

A morning at the Angkor Hospital for Children

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An uncomfortable drizzle soaked through my only set of good clothes. It was a cool monsoon morning in Cambodia and I was holding on tightly to the back of a moto-taxi. I was late for my appointment at the Angkor Hospital for Children (AHC). The taxi had taken me to the other, more modern private children's hospital across town by mistake. When I arrived at my proper destination, which turned out to be only 5 minutes from my hotel, I did not appear as neat as I had hoped.

Ever since I first visited there in 1992, Cambodia has been a favourite destination of mine. Its charm and adventure have drawn me back several times over the past 15 years. But to many people Cambodia evokes images of death and misery — a place known for Pol Pot's Killing Fields and post-genocidal civil war. However, despite an ongoing landmine issue, Cambodia has recently awakened from the nightmare of the past 30 years and a relatively peaceful period has encouraged an increasing number of travellers to visit the country, in particular, to explore the famous temple complex of Angkor. The scene today of busloads of tourists snapping terabytes of themselves in front of jungle-covered temples is in sharp contrast to my visit to the area in 1992. At that time, Khmer Rouge soldiers were shooting and kidnapping United Nations peacekeepers. The temples were almost abandoned, and, ironically, for security reasons, road signs were nonexistent (I accidentally rode my motorcycle into a minefield, but that's another story).

Now, all of that has changed. Siem Reap has grown by 50% in the last 3 years to about 1 million people. Funky bars, exotic restaurants and megahotels have sprung up overnight and are fueling a population boom that has left a quiet fishing town struggling with infrastructure problems

and a surge in population, half of which is under the age of 15.

A visit to the ACH, one of the 2 children's hospitals, illustrates how this huge population of children is being treated in a surprisingly holistic way. Rahul Singh, director of the Toronto based NGO Global Medic introduced me to the ACH. Singh has been supplying desperately needed beds, generators and medications to the hospital. Arun Sinketh (Fig. 1), a former nurse who is now Director of Public Relations, gave me a tour of the hospital. Following this, I joined the medical team on rounds.

I am familiar with hospitals in Africa and have worked closely with colleagues there. I am always amazed at how they are able to cope with so much difficulty and so few resources. It is easy to forget how well off we are once we are re-immersed in our relatively wealthy home depart-



Fig. 1. Ms. Arun Sinketh in front of the new outpatient triage area.

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ments. My experiences in developing countries always remove me from our microcosm of developed country-related difficulties and give me a glimpse into the challenges of medicine with which most health care professionals must contend.

The ACH is a teaching hospital and is undergoing extensive renovations. By renovations I mean the tearing down of operating room walls while surgeries are taking place next door. It was in the modern part — the triage area (Fig. 2) — where I witnessed the clash between rural sensibilities and the new facilities when a loud bonk interrupted my tour. A small child who had run into the glass wall and fallen over was holding his head and crying (I think he was more shocked than hurt).

He was one of about 300 children seen every day in the outpatient clinic (400–500 on Mondays) by 6 doctors. Patients are asked to pay 1000 riel (25 cents) for the first visit and 500 riel for subsequent visits. Forty-five percent can-



Fig. 2. The new outpatient triage area.



Fig. 3. A patient who is cared for by family.

not pay but are seen anyway. Children are triaged and given a different coloured paper depending on their condition: urgent, clinic appointment, low acuity or dental. The average wait for a clinic appointment (non-urgent) is 1 to 2 hours. While waiting, there are 2 “play therapists” who interact with the children and provide parental education in the waiting room.

Urgent patients are sent to the emergency section to be seen promptly. There are 6 beds in the emergency room and 3 in the intensive care unit (Fig. 3). Respiratory illnesses, gastrointestinal infestations (e.g., ascaris, giardia and strongyloides), malaria (66 cases in August 2006) and HIV/AIDS are commonly seen. Mysteriously, dengue hemorrhagic fever occurs during the rainy season in 4-year cycles. There are 1000 families on the HIV roster, cared for mostly by home visits. Two-hundred patients are being treated with antiretrovirals.

Admitted children are provided with food, which the family is expected to cook at an outside communal kitchen where they also receive nutrition lessons from a chef (Fig. 4). To round off the holistic experience, there is a garden where families learn which crops to grow and how to grow them (Fig. 5).

With the guilty feeling that I cannot keep a plant alive without a great deal of help from my wife, I joined the clinical team that was rounding on patients. In addition to the attending, there was an ophthalmology resident and a general medical resident, who recently returned from training in Minnesota (there is a large Southeast Asian community there).

I listened with interest to the presentations and examined the patients. Then I was asked for my opinion! The attending asked me “Do you agree?” “Um, well. . . you would



Fig. 4. The communal kitchen that provides nutrition education to the patients’ families.

know more about this than I and what you propose I'm sure is quite reasonable," I answered. Diplomatically, this is a tricky situation. Not only do I work in an adult emergency department, but my tropical medicine experience is also limited to a 9-year-old diploma in Tropical Medicine and Hygiene. I have only once been able to impress my colleagues with an explanation of a laboratory result demonstrating *Entamoeba histolytica* (mostly, I use my tropical medicine training to grill residents on the 4 types of malaria). Indeed, my real concern was to not come across as the arm-chair consultant living in the ideal world. This I learned when rounding on patients in Gambia. It is not good form to breeze into a situation and declare that the treatments are not what we learned in our tropical medicine or pediatrics courses. It is important to understand the different resources, experiences and conditions under which the local doctors are working every day. Despite all this, the team seemed genuinely interested in my opinion, and I decided to tread the waters gently.

The team was huddled around a 10-year-old girl who was recovering from falciparum malaria (the kind that can kill you). She had been treated with intramuscular artemether (for 3 days) and was almost ready to go home, except for a nagging urinary tract infection for which she received intravenous ciprofloxacin. Although she was eating, more active and her hemoglobin had improved from 66 g/L to 77 g/L, her temperature was still spiking, and the team was discussing the benefits of intravenous, compared with oral ciprofloxacin. In the end, it was decided that since she still had a fever they would continue with 1 more day of intravenous before discharge.

Next was a 7-year-old girl who looked ill and edematous, sitting miserably on the edge of her bed. She was a

diagnostic dilemma for the team because she arrived the day before with fever, vomiting, lethargy and decreased urine output. Her creatinine was 500 $\mu\text{mol/L}$, her blood urea nitrogen was 15 mmol/L, her sodium was 127 mmol/L and her potassium was 7.2 mmol/L (not hemolysed). Finally feeling on sound ground with a decent knowledge of electrolyte disorders, I said "perhaps she could benefit from insulin and glucose."

"There is no insulin as there is no diabetes in Cambodia" was the response.

"Oh. . . well how about kayexalate?" I asked.

"We don't have that either."

"Dialysis?"

"No."

"I see."

She had been diagnosed with pneumonia and acute renal failure. An electrocardiogram had not yet been done but was ordered. She was receiving broad-spectrum antibiotics and fluids. Her urine output was improving and the team had its fingers crossed. They were doing all they could under the circumstances.

Next, onto a child with a dental abscess that was disfiguring the right side of her face. She was obviously in great pain and was being treated with cloxacillin and flagyl. The dentist agreed to treat the abscess once the infection was under control. Her pain control? Ibuprofen. . . when available.

A 7-year-old boy with dengue hemorrhagic fever was getting better. He presented 4 days earlier with fever, vomiting, headache and lethargy. His hemoglobin was 74 g/L, and his platelet count was $50 \times 10^9/\text{L}$ blood. There was no obvious bleeding, but this still counted as hemorrhagic fever. His dengue serology was positive. His discharge planning was going to be complicated because his home



Fig. 5. The hospital garden, which is used to teach the families about nutrition.

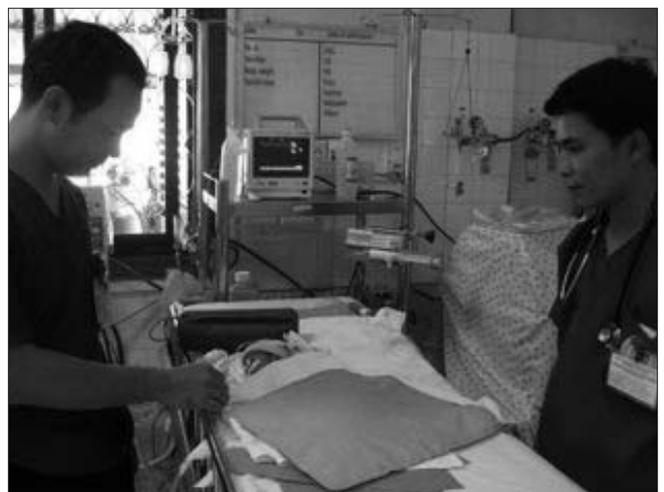


Fig. 6. Dr. Viboun (right) and Dr. Pises (left) caring for a 28-week-old premature baby who was on a ventilator.

(along with much of rural Cambodia) was under water owing to recent flooding.

In addition to these children, there were a few malnourished HIV/AIDS patients and even a 28-week-old premature baby who was on a ventilator (Fig. 6). An orderly passed us in the corridor; he was struggling with an unconscious 12-year-old boy in his arms as he moved the patient from surgery (and construction rubble) to a post-op bed. It struck me that there was an interesting array of resources and that the level of care was very good.

I left with Ms. Sinketh to lunch at the local Foreign Correspondent's Club and to discuss life in Cambodia. She described growing up in Cambodia, her love of deep-fried crickets, a town where you could find delicious giant spiders (although she wasn't a big fan) and her hopes for the future. Throughout our conversation, her spirit of determination and hope under difficult conditions reinforced in me

respect for a culture that has overcome incredible obstacles in a matter-of-fact way. Almost everyone I spoke with had a story involving death and deprivation of the most traumatizing nature, yet they somehow carry on, focusing on the challenges of life in the present and their optimism about the future. I will keep Ms. Sinketh and the doctors of ACH in mind during my next emergency department shift and I will give thanks for what we have.

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