PAEDIATRICS

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Elective Report

I spent my five week elective at the National Paediatric Hospital in Phnom Penh, the capital city of Cambodia. It is a Government run paediatric hospital managed by the Ministry of Health, with a staff of 100 doctors and 225 nurses it is the specialist paediatric referral hospital for the country. Much of its work is carried out in conjunction with various NGOs and many of the buildings and much of the equipment is provided through donations from other governments and organisations. Further funding comes from the children's families, about half of whom pay towards their treatment. Further discussion will take place below under objective two with regards to this.

Whilst at the hospital I spent two weeks in the respiratory ward, one week in the emergency room and two weeks in the surgical department. The objectives made before my placement were as follows:

1) What is the pattern of paediatric disease in Cambodia compared to the UK?

2) What is the pattern of paediatric health provision in Cambodia compared to the UK and the rest of the world?

3) How does basic investigation and treatment differ to that of the UK?

4) What will I change in my subsequent practice following this placement?

These objectives will now be briefly addressed based on my experiences of the National Paediatric Hospital and the UK.

What is the pattern of paediatric disease in Cambodia compared to the UK?

The most obvious difference in the pattern of disease was the presence of tropical diseases which would be unheard of in the UK, additionally there appeared to be a lot of preventable disease, partially attributable to the lack of a complete vaccination programme. However, the most obvious cause of a difference, both in the hospital and in the country in general, was poverty. This leads to poor living conditions, child labour and perhaps the country's unfortunate, but improving, association with child abuse. Much of this could be attributed to the country's unstable and violent recent political history; a contrast to the peace and relative prosperity enjoyed by the UK.

The respiratory ward had a large number of infants with bronchiolitis caused by RSV which was similar to the UK, as is the rising incidence of asthma. Surprisingly the Emergency Room was the quietest ward in the hospital, a stark contrast to the UK; this is partly explained by the fact that most patients are seen in the outpatient consultation rooms and either sent home with advice or admitted straight to the relevant ward. The patient's in the Emergency Room were severely ill with conditions such as cerebral varicella and had

often travelled distances that in the UK would have taken you past many appropriate hospitals.

A lot of the work of the surgical department was taken up with cleft palate repairs, a not uncommon condition in Cambodia and one where an operation will make a marked difference to the child's life. Similarly to the UK a lot of young boys were undergoing routine hernia repairs.

Another big problem in Cambodia, partly due to the state and safety of the roads, is broken limbs and as such the orthopaedic clinic was particularly busy. The general surgical clinic also appeared to have a much wider range of problems than in the UK with many severe infections and birth abnormalities, which have a higher incidence in Cambodia.

What is the pattern of paediatric health provision in Cambodia compared to the UK and the rest of the world?

The most noticeable difference is the state of the hospitals in terms of cleanliness and equipment, generally far below modern Western standards with exceptions such as donated anaesthetic equipment. Aside from the National Paediatric Hospital there are a number of charity hospitals in Phnom Penh and other Cambodian towns which provide care free of charge, arguably reducing the workload and incentive for investment in government hospitals.

Another major difference between the two countries is the fact that the Cambodian population is 80% rural, travelling through the country it is evident that international standard health provision is sparse; most provinces had a few clinics but these will not be able to provide comprehensive paediatric healthcare meaning many sick children travel hours with their family to the National Paediatric Hospital in Phnom Penh. Indeed the accepted advice for foreigners is to travel to Bangkok or Singapore for medical assistance.

Throughout the city many doctors also run their own private clinics where they will see patients with any problem, more akin to the GP in the UK however the quality and cost varies greatly as regulation is much less strict. Many families also attempt cheaper traditional medicine before consulting the hospital, delaying presentation in some cases.

The UK on the other hand has a comprehensive vaccination programme, community paediatricians, GPs, district nurses, paediatric wards at every DGH and tertiary referral centres in each region for more serious conditions and specialist treatment. In addition Great Ormond Street Hospital in London is a world leader in paediatric care. However, the structure of the system is not the main difference, it is the lack of funding and facilities which is; the availability of investigations, procedures and medicines is much reduced.

In terms of the rest of the world Cambodia is a typical developing country, as are many of the world's countries outside of Europe and North America. The only other major distinction worldwide is the type of healthcare system adopted by various Western

countries, ranging from the NHS in the UK to the totally privatised system of the US.

However, in many ways the hospital did run on similar lines to the UK with department meetings, case presentations and regular audits with some doctors also publishing research carried out at the hospital. There were also regular teaching visits from foreign doctors in addition to groups of Cambodian doctors from rural areas carrying out internships to improve their skills.

Another obvious difference was the multi-lingual nature of the hospital, with both staff and patient notes moving seemingly at random between Khmer, English and French; in the UK anything other than clear English would result in inaction and confusion.

How does basic investigation and treatment differ to that of the UK?

In terms of basic investigation the hospital had an on-site laboratory that could carry out simple haematology, biochemistry and microbiology, however the turn around time was much slower; for example 24 hours for a full blood count, in London a result can be obtained in 5 minutes if necessary. In terms of radiology there was only access to X-ray and ultrasound meaning good interpretation was vital, as more detailed scanning to give a clearer picture was unavailable without expensive referral.

Another noticeable difference was that all patients were put on IV fluids regardless of hydration status or if they could take water by mouth; in the UK IV lines and fluids are discouraged unless clinically essential. Apparently the reasons for this were partly cultural, as parents like to see that something is happening, but also to maintain clean IV access as it may be less likely to become infected if there is a constant flow. Additionally as there were no patient gowns it makes it easy to identify the patients and perhaps prevents them discharging before paying for their care.

Probably due to the fact there is a reduced availability of investigation and treatment most clinical work took place in the morning and by lunchtime the majority of the doctors have left for the day, just a dream for a junior doctor in the UK.

Most basic drugs were available and were often provided through donations by various countries, charities and companies; however the range, quality and storage conditions seemed to not always meet Western standards. This was also reflected in the availability of surgical equipment, the mantra 'we use what we have' was commonly quoted; for example suture use may not always perfectly match the job but often there was no alternative but to improvise. Another problem was the regular power cuts which interrupted many of the operations I attended. Additionally, in contrast to the UK, almost everything used in theatres was reusable after being sterilised in the department, a stark contrast to much of the single use equipment used in the UK.

What will I change in my subsequent practice following this placement?

The first point is to realise the high quality of care freely available in the UK, despite the complaints of many British people; perhaps helping them to remember this point would make a big difference. Additionally it will make me further consider the use of unnecessary investigations and treatments which are often ordered in the UK for completeness, but rarely add to the clinical picture; with growing health costs and falling budgets on the horizon a more economical use of these will become essential during my career. This approach will be helped by a greater reliance and understanding of basic clinical signs, as is often evident in Cambodia, allowing me to diagnose patients more simply and cheaply with a greater degree of accuracy.