

Charles Kent
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I began my two month elective at a community hospital 100 km west of Bangkok. The Crown Prince Royal Hospital was located in Chombung, a village of 1,000-2,000 people. The local economy was based on farming, primarily sugar cane, and pottery making. The hospital had 30 in-patient beds, one operating room, and was staffed by four general practitioners. The practice of medicine mostly addressed acute problems. In fact, the most common diagnosis was acute upper respiratory infection. But the more interesting cases were always the in-patient admissions. People were often admitted with the diagnosis of fever. In their differential, malaria, Dengue fever, scrub typhus, and typhoid were always considered. These were four diseases that I could never remember because we never saw them on a daily basis in the US. Another disease that was endemic was tuberculosis. In Cleveland, diagnosing tuberculosis always started with a positive Mantou test, and rarely was made on a sputum sample. In Thailand, the preferred diagnostic test was a sputum sample. Patients were always assumed to be exposed to tuberculosis, and they never sought care until several months or years after having developed a chronic cough. We would often see patients who had been on triple drug regimens several years earlier reappear in the clinic complaining of a cough. They were usually elderly, lived with their extended family, and often took care of the children while the parents were at work. Families were never screened though. It was deemed too costly.

The medical system was a socialized one. Care was essentially for free if one could access it. The hospitals were organized in a hierarchy from a provincial level to the community level. There were 74 provinces in Thailand, and only in the last ten years have all provinces had a hospital system. On the community level, the situation was not as good. There remained areas of the country where the people would have to travel many hours to receive basic care. Yet, transportation to the hospitals was not free and not well organized. The government tried to rectify the situation by having community hospitals organize local village clinics, and by training volunteers as health officers. These people were periodically instructed on screening techniques for high blood pressure and diabetes, and on health education for the local villagers. Once a week, one of the community doctors visited the site to see patients who needed further care. The system worked well for patients with acute diseases. Those with chronic disease often were lost to follow-up even on the village level. The health officers also varied in their effectiveness. Some limited their education to posters at the village clinic, while others kept detailed records of each

village family and were more involved with the community.

At present, local communities seemed most concerned about two issues: accidents and sexually transmitted diseases. Accidents were the number one cause of death in Thailand, and certainly, no one wonders why. Few cars have seat belts, and even fewer people use them. Speeding was a common phenomenon especially in the rural areas. Another popular mode of transportation was the motorcycle. Again, no one wears safety helmets, and they often put entire families on board including infants. Industrial or farming accidents were equally common. Equipment was often outdated and not designed with safety in mind. Amputations and ocular trauma were frequent reasons for hospital visits.

The other issue has come to light with the recent statistics on AIDS in Thailand. Having safer sex was encouraged at the local level, but it had little impact. There were some cultural practices that people seemed unwilling to change. For example, prostitution was well accepted, and most men visited a prostitute regularly. Few used condoms which was evidenced by the high rate of urethritis and pelvic inflammatory disease.

Medicine in Thailand is heavily influenced by the Buddhist beliefs and the limitations of a socialized system. Here in the US, preventive medicine has been the emphasis of primary care. Women are routinely screened for cervical and breast cancer, and every one is screened for colorectal cancer. Weight control, and the use of tobacco, drugs or alcohol have been important issues to be discussed with patients. In Thailand, preventive medicine is too costly. Pap smears, hemacult test, and mammograms are beyond the community medicine scope. It is unfortunate especially since cervical cancer is the number one killer of women. Next to hepatocellular carcinoma, lung cancer is the number two killer of men. However, doctors are still reluctant to discourage patients to stop smoking and drinking. According to their Buddhist beliefs, they would be offending their patients if they talked too critically about personal habits. The general public is considered too uneducated about science and medicine, and would not understand that the criticism is derived from scientific data. Strangely though Thailand is considered one of the better educated countries since the literacy rate is greater than 90%.

After one month in Chombung, I returned to Siriraj Hospital in Bangkok. My first two weeks I spent in the infectious diseases department. The most striking feature about their patients was the severity. People generally sought care very late in their disease plus they had to be referred from a provincial hospital to be admitted. Most of the patients I saw

required ventilatory assist, and were immunocompromised. Patients were kept in an open ward area whether they had active tuberculosis or had a low T4 lymphocyte count. The most shocking aspect about the care was the lack of handwashing as doctors examined successive patients. There was a lot of cross contamination especially with MRSA.

My last two weeks I spent in the ophthalmology department. I was not able to observe many surgical procedures because the surgery room was closed after ten cases of end-ophthalmitis in the span of two weeks. The room was closed for fumigation of mosquitoes and a thorough disinfection. I was able to see many interesting cases though in the out patient department. The most common ocular problem was a pterygium which was due to ultraviolet ray exposure. However, people in Thailand disliked wearing sunglasses because it was considered rude. Other problems I saw were advanced diabetic retinopathy and hypertensive retinopathy. Ophthalmology visits were considered superfluous medical care, and people were never referred for routine check-ups. Most presented to the ophthalmologists with no vision in one eye, and compromised vision in the other. It left little room for the ophthalmologists to help their patients.

Another common ophthalmology problem was cataracts. Patients were often not referred on the community level because most were over the age of 65 and no longer considered contributors to the economy. Families were expected to care for them. Those that were referred could get the operation, but they had to pay for an intraocular lens and home-going medications. Only wealthy patients could afford to have a lens implanted.

My experience in Thailand certainly was educational. I learned that medicine can still be practiced effectively without sophisticated machinery. It is sad though that the government is not more supportive of preventive medicine. I am sure they could decrease the amount of money spent on hospital admissions if they invested on education at the local level. I left Thailand having achieved my objectives. I learned a lot about a very rich culture, Eastern ways, and the role of medicine.