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An Interview With Dr. Jim Gollogly of ROSEcharities, Cambodia

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An Interview With Dr. Jim Gollogly of ROSEcharities, Cambodia

by Jennette Townsend, MAIC

I'm Not Interested in Cambodia

"I didn't have an interest in Cambodia," said Dr. Gollogly when I asked him, "Why Cambodia?"

The tale of how the English-born orthopedic surgeon landed in Cambodia begins in Fairbanks, Alaska. "One summer evening I was sitting with my buddies, drinking beer. They were all talking about going on sabbatical for the winter. I thought, 'Why couldn't I take a sabbatical?'"



Dr. Gollogly with a patient.

Within a few days, Gollogly had his office organized and handed over to Dr. Longquest, an old friend who agreed to manage the practice for six months. Next, Gollogly called Dr. Jim Colby, on the board of the American Red Cross (ARC) in Washington, D.C., and told him that he would be happy to volunteer to work in a developing country. "You are an answer to a prayer," said Colby. "We need somebody in Cambodia." "No," said Gollogly, "I'm not interested in Cambodia. I want to go to Africa." Colby insisted, "You go to Cambodia. You'll really like it."

Two weeks after that summer evening in Fairbanks, Dr. Gollogly was in Cambodia. "What is the good of asking and then turning down the offer?" said Gollogly. "This is what I call The Winds of Fortune."

In the conversation that ensued, Dr. Gollogly told me the story of his arduous first day of work in Cambodia, which prefaced the establishment and development of ROSEcharities.

The First Day of Work: Cambodia, 1992

I got to Cambodia on a Friday. I showed up to work at 8:00 Monday morning for a staff meeting. The meeting took half an hour to get going. Shortly after it began, a motorbike pulling a trailer drove into the yard. The three guys on the trailer were in a landmine accident. One guy's arm was blown off, one guy had a huge laceration across his cheek and the third guy didn't seem to be injured, but they were all covered with blood. I was asked to operate on the guy whose arm was blown off.

I operated on the guy—amputated his arm below the elbow. I sewed up some holes in his intestines from shrapnel that went through his belly, put him out in the ward and went back outside. The guy with the gash on his face was gone but the other guy was still in the trailer, in the hot sun. No one put up an IV, nothing. He was slumped in the trailer. It

had been two hours since they had driven in to the hospital.

Upon closer examination I found a small wound on the upper thigh. I shouted for help and got people to carry him to the operating room. I couldn't speak Khmer so I was communicating in schoolboy French and their French wasn't good either.

So I left him to the anesthetist to get on with it. The femoral artery was torn; I clamped it and looked up at the anesthetist. It was clear that he had no idea what to do with the patient. The guy didn't have much blood pressure, but I didn't pay attention to that. I started to work on repairing the artery rather than tying it off because I didn't want the guy to lose the leg. Suddenly, all the blood was dark—the guy wasn't breathing and no one was breathing for him. He still didn't have a tube down, he didn't have an IV up and there was no one around—they had all gone to lunch.

It took about half an hour of me trying to keep this guy alive and get some fluid into him before it was obvious that he was dead. He was only a teenager. There was nothing to do.

So I went out. I was depressed because the guy shouldn't have died. There would have been no problem if he had been taken care of at 8:30 a.m.

I went to look at my first patient. The ward was empty—everyone had gone to lunch. This guy was dead too because he vomited and aspirated. He was lying on his back and there was no one around to help him.

Out of the three patients, two were dead. They didn't need to die. The third guy was gone. I didn't know what happened to him.

That was my first morning.

That night I couldn't sleep. I began thinking of the situation in a different way; I needed to organize on a larger scale; I couldn't expect everyone to know what his or her job was. I took a big step back and said, "These people don't necessarily know how to do any of this. I have got to see what they know, to pay attention to what they are doing—assess what they can do and pick up what they can't do." It was a transition from the States where everyone knows what he or she is doing. The most important challenge that I had to overcome was the culture shock—figuring out what was happening, what the staff could do and what I could rely on.

Six months later, we were doing four to six operations a day. We saved a lot of people that the Khmer doctors didn't want to do anything for. The hospital made a lot of difference. The ARC was supplying the fluids, drugs and whatever else we needed. With the resources and some knowledge, we made a huge difference.

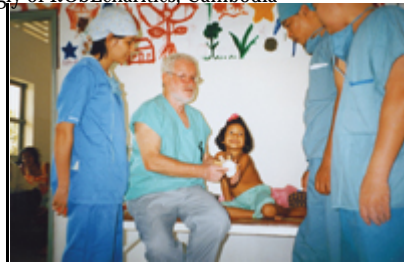
A Need Identified

Within the six months that I spent in Cambodia in 1992, an eight-year-old girl came in. She had a horrible facial wound. She and her younger brother, age six, had been sent to get a pail of water out of a pond. The boy had the bucket. When he scooped up the water with the bucket he also scooped up a mine, which exploded. He was killed and his sister had half of her face blown off. The other half of her face was unscathed. We managed to keep her alive, but she had an audible deformity. She'd lost an eye and the mine had blown away her cheek. We couldn't do anything about it. I didn't know much about facial surgery because I am an orthopedic surgeon by training.

I always remembered that girl and that nobody could do anything about her deformity. Obviously it was going to stay with her for the rest of her life.

This incident sparked my interest in the problem of chronic landmine injuries. There are a lot of people who

have had their hands blown off while laying or removing mines. That's pretty difficult to deal with; it is hard to eat, hard to wash, hard to wipe your butt, hard to comb your hair—hard to do anything when you have two stumps instead of hands. I had seen a lot of these people in Bangladesh. Many of them had a chopstick forearm, done by an American surgeon, Ron Garst. He had done a lot of these operations following the war in Bangladesh in the '70s. This was just a simple operation for those who still had a forearm but it helped them a lot. It was a functional procedure.



Dr. Gollogly and staff examine a young girl's hand injury.

Likewise, from a cosmetic point of view, from a facial point of view, if a victim has scars and shrapnel that have not been removed, one can improve the scars and remove metal in his/her face and perhaps rebuild his/her face. A simple operation can make a big difference.

ROSEcharities is Established

The idea of ROSEcharities came from a group of Nepali eye surgeons who were in Phnom Penh, Cambodia. They had some extra time on their hands and suggested starting a program for landmine victims. I was asked to set the program up. I thought, "Well, this could make a lot more difference than seeing another sore knee in Alaska." I had been to Cambodia in 1992 and I knew what had to be done. I was also free. I had been divorced and the kids were independent. It was easy for me to take time off. It was only a question of losing money.

When ROSE started in 1998, the mission was to help landmine victims with hand and face injuries. No one was doing much for face and hand injuries at that point. When I came to Cambodia in 1992 there were landmine accidents every day. We were dealing with traumas and amputations—with keeping people alive—versus reconstructive operations intended to improve the condition of the patient. By 1998, there were reasonable numbers of traumas and there still are in Pailin, on the border with Thailand. However, acute injuries in Phnom Penh had diminished and we were dealing with people who had had initial treatment somewhere else. They came to ROSE for further surgery because they were unhappy with their arms, legs or faces.

ROSEcharities Today

Today, ROSE continues to treat people who have been injured in the past and who are looking for improvement of their status. For example, we have people with painful stumps, problems with their faces or eyes, or chronic infection from shrapnel. Recently, there was a man on the ward with a chronic infection of the bone caused by an injury that he sustained in a landmine accident that happened in 1990. He had an abscess on his leg. When we opened it up, the infection went down to bone. There were two fragments in the bone that caused the abscess. So he was still suffering from a 14-year-old landmine injury.

Landmine victims are often referred to us by organizations like ARC, Health Net or Médecins Sans Frontières (Doctors Without Borders) (MSF). They go out into the provinces and find these guys who need care and have never received it because no one offered it to them and they were too poor or too ignorant to look for it. We get a flush of people; we treat them for a month or two and then they disappear off the scene. We also have intermittent patients come in.

Recently, ROSE has had three of its staff members help U.S. Army Special Forces train Cambodian deminers who are with the Cambodian Mine Action Center (CMAC) in first aid care. This was something new to ROSE. This is the first time we have been in the educational field.

We also have a Landmine Outreach Program. Every month, a team of four—a surgeon, assistant, anesthetist and nurse—goes to the provincial hospitals to treat landmine victims. Again, most of the cases they encounter are chronic injuries.



Dr. Gollogly prepared for surgery.

ROSEcharities in the Future

At present, landmines in Cambodia affect 800 people a year. This number will decrease and it will continue to decrease more quickly in the future. The landmine story in Cambodia is dying down. No one is planting new mines; old mines are being removed.

We will continue treating landmine victims for the next 20 years, but I believe we will gradually evolve into a program for kids who have deformities but who don't need immediate treatment. For example, this week we had a couple of kids who fell out of palm trees a month or two ago. The fractures hadn't been treated correctly. They had major deformities and we were able to fix them. Yesterday, we got a 16-year-old girl with a bad burn contracture over her left arm with her breast pulled almost into her armpit from the scars. She couldn't move her arm away from her chest and she couldn't straighten her elbow. The burn contracture was the result of a burn accident that occurred when she was six—she had dealt with the injury for 10 years.

There are a lot of these kids hanging around Cambodia. Even though there is health care available, the people that have kids with deformities have dealt with the deformities for a while and they don't have the money to pay for surgical care. Most people here are poor and can't afford surgery with the way the Ministry of Health has it set up—where the user pays. If you have a kid with polio, burn contractures or a cleft lip, people don't have to have it treated today and they are always waiting, as my mother would say, "for when my ship comes in"; for when they win the lottery. Cambodia is never going to provide money for a crippled children's program, but Westerners may provide the money. This is where ROSE comes into the picture in the future.

Dr. Gollogly: "A More Disadvantaged Population in Cambodia"

There is a lot of focus on landmine victims—we tend to ignore the other problems. When I first came to Cambodia with ARC in 1992, there were a lot of landmine victims and no traffic accident victims because there was no traffic, just bikes. Now the traffic is horrible and there is a terrible traffic accident problem. No one wants to finance the treatment of traffic accident victims. There are no big international organizations for this; it is qualified as normal wear and tear. We are all immune to that.

The goal in 1991–1992, when western powers came into Cambodia, was to concentrate on landmine victims. However, they have found a wealth of other diseases and problems and, gradually, they have begun to attend to these as well.

When ROSEcharities began in 1998, people came with problems that were not necessarily the result of landmine accidents. They were similar sorts of problems as those caused by landmines, but they were caused by traffic and industrial accidents. We also began dealing with congenital deformities, infections and polio.

So, people come to us because they are thinking of landmines. But when they come, they see kids with polio, burn contractures and with clubfeet. They see old people who are blind from cataracts. When they come and see these other conditions, they realize that there is a more disadvantaged population in the country.

A Shoestring Budget

In closing, I mentioned to Dr. Gollogly that ROSEcharities has been recognized for its ability to run on a "shoestring budget." Last year ROSEcharities operated on \$20,000 (U.S.) a month. "We do this by being efficient," Gollogly explained. "We don't have too many Westerners working for us at Western salaries. We have two foreigners and everybody else is Khmer. On a Khmer economy you can run pretty well."

ROSEcharities often has Westerners come in, but only as volunteers. Gollogly's two eldest

children, who are doctors, have been over and have worked with him.

In seeking sponsors, Dr. Gollogly clarified that they hope to gain the support of those who have a long-term interest in the activities of ROSEcharities—those who are willing to make a commitment to funding developing programs such as their Landmine Injury Program. Dr. Gollogly expects no more of those who choose to support ROSE than he requires of himself. Jim Carmicheal, secretary of ROSEcharities, emphasized, "Jim Gollogly is there long-term and he is effective."

When I asked Dr. Gollogly, "What motivates you to devote your life to ROSEcharities?" his answer was simple. "I like doing surgery and helping people. It is much more satisfying doing it in Cambodia, with the amount of disease there is, than in the States where there are plenty of doctors who can do the same as I."

**All photos courtesy of ROSEcharities.*

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