

## **ELECTIVE (SSC5c) REPORT (1200 words)**

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

During my elective posting in paediatrics at Sarawak general hospital I was exposed to a variety of conditions. There were many illnesses that would be seen throughout paediatric wards in the UK such as bronchiolitis, upper respiratory tract infections and pneumonia. The treatment of these conditions was very similar in both countries with the use of American and European guidelines.

There were other conditions seen in Sarawak that are seen throughout Malaysia due to the climate and presence of mosquitos. There were many cases of dengue fever, malaria and rarely Japanese encephalitis. I could compare the education of patients about mosquito borne illnesses in Malaysia and India, where I undertook my SSC. There were more resources available in the government hospital in Malaysia with a greater focus on patient confidentiality and education over time.

There were some conditions which were prevalent in Sarawak, along with the UK such as Asthma. I was surprised with this as I associated atopic conditions as a disease of the western world following the hygiene hypothesis. However, developing countries often begin to suffer illnesses associated with the west including obesity. Childhood obesity has increased in prevalence in Malaysia but it is still rarer compared to the UK. This is in part explained by the adoption of western lifestyles and food habits.

The healthcare system in Malaysia is divided into public and private care. The public government funded health system is similar in structure to the UK. There is general paediatric care under a consultant with a team of junior doctors, nurses and other members of the multi-disciplinary team. There is access to radiology, surgery and outpatients clinics. The consultant ward rounds are a good learning opportunity for junior members of the team. The ward rounds were larger in Sarawak with there being on average 12 members of the healthcare team, excluding medical students. There were similar expectations of members of the medical team, for example, due to the specialist nature of paediatrics most interventions were to be undertaken by more senior members of the team.

In Sarawak, I also had the opportunity to visit a private hospital to explore the wards and outpatient clinics. There was a huge difference between the two settings including the buildings, the speed at which patients were managed, the wards and the way in which their care was managed. In a private setting patients pay per service and they receive a bill at the end of their treatment. There was also a need for patients to place a deposit down initially to cover initial treatment costs. In the private hospitals there was always access to a consultant even if patients arrived out of typical working hours. Radiology, including MRI scans could be arranged swiftly. In the UK private healthcare is mainly present in the tertiary sector with most patients using the A&E departments of NHS hospitals. This is in comparison to Malaysia whereby private patients would use all services at the private hospital.

Although the majority of consultations were carried out in Malay the medical team were very helpful in translating. This experience allowed me to appreciate non-verbal body language and the importance of maintaining a positive image throughout the consultation. The consultations were very similar in structure to those carried out in the UK with a thorough explanation of conditions followed by an opportunity for questions. I was able to observe the paediatric consultant explain the diagnosis of nephrotic syndrome, of which I saw a similar exchange in the UK. The main difference was the lack of information leaflets and investigation results used in Malaysia. I think this is an aspect that can be developed in Malaysia, which may benefit patient understanding.

The UN developmental goal targets have been met in Malaysia following the data from 2005 (2015 data yet to be released). The infant and child mortality have declines dramatically over the past 30 years. Current levels are similar to other highly developed countries.

Another difference I experienced whilst in Malaysia was the paternalistic approach to medicine shared by patients and doctors alike. In the consultations undertaken in Malaysia, patients were less inclined to question the advice given by healthcare professions. This is in comparison to the UK whereby patients often read up on medical conditions prior to any consultations with medical professionals which sets the tone for any further conversations.

Whilst in Malaysia it was important to experience all aspects of Malay life. There were many opportunities to explore the attractions around Sarawak which included many national parks, orang-utan sanctuary and impressive caves. This was useful to understand the culture of the local community. For example, when suggesting increasing exercise for children it is useful to use suggestions of going for a hike, which is more common within this region in comparison to going to the gym.

Another aspect of sarawakian life that was important to explore was the food. There are many food hawkers which provide food at an affordable price to locals and tourists alike. It is common place for locals to eat at such places and it may explain the many cases of bacterial and viral gastroenteritis, as there are no stringent health and safety regulations. I was able to understand basic words in Malay which was quite enjoyable. There was also a great relationship within the medical team, there were many opportunities to socialise with the team.