ELECTIVE (SSC5b) REPORT (1200 words)

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

I completed my medical elective at Sarawak General hospital, the main tertiary care and referral hospital in eastern Malaysia. Sarawak is a Malaysian state in northwest Borneo. I spent most of my time in internal medicine and accident and emergency. My consultant also worked in a private hospital, Borneo Medical Centre, and we were able to experience healthcare in both hospitals and compare the healthcare provided by each as well as compare to healthcare systems in the UK.

1. To compare and contrast the healthcare system in Kuching, Malaysia to that of the UK

I was able to spend a large amount of time at Sarawak General hospital, a government-owned hospital and I noticed many similarities and differences in the way the hospital operated compared to hospitals in the UK.

Like the UK, the hospital had an accident and emergency department, 24-hour paramedic services and ambulances, and specialty wards and outpatient clinics. High levels of under-staffing affect the hospital; the state of Sarawak is very large relative to mainland Malaysia and there is an uneven distribution of medical doctors who predominantly practice in mainland Malaysia. The relatively uneven supply of resources in Sarawak state compared to mainland Malaysia was apparent during our time at Sarawak General Hospital. The accident and emergency department was crowded with patients and their families, it was incredibly busy yet understaffed and multiple patients were seen sitting up on the same bed. The waiting areas were far more chaotic than a busy A&E shift in England. Another thing that was apparent was how sick some of these patients were at presentation compared to patients presenting to hospital in the UK. Some of these patients came from very remote villages, where access to family physicians was very difficult, causing a delay in seeking medical attention. There are a number of government-run rural clinics, but they have low staffing levels and resources. The patients wait until they get very unwell before they commute far to reach the government hospital. We saw elderly patients presenting with community-acquired pneumonia with complete white-out on chest x-ray indicating consolidation of the entire lung. In comparison, patients with pneumonia in the UK present much earlier, usually with localised consolidation to one lobe of the lung.

Another difference to healthcare here is that when patients are found to have chronic conditions such as diabetes or atrial fibrillation, it's difficult to initiate long-term medications. If patients from rural villages were to be sent away with medications with potentially dangerous side effects, it is difficult to call them back for monitoring. They would also be unable to afford repeat prescriptions and costs to see the nearest general practitioner. In the UK however it is very easy to medicate patients for chronic illnesses and monitor them when starting new medications.

I also spent some time at Borneo Medical Centre, a private hospital in Sarawak. I could already see the differences between this and the government hospital. It was more spacious, less crowded, more organized and a much calmer environment. Patients came from as far as Indonesia to be treated here.

And the hospital had state of the art diagnostic equipment such as new MRI machines for detecting cancer.

2. To observe how the practice of anaesthesia and intensive care differs to that of the UK

The practice of anaesthesia is largely the same as in the west, anaesthetic agents were the same and methods for inducing anaesthesia were also the same. Anaesthetists are involved in the care of patients from pre-operation until the patient wakes up. Just like anaesthetists in the UK, anaesthetists in Malaysia also additionally practice perioperative medicine, intensive care, pain management and resuscitation.

The equipment used slightly varied to that of the UK in that it was not single use, although this was more cost effective, equipment had a higher chance of being non-sterile. Some trusts in the UK also do not use single-use equipment. Although the provisions for anaeasthesia were adequate, staffing levels were very low and the hospital had been short of anaesthetists. Being in east Malaysia on Borneo island, its difficult to recruit anaesthetists from mainland Malaysia.

Similar to how we have emergency air ambulance services in the UK to transfer patients to specialist centres in the event of life-threatening emergencies, Sarawak has The Flying Doctor Service providing transport from rural clinics they cover to the nearest hospital as well as providing basic health services.

3. To appreciate the scale of maternal morbidity and mortality in obstetrics in Malaysia and the provisions available for maternal critical care, comparing to results from my research in this field on pregnant women at The Royal London Hospital, UK

Over these last two decades, the maternal mortality ratio has declined from 44 to 27 per 100,000 live births in 2011. Malaysia's Millenium Development Goals target, however, is 11. [1] In comparison, the most recent maternal mortality rate in the UK is 8 per 100,000 live births. [2]. Improvements in multiple aspects of maternal care have contributed towards the decline in the maternal mortality rate. Midwifery training has been improved to provide midwives with a larger skillset required to provide optimum levels of care to mothers during pregnancy. Policy changes on a national level, improved services and monitoring during pregnancy, and improved home-based and primary care for pregnant women have all contributed to the decline in maternal morbidity and mortality. Pharmacotherapy for the management of critical conditions such as pre-eclampsia, eclampsia, and post-partum haemorrhage have become widely used, reducing maternal morbidity and mortality. Midwives are able to initiate treatment for pre-eclampsia or eclampsia from first contact with the patient. These improvements in the management of common critical conditions in pregnancy mirror the improvements made in the UK to manage maternal morbidity, as I found in my research projects conducted on maternal morbidity and mortality in the UK. Provisions for maternal critical care in Malaysian hospitals are similar to those in the UK. There are labour wards, high dependency wards and theatres. Recognition of critically ill women allows for admission to the high dependency ward, conditions include maternal sepsis, hypertension, pre-eclampsia, eclamspia and post-partum haemorrhage, these are all also indications for admission to high-dependency units in the UK. A

significant difference to the UK however is that not all pregnant women have access to antenatal services, for example, women from rural areas with limited or no access to rural clinics.

4. To build my confidence in my communication, clinical and practical skills.

During my time on my elective, I was able to interact with people of a diverse range of cultures, religions and backgrounds due to the diversity of Malaysia's population. This allowed me to appreciate there is diversity in most healthcare systems, in the UK, Malaysia, or anywhere else in the world. I was able to practice and develop my interpersonal and communication skills and consolidate my sensitivity towards staff and patients of all cultural and social backgrounds. I was able to practice and strengthen my clinical skills whilst on the ward and in clinics. Limitations included that a lot of patients didn't speak English and communicated in Malay, so I was unable to take histories from patients on the wards or follow what was going on in clinics. Although this was a significant barrier in my ability to communicate with the patients, I was still able to observe consultations and follow what was happening with the help of the consultant translating and explaining what was happening.

Summary

Overall I thoroughly enjoyed my time at Sarawak General Hospital and state itself was beautiful. I observed how healthcare is both similar and different to practices in the UK. A lot of the common conditions I saw were also common in the UK. However I also observed more extreme presentations of such conditions. My experiences allowed me to reflect on how fortunate we are to have the National Health Service in the UK. I appreciate that in the UK, geographical location and finances don't usually limit our access to healthcare and treatment, whereas for some patients in Sarawak this was not the case.

References

1. Jeganathan, R. (2014). Malaysia's experience with maternal deaths. [online] World Health Organization. Available at: http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/malaysia/en/ [Accessed 20th April 2018].

2. Knight M, Nair M, Tuffnell D, Kenyon S, Shakespeare J, Brocklehurst P, Kurinczuk JJ on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. Oxford: National Perinatal Epidemiology Unit: University of Oxford; 2016.