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GYNAE

Medical Elective in Bali

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In Bali the health system is divided up into three tiers and is dependent on the patients income. The three tiers represent different standards of care and facilities, the higher the care the more it costs. Many working-class Balinese people earn around 1,500,000 rupees (£110) a year and therefore cannot afford health care. This can result in delayed treatment, for example I saw a V-P shunt being inserted into a one-year-old boy with hydrocephalus. The operation had been delayed, as the parents could not afford it. The government does provide some funding for low-earning patients but this is usually only half of the cost. As a result I spoke to and met a number of Balinese people who would go and see a "medicine man" instead of going to the hospital. Nearly 95% of Balinese people are Hindu's and are strong believers of spiritual healing. Patients would take offerings to the medicine man and small amounts of money in exchange for a "consultation". After meeting a "medicine man" in Ubud I learnt that he healed not only many different infections and medical conditions but also healed naughty children. It was extremely interesting to compare the different health system in Bali to the UK but also explore the amount of complementary therapy that occurs, particularly in the rural areas.

Objective 1 - Describe the common obstetric and gynaecological emergencies in Bali compared to the UK.

Pre-eclampsia is very common in Bali, most of the women I saw in the labour unit had pre-eclampsia. Patients are commonly diagnosed with pre-eclampsia within the community by the local general practitioner and then referred to the local hospital. In the international hospital in Denpasar, they see a large number of patients with pre-eclampsia. The women would be monitored closely in the outpatients department and quite often would be induced early. As pre-eclampsia can cause complications to both

the mother and the baby the women were placed in a special delivery suite and were delivered by the doctors instead of the midwives. In Bali the most common gynaecological cancers are cervical, ovarian and uterine. However due to the health system many of the patients do not present to the hospital until they are in severe abdominal pain. As a result many women do not receive any treatment until the advanced stages. On a more positive note, the health system has set up a cervical screening service and as a result has reduced the number of cervical cancers.

Objective 2 – Compare the maternity services in Bali to the UK, including antenatal, delivery and post-natal.

The international hospital in Denpasar has a large obstetric and gynaecological outpatients department. It is a large room that is divided up into a number of different cubicles around the edges of the room. These are used for ultrasound, obstetric examinations, fertility consultations and a gynaecological suite that is often used for cryotherapy. However the general consultations occur in the centre of the room around a number of tables, these are completely open and provide no confidentiality for the patient. In comparison to the UK there is a higher number of staff to patients, there would be one or two chiefs (consultants), around eight residents (registrars) and between 15 and 20 nurses or midwives. As a result Balinese women seem to receive a good standard of antenatal care. The labour ward was extremely small in comparison with six beds in the ward and two beds in the special delivery suite. In comparison to the UK, Balinese women are not aloud to scream during pregnancy and are given very minimal pain relief. The only occasion I saw pain relief being given was in a woman with pre-eclampisa. If a woman made too much noise the doctors and midwives would ask them to be quite, a massive contrast to the labour wards in the UK. The set up was extremely similar to the UK with the majority of the deliveries being carried out by the midwives and the high-risk cases by the doctors. Postnatally, the women are looked after by the midwives on the ward and then sent home.

Objective 3 – Explore the common co-morbidities in Indonesia.

I was unable to explore this sufficiently as I was in the obstetric and gynaecology department the majority of the time. After speaking to some of the medical students the major co-morbidities are similar to those in the UK. Obesity, diabetes mellitus and hypertension are common. The major problem with the management of these co-morbidites is the health system and the inability of people to be able to pay for the treatment.

Objective 4 – To practice and extend my clinical skills (history taking and examinations).

This objective proved to be absolutely impossible. Due to the language barrier I was unable to take histories from the patients myself. I did try and get round this by utilizing the medical students and using them as interpreters. However they are worked extremely hard and have a lot of responsibility with the patients so they were frequently too busy to be able to spare the time. As I was unable to ask the patients for consent I had to rely on the doctors to be able to examine the patients. However, I found out quite quickly that informed consent in Bali is not deemed necessary and this made me feel quite uncomfortable. In one situation an older lady came in with severe abdominal pain, the doctor did an internal examination and the patient was clearly in severe pain and distress but without consulting her offered for me to examine her. I declined to examine her as I felt that it was her decision as to whether she would want me to examine her as well as the fact that she was in a lot of distress. I was disappointed that I was unable to strengthen my clinical skills during my elective but I got to observe and see many different clinical cases.