ELECTIVE (SSC5c) REPORT (1200 words)

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

Describe the most common reasons why patients present to the emergency department in Borneo. How does this differ from the UK?

During my placement at Queen Elizabeth Hospital II (QEH II), I saw many different reasons why patients presented to the emergency department. Just as in the UK, there is a wide variety of causes which bring patients into hospital. However as QEH II is a specialist trauma centre in the area, I saw lots of trauma cases in the emergency department. Most of the trauma cases were due to motorcycle accidents as there is a higher proportion of motorcycles on the roads in Sabah than what we see in the UK. There were also high numbers of trauma cases due to accidents on construction sites. The workers did not have adequate safety equipment to protect them and the emphasis on health and safety training also seemed less than in the UK. This contrasts to trauma cases seen in London where the most common causes include road traffic collisions where pedestrians are hit by cars and in recent times there have been increased occurrences of bicycles and vehicle collisions.

The medical cases seen in the emergency department in QEH II were mostly due to infectious diseases. On arrival, patients are screened for infectious diseases during their initial assessment. The main diseases that the doctors are concerned about are malaria, dengue fever, tuberculosis and leptospirosis as they are prevalent in the region. This contrasts to the UK where infectious diseases are less common and common medical causes for presentation to the emergency department include heart disease, COPD exacerbations and falls in the elderly population. In east London, there is also a high prevalence of alcohol related incidences which is something I did not see in QEH II.

Most patients arriving at the hospital have usually been transferrred from a district hospital from any of the smaller hospitals in the state. This differs from the UK where most emergency department admissions are patients who walk in or are brought in by ambulance from the community. There are very few emergency department admissions transferred from other hospitals. Patients in QEH II also presented late with more severe disease and therefore often required more vigorous treatment.

Describe the organisation of the emergency department in Borneo. What are the key differences between how patients are triaged and treated in comparison to the UK?

In QEH II, patients are initially triaged outside of the hospital in the ambulance bay. There is a desk which is staffed by Assistant Medical Officers (AMO) who have similar roles to paramedics. The AMO will assess the patient and refer them to either the red, yellow or green zone.

The red zone is the resuscitation area where patients are seen immediately. The hospital staff are alerted to the arrival of the patient by 3 buzzer calls. The yellow zone is the semi critical zone where patients must be seen within 30 minutes by the medical team. The arrival of a patient to the yellow zone is signalled by 1 buzzer call. The green zone is the minors area. Patients must be seen within 1 hour by the medical team and there is no buzzer call to alert staff.

This system contrasts to the UK in many ways. The patients in the UK will be triaged inside the hospital usually by a nurse but in some cases - such as in paediatrics – by a doctor. The staff will aim

to maintain confidentiality as best they can, however when triaging patients outside the hospital such as in QEH II, this is harder to maintain.

There are also differences in the treatments that the patients received at QEH II. Patients who had a stroke did not receive thrombolysis. There are other hospitals in Malaysia which offer thrombolysis but QEH II is not one of them. The other hospitals are too far away and therefore most patients do not receive this treatment.

The nurses and AMOs perform most of the practical procedures in QEH II such as obtaining a radial artery blood sample and inserting cannulas. The AMO is also trained in suturing wounds and intubation. This contrasts practice in the UK where it is the doctor who usually performs these procedures.

How are diseases investigated in Borneo? How does this differ from the UK?

The way in which illnesses are investigated in QEH II are mostly similar to what I have seen in the UK with a few differences. The hospital has facilities to carry out laboratory blood tests, electrocardiograms,ultrasound scans, X-ray and CT scans. QEH II does not have an MRI scanner although there is one in one of the other hospitals in the city located approximately 30 minutes away. Patients requiring an MRI scan are transferred there.

The way in which the results are presented vary from the UK. Doctors in QEH II have to phone the laboratory to obtain the results and they write down the results given to them. This differs to the UK where blood test results are available electronically on computers. X-ray and CT scan images are printed on film and examined against an illuminated film viewer. The ECGs leads also differ as they have rubber bulbs which attach to the patient. Although there are differences in the equipment, the same investigations are performed and aid in the overall diagnosis and treatment of the patient.

What have been the main differences you have noticed between how doctors practice in Borneo and in the UK? How will this experience change the way you will practice as a doctor?

During my time at QEH II, I witnessed a close working relationship between all the staff working in the emrgency department. The doctors, nurses and AMOs worked very effectively and efficiently in a team. All the different healthcare professionals have teaching together. It is not divided by role or grade. The handover and briefings occur with the entire team present. I saw how this helped the team to form a strong bond together. This then enabled them to work successfully as a team in the interest of the patient. In the UK there are separate meetings and teaching for doctors, nurses and other healthcare professionals and this may sometimes prevent stronger bonds forming as there is some segregation. However I will try to work around this to ensure that all members of the team work well together.

I also noticed that during ward rounds, the medical team do not always include the patient. They will talk about them but not to them whilst around the bedside. I could see that the patient was excluded and not always aware what decisions were being made about their treatment and were not consulted about their choice or opinion. From seeing this, I will always aim to be mindful to include the patient in all situations.