Working in a Saudi ED

By Mary Cunningham, MD

This is the first of two articles about the author's four-month stay in Saudi Arabia.

I WORKED FULL TIME as a senior physician at the King Faisal Specialist Hospital and Research Center in Jeddah, Saudi Arabia, from November 2001 to February 2002. Most things I didn't do differently than I do here. I wore my usual slacks and lab coat. I took care of both men and women. Often, for the women, though, one had to listen through a top to hear heart and lungs.

I had been told that a woman doctor should not touch the men. Now, how could you work that way? Anyhow, it wasn't true. I had been really concerned because I am an inveterate shoulder patter and knee patter and hand patter; yet all that was no problem. But, lest you think that all was exactly the same as in the U.S., here are some Tales of Arabian Nights — and days.

KFSH & RC was "acquired" by the Royal family a year before I got there — it had previously been a private hospital. The hospital of the same name in Riyadh is about 27-years-old and took the new one in Jeddah under its wing to get it up and running, and to provide senior staff.

The hospital serves several functions. First, it is always available to the king and the royal family while they are in Mecca and/or Medina.

Second, it is a referral hospital for the Middle East. For example, a government may have a patient who needs medical care unavailable in the patient's home country. It can apply to King Fahd for a royal order. If granted, information about the patient is sent to a committee in the hospital for review and a decision on whether KFSH can offer help that other hospitals cannot.

Third, people besides the various princes who nonetheless are considered VIPs can get care there. And fourth, in Jeddah (but not in Riyadh), anyone who can pay can receive care. For everyone else there are government hospitals.

We dealt therefore mainly with "VIPs" and with referrals from other countries. Among the VIPs were a number of Saudi princes and princesses, some closely related to the royal family, others only distantly. Most wanted Western-trained doctors and at our hospital all permanent staff doctors had to be Western-trained.

There was an order of preference — they considered American doctors to be the best, then Canadians, next the British, after that any trained in Europe. Saudi doctors, even if trained in U.S. medical schools and/or residencies, seemed to be last on their list. This prejudice seemed unfounded; I remember two Saudi cardiologists as being absolutely wonderful, both technically and as human beings.

Many of the princes and their families arrived with folders of treatment records from Johns Hopkins, Harvard, Stanford, Cleveland Clinic, Mayo Clinic, etc. They were very

familiar with the U.S., many having traveled there extensively; most seemed to love Los Angeles the best, and many had a great desire to go to Las Vegas.

The princes also favored Western nurses and tended to consider Philippine, South African, and Indian nurses as inferior, even though we had excellent nurses from everywhere.

Our hospital had a paramedic team from the U.S. and two U.S.-equipped ambulances. The paramedic team was excellent. I don't know what the situation in Riyadh, Taif or other cities was, but the general ambulance transport in Jeddah was abysmal. The staff were essentially untrained, and the ambulances poorly equipped; often there was just a driver who loaded the patient in the rear on a gurney — if he had one — and drove off.

I assume those U.S. paramedics are now gone

Preparing for the king

A 9000-square foot suite on the top floor of the hospital is reserved for the king, and accommodates the king's whole retinue. The ED had a room designated as the King's Room, which was held in reserve whenever the King was in Mecca or Medina. Otherwise it was just used as another room in the ED. I think these facilities would be made available to close family members as well.

During Ramadan, we had a big drill at the hospital to be sure we would be prepared should the King come. All patients who could be discharged would be sent home. Those who could be moved would be transferred to other hospitals. No hospital visitors would be allowed.

The King would arrive through the VIP entrance and be taken directly to the ED, which also would be evacuated as far as possible. Triage would be set up in the regular entrance to the hospital so as to admit only those who were too unstable to be transferred elsewhere. As soon as the King was stabilized he would be sent to his suite. The rest of the hospital would remain essentially closed as long as he was there.

Because the ED was "headless" during part of Ramadan — the department chief (a Canadian) had moved up to Administration, and his successor had not yet arrived — I was asked to serve as chairman for three weeks. Should the King have come to us for care, I would have been contacted on the "King's Beeper," which I carried 24 hours a day. A car would have been dispatched from the hospital to get me wherever I might be — cars would have been dispatched for all department chairmen and all consultants who might possibly be needed.

We had a number of "King's Beeper" drills at odd hours; we had to call a special hospital number after receiving a message to report our location. Happily, I never had to face taking care of the king and he returned safely to Riyadh!

Dealing with VIPs

The young Saudi men who were our EODs, the "Executive Duty Officers of the Day" ("executive" was the important word, titles being very important in Saudi), saw to it that only those who were eligible were seen in the ED. They knew who were distant royals, who were VIPS, and who were "Top VIPs."

VIPs might be princes or senior industrial people or diplomats. Top VIPs, as far as I knew, were close members of the royal family. If a Top VIP was coming in, everyone was alerted, including whatever specialists they wanted to see. The VIP was met at the door by the EOD, who would escort the VIP, with much todo, to the ED. It was not unusual for specialists to come in at three in the morning and cool their heels for several hours waiting for the arrival of the patient — who might or might not get there.

Almost all of the VIPs were considerate, friendly, and spoke excellent English, so I could

avoid the unsettling task of asking a translator why the patient was there, and have them carry on a five-minute discussion in Arabic, only to be told, "He has a sore finger." (I have no idea what those long discussions involved — it sounded like at least a whole past medical history to me!)

Medications and narcotics

The hospital had excellent facilities and very up-to-date equipment. However, one never knew what one might or might not be able to get in the way of medications. Apparently the big Western drug companies weren't always paid as fast as they would have liked, and sometimes refused to deliver anything more until they obtained the money.

One night there was absolutely no morphine or other injectable analgesic in the hospital. On another night, we had no Ativan or Valium except for one Valium suppository in the possession of the ICU. "We should get more tomorrow, Inshallah." "Inshallah" means "God willing" or " by the grace of God," but in this case was used more like "mañana" — it was a word I heard often and learned to fear!

Attitudes toward narcotics were unusual. We heard tales from the nurses of cancer patients lying in agony being denied morphine, Roxanol, etc. Only oncologists could prescribe these drugs, although we could give a single dose in the ER. We had one poor man who came almost every day and we pleaded with one of the oncologists to prescribe something to help him.

This oncologist was a compassionate Indian doctor, and he prescribed Roxanol for the man. A few days later the patient found out what Roxinal was and called the police to arrest the doctor for "prescribing such medications for me — this is a narcotic drug!" I don't know what he thought the morphine was that we gave him in the ED! The oncologist explained the situation to the police and they went away.

Physicians and nursing staff at the hospital came there from all over the world. All physicians had to be Western-trained to serve on the staff. Pay depended on where you came from —scaled so that you would receive something more-or-less equivalent to what you would expect to earn in your home country. Physicians were usually paid on time. However, if the hospital was short of money, nurses might have to wait for four to six weeks to collect their pay.

Inherited genetic problems

A couple of generations ago many Saudis were Bedui, living in tents in the desert.

It was very important to cement tribal ties, and so the preferred marriage was between first cousins. This ideal marriage is mentioned in the Koran. Babies often died in the neonatal period, and while this could be due to many causes, the people were not aware that in many cases the problems were genetic.

Now, among the more educated Saudis in the cities, there is an understanding of genetic problems caused by generations of intermarriage. Many young Saudis, like some of our EOD's, say they will never marry their cousins (nor do they want their marriages to be arranged). Because of the incidence of genetic disorders in the population and because we are a tertiary referral hospital, many genetically compromised babies were seen in our ED.

There was one little boy about 7-years-old who came to the ED every day for his antibiotics — he had a MRSA osteomyelitis. There was no known name for the spectrum of his congenital defects — he had frontal bossing, low-set ears, eyes set at different levels, facial distortion, short stature, syndactyly, and a host of internal defects. He was, despite all this, a very bright, talkative, outgoing youngster and a big favorite of the ED staff.

I saw a number of genetic defects I had never seen before, and had only read about very briefly in second year medical texts. At KFSH in Riyadh, Dr. Ozand has done much

research on children who are missing various enzymes — many in the Krebs Cycle. When one of these babies presents, the head nurse will look and say "Oh, an Ozand Baby — call the pedi res."

We had a whole set of Ozand protocols outlining what to do in various cases. For example, a father came in one day carrying a floppy infant with prominent frontal bossing. The baby was hyperventilating to maintain his pH level. Fortunately, the parents usually know the diagnosis, as they did in this case. He was an arginosuccinyl acidemia baby — open the protocols and find out what Dr. Ozand says.

Not only did we see a lot of these enzyme problems, but also many congenital coronary problems — hypoplastic left ventricle, Tetralogy of Fallot, etc. It was not uncommon to have two or three of these in our small ED at the same time.

We also had many cases of children 3 or 4 years old who had had liver transplants. These pediatric cases were sent to the US to be transplanted and were then followed in Saudi Arabia. Adults were usually transplanted in Riyadh and followed there or in Jeddah. There were many cases of liver cirrhosis, about 40 percent of unknown etiology.

Saudi parents take very good care of their genetically impaired children — they are not put away in some institution to be forgotten. They are loved just as their normal children are loved. The presence of these children is the will of Allah. In Saudi Arabia, family comes before all else. Many business appointments are cancelled because some family member becomes ill or injured or has some other crisis — Western businessmen often have a fit at such times.

A floppy baby, and a second wife

A woman come in late one night with her mentally/physically retarded baby who was about 2-1/2 years old. He had developed kernicterus as a neonate because the hospital where he was delivered kept telling the mom that the baby was fine and that "the yellow will go away."

He was a totally helpless, floppy baby with two feeding tubes, a gastrostomy tube and a jejunostomy. He would smile at his parents, but otherwise did not seem aware of anything or anyone around him. We saw this baby very often with one problem or another and always both parents came with him.

This night mom was alone. When she had fully realized how much care the baby would require, she told her husband that he should take a second wife so that he could have the attention he deserved. He did so, but the second marriage was not a happy one and the husband divorced his second wife.

The first wife was now at the hospital alone because her husband had gone to Riyadh where he would marry again the next day. She hoped her wait at the hospital would be short because she and the baby were to be driven to Riyadh that night to be at the wedding. The new second wife would then come to Jeddah with the rest of the family. Mom said she was looking forward to having some relief from trying to care for this baby, and still keep a home.

Patient fasting during Ramadan

Ramadan is a month of fasting all day, every day. Muslims may not eat or drink any liquid from the morning call to prayers until the official sundown (the exact time for each day is printed in the newspaper). Most shopping goes on at night. Restaurants may not even be open until around 9 p.m. Stores are open very late and the streets are crowded as if it were daytime. It is a nighttime society for the month.

People with some chronic diseases cannot tolerate such a fast easily. In such cases the Koran does not demand that they fast. However, many insist on fasting anyway. A man brought his wife, who has sickle cell disease and was dehydrated and in Sickle Crisis, to

the department one evening — she was moaning and crying with pain. She had refused to come until after the hours of fast because IV fluids would break her fast.

After sundown the fast ends, so people can eat. Diabetics may eat injudiciously at night so their blood sugars next day are out of control — but they will not come in because SQ or IV insulin will break their fast. CHF patients cannot be diuresed as IV medication will break their fast. Patients who are supposed to take medication during the day will refuse to do so. You can reason with them, but they will not listen, especially, I would assume, to an infidel doctor.

One sees dehydrated patients and others who will need IVs or medications sitting in the waiting room waiting for the exact minute of the end of fast. Then they all want to be helped at once. One usually has few patients in the department during the day, but nights can be really terrible.

At the hospital during Ramadan, the cafeteria windows are covered over so that fasting Muslims will not have to see non-Muslims eating. A nice thing about this is that the cafeteria is no longer separated into a section for women and a section for men. The cafeteria staff are very nervous about this aberration.

Originally, the cafeteria was not segregated, but a very conservative administrator came on the scene and demanded that men and women not eat together. Happily, he fasts during Ramadan and never came to visit us while we were all eating together.

Just before the start of Ramadan I had a delightful gentleman as a patient. He was, to say the least, "portly" and he told me how hard it was for him to lose weight. I suggested that with Ramadan soon to begin, he could diet then and get his weight down some.

"Oh," he said, laughing, "You do not understand Ramadan in Saudi Arabia! We fast all day, but at night we feast like pigs! I will gain even more weight during Ramadan." I must admit all the food and sweets and goodies of every variety that are available at night would be very hard to resist!

mclusby@msn.com

Sierra Sacramento Valley Medical Society
5380 Elvas Avenue #100 • Sacramento, CA 95819
916.452.2671 PH • 916.452.2690 FX • Email: info@ssvms.org

Copyright © 2000-2008 Sierra Sacramento Valley Medical Society - All Right's Reserved