

Two months in Quetta

C Cheetham

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I was attending a caesarean section for a transverse lie and the baby was doing well, when the attendant brought another one! This baby also did well, and I had been attending a twin delivery without knowing it. This had happened to me once 40 years previously, when the twins had been undiagnosed. This time the problem was one of misunderstanding due to language difficulties, and visual clues such as two lots of resuscitation equipment were simply not available.

to attend vaginal births. We agreed that I would attend emergency caesarean sections.

The twins were three weeks preterm, and because the mother had had a caesarean, they stayed for seven days. Both were breast fed, and the male had great feeding difficulties, while the female was no trouble. It was a surprise at discharge when I suggested that the babies were weighed to discover that, while the male had thrived reasonably, the female had lost 500 g. It was my first introduction to the great preference afforded to boys. Every minor difficulty with a boy is vital, while girls must look after themselves. I became involved in the details of neonatal care, and wrote a number of protocols in the management of the newborn. Staff were receptive to ideas for help in neonatal resuscitation, early feeds for low birth weight, indications for oxygen therapy, management of jaundice, management of thermal environment, and the detection and prevention of hypoglycaemia. Tasks that are considered easy in the UK such as accurate infant weighing or tube feeding were a challenge in a country where only 15% of women have had any education, but both nurses and doctors were willing to try new ideas.

How does a retired general paediatrician get into such a situation? My daughter was an aid worker with the Afghan refugee camps, and met Ron and Molly Pont, husband and wife surgeons, who had been working in Iran and Quetta for nearly 40 years. When they came to England they visited us, and I found myself agreeing to visit the Christian Hospital in Quetta, Pakistan.

The hospital is a general hospital with five wards containing about 150 beds, an operating theatre, and an obstetric department with 1500 deliveries a year. About a third of deliveries have had no antenatal care, and there are no neonatal mortality statistics. There are no separate facilities for children, and there is no paediatrician. Quetta (population in excess of one million) is the capital of Balochistan, Pakistan's biggest and poorest province. There is a medical school that struggles to provide a service for the enormous morbidity present in a large poor population with a high proportion of migrants and refugees. There are other smaller hospitals including a children's hospital funded by the German Government.

The diocese of Karachi funds the hospital. Capital expenditure comes from external sources, but running costs come from the patients. An outpatient appointment without drugs or laboratory tests is the equivalent of half a day's pay for a labourer, and an uncomplicated delivery a month's. Some patients were funded by independent charities, and some were treated free by the hospital. Charges at the university hospital were a little lower, but the clinics were seriously overcrowded and time for individual patients was necessarily limited.

I was asked to help in the outpatients, examine the newborn, to see child in-patients, and to help with nurse teaching. I thought that attending high risk deliveries might help with teaching resuscitation of the newborn, but discovered that male doctors were not allowed

Newborn babies are given honey or black tea at birth, and breast milk after a day or too. Babies born vaginally go home within hours of birth, but babies born by caesarean section stay for seven days. In my first four weeks I saw two babies, who had stayed because of caesarean birth, but who became critically ill with hypoglycaemia, and I assumed that the preterm low birth weight babies who went home early might suffer a similar fate. I visited a basic health unit where birth weights of home confinements (85% of babies are born at home) were recorded, hoping that low birth weight babies might have extra attention from the lady helpers or traditional birth attendants. However the quality of the records emphasised to me how difficult a task that would be in a country where the education of women has low priority and where men are never involved in childbirth or infant care.

A boy came to outpatients with a history suggestive of partially treated typhoid. I suggested a visit to the lab and the father agreed. When I later tried to find the result, I was told that the father had enquired the cost of the test, had decided that it was too expensive, and had gone. If I had known, I would have treated the child. Mothers rarely came to outpatients, and would never do so unaccompanied by another adult. Follow up or observation of a symptom could not be practised, as patients would go to another doctor for treatment. My knowledge of medicine was enough for the patients who came,

Correspondence to:
Dr C Cheetham, 6 Pretoria
Road, High Wycombe
HP13 6QW, UK;
kimcheetham@
bopenworld.com

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but my knowledge of social conditions was insufficient and could lead me to give the wrong advice.

In outpatients during Ramadan (a quiet period), I saw about 10 unselected patients a session who might have intercurrent infections, or long standing illnesses or disabilities. Children with chronic conditions such as cerebral palsy or rare inherited conditions came to see if the British doctor could do something that Pakistani doctors could not. Many had been superbly cared for. One 2 year old had a catastrophic spastic quadriplegia. There had been no physiotherapeutic advice but the father said that he had regularly turned the child from birth, and there were no contractures, the spine was straight, and the skin was healthy. Many children had appropriate diagnostic labels, but most fathers stated that they had had no knowledge of the prognosis or

possible aetiology, including genetic advice, explained to them.

Was it worth going? Two months away from home in a place where it was not practicable to take my wife was a strain for both of us. My Pakistani colleagues and hosts were very welcoming, and I was given good accommodation. In my everyday practice I was as effective as I had been at home. In suggesting different neonatal routines I may have been of help. I enjoyed teaching student nurses who proved to be both receptive and thoughtful. I certainly learnt a great deal of the difficulties that doctors must face when they practise in a society with limited resources and where the infrastructure is poorly developed. My medical background was sufficient to deal with the clinical problems that I encountered, when supported by the medical texts that I took with me. Local interpreters helped me with language, but different cultural and social practices were harder to understand. For example I totally failed to realise that the girl twin would have different management from the boy, and I underestimated the difficulty a father would have in telling me about his inability to pay for the typhoid test.

If other retired paediatricians have the opportunity to undertake similar postings, I would advise that their medical competence would certainly suffice, that they may find some difficulty in interpreting local culture or custom, and that their advice and help will be greatly valued by the doctors, nurses, and patients whom they will meet.

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