In the Moment

88 Bikes

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As I started my third year of residency, I felt that I was finally getting a handle on the practice of pediatric medicine. I knew the algorithms for the most common diseases, and I could form a reasonable differential diagnosis for uncommon complaints. However, what I lacked was exposure to medicine in the most common pediatric setting on earth: the developing world. Just as practicing pediatrics solely in a tertiary-care setting would be to neglect the majority of what constitutes the practice of pediatrics in this country, so too practicing only in the developed world neglects the reality of health care for the majority of the world's children. To fill this gap, I contacted the Global Pediatrics program at my university and was told about many opportunities abroad. They offered rotations at rural communities in South America, at tertiary-care hospitals in Africa and Southeast Asia, and many others. In the end, I opted to go to Cambodia and spend an elective month working at the Angkor Hospital for Children (AHC), a dusty 6 km from the famed temple, Angkor Wat.

No trip to Southeast Asia could go unnoticed by my adventurous filmmaker/writer brother, Dan, and he enthusiastically decided to come along. We had biked across the United States a decade earlier, and Dan had produced a feature film documenting the journey. We decided to replicate the adventure in Cambodia and give away our bicycles at the end of the trip. Through a mutual friend, we found that the Palm Tree Orphanage of Phnom Penh would gladly accept our travel-worn bicycles.

The problem was that there were only 2 of us, and 88 children at the orphanage. So, doing what any sensible filmmaker–pediatric resident sibling combination might do, we decided to raise enough money to buy all the children at the orphanage bikes before we left on our trip. We launched a Web site (http://www.88bikes.com/) to solicit donations, and in 4 days, we had all the money we needed for the bikes, plus enough for helmets, locks, and equipment for an on-site bike shop. The bike shop would be staffed by a few of the older kids and would provide both a source of income and an employable skill. With this sense of purpose, we headed to Cambodia.

At the hospital, I saw the everyday—but, for me, exciting—cases of malaria, dengue fever, and typhoid fever, and I came across 3 children with undiagnosed congenital heart disease during routine visits. I listened intently on rounds as Khmer residents presented patients with unusual nephritic-nephrotic syndromes and seemingly untreatable cases of pneumonia. The most striking lesson for me was not the exotic but rather the mundane. I was surprised by the large percentage of children who sought care for what I thought were complaints of the developed world: asthma, upper respiratory tract infections (URIs), bronchiolitis. For some reason, I held the idea that URIs were mainly found in cold environments (and coming from Minnesota, few environments could be colder), and that the many visits to pediatricians to treat these symptoms would not exist in the developing world. What surprised me even more was not that these diseases existed in the developing world, but that they caused the same level of anxiety for parents there as they do here. I remember thinking, "Your child has a viral URI. He'll get better. Why even bring him in? It's not like he has malaria." I remember similar feelings during residency, when I saw patients in clinic with what I thought were minor complaints. I dismissed them by saying to myself, "This parent is just concerned about her child, and she doesn't have the knowledge or training to identify or distinguish serious from benign disease." My mentor has an apt description for such patients: "sick, but well."

In Cambodia, I thought, "Gosh, these parents have seen more disease and death than I have. Surely they know how to distinguish the difference between minor acute complaints and serious illness." Actually, I think they do know the difference a bit better than parents here. But I think that this is precisely the reason they do bring in their "sick, but well" children: a benign-appearing illness can turn into a deadly one much more easily there—and it does, and with greater frequency. This didn't hit home until later in my rotation, when a well-appearing child with chicken pox seized in front of me while in clinic, was admitted, and was found to have varicella encephalitis.

My response to "sick, but well" patients underwent a marked evolution during my trip. At first, I simply counseled parents that the cause of the symptoms was a virus that would go away on its own, without any treatment. I was met with dissatisfied looks and disappointed parents. They didn't like being sent off empty-handed after waiting

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for hours in the tropical heat to be seen. This was different from my suburban Minnesota clinic, where most parents accepted reassurance happily, without medication. The Cambodian doctors cleverly worked around this dilemma by prescribing all children with URIs normal saline nasal drops and acetaminophen, which we had in ample supply at the AHC. Occasionally, 3 days of mebendazole or a dose of vitamin A was doled out for good measure. I quickly adopted their practice and had much better patient interactions afterward.

At first, I extensively questioned every child with a cough, regardless of the duration, about possible tuberculosis (TB) exposures and related symptoms, such as weight loss and night sweats. I was determined not to miss a single case of TB. After a few long, drawn-out patient visits, the nurse who was translating for me kindly said, "We have a lot of TB in Cambodia, but most children with cough do not have TB." I got the hint and adjusted my approach appropriately.

One weekend, Dan and I took the bus to Phnom Penh. We found a bike shop and handed over $4000 in donated funds to purchase bikes and equipment. Three hours later, joyful cries and shouts of "Bike! Bike!" arose from the Palm Tree Orphanage. Such jubilation as I have rarely seen erupted as the children picked out bicycles and tried them out around the orphanage grounds. It was mass chaos, and I loved every minute of it. The children loved every minute of it too. Many of them took their new bikes to bed with them that night. The next day, the bleary-eyed caretaker told us that early that morning the orphanage was awakened to the sound of 88 little bike bells and the laughter of children playing. We determined then and there to pick a new country every year and bring bikes to children that don't have them.

Dan left, and I spent my last week in Cambodia alone. I walked to the hospital every day, and I spent exorbitant amounts of money in dingy internet cafés on calls and e-mails to friends back home. As I walked across the tarmac before boarding the plane to the cold, snowy north of the United States, I drew in a long, deep breath of warm, tropical air. Four weeks had flown by. I felt rejuvenated by the joy I had witnessed at the Palm Tree Orphanage. I felt edified and enlightened by the diseases I'd seen and interactions I'd had at the hospital. Mostly, I felt incredibly proud to be a pediatrician with the opportunity to do such work in a foreign land, and I knew that this would not be my last foray into the world of global pediatrics.