A reflective account of a dental elective in Pokhara, Nepal

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Introduction

Dental electives have an impact in the communities in which they take place and also hold value for the students, both academically and personally. The aim of this account is to reflect on our visit to Pokhara, Nepal, and the opportunities that accompanied this, whilst discussing the differences between dental practice and dental health in the UK and Pokhara.

Why do an elective abroad?

Alongside observing the differences in dental diseases and practices, the travelling aspect of an elective abroad encouraged us to gain independence. For example, we were forced out of our comfort zones by immersing ourselves into a new environment with language barriers and cultural differences. Consequently, we feel that we are now more confident in our practice and when we approach colleagues in the dental profession, regardless of communication difficulties.

Additionally, we had the opportunity to meet other healthcare students from all over the world in the elective accommodation. This has led to long-lasting friendships, as we explored the city together and created memories. Furthermore, we had the opportunity to learn about each other's exciting experiences in the hospital, discovering how hospital care is carried out in different departments.

Why did we pick Pokhara?

Pokhara is situated in the Himalayas, which provided stunning scenery and trekking routes, making our experience even more memorable **(Figure 1)**. The people and the city are extremely welcoming.

Figure 1. View from the Work the World accommodation.

We decided to undertake our elective for 2 weeks in Manipal Teaching Hospital in Fulbari, Pokhara, Nepal, through Work the World, a company that organises healthcare-related electives. Manipal Teaching Hospital has 750 beds in order to provide tertiary care to all members of society.[1]

This placement specialised in maxillofacial surgery, which allowed us to witness rare dental diseases that are uncommon in the UK. According to the 2009/2010 Annual Report by the Government of Nepal's Ministry of Health and Population,[2] in Nepal 392,831 citizens suffer from dental decay or toothache. In addition to the 73,309 suffering from periodontal diseases, 62,747 have other tooth disorders and 113,819 have oral ulcers, mucosal lesions and other related diseases.[2] These statistics are significantly higher than in the UK.[3] Through this placement, we believe we made an impact by contributing to the treatment of dental diseases within the community.

What we saw and learned

We were overwhelmed by the contrast in the way that care was provided at the hospital, as compared with the UK. The first thing we noticed was the lack of cross-infection control in a particularly small working environment. There were three active dental chairs in a small room **(Figure 2)**, with the dentists sharing burs and endodontic files between patients. This was particularly shocking for us as these are single-use instruments in the UK.[4] We had to accept that this was the norm in the practice in Nepal due to a lack of funding.

Figure 2. Three-chair dental surgery.

As our entire UK curriculum is centred around prevention,[5,6] we were surprised to witness the drive for intervention of dental disease over any preventative measures. In addition to this, the intervention was only provided once the patient had paid the full fee, regardless of the pain or extent of infection. This was upsetting for us, as we struggled to turn away patients in pain; this would not happen in the NHS.

Moreover, the importance of communication with the patient was overlooked and no shared decision making was carried out. We considered this to be old-fashioned dentistry and were taken aback by the lack of discussion about treatment and the risks involved. This seemed foreign to us as we are expected by the General Dental Council (GDC) to carry out patient-centred care and to gain valid, informed consent.[7]

With regards to the maxillofacial department, we were fortunate to witness 'textbook' diseases that we would not frequently see in the UK. Some examples, which were significant to us, were a buccal space infection, a haemangioma of the tongue and trauma.

The buccal space infection was caused by a self-conducted extraction of two molars using a screwdriver under no anaesthetic. This patient resided in a remote village and they could not afford to attend the hospital to have them removed. We were stunned by their circumstances and it was distressing to see the extent of their pain and learn of the financial burden caused by having to pay for a hospital bed. However, from this, we had the opportunity to help the consultant drain the buccal space infection over several days, which meant we were able to see the patient's improvement throughout our time there.

Furthermore, we had the chance to be present in the operating theatre whilst the excision of a haemangioma was carried out on a child **(Figure 3)**. This enabled us to witness the entire surgical procedure from start to finish, including general anaesthetic administration and follow-up care. This was something we could not have predicted we would have the opportunity to observe, but found extremely valuable.

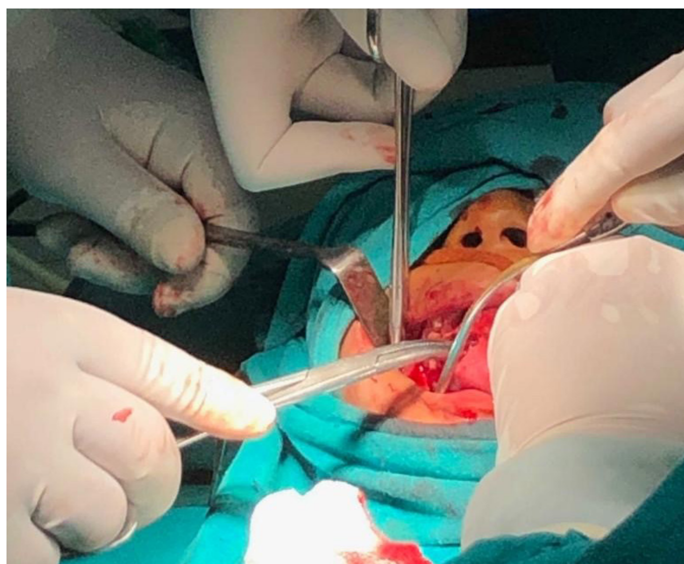

Figure 3. Exclusion of haemangioma.

On our final day of the elective, a patient presented in the Emergency Department with multiple injuries from a road traffic accident. Whilst several consultants were conducting their assessments, we were lucky to closely observe the maxillofacial consultant conducting inter-maxillary fixation openly in the emergency room. This was the most memorable case as we were aware that these injuries are more prevalent in Nepal due to high motorbike use in comparison with the UK.[8,9] As dental students, we rarely encounter procedures like these during our time studying. Hence, observing this was invaluable to our learning as it applied what we only get to learn in theory.

What we took away from the experience

Personally, we both feel that our knowledge, management and problem-solving skills were enhanced greatly by witnessing varying cases; we are now more confident to apply these new skills to our practice, whilst treating patients as students.

On the other hand, the benefits were not purely academic. Travelling to a new country allowed us to mature in multiple ways, such as having the confidence to navigate ourselves in a foreign country. We were also able to completely immerse ourselves into a new culture by learning the language and cooking local cuisine as part of the Work the World scheme.

Conclusion

In conclusion, this experience encouraged us to grow as individuals by pushing us out of our comfort zones and understanding the difference in dental care in a less developed country as compared with the UK. We have noticed the influence on our academic, clinical and personal lives and appreciate that the elective is responsible for these changes.

This account is a reflection of our elective and there is plenty of scope to extend the experience further, such as conducting research on the prevalence of dental disease in the country that you choose to do your elective, or providing care in remote villages.

Therefore, irrespective of where, what and how you conduct your elective, from students-to-students, we highly recommend considering any opportunity to carry out one.

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