

ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Palliative care is delivered in Queen Elizabeth Hospital (QEH), Kota Kinabalu in a dedicated palliative care unit (PCU). The unit though not part of the main hospital building, is just a short two-minute walk and is a significant part of the hospital. It was established in 1995 under the care of the surgical department who at the time were operating large number of patient with advanced cancer and became increasing aware of the somewhat unnecessary hardship they were putting majority of these patient through. 70% of these patients despite the surgery and subsequent radiotherapy and chemotherapy returned with recurrence of their cancer, in pain and due to no service available for them, were sent home to die. It was the first palliative care unit established in Malaysia and initially consisted of four beds. Since then, it has grown to contain 16 beds and is available for any department in the hospital to refer patient they feel is in need of palliative treatment. The PCU also collaborate with a local non-government organization (NGO) and voluntary sectors to provide at home palliative care to patient within 30km of the hospital.

The services provided includes all range of palliative care including palliative radiotherapy and chemotherapy, symptom control, cancelling and respite care. During my time at Queen Elizabeth Hospital, Kota Kinabalu, the main cause of illness for patients in the palliative care unit was terminal cancer of the bowel, lungs and bone. Most of these patients were elderly but I met a child whilst with the orthopaedic team who had osteosarcoma and I believed was also initiated on palliative care at home. This is very comparable to the UK where most patients under palliative care also have terminal cancer of the lungs. Somewhat, a noticeable difference is the prominence of breast cancer in patient under palliative care team in UK, something I did not witness in QEH.

Healthcare in Malaysia is mainly delivered via a system which is very akin to the health care system in the UK where there is a two-tier health system comprised of public health system in which the funding mainly comes from taxation and a private health system in which patient either pay for themselves or via an insurance scheme that they possess. For patient to use the public health system they are expected to contribute an affordable small fee. These amount is very affordable to most of the Malaysian population and I did not meet anyone that was unable to pay. In contrast to this, palliative care delivery is free at the point of contact which majority of the money coming from fundraising events such as charity dinner.

Health care service provision varies across countries in the region. Thailand healthcare system is a universal health care system and free from the point of access for Thai with relevant documents. Whilst Singapore also a universal public healthcare system, it is not funded by taxation but rather uses mixture insurance based system or deduction from monthly income saving which is then saved for any future use of medical services. Comparative, majority of Vietnam healthcare is delivered via the private sector with most of the citizens; government funding only covers 30% of the population. With regards to palliative care provision, along with Malaysia, the other countries in the region with well established palliative care services are Singapore, Taiwan, Thailand, Myanmar and Philippines. This generally reflects the wealth of the country with Malaysia, Singapore, Taiwan and Thailand having one of the highest rated palliative care in the region though most of the report into the palliative care provision in the region highlights many shortcoming and need for further improvement.

Overall, I felt that the attitude towards palliative care in Malaysia was overall positive and very similar to the UK. As mentioned, the palliative care service delivered in Kota Kinabalu relies on voluntary services and donations to function. To my knowledge, they remain a well-funded service without financial hardship afflicting limitation to service provision. These I believe are indications that the attitude to palliative is positive and akin to the UK. The team also seemed very passionate about their work something that the local medical students I talked to agreed with.

What I most cherished from my time at QEH was learning about the history of the establishment of palliative care. It showed me the importance of being prudent and knowing when you are afflicting more harm than benefit to your patient. The awareness of this by surgeons in 1995 paved the way for one of the most established palliative care service in South east Asia. It also showed me the importance of NGO and voluntary sector as an important part of continuation of health provision. So, I feel the need to ensure that I know how to work with people within these sectors. I will ensure that I develop the subtle skills needed to communicate and interact with these people especially when it comes to using medical parlance in a manner they can understand but not in a condescending manner. Moreover, it also showed me the need to be willing to update my knowledge and further health provision to the patient. The team could have being satisfied as they did their best for the patient but they were not and wanted to tackle the shortcoming. This is very poignant for me as I feel it epitomize the field of palliative care.

I also understand the value in being patient and realised that palliative care also involves being their for family members. This was highlighted to me in some of the patient that came in for respite care and order to ease the burden on family members and keep their spirit up as they continue to care for their loved ones.