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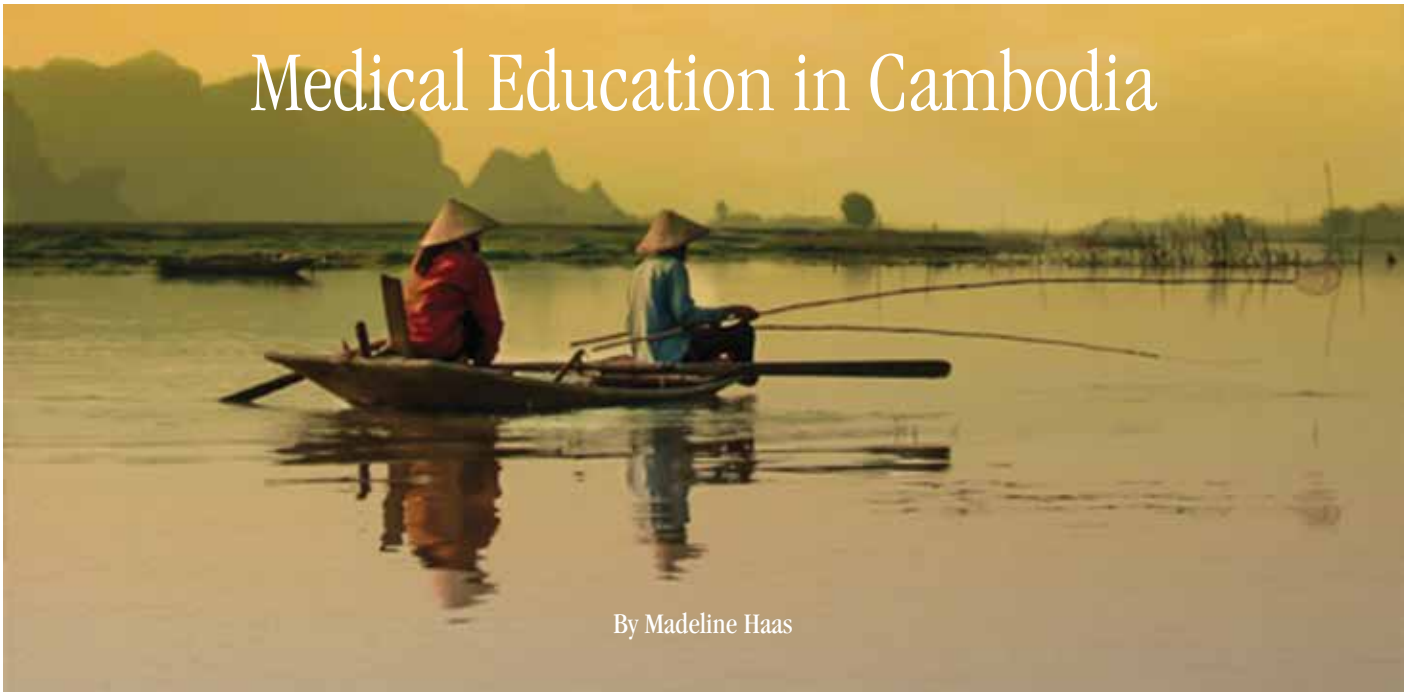

Medical Education in Cambodia

By Madeline Haas

The drive across Phnom Penh to the University of Health Sciences (UHS) is harrowing. My mother and I sit in a tuk-tuk, backpacks hugged tightly across our laps, outer arms holding the metal railing of what is essentially a small tin cabin slung onto a motorcycle. Swarms of motorbikes pull up beside us at every traffic light. We turn off of the main road onto a quiet tree-lined street and zip past outdoor restaurants, fruit stands, and a pet store. The street life here is enviable: all transactions, from soup to piles of green coconuts to stacks of fish tanks, take place on the wide sidewalks. The city is full of contrasts like this, with luxury apartments and commercial buildings going up around markets and low two-story buildings. We turn left once again and arrive at UHS: four large, rectangular, white buildings with open-air corridors and red tile floors.

Around us, medical students arrive on motorbikes, dressed neatly in navy skirts or slacks and bright blue blouses. We enter the campus on foot. I bid my mom goodbye—she is off to facilitate a meeting with faculty, and walk up the six flights of stairs to my classroom. Upon entering, I am greeted by the intimidating sight of 60 desks filled with uniformed medical students. Although this is new to me, I try to project confidence as I walk across the front of the room to where a desk has been set up for me with a projector and a bottle of water. The class monitor, a prim-looking young woman with long, straight black hair welcomes me and shows me how to use the microphone.

I move to the center of the classroom and begin my first presentation, "A Day in the Life," about my experience as a third-year student at Albany Medical College. I am lucky enough to have a mother who is an academic family doctor, and she invited me to Cambodia as part of the Boston University (BU) Family Medicine Global Health Collaborative. For many years, the Collaborative has been working with several Southeast Asian countries to strengthen the training and quality of general practitioners; now they are working with Cambodia's public medical school to design a competency-based undergraduate medical curriculum. As part of an effort to raise standards for its graduates, UHS recently created a simulation lab to help students practice clinical competencies. I asked for my own role on the trip, and was given the opportunity to teach clinical skills for the week. I decided to teach history-taking and the oral presentation, tasks that I feel confident with by this point in third year; my goal for this first morning is to lay out the context for these skills.

The students in my class are part of an international program and were chosen for their language skills in French and English in addition to Khmer. After some coaxing, they raise their hands and speak in accented but free-flowing English; they have the mixed confidence and shyness of academically successful college students. The front row is a little bolder than the rest: after I explain the U.S. medical education system, they want to know why we have four years of college before medical school and how we study for the USMLE exams, which they have heard of. Some of these students will go on to pursue specialty training abroad in France or the Philippines; their curiosity suggests a dream of studying in the United States as well.

In exchange, I ask them how the Cambodian medical education system differs from the US system. I want to know my audience, and I hope to be helpful to the BU Collaborative by sourcing information directly from students as their peer. I learn that these students entered medical school just after high school; after three preclinical years, they have just begun half-days of rotations while continuing to attend lecture in the afternoons. In the mornings, they shadow at-

tendings on rounds; afterwards, they have some time to return to the patient to practice history and physical exam skills. Their aim at this point is to recognize the signs and symptoms of known diseases. Unfortunately, because they have afternoon lectures, they do not have an opportunity to do admissions until the fifth and sixth years of medical school, when they take call. As a result, they are unfamiliar with the concept of team-based learning and skeptical that the complete history and physical ever takes place.

A few hours into teaching, I have already discovered a challenge for the rest of the week: how can I teach history-taking and oral presentation skills to an audience that doubts their value? Fortunately, the students remain engaged and this becomes a focus of discussion, rather than an excuse to lose interest. Why take a complete history? When to take a complete history? How to maintain the patient's goodwill and cooperation? While these have been challenges that I have faced throughout my first semester of third year, I am surprised to hear them articulated by my Cambodian peers. Throughout the week, I am challenged to strengthen and communicate my understanding of these questions.

To teach history taking, I had prepared a series of activities based on my clinical skills and medical Spanish courses. What made me think I could teach clinical skills? At my medical school, we learned clinical skills from the fourth years, who take a required rotation called "Learning to Teach, Teaching to Learn". While our curriculum is faculty-led, fourth years demonstrate for us, provide one-on-one instruction, and observe and grade us taking histories and doing exams on standardized and real patients. We begin teaching our peers as early as first year, when we teach anatomy to each other in small groups around our dissection tables. Although I am still a year out from my Learning to Teach rotation, I feel comfortable with the format and methods of this process. I also studied medical Spanish, and have a sense of what it is like to study medicine in another language.

I break the history down into pieces, as I had learned it: introduction and chief complaint, history of present illness, past medical history, family history, social history, and review of systems. First we review the complete history as a class. To make the session more interactive, we discuss the purpose and value of certain components, such as a proper introduction or taking a social history. The students proved themselves active participants. Based on their high level of comfort with English, we move faster through the material than I had anticipated, and finish reviewing the complete history after the first day.

On the second day, we launch into exercises. First, I demonstrate a segment of the history in front of the class with my mock patient, a young Cambodian attending physician. Next, I ask a volunteer from the class to ask questions of our patient, which gets the class talking and using English phrases. Then we break into small groups of three and the students take turns role-playing patient, medical student, and listener/observer. Faculty from the simulation lab and two young attending guests circulate to answer questions and give feedback. Finally, we reconvene as a large group for questions and feedback from the attending physicians.

Clinical skills faculty were present throughout to observe these interactive exercises and the impact they had on the medical students. They later told me that they were impressed by the dramatic progress the students had made in just a few days, which they attributed to the role playing. The students displayed an impressive comfort with medical English. They understood the nuanced differences between taking a history from a patient in lay terms and giving an oral presentation in technical language; they even challenged me to explain the difference between tachypnea and palpitations and to describe "dull" pain. I loved the energy in the room and appreciated how teaching forced me to better understand the role of the medical student.

This was my first experience with academic family medicine, and it was thrilling to join a team of attending physicians with years of experience in teaching and global health. I was even able to dip my toes into research by conducting a survey for students at the end of the week. Many noted that they felt more comfortable asking questions of a peer teacher. Similarly, practicing in the simulation lab was a relaxed setting that helped to combat the time pressure they had reported they felt on the wards and gave them an opportunity to receive feedback. Returning home, I felt some trepidation at giving up the role of the teacher for the job of the third year medical student. Re-entering rotations, I was reminded of how much basic medical knowledge, patient interaction, and inter-professional communication I have to continue to learn and practice. I feel freshly aware of medicine as an iterative process, a continuing exchange between learning and teaching.

Madeline Haas *is a third year medical student at Albany Medical College in New York. Before medical school, she majored in history at Harvard College and learned to give presentations as an associate consultant at The Bridgespan Group, a nonprofit organization. Her interests include medical education, advocacy, and the medical humanities. You can follow her reflections on being a medical student in her blog and column, The Med School Cookbook, on www.medschoolcookbook.blogspot.com and at www.in-Training.org. She will be following her mother into family medicine.*