EDITORIAL

Life After BMH Dharan

The British Military Hospital in Dharan, Eastern Nepal, had a special place in the hearts of those AMS personnel who served there. They probably worked harder than at any other time in their Service lives and saw new and unfamiliar pathology in large quantities every day. It was a means of keeping up the historical reputation of the RAMC in practical as well as academic tropical medicine. Above all, it gave a special relation with the Gurkhas, as warm, friendly, hospitable and interesting a group as can be found anywhere in the world. The hospital was used by serving and retired Gurkhas and their families and, indeed, by Nepalese from the whole of eastern Nepal. Sadly, the demand was so great that potential out-patients had to be screened daily and some turned away so that the crowds could become manageable.

Foreshadowing BMH closures elsewhere, the decision was taken to withdraw from Dharan in 1989. The hospital was then operated as the Eastern Regional Hospital for HMG Nepal by the ODA with a mixture of British and Nepali staff, intending to hand over fully to the Nepal Government. However, a further change in direction came when the hospital became the BP Koirala Memorial Institute of Health Sciences, which opened a fully-fledged medical school in October 1994. There is a good deal of Indian co-operation and many Indian doctors, though the Medical Director is Nepali.

Replacing BMH

After the closure of the BMH it fell to the Gurkha Welfare Scheme (GWS) to fill the medical gap as far as possible for the ex-servicemen and their families. In 23 Area Welfare Centres in Nepal are Medical Rooms manned by Medical Assistants. Some of these are former RMAs, others have not served in the Brigade, but all have been trained as Auxiliary Health Workers in the DEMPTS programme based in Dharan. They give primary care and health teaching to the local ex-Gurkha population, and in particular to the Welfare Pensioners. These are the many ex-Gurkhas who left the service on redundancy with no Service Pensions, especially in 1947 and 1967. At a cost of £1.4 million a year, GWS provides a small pension to help those who have been struggling to survive in the harsh hills. It is hard to overcome the misconception that all ex-Gurkhas have a Service Pension and are wealthy.

In most of the AWCs, GWS employs a part time doctor for about an hour a week to treat the most difficult cases. Usually, he is the doctor at the nearest District Hospital. These are established for three doctors, but in practice usually have only one or none at all.

The Health Services in Nepal are developing rapidly, but not necessarily in a balanced manner. In Kathmandu, there is a Teaching Hospital and another central hospital which have quite advanced technology; CT scan, echocardiography, neurosurgery, intensive care, renal dialysis and so on. The problem is the lack of infrastructure, including basic cleanliness, equipment maintenance and support facilities. An example is the plan to set up a centre for open heart surgery at a time when there is virtually no access to reliable prothrombin time testing. Sadly, too, the lack of resources for public health care means that the best work is done in the private sector, with many “Nursing Homes” (which are really private hospitals) springing up in the main towns. Though fees are extremely low by Western standards (about £1 for a consultation), the effect is to exclude the most needy from the best standards of care. Outside of the capital and a few other centres, the facilities are very basic and doctors are few. Health care falls on Health Assistants and other paramedical workers in poorly equipped and supplied Health Posts.

Problems

In 1993 the Brigade of Gurkhas and Gurkha Welfare Trust (GWT) realised that they had a number of problems in the area of medical aid. On the GWT side, the only medical supervision in the AWCs was being provided by occasional medical trekkers and the local doctors. Medical assistants were receiving no in-service assessment or training and their medical records and drugs lists left a lot to be desired. Many ex-service men and family members were receiving drugs prescribed many years before near the end of service without any on-going medical supervision. For example, it appears that three patients had been taking amiodarone regularly at GWS expense and never being seen by a doctor. Area Welfare Officers were re-imburasing some patients for medicines bought in the nearest bazaar, but there was no control and plenty of opportunity for abuse.

Meanwhile, the Brigade was trying to cope with another medical problem. Over the years, means had been found to transfer to Hong Kong any Gurkha soldier with a serious or chronic medical condition in the family, so that the patient could be cared for by the BMH and local hospitals plus strong local support, including a Special Education Unit for handicapped children. With the planned drawdown of the Brigade and final withdrawal of virtually all troops from Hong Kong by October 1996, it was clear that large numbers of these long term sick were to be unloaded onto the limited social and medical services in Nepal. Just to quote a few examples:

- twins with pyruvate kinase deficiency requiring regular blood transfusion and iron chelation.
- post kidney or liver transplant patients requiring cyclosporin and other immunosuppressants (costing £2,000 or more each per year).
- patients with artificial heart valves (control of anticoagulation?).
- children with shunts for hydrocephalus (what happens if they block?).
- a girl with SLE on regular dialysis.
• a soldier with aplastic anaemia.
• paraplegias following RTAs.
• many physically and mentally handicapped children.
• inoperable cyanotic congenital heart disease (what will happen at high altitude?) . . . and so on.

How could they best be cared for by the limited facilities in their own country and, given that there is no entitlement for ex-Gurkhas to be treated at British Government expense, who would pay for it?

An unusual posting

This is the background to the request for the post that came to be known as Senior Medical Officer (Temporary Manning Attachment) British Gurkhas Nepal, for a limited period initially of one year, later extended to about 16 months. He was to head a new Medical Cell which, according to original planning, was to have 9 members. However this shrank to 4 full time and one part time and then 3 and a half. Having spent 17 years in Nepal, speaking Nepali and with experience of practising medicine, teaching in the Medical School and directing a hospital in Kathmandu, I suppose I was a natural choice for SMO. I was extremely fortunate that SSAFA sent an experienced sister, Andrea Doolan, to work with me and she was happy to take charge of the family problems and the arrangements for the handicapped while I concentrated on specific medical problems, AWCs and developing plans for the future. Mohan Rai, who had worked at BMH as a Medical Assistant, and a part time SSAFA clerk, Bimala Gurung, completed the team apart from two temporary Gurkha Clerks.

The Medical Cell task resolved itself into three main areas:
• Upgrading medical care at AWCs.
• Finding better ways of helping long term sick.
• Helping returnees to find the best sources for medical care.

AWC Medical Care

My function was both to advise GWT on ways of improving the service and to introduce at least those changes that did not involve high expenditure. Some were very obvious; improving medical record keeping, adjusting medicine and equipment scales, providing suitable textbooks and drug information and, above all, arranging regular annual refresher training. It was possible to provide this through my old friends in the Lalitpur Community Development and Health Project based on Patan Hospital. The first year’s training consisted of two weeks of classes, demonstrations and hands-on experience, both in Patan Hospital and in associated Health Posts in rural areas. It is hoped in future years to provide training in basic dentistry and oral health, enough laboratory skills to do simple tests and, possibly, mental health.

Another old contact enabled me to identify a much improved source of good quality medicines for the AWCs, at a much reduced cost. As these come ultimately from charitable sources in Europe, and are imported duty free, there were some lengthy negotiations with the Ministry of Health to establish eligibility to make use of this facility, but it was time well spent.

Visits to the AWCs were always pleasant. They are tight-knit communities of (usually) four men who share all the duties and household chores and keep the ground immaculate and productive with pigs, buffalo, rabbit bees and vegetables as well as flowers and attractive shrubs. On Welfare Pension paying days, they are extremely busy and the staff also spend a good deal of time on tour investigating events such as landslides and house fires and assessing the need for help.

The Long Term Sick

It soon became apparent that the long term sick were receiving a very uneven and unjust service. Some, by “fiddle”, had managed to get themselves supplied with MoD medicines to which they were not entitled, others were receiving partial or full refunds of the cost of doubtful locally purchased medicines and some were being treated free from AWC stock. Some were getting no help at all and few had proper medical supervision. It was necessary to establish the principle that long term sick had is a hardship in itself and to develop a process for providing long term medicines free of charge through AWCs with proper financial and medical supervision.

Costs of this can be met through a Medical Subvention from MoD given to GWT, though special provisions will be required for the more expensive cases, such as post-transplant patients.

Very simply it was a matter of developing and matching two databases. One was of patients already in Nepal and expected to return, detailing their needs in terms of facilities and drugs. The other was of the available facilities. Sister Andrea concentrated on the handicapped, Community Based Rehabilitation units, Association for the Welfare of the Mentally Handicapped, schools for the blind, deaf and handicapped, physiotherapy and so on. I investigated the facilities in various hospitals in different centres. In this way, we built up the information needed to advise families where the child should go for the best available care and we referred them by letter or accompanied them personally. Not that everyone took our advice. One child with cerebral palsy was taken almost immediately to the far east of the country and put under the care of two different types of witch doctor, the dhami and the jhankri. So far as we know he is there still and not receiving the physiotherapy which we believe is his best hope of an active life. Some families turn up their noses at facilities they see as inferior to those in Hong Kong. Others seem unwilling to spend even modest amounts of money on their children’s care, having come to expect it all free. However we feel we have been able to help some, including recommending financial help for those who need it most.
Families anticipating return to Nepal with their medical problems experience great anxiety and, indeed, resentment that they must leave the security of Hong Kong. It is now possible to give them at least a degree of reassurance that there is a Medical Cell to help them, sometimes meeting them from the aircraft, and to guide them in the medical aspects of resettlement.

The future

There was never approval for the SMO(TMA) post to be permanent. However UK Land has agreed to fund a full time locally-employed Civilian Medical Practitioner to take over medical care for entitled personnel in British Gurkhas Nepal and also to supervise the return of sick servicemen and families and the medical aid of GWS, including the Welfare Centres. Of 65 applicants, 8 were shortlisted and I am happy to report that the Selection Board was unanimous in appointing one of my former students. The SSAFA sister will stay at least until all the families have returned from Hong Kong, Mr Rai will stay on and some clerical support has been promised.

So it looks as if I shall be the last RAMC doctor to be posted to Nepal and even the cherished Medical Treks may have to be given up. Of course it has felt like living in the shadow of BMH Dharan, but that is lost forever and no arrangements can fully compensate for its loss. On the other hand, medical care has been taken closer to the homes of the ex-servicemen and primary care is more convenient for them. I doubt if much further progress can be made until the general standard of health services in Nepal can be raised.

JG DICKINSON

ACADEMIC ACHIEVEMENTS

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<tr>
<td>FRCOphth</td>
<td>Major AS Jacks, RAMC</td>
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<td>FRCS(Plas)</td>
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