Lessons from Nepal

By Dr Terence Teo

The adventurous medical officers:
Front row: Ong Cheng Ean, Moh Yee Hui & two guides
Middle row: Zena Lim, Marcus Tan, Ho Yew Mun, Terence Teo, Bernard Lim, Mark Tan & Nepalese guide
Back row: Benjamin Koh, Nepalese guide, Lim Keng Hua, Vincent Tan & Koh Wee Yao

Although I have not been a doctor for very long, having just graduated in April 2000, I have had my share of both pleasant and unhappy episodes involving patients and their relatives. However, I will never forget the first patient whom I saw, and the lessons that she, and the encounter, had taught me.

It happened in the most unlikely of places – Nepal. Right after graduation, my friends from medical school and I decided to fulfill a life-long dream of trekking in the most mountainous country in the world. We wanted an adventure before starting Housemanship (which is one hell of an "adventure" in itself). We chose the less-trodden *Langtang* trek, a seven-day round journey that would bring us deep into the northern border of Nepal. We were expecting to see plenty of yaks, glaciers, snow, mountains, but definitely not a patient.

We arrived in *Langtang* valley on the third day of our trek, and we expected to reach *Kyanjin Gomba* the next day to see the famous Buddhist monastery and cheese-making done in the traditional way. We arrived on a cold night, and after having a shower (yes, they do have hot showers even in the mountains – they use solar energy to heat up icy-cold mountain water), we settled down to a well-deserved rest in the dining tent. We had our fill, cooked by our entourage, and were preparing for a Nepalese party under the stars. Suddenly, the head Sherpa came bursting into the tent and asked if any of us were doctors. He said that there was a woman in the village who was very ill and needed medical attention. As the organiser of the trip and hence the de-facto leader, I was asked to go. Bernard and Marcus accompanied me.

The distance to the house was short, but the cold and the darkness made walking difficult and arduous. Finally, we arrived at an old building on stilts, with some cattle resting under the raised floor. We climbed a flight of rickety stairs and entered a small hall. The patient was lying on a bed on the right side of the hall, while the family was sitting around a fire on the other side. There were no individual rooms nor curtains to ensure privacy. A moderate-sized central clearing served as a place to sleep. It was certainly a privilege to be standing in an authentic Nepalese village home.

All eyes were on us and there were looks of hope all around: that we foreign doctors could somehow bring about a miracle to help this poor lady. Without equipment that we in modern Singapore had come to expect as a standard, we were unable to measure temperature or blood pressure, or to listen to the heart and lungs. All we had were the knowledge and basic clinical skills taught to us in five years of medical school.

A quick inspection told us that the lady was very dehydrated. The tongue was furred and lips were cracked. Her pulse was tachycardic and tready. She was distressed, and resisted even minimal movement. Her family said that she had not eaten nor drunk for days, and was vomiting bilous content. The abdomen was mildly distended, but soft, and no masses were felt. However, her bowel sounds were absent (I had to place my ear on her abdominal wall). Only later did we learn that she had similar symptoms several weeks previously, and was told by the Nepalese doctors in Kathmandu that she needed an operation. She had declined, as she wanted to return to her home to try traditional methods.

Without an abdominal X-ray, and without any other parameters except for her pulse and respiratory rate, the three of us concluded that the patient was in hypovolaemic shock secondary to intestinal obstruction. The lessons learned from basic resuscitation returned. This patient needed fluids. Her family told us that the village had a dispensary, which was manned twice a year by either a doctor or a nurse. There was a budget for replenishing perishable supplies, but the money would invariably be siphoned off due to corruption.

Bernard and Marcus stayed behind to monitor the lady, while I was tasked to return with the necessary supplies from the dispensary. A villager with the keys to the dispensary accompanied me, and others helped with lights to show the way. Meanwhile, the night seemed to have turned colder in the short span of fifteen minutes that we were in the house. Could it be due to the knowledge that this patient had a poor prognosis, but which none of us dared to voice?

After crossing the fields, and trying to avoid yak droppings, we arrived at an old, wooden shack that passed for an infirmary. The key did not work, so the villagers had to break the lock with a sledgehammer. The room stank, as it had probably not been aired for a long time. With the help of torches, we found our way in the dark dispensary. The cabinet doors were not locked, and some were broken. A quick look around told me that there was no medicine that I could use, as they were either inappropriate, or had passed their expiry

Page 7 ►

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◄ *Page 6 – Lessons from Nepal*

date. I searched for some intravenous fluids and cannulae, and managed to find some fluids that had not expired. However, there were no plastic cannulae, only bare needles. I remembered the time that my mother said she had to endure a needle sticking in her when she received intravenous fluid in the 1970s, and I finally realised what she meant.

I returned to the dining tent first, after I saw that it was actually quite near the infirmary. I updated the rest, and the ladies in our group wanted to help. I thought that that was a good idea as the patient was a female. We quickly made our way back to the patient's house.

The immediate medical management of an intestinal obstruction is 'drip and suck'. We had an intravenous set, comprising the needle, tubing and pints of fluid. Some of us helped to set up the IV set, while I tried to find a vein. However, even with the use of a tourniquet, and after exercising the hand, I still encountered much difficulty. There was no doubt that I was causing much discomfort to the patient, but she was so dry and weak that she did not whimper nor moan. She was too ill to even draw her arm away from the pain.

With the number of doctors around, we began to resemble a medical conference (not that we were of very great minds). Some of us wanted to use the intravenous tubing as a nasogastric tube to help decompress the stomach. Others even wanted to perform a venous cut-down! Thankfully, Keng Hua had the calmness to remind us that as doctors, we should first and foremost "do no harm". Sticking in a NG tube, or locating the great saphenous vein without a proper local anaesthetic and surgical blade, would result in more discomfort and pain. With that timely reminder, we realised the follies of our thoughts and the depth of our inexperience. This is a lesson that I am very grateful to Keng Hua for.

After several unsuccessful attempts, the ladies in our group wanted a go at the veins. Yee Hui, Zena and Cheng Ean were confident that they could cannulate the femoral vein. They were successful at their first try, and the IV fluid started to flow steadily. Perhaps all that was needed was a woman's gentle touch!

Remembering that the first sign of shock is tachycardia, we set up a chart to take the patient's pulse rate at 15-minute intervals to help us determine the effectiveness of the fluid resuscitation. Using our Sherpa as a translator, we informed the family that the patient required urgent medical attention and all we could do was to tide her over for the night. The use of a heli-evacuation was out of the question as these villagers cannot afford it. Even if we had wanted to help, there was no radio contact with the outside world. The only way to transport the patient out of the village was to wait for morning and then carry her on piggyback. But even with their familiarity of the mountains, the men of the family estimated it would take two days to reach the outpost where they would then take a one-day bus trip into Kathmandu!

As it was getting late and we had an early start ahead the next day, we decided to rotate hourly shifts so that some of us could have a rest. I was in the first shift. After the others had gone, we continued to monitor the patient's heart rate and later changed another pint of fluid. Towards the end of my shift, she was able to move and adjusted herself into a more comfortable position. She even managed to mouth a word or two to her family members. Keng Hua returned to replace me and I trod back out into the chilly night, back to my bed to try to find some repose.

Our first patient died that night. She passed away about half an hour after I left her. Keng Hua told us that she had become more lucid, and even wanted to get up to go to the toilet (at least that was what it had seemed to him). Her daughters helped her, lending their bodies to act as clutches. However, she fell to her knees, leaned forward and landed with her head on the ground. In this tripod position, she resembled a person in deep prayer – and one who has finally breathed her last. Her family tried to revive her by applying a greenish paste on her body, a kind of traditional herbal remedy, but she failed to stir from her final sleep.

We heard the news the next day at breakfast. As we ate in silence, the mood was one of sadness and self-reproach. Though unspoken, each of us questioned ourselves. Could we have done more to help? Should we have brought some resuscitation supplies? Could we have been more frank with the prognosis, so that the family could be better prepared? A million other questions flashed through our minds. The Sherpa who was in that *Langtang* house throughout the night told us that the family wished to extend their gratitude. They appreciated the help, and were grateful for our attempts at trying to revive her. They were happy that she managed to say a final prayer and made her peace with her gods.

As we continued our trek to *Kyanjin Gomba*, we passed the house. Villagers and family members had gathered, and the womenfolk were kneeling in front of the house chanting prayers. They were in their traditional mourning clothes, preparing the last rites. We walked on silently.

Langtang Village.

Page 9 ►

◀ *Page 7 – Lessons from Nepal*

I never did get to see the same family again on our way back down. However, I will always remember the lessons that my first patient taught me.

The best instruments that we have as doctors are our hands. The best computer we possess is our knowledge. Together, this synergistic mix becomes a potent combination. Temper this with basic clinical skills and experience, and I can finally understand how doctors can work in backward kampongs and impoverished areas, with little or no laboratory help and elaborate set-ups.

Treating the patient is important, speaking to the family is equally so. The family will always want to help, and by allowing certain practices that will not cause harm to the patient, they can feel that they are in a way also contributing to the recovery process

View of glacier in the background.

(although in this case, not much harm could be done to a person already dead).

As doctors, we should do as much as we can, and as much as our ability and training allow us to. However, we also need to have a therapeutic end-point. Too often in hospital care, we blindly order tests that more often than not, do little or nothing to change the management or prognosis of patients. These tests can be uncomfortable, painful or expensive. Sometimes, choosing not to do anything more is a valid option. Whenever we feel that we must do otherwise, let Keng Hua's timely words spoken on that fateful night in Nepal remind us – "First do no harm." ■

Editor's Note

See pg.8 for a related article by a Senior Consultant in Emergency Medicine.