CONSULTING REPORT
ON
PEDIATRIC TRAINIG IN PRIZREN HOSPITAL
PRIZREN, KOSOVA

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I. INTRODUCTION:

Kinderberg International has been supporting pediatric patient care in the Prizren Hospital, Kosova for the last two years after the 1999 war. The goal of the project is to provide practical pediatric training for physicians and develop the pediatric department as one of the key training sites in pediatrics in Kosova. Currently, there is no pediatric training site collaborating with foreign institutions other than this program in Kosova. Considering the fact that more than 50% of the population is age under 18 years old, pediatrics is one of the most important medical areas for training.

I stayed in Prizren, Kosova between 5/5/01 to 5/25/01 to provide bedside clinical training for residents and pediatricians at Prizren Hospital. This is my third trip to Kosova following March and November 1999. This time, I could notice many physical improvements compared to my last visit 18 months ago: The automobile registration has implemented; more grocery and other stores were opened in town; there was barely any long power outage in Prizren; most of the damaged houses have been repaired or are under construction.

Some of my observations on delivery of pediatric care are summarized in the section III. Section IV provides further analysis for these observations based on old and new problems. Section VI will address some of the recommendations for the project also for those expatriate physicians involved in this program.

II. PROJECT DESCRIPTION:

1) Patient Care:

There are four attending pediatricians with nine residents in the Pediatric Department in the Prizren Hospital. The residency training is for three years. All the residents are former GPs (General Practitioners) working in Ambulanta for 8-14 years until they were selected for further training to be pediatric specialist. Their work hours are between 7am to 3pm. All attending pediatricians have their own private practice outside the hospital between 5pm to 10 PM from Monday to Saturday. Night duty starts from 3pm until 7 am in the next morning. One resident and one attending are on duty everyday. Each resident and attending takes calls once a week on average. On the weekend, they take calls for 24 hours between 7am to 7am.

The pediatric floor is divided into two sections, pediatrics and neonatology. In pediatric section, the floor is divided into four different sections based on the organ systems; neurology, pulmonalogy, nephrology, and GI. Each attending pediatrician is assigned to each section. A ground round or professor round is performed twice a week, in which everyone in the department rounds and discusses all the patients together. At the grand rounds, attending pediatrician will present the case discuss treatment plans without asking the opinions of residents. Residents have never been asked to express their own treatment plans or diagnosis.

There are only limited opportunities for residents to learn in an organized way. They have no lectures, seminars, or journal clubs. Additionally, the resources are fairly limited: on the shelf in the doctors' room, they have only the latest edition of Nelson's pediatrics and Mandell's infectious disease textbook. They want to obtain their own copy of Harriet-Lane manual and Sanford Guide for infectious diseases. However, many of them find it difficult to read textbooks in English. As a result, they do not make the most of pocket manuals at the bedside.

Charting system:

Kosovar doctors write a long admission note. However, no notes are usually written after admission. It is instructed that a progress note should be written everyday in complicated cases. However, they simply write medication instructions in the vital sheet. Laboratory orders are also written into the sheet. At the time of discharge, discharge summaries are typed and the copy is given to the patient. Although the vital signs (temperature few times a day, RR) are recorded, they often fail to record Ins and Outs. BP is optional. Concept for Ins and Outs seems to be hard for them to understand and usually those records are left out even in renal patients such as nephrotic syndrome. During my stay, some residents started to write progress notes, not by the SOAP system but with their own one or two lines of impressions. Interestingly, physical examinations are rarely recorded in the chart. Both in admission notes and progress notes, assessment and plan are hardly discussed in the chart.

Laboratory test:

There is a serious problem for reliability of lab test ordered in the Prizren Hospital. They can not run electrolytes, only CBCs. Cultures are not reliable, nor are antibiotics sensitivity tests available. Due to the wide spread abuse of antibacterial medications, in sick patients, drug sensitivity is a crucial piece of information, but it is not available. On average, patients are on three different antibiotics before they are seen by the pediatric service in Prizren.

Kosovar pediatricians concentrate on finding abnormal results in labs or xps. They seem not to have had limited training in communication skills with patients. Exploring the patient’s belief system seems to be considered a waste of time and was never taught.

Outpatient care & emergency room:

There is no specific section for pediatric emergency cases in the emergency room. Patients’ families take their children directly to the pediatric floor, where the regular examination room is used as a triage room. The same room is used for general referral cases from Ambulantas or private clinics. There is a room in the second floor for general follow up cases after discharge. It is extremely difficult to see how the referral system works or how the emergency cases are brought in. There seem to be an unconventional triage system existing. It seems like patients are self-triaging and handling problems in their own way. The workloads of emergency cases are helped significantly by the fact

many private clinics are open until 10pm every day except weekend. However, I am not clear how they handle serious cases such as pediatric trauma cases, as I've never seen them on the floor.

Medical evacuation:

Expatriate physicians are often asked to see cases for potential foreign evacuation. Some of them are fairly serious cases. These are as follows.

Case 1:
12 years old girl with left leg swelling.
She came with a complaint of left knee swelling and pain started almost two years ago and got worse over the past two months. At the time of the examination, she could not bear her weight on the left leg. On examination, there was more than 10 cm swelling noted on left proximal tibia. On X-rays, there was pathological fracture of proximal tibia and similar size neoplasm was identified. Osteosarcoma was suspected clinically. Bone biopsy was performed in Pristina Hospital a week before I was consulted, however, due to the lack of stain materials, pathology results were inconclusive for malignancy. The patient is an orphan whose father was shot to death in front of her during the war. The patient's family does not have any financial support for any other management. I recommended her to go back to Pristina hospital for early amputation of the leg.

Case 2:
4 years old girl with esophageal stricture.
She accidentally ingested cleaning liquid when she was two years old. Since the accident, she has been only eating juice and pureed food. However, she was not severely malnourished. Gastroenterologist at Pristina hospital could not perform endoscopy because of technical difficulties and they recommended bugees but it is not available in Kosova. On the examination, her teeth were all decayed and poorly developed lower jaw probably due to no chewing movement since the accident. She had significant rhonchi at both lung field probably due to her chronic aspiration. In her mouth, there were several mucosal stricture band. I surgically cut one on her left side. I refereed the case to Dr. Agim, a pediatric surgeon at the Prizren Hospital, for consultation for PEG or jejunostomy tube and preparation for either bugeeing or esophagectomy with reconstruction.

Case 3:
2 year old boy with 2nd finger contraction after skin grafting.
He had a right hand and forearm flame burn at the age of one. Partial thickness skin grafting was performed immediately after the accident. Unfortunately, severe contracture was developed on the right 2nd finger involving PIP and MP joints. It seems like Flexor digitorum superficialis and profundus were intact. I recommended Z-plasty at Prizren Hospital. I refereed the case to Dr. Agim.

Case 4:
8 year old girl with recurrent nephrolithiasis and enuresis.

She came in for consultation for further workup in Germany. She had a history of nephrostomy for stone removal. Also, she has been suffering from enuresis in the past few years almost 5 days a week. Work up at the Pristina Hospital showed recurrent nephrolithiasis on ultrasound. Her father was one of the 230 men killed during the war in front of the family members in the village called Krusha e Madhe. There was a suspicion that her enuresis was a psychological etiology cause secondary to her trauma. I recommended the close follow up of her kidney stones and renal function at Prizren Hospital.

If you are interested in more consultation cases, please check Kinderberg telemedicine website at www.argess.de.

2) Education

The schedule of lectures & workshop provided each morning during my stay is attached in the table in this report.

The "Professor Round" is provided twice a week for all the patients on the pediatric floor. All pediatric staff including attending physicians, residents, expat physicians and charge nurses rounded together.

"Saving face" is an important part of the culture. Generally, confrontational teaching style does not work here at all. Rather, facilitating collegial discussions seemed to work better than "banking method", which just instruct them what to do. Also, residents learn by observing their seniors, not by asking questions or challenging their seniors' judgements. However, residents express more opinions and questions at the bedside as the days went by during my stay.

II. ISSUES IN PEDIATRIC CARE IN KOSOVA

I would like to discuss some of the current issues in patient care I observed in the Prizren Hospital from both patient's and physician's viewpoint.

1) Observations among physicians:

- Lack of Coordination: Fragmented care without any coordination

Due to the lack of communications among physicians, patients have to run between clinicians with a carbon copy of typed report in hand. Patients are often confused since they do not know whom to trust and which diagnosis is right. People seek care with any specialists (pediatricians or pediatric neurologists, urologist and so on). People are running between several different clinicians for second or third opinions until they are satisfied with the diagnosis or treatment plan.

- Physicians have no training for patient communication

Physicians provide no explanation for their patients. Patients' feelings are not in the equation of treatment plans. Patients, unfortunately, do not have enough information to decide on which treatment and management options they can choose.

- Dealing with emergencies

Kosovar doctors do not seem to be comfortable dealing with emergencies. This observation certainly relates to their past and current medical training and education. In medical textbooks they use, there are only a few sections that mention resuscitation or emergencies in a practical sense. There is no well-organized book chapter for this topic. At medical school, professors/instructors usually teach them medicine as very "static", which means that the medicine is for finding cause and assign treatment rather than dealing with patients' condition and complaints which tends to change dynamically. Even though it is indispensable to observe and assess patients repeatedly in short intervals to assure the patients are stable, it is a difficult concept to convince many practicing physicians. They are not taught that patients' condition would dynamically change.

- Medicalization

Physicians tend to overmedicate patients. Physicians in Ambulanta or health posts do not learn to spend time to educate patients, and also they are not sure when and what is the true medical necessity.

In my observation, physicians do not deal with anything that is not in the medical text books. For instance, in case of subtle muscle strain of the neck or back, they initiate full workups including blood work and X-rays, instead of assessing patients' severity based on physical examinations.

Poor history taking related to history of present illness further confuses physicians to organize their possible differential diagnosis for the symptoms. Other than major disease categories, they do not have any attributable illness categories for minor pains and complaints. Lack of skills in systematic collection of data makes them rely on more labs and imaging studies. They are not trained to discuss differential diagnosis based on clinical signs and symptoms.

2) Observations among patients:

- Expectations

The expectation for medicine is different among patients. In my observation, patients are seeking care for either of these two reasons; 1) they want magic bullets or 2) they want biomedical explanations for their complaints (and disease legitimization). Many patients have a significant lack of trust for their medical system and the level of medical care compared to outside Kosova. This belief leads to seeking possibilities for medical evacuation for many cases.

People believe that "modern" technology, which they believe they do not have, would successfully reveal something accountable for their complaints. They do not believe that they are actually the victims of fragmented "organ-specific" care. Ordering tests or giving away medications often cause more problems unless you have high suspicion of specific conditions. Lab tests and imaging studies are often ordered without considering clinical suspicions (pre-test probability) and this attitude often results in even further confusion due to unreliable lab tests and poor quality of imaging studies.

Several questions and hypothesis can be addressed to verify these health-seeking behaviors.

- Biomedical myth nurtured through a culture of medicine before the war exacerbates the health-seeking behavior for medication and treatment.

- Medical training is based on pathophysiology based on limited evidence based solely on experimental animals rather than through evidence-based discussions.

- The wide spread perception that the lack of resources and technology due to the war, the disappointment for the existing medical system, and the past oppression have made them seek help from outside Kosova.

- Behavioral modifications

Their own behavioral modification seemed to be the last thing the Kosovars would think of. It is true, in many countries people would like to have a painful injection rather than stopping smoking.

- Medicalization

As I described in previous the section, medicalization is observed both among physicians as well as patients. There are three typical phenomena in the primary care offices in Kosovo now: illness legitimization, overmedication and somatization. Overmedication would be contributed to two factors, 1) lack of clinical and communication skills among GPs and 2) peoples' expectation for health care.

GPs out in practice are always under the pressure of patients' demands to prescribe something when they can not assure patients with their experience, knowledge and communication skills. Also, free medication by NGOs and relief organizations have conditioned patients' high expectation for many shots and pain pills.

Patients are almost always heavily medicated for viral infection or any other inappropriate conditions. For example, a 16-year-old otherwise healthy male patient with a few-month-history of muscular strain presumably due to computer work a few hours a day was prescribed NSAIDs, muscle relaxant and benzodiazepine for sleep. A 4-year-old girl was on amoxicilline for bed-wetting. Patients are conditioned to seek a quick fix or

magic bullets for quick relief or solution. This attitude promotes a barrier for any long-term intervention or behavioral modification.

IV. HEALTH CARE IN TRANSITION

In this transitional society, people seem to be suffering from two kinds of problems, old and new.

1) Emergence of new problems

- Destruction of health care system

The absolute lack of resources has exacerbated current chaotic systems.

- Somatization related to trauma

I am not sure whether it is new or old problem, but there is significant number of pseudoseizures or pass-out episodes among patients.

- Lack of standards of care in chaotic society

There is no standardization of care. The government and the universities have failed to set any practice guidelines or licensing. There is no concept of board examination, continuing medical education or re-certification. GPs out in practice in communities still overmedicate patients. Unsatisfied patients can go to any doctors for second or third opinions if they pay consultation fee. Due to the lack of communication and lack of collegial discussions among physicians absolutely further deteriorate patients' suspicion for the diagnosis and treatment. Subsequently, patients have to run into several different physicians for several different problems.

2) Old problems

- Patients' health seeking behavior

It is uncertain what was the level of health seeking behavior among Kosovars before the war.

- Medical education

Medical education has not been radically changed since the war. The expulsion of ethnic Albanian faculty members and the subsequent development of a parallel education system have been the main source of medical academia in the past ten years. This system has not yet radically changed or improved after the war. The medical education in Kosova is still heavily stressing on knowledge by reading textbooks rather than practical skills by problem-based learning.

- Position and locus of medicine in the society and culture

After I reviewed book chapters from a pediatric textbook published in the Balkans, I have concluded that their stance for a medical condition is fairly static. Static state medicine means that a physician's job is to make a diagnosis and assign each patient diagnosis and treatment in the textbook. It is obvious that the book chapters are not dedicated to any signs or symptoms indicating rapidly changing patients' conditions or how to initiate resuscitation for these patients. This will explain why they do not feel comfortable dealing with emergencies or any other conditions not described in textbooks. Physicians are trained to assign diagnosis and treatment and are not trained for managing changing conditions. The long-standing history of this concept has affected not only physicians but also patients and society in general.

V. WHERE IS A HEALER?

There is a serious need to develop new medical training modules to raise new groups of health practitioner to deal with diverse complaints. New training modules should train physicians to understand patients' diverse primary care needs.

These new groups of physicians are healers in a sense to care for patients as well as cure or treat them. It is the time to restore trust between physicians and patients. The physicians should be able to

1) Educate patients and their families with proper knowledge and guidance.
2) Communicate with other physicians through collegial discussions.
3) Coordinate different opinions among different specialists.
4) Deal with variety of problems related to psychosocial dimensions.

The reform in medical training should include a new translation for medicine. The new model or paradigm should not only approach patients as a collection of diseases and abnormal findings, but also care for patients including psychosocial dimensions. Medical education requires serious reforms to prepare physicians problem-solving skills rather than make them a tank of knowledge. They have to understand the rationale behind the "evidence-medicine" movement.

VI. RECOMMENDATIONS:

- *Expatriate physicians and nurses should focus on maintaining collegial discussions with local staff.*

In order to assist in the development of sustainable medical management skills, facilitation of collegial discussions is extremely important. Kosovar physicians seem to appreciate the collegial bedside discussions. Even though traditional educational system in Kosova focused on banking system, it is not working obviously at the bedside.

- *Expatriate physicians should facilitate communications among physicians as well as physicians-patients communications.*

  Communications among physicians are non-existent now in Kosova.

- *Expatriate physicians should be aware that practicing medicine under the limited resources is extremely challenging not only for Kosovar physicians, but also for us.*

  Some local physicians look their levels of medicine as being very behind the standards of Western medicine. It is not a matter of level of science, it is rather cultural and social in terms of how the position of medicine is placed in the society. We have to fight against this unnecessary inferiority complex among physicians and let them understand that discussions and teaching are a mutual process that we learn from them as much as they learn from us.

- *Expatriate physicians should encourage local physicians to enhance the knowledge level of local pediatricians by presenting at the local meetings and conferences.*

- *The current training program should be integrated into the plan for reforming medical education and resident training in Kosova.*

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experiences and interactions with physicians in the Prizren Hospital, Dr. Uke, Dr. Gezim and other staffs. I appreciate the help and discussions with Dr. Arnold Boysen. I also appreciate Mr. Michael Weinhara for coordinating these activities, Ms. Kermit Zysman for her stimulating discussion and explanations for current affairs in Kosova. I also owe much to Mr. Driton Zyflier for his assistance in translation.

Appendix 1. List of activities and lectures

Date	AM	PM
5/5 Sat	Arrived in Zurich from Newark on time	Arrived in Prizren
5/6 Sun	Made plans for lectures	
5/7 Mon	Rounded patients in GI section Fixed ultrasound machine	Alan's lecture on follow up immigrant patients in New York Strategy meeting with Allan, Michael, Arnolf, Wanda
5/8 Tue	Lecture 1. B*edside management of patients* **Workshop 1: Ultrasound**	Professor Rounds 1 Made emergency medication list for refugees from Macedonia
5/9 Wed	**Workshop 2: Ambu Bag, Respiratory support**	Visited Macedonian border villages, Zaplluzhe, Bljac, saw approx.20 patients including adults
5/10 Thu	Lecture 2. *EKG*	Observed operation at OR
5/11 Fri	Lecture 3. *Abdominal pain*	Professor Rounds 2 Visited Kosovo League Museum

5/12 Sat	Visited Krusha, consulting two patients	Visited pediatric surgery department Visited pediatrics floor for on-call house officers
5/13 Sun	Visited Albanian border villages	
5/14 Mon	Went to Krusha to perform procedure for 4 y/o child with oral stricture	Consulted by pediatric surgery department for pediatric anesthesiology training Lecture 4. *Taking Notes*
5/15 Tue	Dr. Gazim presented "hereditary angioedema"	Professor Rounds 3 Visited Macedonian border villages, Manastirica, Struzhe for look for Macedonian refugees. Visited frontline and Macedonian border German KFOR post
5/16 Wed	Dr. Wanda presented Hematuria	Prepared lecture for tomorrow
5/17 Thu	Lecture 5. *Fever Workup*	Consulted for 12 y/o girl with left knee mass, poss. Osteosarcoma GAVE A SPECIAL LECTURE: "EVIDENCE-BASED MEDICINE TRAINING IN THE US"

5/18 Fri	Lecture 6. *UTI workup*	Professor Round 4 Visited 6 months old male, s/p neuroblastoma op in Germany in village
5/19 Sat	Visited "medicine and pharmacy" seminar in cultural center in Prizren	
5/20 Sun		
5/21 Mon	**Workshop 3: Intubation**	Interviewed by "Radio Prizren" and "Kosova Sot"
5/22 Tue	Lecture 7. *My impression in pediatric care in Prizren* Consultation from Prizren Health House GP for post-op fever patient	Professor Round 5 Met country representative from AMDA (Assn for Medical Doctors in Asia)
5/23 Wed	Discussed about the protocols and guidelines for file with Mr. Driton	Visited Prizren Health House for IMCI (Integrated management of childhood illness)
5/24 Thu	Presentation: Nephrotic syndrome by Dr. Byram	Visited Krusha, Suva Reka Visited health house and polyclinic in each village.
5/25 Fri	Rounded patients on the floor with Dr. Uke and residents	Left Prizren

Appendix 2. Emergency Medication list for Macedonian Refugees

It is estimated by UNHCR that more than 6,000 refugees have been moved into Kosova since the offensive at Tetovo exacerbated. During the first two weeks of my stay, UNHCR estimated that there are 1,620 refugees moved into Kosova. As the days went on, however, the focus of the offensive has shifted to northeastern part of Macedonia, which is closer to Serbia and US sector of Kosova. Ministry of Foreign Affairs, Germany implemented emergency funding for the relief of these refugees and the following list of medication was prepared for this project.

Eferalgan	Paracetamol	05131	30 tbl.
Eferalgan	Paracetamol	05131	100 tbl.
Aspirin	Aspirin tbl.	79002	100tbl.
Captopril	Captopril	27225	100tbl.- 12.5mg
Captopril	Captopril	27225	100 tbl.-25mg
Carbamazepin	Carbamazepin	15016	100 tbl.-200mg
Furosemid	Furosemid-Heuman	36044	50 tbl- a40mg
Intal	Natrium Cromoghlycate	28126	50 Brechamp. Losung 10ml
Diazepam	Diazepam Rectal Tube	71306	5 Rectal tubes a5mg
Diazepam	Diazepam Rectal Tube	71306	5 Rectal tubes a10mg
Diazepam	Diazepam i.v.	71306	5 Amp. a 10mg
Digoxin	Digoxin Godecke 0.1mg	53026	50 tbl.-0.1mg
Imipramin	Imipramin	71105	50tbl. A25mg
Ferroinfant	Ferroinfant	08011	100ml
Ferroinfant	Ferroinfant	08012	250ml
Ferrosanol	Ferrosanol	08014	50kaps.
Ferrosanol	Ferrosanol	08015	100kaps.
Paracetamol	Paracetamol supp.	05131	10 supp a125mg
Paracetamol	Paracetamol supp.	05132	10 supp. a250mg
Paracetamol tbl.	Paracetamol tbl.	05038	20tbl a500mg
Ibuprofen	Ibuprofen a400mg	05259	50 fillmtbl.
Zyrtec	Zyrtec Filmtbl.	07041	50 tbl. 10mg
Zyrtec	Zyrtec liq.	07041	75ml.
Vermox	Mebendazole 100 mg	06004	6 tbl
Amoxicilin	Amoxicilin-Heyl 1000	10054	20 tbl.
Prednisolon	Prednisolon 5mg	31050	50 tbl.
Penicillin	Penicillin V 1.5 mega tbl.	10028	20 tbl.
Penicillin ing.	Penicillin-Heyl 1mega	10005	10ing.+10amp. a2ml.

Erytromycin	Erytromycin 500	10271	50 tbl.
Erytromycin	Erytromycin forte susp.	10271	100mg.= 33.3g
Erytromycin ratiopharm TS	Erytromycin TS	10273	250 mg
Cefotaxim	Cefotaxim Azu	10114	50ml = 2g
Bactrim	Bactrim Forte	10327	20tbl.
Bactrim	Bactrim Syr.	10327	100ml.
Sulfacetamid	Albucid	68011	10ml.
Salbutamol	Salbutamol Basics	28034	15ml a 0.1mg
Salbutamol	Salbutamol Basics	28031	50ml
Clonidin	Clonidin	17009	50tbl. a o.15mg
Clonidin	Clonidin	17009	50tbl. A 0.3mg.
Verapamil	Verapamil	27167	20 filmtbl. a 40mg
Verapamil	Verapamil	27167	100 filmtbl. a 40mg
Betaisodona Salbe	Povidon-Jod	85017	100 gr
Betaisodona Salbe	Povidon-Jod	85017	300 gr
Betaisodona Lösung	Povidon-Jod	33023	120 ml
Cephalexin TS ratiopharm	Cephalexin	10144	72 g (120 ml)
Elotrans	ORS	60356	20 Btl
Fenistil Tropfen	Dimetindenmaleat	07008	20 ml
Jacutin Emulsion	Lindan	22004	100 ml
Jacutin N Spray	Lindan	22007	90 g
ES Kompressen 10X10	Verbandmull	Dambeck 1407086	25x2 Stck
Meaverin Gel	Mepivacain HCL	59092	20 ml
Megacillin oral TS	Phenoxymethylpenicillin -Kalium	10021	1 Doppelpack a 56.82 g
Elastomull	Mullbinde 8 cm x 4 m	Dambeck 3486204	20 St
Elastomull	Mullbinde 12 cm x 4 m	Dambeck 3486227	20 St
Otriven 0.05%	Xylometazolin HCL	72056	10 ml
Pulmicort 400 microgr.	Budesonid 0,2 mg	28099	10 x 6.25 125 Einzeldosen
Rectodelt 10 mg	Prednison	31061	2 Supp a 100 mg
Refobacin Augentropfen	Lyophilisat	10237	5 Amp. 5 mg
Scandicain 1%	Mepivacain HCL 1.0 %	59027	5 Amp 5ml
stas Hustenloeser	Ambroxol- HCL	24231	100 ml