ELECTIVE (SSC5c) OBJECTIVES

OBJECTIVES SET BY SCHOOL

1 Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health

I expected to find tropical diseases such as malaria and dengue more frequently in Timor Leste, compared with Malaysia, but my experience was actually the opposite. The Bairo Pite clinic has not had case of malaria for a year, which is very good news for the rural communities, but I saw two cases in just one week while at the Queen Elizabeth I hospital. There were a couple of suspected cases of dengue fever in Timor Leste, but these were not confirmed with the tourniquet test and so the diagnosis of a viral illness was made. Both showed equal prevalence for schistosomiasis and leischmoniasis. Aside from tropical infections, the most prevalent disease by far in Timor is Tuberculosis. Interestingly, this is often extra-pulmonary, something we rarely see in the UK. Having worked in East London, I had more experience than most medical students with TB, but I was unaware of the 50% incidence generally in the population of Timor. Tuberculosis is similarly prevalence in Malaysian Borneo, with multiple cases being admitted during my stay.

2 Describe the pattern of health provision in relation to the country which you will be working and contrast this with other countries, or with the UK

Timor Leste is the newest country in the world being just over a decade old. As a consequence, much of its infrastructure is immature and the population are just learning about western culture. The concept of seeking medical attention when unwell is a relatively new concept to the Timorese, and this proved the most difficult aspect to overcome when setting up the clinic initially 15 years ago. There is a strong culture of religion and black magic in the rural communities, and so western medicine is often seen as a very last resort which family members are unwell. Despite this, Dr Dan and his team have been able to help thousands of people and in turn have gained the trust of the Timorese people. The reputation of the clinic is far-reaching with some patients bringing relatives 5-6 hours by whatever means possible. I think that in itself, is a huge achievement, having gained a people's trust to such an extent that when patients are at their most vulnerable, they travel such distances just to be treated at this one place.
I expected the clinic in Timor to be as basic as it was, but I thought the Malaysian hospital would be a step between the very simple clinic and inpatient rooms of the Bairo Pite clinic and a normal district general hospital back home. However, when I arrived at the Queen Elizabeth Hopsital I was pleasantly surprised to see it functioning exactly like a district general hospital A&E department. They had intubation facilities, ATLS protocols on the walls, and I was generally very impressed with the set up and staff. I think I had expected something less well organised perhaps and with fewer resources. Both the QE1 and the Bairo Pite clinic provide healthcare services to approximately 180,000 people, around the same population as Whipps Cross, my nearest hospital back in London. Bairo Pite clinic provides all its services for free,

and the QE hospitals only ask a nominal fee for registration of 1 Malaysian Ringgit (20p). It was interesting to compare the three hospitals in terms of resources, money and outcomes. Obviously a london hospital has a far larger budget than both of these two locations, but it was interesting to compare the outcomes. While the larger hospitals provided possibly better medical care purely because they had access to better drugs and equipment, I feel the patients of Bairo Pite had a better inpatient experience. Due to the small nature of the clinic, having approximately 40 inpatients at full capacity, the care they received was extremely personal as it was all provided by 2-3 doctors. The A&E department of the Queen Elizabeth, like any hospital in London consists of multiple staff with doctors and nurses breezing in and out of wards meaning the patient is left unsure of who is directly providing their care.

As perviously mentioned, I was surprised at the apparent superiority of the Malaysian system to what I had imagined, but after a lengthy chat with one of the doctors it became clear that while the resources were plentiful, staff were not. For example, there is one public cardiologist who covers the entire state of Sabah, and he works office hours only meaning that PCI can only be accessed between 9-5. With ACS being the most prevalent presenting complaint in the QE hospitals, the fact that interventions don't happen throughout the day astonished me. There is also no thrombolysis treatment for ischaemic stroke, the second most common presenting complaint. The lack of staff is apparently due to the huge pay gap between the private and public sectors with many doctors choosing to work privately instead.

OBJECTIVES SET BY STUDENT

3 To learn more about healthcare in a resource poor environment, and how this changes the care we provide patients

While the Queen Elizabeth hospitals didn't really meet this objective, the Bairo Pite clinic was an experience I will never forget. Working in such a difficult clinical environment made me challenge myself in so many ways. Firstly, on a personal level was getting used to the 38 degree heat, from 8 degree drizzly England! Working in a place like Bairo Pite you sort of have to remove yourself from all medicine you have experienced before, and just deal with the situation in front of you. It was a privilege to work with such an incredible team, where I felt I could push myself, but always felt supported when I was uncomfortable or out of my depth. It was frustrating at times to be unable to provide the care you knew would be available in any other country, and it was challenging to think of new ways around the limited resources and medical lists. But it by far taught me more about medicine than I think I have learnt in any clinical attachment. I feel my clinical acumen is improved, as is my ability to pick up signs, and I have seen cases I would never have done in the UK. More than that, my confidence in my own medical instinct has been developed and I feel far more comfortable dealing with emergencies and sick patients.

4 To gain experience of working in different teams in a range of healthcare settings, and communicating efficiently with all team members in circumstances unfamiliar to me.

Commutation has played a large role in both my attachments with English not being spoken by the local populations in either location. The doctors in Timor were mostly foreign, and from Australia and England. In Malaysia, the doctors often spoke fluent English, which was impressive, but hand overs etc. were in a mix of Malay and English to benefit the nurses and other staff. In Timor, I learnt some of the basic phrases in Tetun, the language of the Timorese. This was mainly because talking through translators is a lengthy process, and sometimes not completely accurate. However in Malaysia, because clerking was less important in the A&E cases due to them coming in with a handover in English, I did not learn much Malay, which perhaps I should have done.
All in all, my experiences on my medical elective are ones that I will never forget and will shape the doctor and person I will become.