ELECTIVE (SSC5c) REPORT (1200 words)

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

Obstetrics & Gynaecology in UMMC, Malaysia

Introduction

My elective in obstetrics and gynaecology was undertaken at the Universiti Malaya Medical Centre in Kuala Lumpur, Malaysia. The hospital is attached to the first faculty of medicine that was established in Malaysia in 1963, and as such strives to provide excellence in education, research and healthcare provision. Malaysia runs a two-tiered provision of health services: a tax-funded government run service, available to all, and a private service, mainly available in urban areas. The country is multicultural, mainly consisting of Malay, Chinese and Indian ethnicities. The official religion is Islam, with the country run in a secular manner.

The medical education system is very similar to the UK, students attend five years of medical school and then do two years of housemanship (equivalent to Foundation years 1 and 2). However, the training is more hands-on in approach, with students being required to perform many procedures we still cannot do unobserved in FY1, and being trained in ALS. With regards to obstetric and gynaecology specifically, students do a full month's rotation in obstetrics, followed by a full month in gynaecology and they are required to deliver five babies on their own – while we in the UK are only allowed to observe, not even assist.

Identify the prevalent obstetric and gynaecological conditions in Malaysia and compare to those in the UK.

The prevalent conditions were comparable to those seen in the UK. These consisted mainly of fibroids, endometriosis, PCOS and infertility in gynaecology and GDM and hypertension in obstetrics. The way the clinics operated was also very similar, however, unlike in the UK, the doctors did not behave as though they were rushed and gave patients the time deemed necessary for each consultation, even though the clinics were busy. The doctors would also helpfully explain to me after each consultation, as most were conducted in Malay.

Infertility, although prevalent, is not treated as an important issue that requires funding. Infertility treatment has to be paid for by the patients, costing 300-500RM for IUI and 11,000 RM for IVF; double for foreign nationals. I witnessed more younger women presenting for fertility treatment, unlike in the UK where it is often older couples who have been trying for many years before they qualify for the NHS funded treatment.

I was interested to discover that all mosquito-related illnesses need to be notified to the Ministry of Health (e.g. malaria, dengue). There was a patient in antenatal clinic who had suffered from malaria in the early stages of her pregnancy and been treated in a different hospital. When the doctor discovered the previous hospital had not notified it, the O&G doctor now had the responsibility of ensuring it was notified.

Compare the provision of maternity services in Malaysia and the UK.

Unlike in the UK, obstetrics is a doctor-led speciality, with midwives present only in hospitals to assist. There are no community midwives or freestanding birthing centres. Nor are women given options such as water births, or asked for a delivery plan. There are many more female OBGYNs, and they seem more able to have an effective family and work life balance, which is difficult in the UK and a reason fewer females choose to train in obstetrics and gynaecology. Antenatal care and testing is similar, and they also use the RCOG guidelines to guide patient care. The maternity costs are mostly covered by the government, and are free for government employees.

At UMMC, the policy was that no family was allowed to be present during labour and delivery. I was shocked by the number of medical staff who then came in to observe every delivery: all junior doctors, all nursing students and a midwife, about 18 people around the bed, none related to the patient. Every woman who is primigravida also undergoes an episiotomy. It was surprising how the labour ward was run mainly by the housemen, who did all the normal deliveries themselves. Every doctor in Malaysia has a rotation in O&G and are expected to capably manage normal and complicated deliveries, unlike in the UK where you can be a fully qualified doctor who has no idea how to deliver a baby.

Understand how the country's political, socioeconomic and cultural aspects have affected the population's health beliefs with regards to obstetric and gynaecology conditions.

It is still tradition in Malaysian culture for women to have large families. It is unusual for women to not be married with children, and therefore there is good, affordable provision of ante- and postnatal care, which is sought out by the women.

One case that I found culturally interesting was of a child with an imperforate hymen from an Arab Muslim family. The mother feared that the treatment would harm her child's chances of marriage as being a virgin is of extreme importance. So much so that she was requesting official letters explaining the situation before even beginning treatment. It was interesting that the harm to her child's health came second to fear of harming her daughter's and family's reputation.

Despite the population being mainly Muslim, not once did I hear a woman reject examination or treatment by a male doctor. In the UK I came across that problem frequently in areas with more Muslim or Asian populations, and it would always cause disruption to the patient's care and to the running of the services as time was spent attempting to find an available female at the right level or transfer patient care somewhere else.

Improve communication skills with patients who speak a different language and come from different cultural backgrounds.

I was given opportunities to clerk patients, which could be difficult as not everyone speaks English. It was a lesson in simplifying your language, ensuring jargon was avoided and the importance of gestures and body language. I found the infertility histories the most difficult as I was unsure if there were any cultural restrictions to asking personal questions during sexual history taking.

The doctors here also come across patients, especially from India/Bangladesh who do not speak Malay or English but unlike in the UK, no official translator services exist. I observed a consultation counselling a woman about an important decision regarding VBAC using basic words and gestures. A colleague who spoke the patient's language had previously been called in to help, but there was no interpreter available during that session, where an important decision needed to be communicated.