

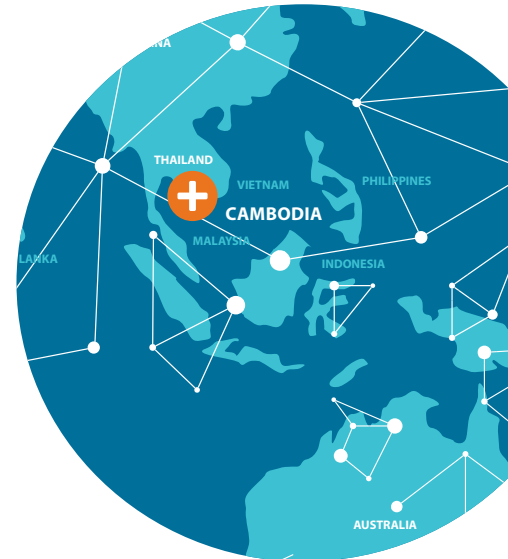
Elective Grant Report



*Pre-op with
Dr Minna, Anaesthetist
and keen teacher*

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Phnom Penh, Cambodia



In December 2017 I had the amazing opportunity to undertake a three week medical elective in Phnom Penh, Cambodia. Specifically, this involved two weeks of placement in the Preah Kossamak Hospital Emergency Department and one great week at the Sla Health Centre in Takeo, about four hours south of Phnom Penh in rural Cambodia.

My elective was such a fantastic experience. The opportunity to learn, engage and strengthen my understanding of health and disease, on an individual and global level, through the Cambodian lens was a unique privilege. My trip has also instilled in me a strong appreciation for the strengths of the Australian health system and reinforced my appreciation of the challenges we still face – many rural and urban Australians' health literacy and access to health care is not dissimilar from my Cambodian experience. The Indigenous Health Gap is significant. Thanks to MIGA's support I have had an incredibly rewarding experience that will no doubt influence my career both at home and abroad.

I chose to undertake my elective in Cambodia recognising the challenging history the country has faced and the burgeoning opportunity it has created in the last two decades.

As a brief background, the Khmer people were colonised by the French just prior to the turn of the twentieth century. At the time, the French demanded and relied upon western medicine, abolishing Cambodian medical traditions altogether. In 1945, the Japanese briefly ousted the French before Cambodia regained its independence throughout the 1950s and 1960s.

It was with the United States (US) invasion of Vietnam that Cambodian history entered a very dark period. As Western allies we find it distasteful to acknowledge, yet many Cambodian people were massacred by the US military as a spill over from Vietnam. The number of bombs dropped in Cambodia alone was almost equal to what the US dropped in the entire Pacific theatre in WWII. The rationale was that it was for democracy.

In 1975 the Khmer Rouge began its 'Reign of Terror' under Pol Pot's Democratic Kampuchea resulting in deaths of an estimated 1.7 million people or 25% of the population. The deliberate targeting of educated professionals, many in healthcare, has been shattering for the health system and the right for Cambodians to receive adequate care for their health. The flow on effects have been pervasive and continue to harm Cambodia's capacity for human development.

According to the World Health Organisation (WHO), Cambodia had fewer than 50 doctors following the US led Vietnam War and genocide under the Khmer Rouge. Today the country is still in the process of recovering from the cruel legacy of generational knowledge and skill loss and a high rate of poor health. It has among the highest rates of tuberculosis in the world, with approximately 380 people per 100,000 infected, a disease that I encountered daily in the Preah Kossamak Hospital.

However, emerging through their history of conflict is incredible positivity and hope. Cambodia is now one of the fastest growing economies in Asia, with life expectancy sky-rocketing from 49 years (1999) to 72 (2014) and investment in vocational education in rural areas contributing significantly to reducing poverty and unemployment.

This history has been integral for understanding the context of my medical placement and I found it vital to appreciating the reasons for the disparity in resources, treatment and culture of the health profession.





Emergency Department 'B'
and ICU 'B' at Preah
Kossamak Hospital



Sla Health Centre in Takeo
Province, approximately 4
hours south of Phnom Penh



Diabetes health check in
Sla Health Clinic

Preah Kossamak Hospital Emergency Department

Originally a Monk Hospital, Preah Kossamak Hospital is now one of the largest public hospitals in Phnom Penh. Every department was split into an 'A' and a 'B' area, dividing patients into those with wealth that could afford treatment and those who would be supported with very little resource. My placement in the 'B' Emergency Department would start at 0800 each day and continue through until 1130 for lunch, followed by an afternoon shift from 1300 to 1700. Many of the patients coming through the ED were due to motor vehicle accidents. In a country without a 'Medicare' these patients would often need to wait for family to arrive to organise payment for investigations and surgical treatment. At first observing these situations was challenging – our environment is one of many resources, this guy needs a CTB! However, from my placement I now have an insight into what 'low resource' really does mean, more so the consequences of low wealth and poor resources on health and what that looks like in practical and often tragic terms. For example, the classic chest pain had to be managed without a serviceable ECG. I found it very humbling and inspiring to watch the doctors improvise and manage around these obstacles.

Initially, my main role during placement was observation. However, with time the doctors began to delegate greater responsibility with history taking and examination. Each day there would be many local medical students who I could pair up with and together we'd speak to patients in Khmer with my new student friends translating. Some of these experiences being involved in the responsibility of a patient were invaluable.

"I think he's got gastritis and a cough".... "No – strongyloides infection!"...

It was fantastic to experience and be immersed in some very different diseases, stages of presentation, and management protocols. I found the opportunity to ask questions on different medications, triage protocols and the like a great way of building relationships with the staff over the course of my two weeks.

Other common diseases I observed on placement were HIV and tuberculosis. These were both common and often comorbid diseases noted on presentation to the ED. It was eye-opening to note the spectrum of symptoms and complications that both diseases resulted in. More so I found it eye-opening to appreciate the greater socioeconomic determinants that are contributing to Cambodia continuing to see such high rates of these diseases – historical factors, ongoing poverty, housing, gender equality and significant foreign ownership with little local employment.

One memorable experience was when a factory truck crashed and rolled about two hours outside of Phnom Penh. Approximately 50 women and young girls who were herded into the open top truck were rushed into the Emergency Department with multiple head wounds and fractures. The ED was frantic with the five ED 'B' doctors, trauma team, Emergency Department 'A' doctors assisting, nurses, patients and their families turning up to pay for treatment. Despite being busy I was in admiration at the experience and control of the leading doctor at coordinating the flow of patients in beds, on the floor and out the hall.

Again, it was an inspiring experience to observe the capacity of the staff to operate in such a resourceful and resilient way despite being poorly resourced and poorly funded. For example, given the volume of patients, we were splinting with cardboard as a temporary measure and bandaging only significant wounds that would require major or minor surgery.

Sla Health Centre – Takeo Province

My experience in a rural Cambodian health centre was the highlight of my elective. For one week I lived with a host family in Takeo Province, about four hours south of Phnom Penh. There I had a translator, Sreyna, who spent the entire day with me.

Primary health is very limited in Cambodia. Only in recent years have rural health clinics (in the western medicine form) been developed to increase the accessibility of care to Cambodians. Previously, the 80% rural population would have to travel in to major cities to attend a hospital to receive care – so many didn't get it! The Sla Health Clinic was one of eleven in the province staffing two doctors and four nurse/maternity nurses.

A challenge for the model is that most Cambodians – men and women, young and old – are still farmers that must prioritise growing food for their family. The incentives to attend a health clinic are less, particularly for chronic disease like hypertension and diabetes that mean the season's rice harvest might be missed.

I attended the clinic each morning from 0800 to 1100 and found engaging with patients on the level of a family doctor was very different to the emergency department. I was able to learn about how the barriers to health care differ from Australia in countries such as Cambodia.

For example, I found myself having to be creative when discussing 'lifestyle change', when there is no place to go walking, leisurely swimming is non-existent and white rice is the staple food available. I found that as I learnt more about the culture it became much easier to communicate freely with the patients and make suggestions that were tangible and accepted.

Similar to elements of our Indigenous Australian population, many barriers such as access and cultural safety meant that long-term ongoing care was a challenge for the health centre and reflected in the way treatment and management was structured.



Farming rice with my host family on a spare afternoon in Takeo Province



My host family in Takeo Province for my week at Sla Health Clinic



Community briefing meeting with Clear Cambodia, recipient of the \$1,500 MIGA Grant



Sunset in Kampot, six hours south of Phnom Penh on a weekend away from the Hospital

Another challenge during my health clinic placement was that in an attempt to incentivise greater patient attendance and engagement the clinic would only prescribe medication for 5 days. This made it challenging for the doctors to manage many long-term conditions – tuberculosis, HIV and hypertension to name a few.

In the afternoons, I had free time to spend with my translator Sreyna so we had an awesome time immersed in the local culture. One afternoon we went and helped in the rice fields cutting the stems and gathering the rice grass into piles for processing. On another afternoon we hired an oxcart and took a ride through the village to the local temple to meditate and practice being mindful.

I found the opportunity to spend time embedded with a family one of the most rewarding and insightful experiences. Every day my 'host mum' would wake at 0500 to start cooking breakfast – rice and fish – before the health clinic and my 'host dad' would already be at their rice farm. I enjoyed waking early with them and being able to spend time learning and just existing without the updates and emails. I enjoyed the opportunity to streamline daily life and have time away from the usual pressures of both medicine and Australian life. Certainly the week was a privilege to listen, contribute and share in the family's experience.

When considering where to best allocate the \$1,500 community donation from MIGA, my objective was to meet three criteria. Firstly, it must be sustainable – how will this money contribute to making an ongoing impact for the Cambodian people. Secondly, it must be meaningful – given our medical electives are always so short, how could I donate in a way that the money could be utilised purposefully and with a known benefit. In this regard, there is a school in Nepal that paints the school every 3 months because naive donors are happy to feel good funding it. Thirdly, the donation must be wanted and fulfilling the needs of the Cambodians and not my own.

After researching prior to my trip, I chose to donate the MIGA Grant to Clear Cambodia, a locally owned and run company that implements water and sanitation projects in partnership with local government offices in outlying provinces. Their goal is to provide families in rural communities with access to safe water, sanitation facilities and hygiene education.

I particularly liked Clear Cambodia because the materials and labour used to complete projects are sourced from local vendors located near their project areas.

I was able to enter an agreement with the company and purchased fifteen Stainless Steel BioSand Water Filters that will supply clean water to fifteen families in the Kampong Speu Province outside of Phnom Penh.

Given that the most common diseases in Cambodia today are related to water and sanitation I am confident that investing in this product will contribute to providing greater access to clean water for these Cambodian families.

Each year MIGA's Elective Grants Program offers 10 Grants of \$3,000 to medical students undertaking electives in developing communities. Each Grant includes \$1,500 to cover the student's personal elective costs and \$1,500 to provide medicine or other aid to the local community. To be inspired by other past recipients and find out more about applying, visit our website.

MIGA's free Protection Package for medical students provides automatic cover for your elective and Clinical placements. Insure with MIGA and undertake your elective with confidence – complete our simple online Application Form for immediate confirmation of your cover.

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