ELECTIVE (SSC5b) REPORT (1200 words)

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

Malaysian healthcare system is dual-tiered; it is divided into a government-led and funded public sector, and a flourishing private sector leading to a dichotomous yet synergistic model. Although in terms of facilities and institutions, the private sector comprises more than half of the service, the majority of the population (more than 65%) is catered by the public services.

The public health services are delivered by the government via the Ministry of Health. Structurally, the Ministry of Health is headed by the politically appointed Minister of Health, who along with other upper managerial posts, are responsible for policy-making and direction setting. The operational aspect of policy implementation on the other hand, is led by the director-general of health, and this is further organised into different divisions; Of these, the two biggest from the medical point of view is the Medical Division and the Family Health Development Division. Secondary and tertiary hospital-based care is mainly under the jurisdiction of the Medical Division.

There are two types of public hospitals in Malaysia: 1) Hospitals under the governance of the Ministry of Health (this includes state and district general hospitals) and 2) teaching hospitals which are under the governance of public universities under the Ministry of Education (Hospital Universiti Sains Malaysia, which I was attached to is an example of this). Although care and services provided by the two types of hospitals are subject to central guidelines and quality standards, the organization, structure, employment and training scheme differ significantly. Beyond this, there are also private hospitals which also can also provide specialist care, and are regulated by a separate unit within the Ministry of Health.

This main structure is in many ways, similar to the UK healthcare system where the whole system is overseen by the ministerial Department of Health (DoH). However the executive body responsible for the operation, the National Health Services (NHS) is to a great extent, autonomous and separate from the department, unlike in Malaysia. Similarly, both systems are funded by the taxpayers, and the resources flow from the central federal level to the regional centres or states, leading to free healthcare at the point of use (or in Malaysia's case, healthcare at a nominal fee, as patients are charged RM1 for registration fee).

Throughout the three weeks of electives, I was attached to the medical department. There are two general medical wards; one for male and another for female patients. These house patients under the care of three different teams; two general medical team, and a nephrology team. The structure of each team is very similar to the UK counterpart; there is a consultant, specialty trainee registrars, trainee masters students (equivalent to core medical trainees in the UK), medical officers (equivalent to senior house officers in the UK). House officers are not attached to specific team, and are attached to the department as a whole. Apart from this, the main team also works with other teams and

healthcare professionals. On the general medical wards, each cubicle, comprises of 8 patients is taken care for by a staff nurse. Patients under the nephrologist care are also scheduled for regular haemodialysis, and these are operated by specialist dialysis nurses. Other healthcare professionals involved include the physiotherapists and occupational therapists.

However, I noticed that the coordination between these parties could largely be improved. For one, there isn't a medium that gathers them in a single seating to discuss patients' care and interests, unlike in the UK, where most wards have board rounds where inputs from the medical teams, nurses and the physiotherapists are taken into account. Most of the communication occurs via patient's progress notes where some vital information can go missing. Other than that, I found that the multidisciplinary aspect of care on the wards is quite polished and efficient. There is a good referral system to different specialties using paper forms and the processes of handover run quite smoothly. For example, in the general medical wards, there are several oncological and rheumatological cases, and due to the lack of specific wards to house these patients, they remain under the care of the general medical team but are seen jointly by the in-house oncology and rheumatology teams.

Daily jobs on the wards are very similar to the UK. We usually start the morning with ward rounds, sometimes consultant-led and most of the other times registrar-led. Then, from the ward round the team house officers will have a list of jobs that they are required to do, which includes taking blood, ordering investigations, making discharge summaries, and making referrals. As a final year medical students, I got the opportunity to help out as much as I can. One thing I found very interesting in the hospital is the fact that there is a relative lack of subspecialists in certain areas, so a lot of procedures and management have to be undertaken by more junior staffs, simply because there is no one to refer to. For example, I've seen multiple times where a house officer has to insert a femoral catheter by himself after being trained once by a senior medical officer. A lot of patients are also started on noradrenaline for hypotension by house officers, a case that if it occurs in the UK, needs to be referred to the anaesthetists. Consequently, I found that most of the junior doctors are perhaps more well-equipped with better technical expertise, than their UK counterparts. However, these come at the cost of putting patients at risk, and I think it all goes down to the fact that resources are limited.

Apart from shadowing the house officers and doing jobs on the wards, I also got the opportunity to attend clinics, especially those run by my elective supervisor, who subspecialises in infectious disease. There is a twice-weekly HIV and TB clinic, which happens in the state hospital in Kota Bharu. I also attended some of the teachings for third year and fifth year medical students and the house officers. It was a fantastic experience because the style of learning is a bit different from what I had in the UK. There are different sessions. One that I found very interesting is the long-case teaching, where a student will be appointed to fully clerk a patient. This student will then be put on a hot seat, and given time to present the patient, while the other students and the facilitator would ask the student questions and suggest points for improvements. From these sessions, I also managed to learn conditions that are rare in the UK – usually infectious diseases like dengue, malaria, chikugunya – and how they are managed clinically. I also learned a lot on how common conditions like Acute Coronary

Syndrome, and Asthma Attacks are managed in Malaysian hospitals and what kind of guidelines are being used.

As a tropical country, infectious diseases remain to be quite endemic in Malaysia, with outbreaks happening every now and then. Diseases that remain to be major public health concerns are vector-borne diseases like Dengue fever and Chikugunya, and water and food-borne diseases like Thyphoid. Efforts to tackle these epidemics are mainly spearheaded by the health inspectorate unit, which has specific units to investigate cases of outbreaks, inspect food outlets and vendors, carry out vector control actions, and assess and supply clean water supply and sanitation in the rural areas especially. A good notification system is also in use to track cases and facilitate further actions.

However, as Malaysia is becoming a more developed nation, there has been a shift towards a more sedentary lifestyle, especially in the urban areas, leading to the rising prevalence of Non-Communicable Diseases like Obesity and Hypertension. This is evident amongst inpatients on the general medical wards. The majority of patients (in average, they are in their mid-forties) will have a background of at least one chronic condition such as hypertension, diabetes or chronic kidney disease, and a lot of patients have multiple of these. In the state of Kelantan, this is especially attributed to their more laid-back lifestyle, and the diet rich in very sweet and fatty food. All in all, this contributes greatly to the second and third highest mortality causes in the hospitals; cardiovasacular and cerebrovascular diseases respectively.

One initiative introduced by the Ministry of Health to combat these changes is Extended Primary Care Programme where efforts to screen the population for the Non-Communicable Diseases are intensified, and more preventative and promotional actions are being carried out. Examples of health promotion initiatives include healthy eating promotional advertisements in the mainstream media, and programmes targeted at schools.

Throughout the three weeks, I also had the opportunity to practice my clinical and communication skills on patients on the ward. In the beginning it was pretty challenging as I was used to phrasing my questions and conducting the consultation in English so there was a lot of local jargons that I have to get used to. Understanding some of the local dialects also proved a bit challenging, as the local kelantanese dialect is hugely different from the formal Malay spoken in most other states. However, the healthcare staff definitely helped a lot. I also found that the local community is extremely religious and puts huge emphasis on cultural values, so a lot of the doctors tend to incorporate these into their consultation and medical advice to boost compliance. These, at the same time, may also be barriers to them accepting certain advice or treatments, and so, is an entirely different field to navigate.

Overall, I found that the three weeks spent in the hospital were very fruitful, and I definitely learned a lot, and I cannot wait to put what I've learned into practice when I finally start working in July.