Reflection: Thailand Surgical Rotation

Initially when I decided to go abroad for an international rotation, I anticipated being placed in a different country, but as many things in life, not all plans materialize, which in this case ended up being a great opportunity for me to grow as a person. Thailand was the perfect program to attend in this situation, which was flexible with the change in plan - and in retrospect, was a foreshadowing of the experience in Thailand overall. I was placed in the Surgery Department, splitting my time between Plastic Surgery and Cardiovascular and Thoracic Surgery. As someone going into research and pediatrics, I was surprised with the placement, but decided to make the most of it. I thought that perhaps surgery would be an ideal placement due to the language barrier, as surgery has ingrained standards such as sterile technique, which would surely be the same as in the United States. When I arrived in the surgery department, there was a bit of confusion of why a non-surgical student would be placed with the department, but I was still welcomed and made a part of the team. Everyone I worked with, from scrub techs to residents, nurses to surgeons - wanted nothing more than for me (and all international students who come to Thailand) to have an excellent experience in their beautiful and beloved country. It did not take me long to realize that Thai people are very warm, kind, and tended to be more flexible than the standard “type A” personality we often see in medicine in the US.
During my time with the surgery department, I was struck by a few major differences – the first were obvious, such as the reusable draping using in surgeries, and one-size-fits-all hospital-provided flip flops in the ORs and gender specific scrubs (dresses for women, pants for men), but as I started to see past just the visual differences, I noticed a stark difference in patient autonomy, which is the focus of my learning objectives. This is set in the context of a comparison between Thailand and the United States in the setting of emergent surgical management. I was interested in three major sub-topics: 1) patient communication and translation services, 2) pediatric assent and measures for comfort surrounding invasive procedures, and 3) advanced directives and withdrawal of interventions.

In the US, under the Civil Rights Act of 1964, discrimination based on race, color or national origin was prohibited. This extends to healthcare in the form of requiring language access services (translation services) to patients.\(^1\) However, there is no such law in Thailand that requires translation services. While on my CVT Surgery portion of the rotation, I met a 3-year-old Chinese-American patient, who was transferred to Siriraj due to emergent dyspnea and diagnosis of pulmonary pleural blastoma, a rare solid tumor, that had grown to fill his entire chest cavity.\(^2\) This child’s only surgical cure was available at Siriraj due to the proximity of Thailand to China, where this child was on a family vacation. This boy’s life was saved with an incredibly invasive “clam-shell” operation, where the surgeon was able to remove the tumor without major complications. However, the boy woke up in an unfamiliar country, with no one speaking his language, in a room full of other elderly cardiac patients. In the US, we would try to ensure that parents are with the child after surgery, and are able to “room-in.” However, this boy was not taken to a pediatric ward, or able to wake up with his parents surrounding him – in
fact, he was only able to be with his parents during the narrow window of visiting hours. This case presented two issues I found in Thailand with regards to patient autonomy and decision making. First, there were no translation services offered to this child or his family, but only those of the medical staff – who were mostly able to communicate in English, but not at all in Chinese, the family’s first language. Although this child was in an open room with bays separated by thin curtains, he was completely isolated by language, age, and from the familiar faces of his parents. Secondly, this child had almost no measures set forth to ensure his psychological comfort, and there was no Child-Life specialists to be found, who could have assisted in reducing fears surrounding extubation and blood draws - which is in stark comparison to the way we handle pediatric surgery in the US. In fact, a recent study has shown that parental presence during induction of anesthesia in pediatric patients dramatically reduces the anxiety of the pediatric patient, and improves the quality of anesthesia induction.³ Although this child survived his surgery, I think it is likely that he experienced potentially avoidable psychological adverse effects due to the language barriers and non-pediatric hospital experience.

Finally, I was intrigued by the difference in approach to Advanced Directives in Thailand versus in the US. When I interviewed residents and attendings regarding patient choice in death and dying, I was told that they had received notifications explaining the importance of advanced directives, but that it was not practical, nor was it really done. In fact, a study completed in 2009 in Chiang Mai, Thailand, revealed that most physicians affirmed the usefulness of advance directives, but that the actual planning for death was limited.⁴ I agree with their conclusions that this can be attributed this to the traditional Thai culture where
patients and physicians tend to have a more paternalistic approach to patient care, where many patients and families will defer decision making to the physician. However, when I interviewed the doctors at Siriraj, most admitted that they intervene far too much with invasive procedures, when in fact the withdrawal of care would likely be a more humane approach to death. The Thai National Health Act has recently made it clear that patients should be able to refuse life-prolonging care in the terminal stages of life – an important first step in allowing Thai people to die according to their wishes.⁵

Culturally, I was always amazed at the politeness and overall respect that Thai people give each other, and especially to physicians. Even in severe pain, such as the patients who were post-operation day 1, would have such high regard for their physician, that they would continue to put their hands together and bow their heads when they saw their doctor as a sign of respect, even though this motion would clearly cause pain to their incision sites. It always felt strange to both do this motion towards other doctors, but to have this done to me as a visiting student. I think this type of respectful action towards other people and elders likely contributes to the feeling of safety of the country, as well as the paternalistic approaches seen in the hospital setting.

As a final comparison of the attitudes of Thai physicians with myself and my perception of a typical American physician, which I believe sheds light on the overall cultural attitudes of Thailand, I am reminded of the patient that led me to have my most profound clinical experience, a 36-year-old man who we operated on for severe third-degree burns. This man was at his job as an electrician when he was severely electrocuted and covered in more than 30% body surface area burns. His face was disfigured, along with his hands – which will likely
lead to life-long contractures and inability to have manual dexterity, as well as chest and extremity burns. As we started our extensive debridement for this patient, I was struck with how different my opinion of his “luckiness” was, as compared to every other person in the operating room. As we scraped away the dead tissue, I said to the resident, “wow, he is SO unlucky,” to which he responded, “really?!?” The residents and attending were all so surprised that I would consider his disposition “unlucky.” In fact, they all considered his predicament to be “lucky,” even though they knew he had lost his livelihood as an electrician, would struggle psychologically with his appearance, and would likely require serial operations. In fact, the primary surgeon pointed out how lucky this man was to have his eye sight and how lucky it was to not die from smoke inhalation. It was at that moment that I saw how much the Buddhist nature of Thailand really played a role, even in the medical setting – everyone agreed that life was still previous and worth living, and that his suffering may help him lead a fuller life.

When thinking of how to apply my experiences in Thailand to my future practice as a pediatrician, I know that I will be more cognizant of the importance of patient comfort and translation services. It’s tempting to think that I would be able to communicate to patients with my Chinese or Sign Language skills – but I am not fluent, and although I could manage a conversation, it would be too easy to make a mistake, and cause anxiety to the patient. Additionally, just as the people I met around Thailand and at Siriraj Hospital were flexible and able to “roll with the punches,” so too, would I like to become in my own practice of medicine.
References


