PAEDIATRICS

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Elective Report:

Speciality: Paediatrics

Introduction

Hospital Kuala Lumpur or HKL as is commonly known is the largest hospital in Malaysia and is a government run hospital. It has 7,000 staff of which there are 200 consultants and specialists, and 500 medical officers and registrars. It was built in 1857 and continues to develop as the country's leading tertiary referral centre. The institute of paediatrics was completed in 1992 and is located off-site, and is readily accessible via a free shuttle service [1].

Paediatric medicine differs from adult medicine in many respects. It is a branch of medicine that deals with neonate, infants and adolescents. The body size of a child differs from an adult as does intelligence and maturity. This poses not only practical challenges in terms of prescribing drugs but also ethical challenges such maintaining principles of confidentiality, informed consent and legal responsibility and guardianship. In particular, the smaller body size of a neonate or infant is significantly different from an adult physiologically. One such example is that infants have a larger surface are to volume ratio which means they lose heat rapidly from their body [2].

Generally speaking congenital and genetic conditions tend to be more prevalent in paediatrics compared to adult medicine. In the Western World, there are many antennal screening tests for common congenital conditions such as Down's syndrome and spina bifida which can be performed. Routine antenatal screening has thus resulted in a significant reduction such conditions. Screening is not as widely available in developing countries, which means that there is a slightly higher incidence of congenital conditions.

The national language of Malaysia is Malay. However other languages such as mandarin, Tamil and English are widely spoken as well. Consultations and discussions during the ward round are done in their native or preferred language however, discussions, written correspondence as well as note taking amongst the doctors is conducted in English. This is because in Malaysia, the doctors train in English; medical books and lectures being delivered in English. Foreign doctors who train abroad must be able to speak English and Malay fluently before commencing work.

The doctors speak to the nurses in Malay, and in turn nursing staff communicate with each other in Malay too. The majority of nurses can speak English to a basic level but not enough to be able to communicate with the doctors proficiently. One would think that this would inevitably create a

hierarchical system; however this does not appear to be the case. One also wonders whether information is always correctly translated between the staff and the patients and whether information is lost in translation.

The national immunization programme in Malaysia is similar to that of the UK, whereby children are vaccinated from birth until 15 years of age free of charge. In addition, Malaysia has recently introduced the HPV vaccination and is available to girls from the age of 13 years.

Objective 1: Describe the pattern of disease/illness of interest in the paediatric population of Malaysia and discuss this in the context of global health.

Tropical and infectious diseases are highly prevalent in Malaysia in contrast to the UK where vaccination and improved living standards has resulted in a low prevalence. The tropical diseases in Malaysia can be attributed to its tropical climate and landscape. Dengue Fever is particularly common in Malaysia and is a viral illness spread by mosquitoes. It is spread by the bite of mosquitoes, in particular the *Aedes Aegypti* breed which is found in tropical and sub-tropical regions of the world. It is therefore seen in areas such as Indonesia, south East Asia, Sub-Saharan Africa, South and Central America and Indonesia and is increasingly being seen in travellers [3].

There is also a higher prevalence of common infectious disease such as measles and rubella compared to the UK. Despite having a government-funded immunisation programme, uptake of vaccination in some areas is not as high due to lack of education, limited access to healthcare facilities and so on. The national immunization programme in Malaysia is similar to that in the UK, whereby children are vaccinated from birth until 15 years free of charge. In addition, Malaysia has introduced the HPV vaccination and is available to girls from the age of 13 years.

During my stay on the paediatric department at HKL, at least 40% of admissions were due to respiratory problems such as community acquired pneumonia, or asthma. Kuala Lumpur is a big city which is becoming increasingly crowded and is very urbanized. The significant number of respiratory cases can be attributed to a variety of factors including overcrowded living arrangements, malnutrition and pollution.

The Malaysian government has put into place measures which would ensure a swift response in case of an influenza (H1N1) epidemic.

Infant mortality and life expectancy are good surrogate markers of a country's welfare and healthcare system. An infant is deemed a child aged between 28 days to 1 year. The infant mortality rate is the number of deaths of infants per 1,000 of the population. Life expectancy at birth is defined as the number of years a person is expected to live at birth. This too reflects a country's development in terms of healthcare and living standards. In 2005, the infant mortality rate in Malaysia was 10 and the life expectancy at birth was 74. This is comparable to countries in Europe and the USA [4].

Objective two: Describe the pattern of health provision in Malaysia and contrast this with the UK.

The healthcare system in Malaysia is largely run by the government's ministry of health and is said to be a two- tiered system with a government run universal system co-existing with a private health care system [4]. The government run hospitals and clinics charge patients a fee depending on the procedures, investigations, number of consultations and medications prescribed. This fee however is considerably lower than the private health care sector. Patients require health insurance in order to receive any form of medical care. Those who work for the government have their medical expenses paid for.

In contrast, healthcare in the UK is provided by the National Health Service (NHS) which is broadly divided into primary, secondary and tertiary care and is publically funded through taxation. Patients therefore do not need to pay to consult their GP or any doctor and health insurance is not a pre-requisite for receiving treatment. Although treatment under the NHS is free at the point of care to all legal residents of the UK, the NHS faces equal challenges such as long waiting lists and a shortage of doctors.

The UK attracts doctors from overseas as well as 'health tourists' seeking to take advantage of free medical care, particularly advantageous for those requiring specialist treatment. The private healthcare sector in the UK is more tightly regulated compared to Malaysia and it is not uncommon for doctors to work both for the NHS and privately.

The major problem facing Malaysia's healthcare system is lack of doctors and long waiting lists. As with other developing countries, Malaysia has a shortage of doctors. As a result there is a shortage of specialists, which tend to be found in the bigger cities. In a bid to increase the task-force, The

Malaysian government has made it compulsory for doctors who have trained in Malaysia to work a minimum of four years in Malaysia [5]. This includes the first two years post-qualification, equivalent to the UK's foundation programme followed by two years of government service. In addition, foreign doctors are strongly encouraged to apply for jobs.

The majority of private hospitals are located within cities and often better diagnostic facilities. Private health care is not tightly regulated. As a result, private doctors are notorious for prescribing unnecessary medications in order to make more money. This is not only costly for patient's but can potentially put them at risk of side effects. One particular problem is the widespread use of antibiotics. Such unnecessary use has led to the emergence of multi-drug resistant forms of bacteria which then prove very difficult to treat.

Another major disadvantage of Malaysia's health care system is the lack of health provision within rural areas. This is something the ministry of health is trying to counter by increasing the health budget to facilitates expansion within the more remote areas of Malaysia. In addition, the population of Malaysia is growing and the proportion of elderly patients increasing as life expectancy continues to increase due to improved living standards. As money and resources increase so too should the healthcare provision in the rural parts of the country.

In contrast to the UK, GPs in Malaysia operate in the private healthcare sector. As a result, there is a big burden on the public healthcare sector as common conditions which can be managed in primary care such as respiratory infections, result in hospital admission-which is costly both economically and logistically.

This year the Malaysian government has set aside 5% of the social sector budget towards the public healthcare sector. This is an increase of more than 2Million RM from last year [6]. The government is keen to see the development of new hospitals and polyclinics in rural areas; better training of health care professionals; and modernisation of existing hospitals.

Objective three: Compare and contrast the doctor-patient relationship in Malaysia and the UK. What are the strengths and weaknesses of each country?

The doctor-patient relationship in Malaysia differs from that of the UK. In Malaysia, it is very much patriarchal, with doctor-centred consultations. Patients often accept what the doctor says and few question the advice/treatment given. This is in contrast to the UK, where the majority of consultations are patient-centred, with the onus being on finding out the patient's agenda and patient satisfaction.

During my time on the paediatric ward, I observed the relationship between doctors and nurses with the patients. It became apparent that the Malaysian culture was a lot more informal. Ward rounds would be conducted, with the consultant often sitting on the patient's bed, whilst the junior doctors played with the children. The atmosphere during the ward round was often quite relaxed and there was not the same sense of urgency as is often seen in ward rounds in the UK. The doctors spent longer with each patient ensuring they had fully understood the nature of investigations and treatment. Although the parents were concerned, they seldom complained or questioned the medical staff.

It was nice to see that each paediatric bed was placed next to another bed in which the parent (usually the mother) would sleep. I noticed that during ward rounds the curtains were not closed whilst addressing each patient. Privacy in the ward setting is therefore not as prioritised as in the UK. It was not uncommon to see parents looking over and listening to the consultant as she addressed a parent. Although this was the norm in Malaysia, this is a very unlikely scenario in the UK where confidentiality takes precedence.

In Malaysia, they are very strict about child protection. In one case of suspected child abuse, the child, her two siblings and her mother were kept in hospital until they could be provided with safe housing. The child displayed behaviour which was suggestive of sexual abuse and although an internal examination was negative, there was still strong suspicion. The consultant made it explicitly clear that under no circumstances should they be sent home.

Objective four: Compare and contrast the social support system in Malaysia with that of the UK.

In the UK there exists a welfare system funded by public taxation which provides benefits such as income support, disability living allowance and so on. A system such as this does not exist in Malaysia and instead there is a big emphasis on families to look after each other.

There exists a Social welfare department in Malaysia. However it is not as well organised as in the UK. The very poor can apply for money towards healthcare but often the money given out is very little. People with disabilities can also apply for a monthly allowance to help towards living costs.

Conclusion

The healthcare system of Malaysia is similar to that of the UK in that it has both a private and public sector. However the way in which healthcare is delivered between the countries differs considerably. In the UK, there is a bigger emphasis on primary care and although GPs are increasingly being given more autonomy they are still very much accountable for their practice to the GMC or General Medical Council, the main regulatory body. GPs in Malaysia on the other hand do not operate in the public sector and instead work privately. Their practice is therefore less tightly regulated and as a result patients can end up receiving sub-optimal care; one of the biggest problems being prescribed unnecessary medication.

The pattern of disease in Malaysian children differs from that of the UK. Infectious, tropical and congenital conditions are much more prevalent in Malaysia compared to the UK. There are various reasons for this, some of which have been explored in this report. It must be remembered that Malaysia is a developing country and that although standards of living have much improved over the years, lack of education coupled with fewer health promotion strategies means that the healthcare system is not as advanced as in the UK.

The biggest challenge faced by the healthcare system is Malaysia is a critical shortage of doctors but in particular specialists. Access to healthcare is restricted to those who can afford the fees and he travel expenses required to visit the hospitals and clinics in the cities. Like the UK, there are often very long waiting lists for simple procedures as well as life-saving treatments. The public and private healthcare systems of both counties are not without their problems. The main problem facing private health care is the lack of regulation. This means that the level of care expected by patients is variable. Private health care is an attractive option when faced with the prospect of a long waiting list however, whether the quality of care received by private patients is better than the NHS is debatable.

Another major difference between the two countries is apparent in the doctor-patient relationship. Doctors in Malaysia are very highly respected and consultations are very much doctor-centred. Patients are compliant and junior doctors rarely question the consultant. This differs from the UK, where consultations are generally patient-centred and patient satisfaction and autonomy is given precedence. The atmosphere of the paediatric ward was quite relaxed, and ward rounds were conducted at a slower pace. Confidentiality is not as highly revered in Malaysia as curtains were not drawn during the ward round so that the whole ward could hear and see what was going on.

Although the welfare system in Malaysia is not as well developed as in the UK, child protection is taken very seriously and measures are put in place to safeguard against children at risk of abuse.

[2,495 words]

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