An Internationalism

"Oho, why so much camaraderie?" I teased Rabi Gurung, a theatre staff as he was walking with a teenage patient with his arm around the patient's shoulder in the manner that "best friends" are wont to in Nepal. I felt rather stupid when I was told that in fact, Rabi was trying to block the patient's view of the two surgeries in the room under way at the time. The images on the TV monitors of the surgery tables could look gory indeed and there was absolutely no point in adding to the anguish of the about-to-be-operated-on patient.

You may be wondering why on earth a patient had to walk past other operating tables to get to his own. This was no ordinary hospital setting. We were in Patan Baitadi, as far west as we could go in Nepal without stepping on to Indian territory. It was mid-November 2010. We had flown into Dhangadi, then travelled overland for 7 hours in hardy Land Rovers to Baitadi. I was part of an ear camp organised by International Nepal Fellowship (INF). INF has been organising medical camps in Nepal for the past 17 years. This year, the ear camp had been preceded by a gynaecological camp. A general surgical camp was to follow ours.

People in Nepal are not unfamiliar with the idea of medical camps. I remember from my childhood Radio Nepal blaring out dates and venues for "vasectomy camps" and "eye camps". Many probably have some idea that medical camps are vital in allowing the rural populace access to healthcare that is normally reserved for people within the Kathmandu valley, especially those with greater purchasing powers. Like in most things in life, economics rules in healthcare, too. A hospital stay can cost hundreds of thousands of rupees even without any major procedure. Health insurance is still rather uncommon, hence one can imagine how bank balance dictates decisions regarding healthcare. Some consult a doctor at the hint of a sore throat. Others wait until they start vomiting blood.

For people outside Kathmandu and towns with teaching hospitals, those with the wherewithal perforce travel to the capital or to India for any serious healthcare issues. Those without suffer the calamities of ill health the way they suffer other problems like malnutrition or social injustice—silently.

Temporary medical camps try to fill in the gaping holes in the health system. Cynics may liken it to a drop in the ocean. How can medical camps solve the vast problems in healthcare provision? But what is cynicism but the lazy person's excuse for inactivity? Had Dr Mike Smith, a British ENT Consultant Surgeon, erstwhile based at the Western Regional Hospital (WRH) in Pokhara, been subjected to a similar cynicism, a sizeable number of patients living in rural Nepal would not have the opportunity to consult medical specialists.

Dr Smith spent two years working at the Leprosy Hospital in Kathmandu as a general practitioner (GP) and eight years in Pokhara at the WRH as an ENT

consultant, establishing the ENT Department. He was/is part of the INF, a Christian mission to Nepal based in Pokhara. Whilst at WRH, Dr Smith conceived the idea of an ENT camp and experimentally headed off to Beni in 1993, with porters carrying his operating microscope and other equipment. At that time, he had no idea how great a need there was for such a service. Since its inception, the size and sophistication of the camps have increased.

The only permanent members of the medical camps are the local INF staff: Eka Dev Devkota (the smiling and ultra-efficient camps co-ordinator), theatre assistants, theatre sanitation staff, and the drivers in charge of four sturdy vehicles. There are hundreds of neatly labelled boxes and plastic barrels normally stored in Pokhara that have to be carted off to wherever the next camp is. From grommets and sutures to the three operating microscopes and two TV monitors, everything has to be accounted for and transported with care. Given the remoteness of the camps, there really is no room for omission or error.

The temporary members of the camps are the surgeons, anaesthetists and other health professionals who typically come to Nepal for a total of two weeks. The camps run for eight days—seven for medical consultation and surgeries and the last day for "after care". A further six days are absorbed in international and domestic travel and procuring Nepali Medical Council (NMC) permits for the doctors. The NMC permit is valid only for the duration of the individual's visa. Hence, if a doctor were to volunteer to come for two camps in the same year, he/she would have to go through the bureaucratic process of the NMC permit all over. Perhaps not such a big deal but certainly an irritant!

Reliant entirely on donations and voluntary service, one can only guess the amount of organisation required to run the camps. For example, if the INF receives an equipment donation in the United Kingdom, bringing it over to Nepal is rarely just a simple matter of handing it over to a freight forwarder. The Nepali government can impose hefty taxes on the import (to get around which requires a lot of running around). Even the rostering of volunteers in different disciplines cannot be all that easy. For example, there has to be not more than one registrar (medical doctor with a minimum of six years specialist training) for every three consultant surgeons (senior specialist surgeons with at least nine years of experience) and a minimum of two anaesthetists per camp.

INF camps are always run in difficult-to-reach places. Before each camp, Eka Dev and his crew have the task of not just scouting the site but also planning the many minutiae. For all intents and purposes, the hospital at Patan was a concrete structure with intact doors and windows as well as running water (for which I felt eternally grateful). The rather basic existing space had to be converted to a working hospital with facilities for fairly complex surgeries. Owing to the unreliability of the power supply, a generator had to be installed. To get around the inadequate number of power points and lights, temporary electric wires had to be put in place. There were different rooms for different purposes. The theatre consisted of three juxtaposed beds, their heights raised by

wooden blocks on their base so that surgeons did not have to stoop too low. There was a scrubbing area where the theatre staff could sterilise their hands. The autoclave room was where equipment were sterilised by diligent INF workers round the clock. In a separate building were the Pharmacy, an Out Patient Department (OPD) and an Audiology area. Disseminating information about the dates and venue of the camp was another important aspect of the workup. The proliferation of FM radio stations around the country would have certainly helped get the message across. As did the growing number of mobile telephony. Despite its remoteness, mobile phone coverage seemed very good in Baitadi and a sizeable number of people seemed to be carrying mobile phones.

Apart from me, all the other volunteers on the ear camp were British. In addition to Dr Smith (who now works as a consultant in Hereford and continues to return to Nepal for two ENT camps a year), there were three other ENT consultant surgeons. It was Dr Ann Dingle's 7th ENT camp in Nepal but the 1st for Dr Joe Grainger, and Dr V. Nandapalan. Dr Ann Dingle is a specialist in head and neck surgery, Dr Grainger in paediatric airway surgery and Dr Nandapalan in skull-based surgery. The supporting anaesthesists were Dr Charlie Collins (a Nepal veteran who spent seven years in Surkhet Hospital and who comes for ENT camps once a year), Dr Jeremy Bewley (this was his 3rd ENT camp) and Dr Jo Riddell (a 1st timer). Sarah Hill, another 1st timer, had come to assume duties as a theatre nurse. Dr Jonathan Moore, a general practitioner (GP) from "Chipping Norton" with a special interest in ENT, was part of the OPD team, peering into a vast number of ears for screening purposes—to decide whether a patient needed medication, ear syringing, counselling, hearing test or surgery. There was always an ENT surgeon on OPD duty if Dr Moore needed a second opinion. Erica Hughes, a nursing instructor who has participated in several different camps in Africa in the past, was in charge of syringing ears. Because earwax could be hiding sinister conditions behind it, it is important to remove the earwax in order to view the eardrum. Being an Audiologist, I worked most closely with Jonathan Binnington, Chief Audiologist at Walsall Hospital, who graduated to becoming the man with a fan following in Patan, and Emma Hooper, a young audiologist from Hereford, whose sweetness never subsided even as she grappled with the severest dose of cultural shock.

Patients would queue up at the hospital from as early as 4 am lest they not get the white "ticket" to see the camp doctors. Initially, 150 tickets a day were issued. As the backlog increased, the quota of tickets dropped to 100 tickets and, on the last day, only 80 tickets. Some patients had travelled very long distances to get to the camp. I met a man who had brought his two young sons from Darchula, a distance that took two days' walking and a day-long drive. These boys from Darchula suffered from frequent ear infections. When their father heard about the impending ear camp, he jumped at the opportunity to consult "ear doctors".

The sheer volume of people was what everyone found overwhelming. A total of 908 patients attended the camp, with 502 hearing tests! We audiologists had two main roles: the primary one being to perform endless hearing tests as a support service for the ENT team and the secondary one to provide hearing aids for those who might benefit from amplification.

Why the hearing tests? Since a large number of patients appeared to require surgical intervention, it was necessary to categorise them into high priority and low priority cases. Clinical decision regarding prioritisation had to be based on the frequency of ear infections, potential risks in case of no intervention and the amount of hearing loss. This is where audiologists came into the picture. All three of us working in the same room (a very communal setting), battling with the language barrier (there were two nurses helping us with translation—even I needed their help at times as not everyone understood my Kathmandu Nepali), trying to ignore the ebb and flow of ambient noise (which included mobile phone rings, people shouting and babies crying). By no means was it an ideal way to perform hearing tests but we could not exactly insist on soundproof booths! We performed subjective tests on ourselves in order to apply correction factors (especially relevant in the lower frequencies which are most affected by outside noises). We rapidly learnt to work the best we could within the existing conditions.

Our task alternated between being frustrating, fatiguing and funny as we struggled to work through the ever-growing pile of hearing test referrals. Most patients seemed to be totally baffled by the concept of sound being delivered by the headphones to each ear separately. Many tried to push the response buttons into their ears. After a few days, I worked out that that raising their arms in response was simpler for patients to master than the button-press. Some locals pointed out half-jokingly that the raised arm looked not unlike the Maoists' red-salute. Not knowing the political lay of the land (represented in parliament a while ago by a royalist ex-prime minister and now by two members of the Maoist party), I chose to ignore such comments. In a normal ENT setting, a hearing test may take up to 20 or 30 minutes, depending on the type of hearing loss. There was no way we could luxuriate with that length of time for each patient. We made a clinical decision to test only four frequencies instead of six.

The patients who came to have their hearing checked were a motley lot, from a 94-year-old granny to a year-old child. Some were smartly dressed, others turned up in clothes that were falling to bits with wear and grime. There were teachers, farmers and labourers. What struck me hardest was how

malnourishment and the harshness of life had obviously made some 17-year-olds look like 10 and 40-year-olds look like 60!

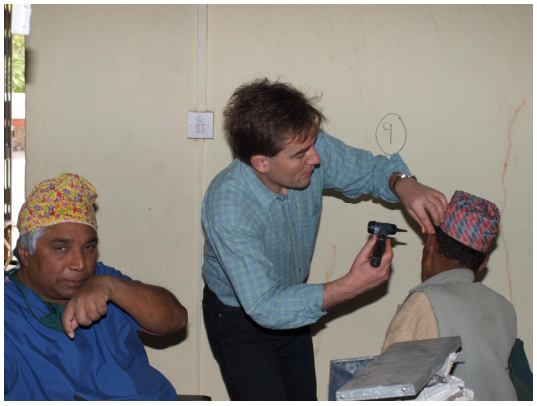
If someone looked like a hearing aid candidate, we had our own style of "Glasgow Hearing Aid Benefit Profile" whereby we asked if they could understand family members in a quiet setting and if they could hear the radio (or TV in some cases) at normal volumes. If they answered in the affirmative to these questions, we would explain to them that their hearing was too good to benefit from hearing aid amplification. This approach may sound haphazard to some but we had to rationalise costs and benefits. We had no dearth of donated hearing aids (both analogue and digital) but lacked time for a "proper" hearing aid fit. In a normal audiology setting, each fitting session is allocated 45 to 60 minutes! That is with earmoulds already manufactured to fit the shape and size of the individual earcanal. In Baitadi, both Emma and I thanked our stars that unlike us who have been trained only to take ear impressions, Jonathan possessed the skills to make the moulds himself. I had a go myself under Jonathan's guidance but decided that mould-making was not my forte after I lost a lump of flesh and nail on my left index finger in the process. Thus, whilst Emma and I did the hearing tests, Jonathan became the "hearing machine" guy.

He always had at least ten patients watching him with a mixture of wonder, admiration and incredulity as he machined away the silicone moulds to near-perfection, all the time singing with jollity or delivering soliloquies. The number of patients waiting did not appear to faze him as he selected hearing aids according to the individual's hearing loss. Yeshu (the fabulous translator) helped him go through instructions for care and use as well as expectation and acclimatisation issues.

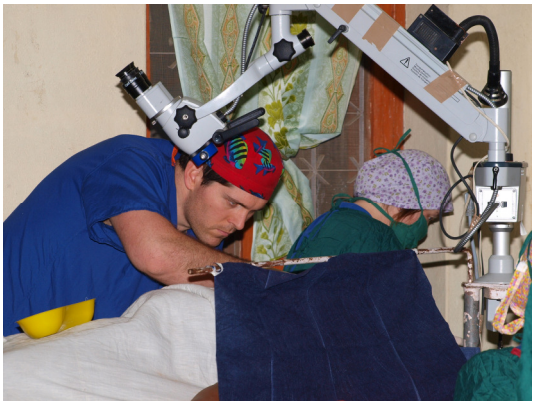
At least 20 aids were issued each day, a feat that would have not been possible without Jonathan's skills and "Never say no" attitude as well as Yeshu's help. There were precious snippets of joy such as when a woman cried as she heard sounds (actually Jonathan's not-so-tuneful whistling) for the first time in many years. But we also experienced great sadness when we saw children as old as 10 with a profound hearing loss whose parents had brought them to the camp with the hope that surgery or hearing aids could do something for them. I personally found it heart wrenching to explain that their level of hearing loss was unlikely to benefit from hearing aids and, in any case, they were past the age of spoken language acquisition. The most useful advice we could give in these cases was to enrol these children at a government-funded school for the deaf in the area so that they could at least have a hope of achieving some level of literacy. We also advised them not to waste money on

medicines. One of the children had been prescribed some tablets by some doctor in Kathmandu in the past, supposedly to cure nerve deafness.

After the hearing tests, patients went back to the OPD where the next course of action was decided. Some were placed on the waiting list for surgery. A whopping 126 surgeries were undertaken in 7 days. Patients who were on the waiting list but could not be operated on were told to come to the next camp (to be held in February 2011 in Darchula) at the very beginning with all the paperwork from the present camp so that they could be fast-tracked for surgery.

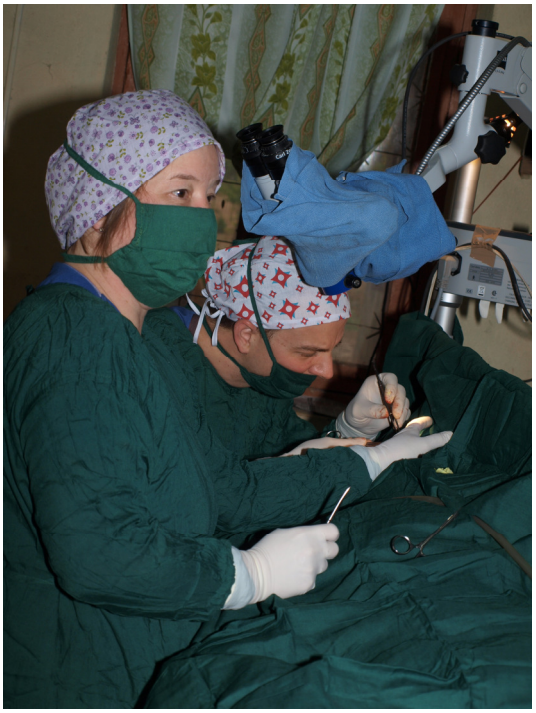


The surgeries were categorised into major and minor surgeries. Myringoplasty (repair of the eardrum) which took about an hour to perform was categorised a minor surgery. Mastoidectomy (whereby the infected portion of the bone behind the ear is removed) and ossiculoplasty (whereby the little bones in the middle ear are repaired) took 2 to 3 hours to perform and were categorised as major surgeries. A patient who presented with a hoarse voice was found to have a tumour in the throat which was removed and sent to a laboratory for analysis so that she could be advised for any further treatment necessary. This last case was the only one requiring general anaesthesia. Otherwise, all the surgeries were performed under a combination of local anaesthetic and sedative (in addition to Ketamin for a small number). During surgery, the patients seemed to be in a state of sleep on the verge of wakefulness. The anaesthetists had the difficult job of maintaining this fine balance at all times.



The surgeons and all theatre staff worked marathon shifts. There were three operating tables being worked overtime (the 4th surgeon being kept busy on OPD duties). Surgeries continued well into the night, sometimes finishing at 9 pm. No doubt it was back-breaking work for the surgical team and made us OPD team feel that we had the lighter deal. I was most impressed that despite the late finish, the surgical team were still able to be ready by 9 am for another day of hard work. As Jo, the ever-cheerful anaesthetist put it, “That’s what we came for!” I have no doubt that had the camp extended longer, it would have been impossible to maintain the momentum.

Thus the surgical team swam uphill to repair the ravages of ear diseases that had been allowed to run thus far. Ear disease may not sound as serious as, say, cancer or heart disease. But ear diseases can also kill people. For example, if the infection on the bone behind the ear (cholesteotoma) is not removed, it could potentially lead to meningitis and death.



The last day of camp was when each single patient who had undergone surgery was required to come back for a change of bandages. With the sea of people walking around with bandaged heads, the place looked like a war zone. Patients and their family were instructed to gather at the courtyard for instructions from Dr Smith (via Eka Dev) on the after-care procedures and follow up. I was impressed by the cleverness with which the camp organisers had obviously got around the problem of patients being potentially illiterate. People who had undergone major and minor surgeries were given different coloured folders, red and blue. At the very onset, Eka Dev would say, "Okay, people with red folders, this information is for you," so that people knew which information was relevant to them.

This aftercare instruction session seemed to go on for a long time, almost two hours. This was understandable given that even very basic things had to be covered, such as how to use the lid of the ointment tube itself to puncture a hole in the tube. Most people seemed relieved that the stitches used would just dissolve and not necessitate a visit to the local

health centre. They were also told to contact their local health centre and the INF office in Pokhara in case of any post-surgical complications. INF commits to organising these patients to be seen at the WRH in Pokhara. All the patients were asked to attend the next camp in February for follow-up. Of course, many of them may not do so. The next camp may be too far away for some and others may think that the surgery itself is the end of the story.

The lack of follow-up is a criticism some may throw at the camp but the way I see it, the organisers are trying to make the best of a bad situation. That the camps move from place to place may make follow-up visits difficult but is important for those who may not be able to travel very long distances. Some may view these camps as band-aid solutions. However, unless the state is effective in giving access to necessary primary and tertiary healthcare service to its citizens, not just those with financial means, the camps seem to be the only idea around.

I was personally very touched and impressed by the level of commitment I saw in the different individuals who had come together for the camp. Being Nepali, I could justify tying it in with my annual visit to my family. Who were these other people who worked so hard with minimal complaints about the living and working conditions? After all, they were living in local lodges with very basic facilities. Apart from a water filter installed by INF, there were no special

provisions. I heard stories of how people on previous camps had to sleep on the floor in barns! We were relatively lucky to have a bed and a squat toilet.

Allegations are often made about medical/surgical camps in Third World countries being practising grounds for novice doctors. I cannot speak for all camps in Nepal but I can say from first-hand experience that the doctors at the INF camp I attended were NOT fresh graduates who came to try out their hands on the hapless poor of Nepal. I doubt that a world-renowned surgeon like Dr Nandapalan or a rapidly rising star like Dr Grainger (one of only four paediatric airway specialists in the whole of UK) would risk their professional credibility by taking part in a "cowboy" camp!

Some people may be under the impression that charities like INF have deep pockets and pay the doctors and others to attend. Apart from the regular INF employees, everyone was there as a volunteer, paying for their own airfare and board. More importantly, these volunteers had used their precious annual leave to come. I often wondered what their motives may be. INF being a Christian mission, one could just call it "one of those crazy things missionaries do." However, the volunteers ranged in religious belief from deeply committed Christians to secular Christians to a secular Hindu to an atheist. At the best, these people might receive a smile or a coy "Thank you" in return for their effort. At the worst, their work might be dismissed as a conscience-washing exercise (although writing a cheque to charity would have been infinitely easier)! I personally saw the whole effort as a sort of internationalism whereby, for whatever reason, people had come to help total strangers.

- Jyoti Thapa