CAMBODIA ILA

"Medical Tourism – Turning it Around and What to Expect Whilst You're There"

Abstract

Coming into the Sydney Medical Program I set out push myself beyond my comfort zone and experience as much as I could. I selected the Cambodia ILA because it was unlike anything I had undertaken in my first degree and it would enable me to experience healthcare in a developing world environment. I must admit I did not spend much time considering how I would be able to give back as much as I thought about what I could gain. That is what most first year medical students think about, especially with overseas placements. Also the opportunity to perform duties beyond their capabilities, because let's face it, at this stage we all just want to cut, suture, inject or withdraw something from our patients. For my sake and the sake of my patients I was glad that the National Pediatric Hospital, Phnom Penh is a large teaching hospital. I certainly didn't get to perform outside my capabilities but I did manage to learn an insane amount in my 4 weeks there. I felt like I took a lot (the essence of being the dreaded 'medical tourist'), but then by chance my time coincided with a visiting American surgeon and I got to give back in a way that will hopefully serve the future doctors of Cambodia for many years to come.

The National Pediatric Hospital, Phnom Penh is a government hospital built in 1974 by World Vision International. It was closed down during the Khmer Rouge Regime (1975-1979) and reopened in 1980 with 75 beds. Today there are 150 beds. The three main departments are General Medicine, Surgery and Outpatients Department (OPD). Each day some 350-400 children present to OPD and pay 6000 Riel (US$2.50) for a medical record booklet and consultation with a doctor. 25-30 children are admitted daily, the most common ailments being diarrhoeal illnesses, respiratory tract illnesses (TB, pneumonia) and Dengue Haemorrhagic Fever (peak admissions during the wet season). I chose to spend my 4 weeks in "Department de Chirurgie" as I

have an interest in orthopaedics and the head of department, Dr. Chhoeurn Vuthy is an orthopaedic traumatologist.

Dr. Vuthy is a good man, salt of the earth. He is friendly, easy going, family oriented and often likes to laugh out loud. He has a passion for his work, he said many times that he “loves working with children” and that he “loves orthopaedics because you can do a knee operation one day and a hip the next. There’s so much variety.” Dr Vuthy’s passion must run deep, it has to considering he only gets paid US$100 per month. So that he can live and support his wife and two sons Dr. Vuthy sees patients in his private rooms at his home before and after his hours at NPH. Such is the life of medical doctors in Cambodia. Although their title gives them unquestionable respect by patients, parents and staff, they certainly do not enjoy the same lifestyle that doctors would in Australia. A typical day for an NPH surgeon starts with the 8am Surgical Team meeting – much like case conference meetings we do in Australia. At 9am the department splits into 3 teams; wards, surgical outpatient clinic or the OR team. Usually work is finished on the wards and outpatients by 11:30am and most doctors disappear. We later learnt that these doctors go to their private rooms where they see patients to supplement their income. The OR usually does 2-3 operations and finishes around 1pm. Dr. Vuthy then does paperwork or lectures and then goes home to start his private rooms in the evening.

I had the chance to see so much during my placement at NPH and I was fortunate to also see a lot of the country. What I got out of my time, upon reflection is an understanding of why things are the way they are. I want this essay to explain some of what I saw (as well as fulfill my student learning contract!) and hopefully prepare future students who plan on visiting Cambodia. In order to do so however it is necessary to have a brief understanding of Cambodia’s recent past.

The Khmer Rouge Regime (also referred to as Pol Pot Regime among other names) overthrew the reigning government in 1975. Their plan, led by Pol Pot, was to return Cambodia to an agrarian society – to be completely self-sufficient. Cambodians living in Phnom Penh at the time were told that the Americans were going to bomb the capital and that they should leave the city.

Citizens were then told they could not return to Phnom Penh and that they had to walk to the rural towns where their families originated. Most were not prepared for more than a few days walk and many died on the way. Educated people were sought out and executed as were any other perceived threats to 'the organisation' (known as Angkar). In total more than 2 million people were executed during the Khmer Rouge Regimes time in power. It is hard to believe that such a radical, almost senseless idea of reform only took place 30 years ago. What is even worse is that only 15 doctors survived the regime. During the period of 1975-1979 medical care reverted back to 'old remedies' such as making pills out of grass, herbs and cow dung. Cambodia, really only one generation later, is now having to rebuild its medial system to bring it back from the dark ages.

Medical education resumed in 1980 with the aid of overseas organisations. Dr. Vuthy was one of the pioneers post Khmer Rouge Regime. He graduated in 1988 and was one of 6 doctors who got to travel to Belgium for their fellowship. They were the start of a new generation of doctors who were charged with the responsibility of helping to rebuild and redesign Cambodia's medical education system. Dr. Vuthy is trying to set the standard at NPH and other regional hospitals he oversees. Some surgical centres have 3 operating beds side by side in the one OR. Although they operate on more patients per day than at NPH, Dr. Vuthy, quite reluctantly (because he does not like badmouthing people) admits it is not an ideal situation. Moreover for the training surgeons who have not been overseas, he does not want them to think that this is 'best practice' in surgery.

Dr. Vuthy states that he wants Cambodia to have Cambodian doctors. Whilst it is helpful having overseas doctors come in and help, he does not want 'parachute doctors' who fly in, do their work and then leave without passing on any knowledge or training to the local doctors. A perfect example of this was a French team who donated an anesthetics machine, however they did not train the local anesthetists on how to service or maintain the machine. Within the first day of being in the OR I noticed an alarm sounding every 2 minutes. I asked the anesthetist who explained they did not know how to fix the machine, so they keep pressing the 'silent' button, which buys them 2 minutes

before the alarm sounds again. The complete opposite of this is Dr. Keith Gabriel. He is an American Associate Professor from Southern Illinois University with a background in paediatric orthopaedic surgery. Dr. Vuthy visited Dr. Gabriel and his now retired business partner in the US and since then Dr. Gabriel has been making annual visits to NPH, usually bringing with him as much equipment and supplies as he can carry.

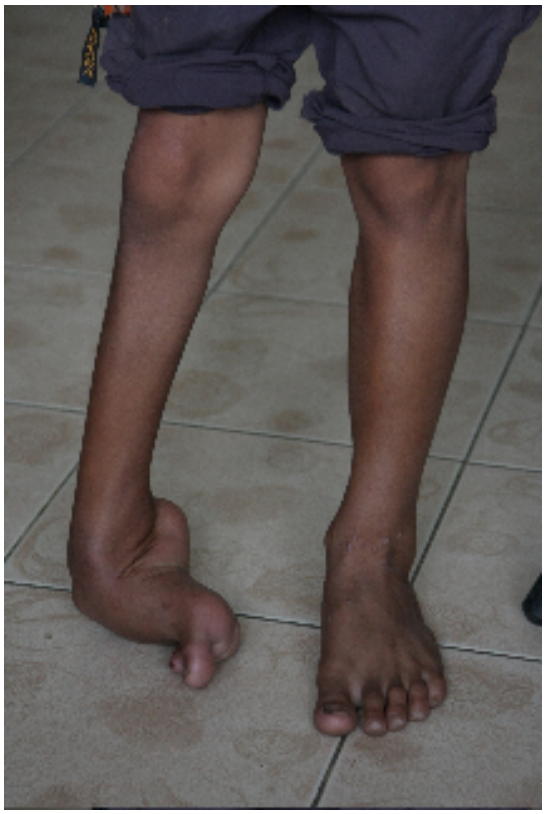
One of my passions is photography. I have a Canon digital SLR which I brought with me for the 'travel section' of my holiday. I intended to only take a few shots around the hospital, being wary of the University of Sydney's policy on taking photographs of patients. However upon seeing my camera Dr. Vuthy asked if I could take photos of some of the surgeries he and Dr. Gabriel were doing. It turns out that many of the surgeries Dr. Vuthy had lined up for Dr. Gabriel were cases at the more difficult end of the spectrum. For example one case was of a patient with a 'one in a million' tibial hemimelia (grade IV). I saw this as my way of giving back – leaving a good footprint. Hopefully in years to come the surgeries that I documented, step by step will be used to educate and train the future surgeons of Cambodia.

As I mentioned earlier, this placement is not so much about performing procedures outside the realm of a first year medical student. From a hands on point of view I only scrubbed in twice. This placement is more about seeing how the medical system works in Cambodia, or NPH specifically, and how, with the help of NGO's they are being accelerated back into the 21st century.

One doctor from the US who visits another Surgical Centre said 'the waiting room is like the bar scene in Star Wars… The deformities are larger, patients younger and equipment older.' Many of the deformities I saw are because screening programs either do not exist or, more often, people are so poorly educated or just plain poor they don't know any better or don't have the money to travel to access free services.

Case 1: Talipes Equinovarus (clubfoot)

In some patients (as old as 19!) walking on their cuboid. This particular 19 year old also had a dislocated right hip since birth (congenital hip dysplasia) which was only picked up when he was preparing for his foot surgery.



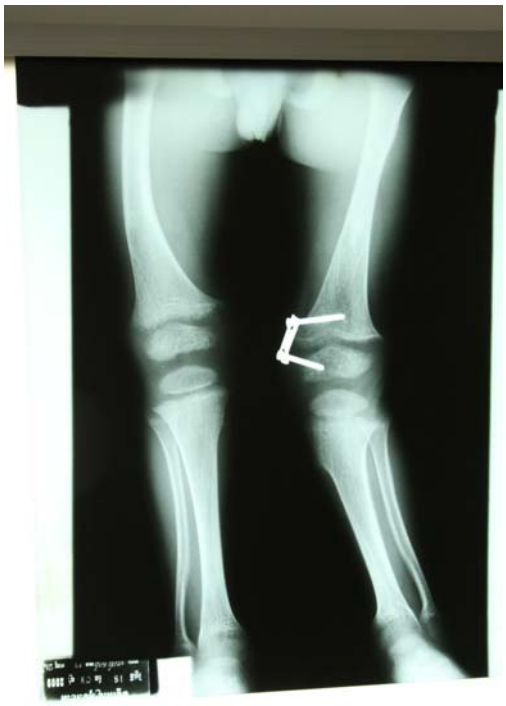
Case 2: Cleft Lip & Palate

In Cambodia people burn their rubbish at the end of the day, exposure to this smoke is teratogenic. Also pharmacies post Khmer Rouge Regime give out medications without prescriptions, this includes anticonvulsants, which can also cause cleft lip and palate. Dr Long Vanna works for The Smile Train, a free service for people of all ages to have their cleft lip and palate repaired.

Photo courtesy of Dr. Vuthy

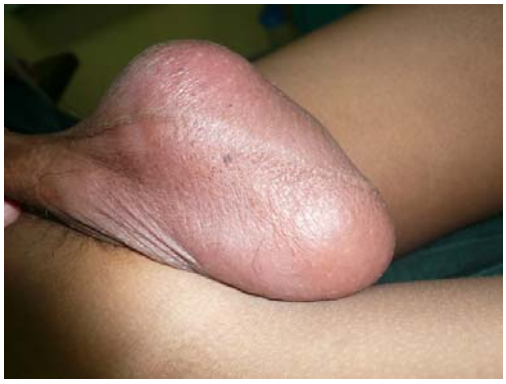
Case 3: Rickets Disease, Achondroplasias

The importance of calcium supplementation is not widely known. As a result many children suffer from Rickets. Following on from this, many surgeries involve osteotomies, K-wires and 8-plates to straighten knees which are in genu varum or valgum.



Case 4: Torsion of the testis

My first scrub in. A 13 year old came in with 6 days pain and swelling in the scrotum. Unfortunately he did not know this was a medical emergency (>6 hours and the testicle is not salvageable).



Two questions I kept asking myself were why is this so? And why is there such an inequity? The answer is complex, and I am sure I don't understand all of it. However I have tried to come up with some causes.

1. No Money

I. The patients are poor. In many cases they cannot travel from the rural areas to the city to access free services. Those that can (approximately 10%) interestingly are accommodated in V.I.P. or 'P' for private rooms, 2 per room as opposed to 2 per bed on the ward. As stated in a BBC documentary on the Children's Surgical Centre, Phnom Penh, "like in developed countries those that can afford treatment do not have much wrong with them."

II. The doctors are poor. Imagine what the rest of the hospital staff get paid if the head of surgery gets US$100 per month. The only way for them to survive is to work privately. Hence the reason why many students are shocked when they find their days are only busy from 8am to 12noon. That being said, there is always a doctor left on duty and OPD usually had 2 doctors working in the afternoon, instead of 6 like in the mornings. I think my stay in surgery was a lot busier because of Dr. Gabriel's visit. We would often be in surgery from 9am to 5pm or even later. As mentioned many of the surgeries were difficult cases Dr. Vuthy had been 'saving up' for when Dr. Gabriel arrived, some took 5 hours to complete.

III. The hospital is poor. Equipment is 'begged, borrowed and stolen,' or sometimes there is no equipment at all. Some examples include suturing skin with large needles, because there are no smaller ones available. Using expired sutures which snap when pulled too hard. Dr. Vuthy has been using the one box of surgical masks for 3 years – wiping the plastic face shield in between operations. At times screws do not fit plates and screwdrivers do not fit screw heads because all the equipment has come in different parts from different manufacturers.

Dr. Gabriel often said ‘this is what happens… the ideal must meet reality.’

2. Lack of Education

I. As was the case with the 13yo boy who had the testicular torsion, he nor his family knew that his condition was a medical emergency. In many cases children are not screened for CHD and it is only when the child starts walking with one leg externally rotated that they realize there might be a problem with one of their legs.

II. It is hard to gauge the interns’ knowledge because of the language barrier. Being surgical interns, they certainly knew their anatomy. The specialists have trained overseas, usually in a French speaking country, so I found them to be a good source of information, however I now only know surgical instruments by their Khmer or French names! Some things the Khmer doctors had never heard of (e.g. Bells Palsy), but most of the time I found Dr. Vuthy or Dr. Gabriel teaching me. As a first year medical student who had not done any paediatric rotations I found myself taking a lot of knowledge and not having much of an opportunity to give back. There was one occasion on my last day when a patient came into clinic 5 weeks after injuring his left knee in a motorbike accident. He had a knee effusion and suspected ligament damage and was placed in a long leg POP for 3 weeks. On removal of the plaster he naturally had atrophy of his quads and restricted flexion ROM. I was itching to assess his knee, as this is my area of expertise (I’m still working as a musculoskeletal physiotherapist). I was able to tell Dr. Vuthy (or at least agree with him) that this young man had a grade 2 ACL and MCL tear, but the menisci were intact. I was frustrated however that he was not going to receive physiotherapy to regain his ROM or address his quads atrophy – which would then lead to patellofemoral joint problems (Patellofemoral Pain Syndrome). I did what I could with the time we had in clinic but got an insight into the frustration that some visiting doctors, like Dr. Gabriel, must feel when

there is so much more that can be done, but not enough time, money or resources are available.

A lack of money also leads to corruption or cash payments on the side. I personally did not see any money exchanging hands, but I heard from other students of days when they saw nurses get paid cash by families to change dressings or administer medications. An Australian doctor we spoke to said it was not uncommon for high school *and* medical students to pay to pass their exams. When I asked Dr. Vuthy he said it was happening less. The problem is if he fails a student they can pay off the review committee or the student gets examined by someone else the next time.

We met an Australian working for an NGO in Cambodia. Norvan is an economist and looked at Cambodia's health system from a financial point of view. He made a good, albeit strong point. One I grappled with presenting in this essay because as a first year student I felt like it wasn't my place to say anything of this sort. Norvan said that the medical system in Cambodia has to be held up to the same standards as those in the developed world, without exception. As medical students we may not know as much technically, but ethically, given our backgrounds, we are just as experienced and therefore justified in speaking up when something we see is not as it should be. As long as the standards are set lower there will be corruption, substandard medical care and people will go elsewhere for treatment. He gave the example of how expats and locals (who can afford it) in Cambodia will travel to Thailand or Vietnam for their medical care. This, he pointed out was because those countries had reformed their system and lifted their standards. Now Thailand has become a major destination for overseas travelers (including Australians) because their doctors are overseas trained and charge less. If Cambodia wanted a share of that market, said Norvan the economist, they need to do the same.

The point here is that the Cambodian health system was shattered by the Khmer Rouge Regime. It is currently trying to catch up to the rest of the world after so recently being knocked back into the dark ages. In 1992 medical services were equivalent to those during the American civil war. Now they have been likened to World War II levels. So in 18 years they have done what

took America approximately 80 years to do. Most of this as I mentioned is due to foreign aid pouring in or Cambodian doctors going overseas for training. The rate of development has been exponential, maybe more than this generation of doctors can cope with. But men like Dr. Vuthy are trying to set the standard, to raise the bar. Some institutions have 3 operating beds in the one OR. In setting up NPH's surgical department and the OR at another regional hospital we visited Dr. Vuthy maintained that there be no compromise. Aseptic/sterile conditions all the way. The design flows from one room to the next, just like it would in a developed country. There are two ways to look at this; one way lifts the standards of Cambodia's healthcare, the other way gets more patients operated on per day. Dr. Vuthy is aware of this. Plus he's the kind of person that "wouldn't say shit if his mouth was full of it" (Dr. K. Gabriel, 2010). It is very much a cultural thing here. They don't bad mouth other institutions. Some of the foreigners are not backward in coming forward though. They will rubbish the Red Cross, MSF and say their hospital has single handedly lowered the infant mortality rate.

There is obviously a lot of politicking going on. It is quite clear that the squeaky wheel gets the grease. Institutions such as Dr Beat Richner's Kantha Bopha hospitals or Dr Jim Gollogly's Children's Surgical Centre get a lot more funding because these foreigners are good at generating interest – the BBC aired a documentary called Cambodia Surgical Ward, filmed and directed by Rob McBride. It was entirely on the CSC and the work they are doing. The issues are the same as those at NPH and those mentioned here, but the NPH does it with less funding and public relations.

Finally a word on cultural aspects. When a doctor, wearing his white lab coat walks into a room or down the corridor patients and parents move out of the way. The power of the white coat though can also work against them. As soon as a child is brought into the consultation room with at least 3 men in white coats the tears start. One point to the examination table and the 'fight or flight' response is triggered in the wary child. Perhaps 'white coat syndrome' has not yet made it into the Khmer vernacular.

Doctors here are trusted implicitly. Not once did a patient walk in with printouts from Wikipedia or question the senior doctor's opinion. By the same

token Dr. Vuthy would not hesitate in asking another specialist for their opinion.

Overall the ILA at NPH was time well spent. I did not get to cut, stitch or puncture anyone as I initially thought I would, but I managed to gain a broader scope of the healthcare system in a developing country. I spent more time in the OR than I think I will during my paediatric term in third or fourth year and I saw a variety of conditions we would never see in Australia. It is hard not to gawk in amazement or be the dreaded ‘medical tourist’ but by documenting Dr. Gabriel’s corrective procedures I hope I was able to leave a positive footprint during my time in Cambodia.