ACCIDENT +EMERGENCY SHAHID Ruba

ELECTIVE REPORT

Questions addressed during this essay:

1. **What is the format of the Accident &Emergency dept and how does this compare to that of a London hospital?**
2. **What are the most common presenting complaints in A&E? How are they different/similar?**
3. **Describe how universal presenting complaints compare to London Hospitals and how are they managed?**
4. **during my time in the placement what new insight/knowledge did I gain that will assist me in the future in my career including the option of gaining further international experience?**

Sarawak General Hospital is one of 2 hospitals in its catchment area that accepts casualties arriving in ambulances. The A&E department is divided into colour coded zones, each one specifying the severity of casualty it is dedicated to. Red= resuscitation , amber = majors and green= minors. All patients arriving into hospital following triage would be forwarded onto their corresponding zones for continuing care. With the exception of minors, patients are kept and treated in the corresponding zone until they improve and can be stepped down to the next level. This way patients starting in resus will eventually end up in minors and then an observation room for upto 24 hours prior to discharge.

The patients typically seen are the same as in the UK. Chronic diseases of the western world are very prevalent here such as MI, heart failure, COPD and strokes. These together with Chest infections such as pneumonia constitute the main presenting complaints in the hospital's A&E department. Although Sarawak is an endemic area for malaria, the number of patients seen with this is generally very few. Any suspected cases of malaria/denuge are stabilised and transferred to the Infectious Disease department which has a team dedicated to the diagnosis and management of malaria and dengue.

Whatever the presenting complaint, I found the management of the above conditions to be very similar to what I saw during my time in a London A&E department. All surgical patients were visited in their relevant zones by surgeons and their management dictated by the latter.

All doctors carried a Sarawak Handbook of management. This is a handbook similar to the oxford handbook series found in the UK. This book is written by a number of physicians/surgeons within the hospital and contains management protocols for all the common conditions. When I looked through the book the management protocols were very similar to the corresponding diseases in the UK. For example the management guidelines for someone with Chronic Obstructive Pulmonary Disease is exactly the same as that laid out by the British Thoracic Society in the UK. This book is updated at regular intervals and is to be used by all doctors at the hospital.

Patients who are able to transport themselves to accident and emergency will first be seen by triage. Here it will be decided whether they should be seen in the hospital or can go to a nearby clinic or smaller hospital which are equipped to deal with their problem. If they were required to be seen in A&E they would usually be sent to minors where a system similar to the 'streaming' system in the UK, is in operation.

Minors included a number of desks in a designated region of the A&E. Here mainly the junior doctors would see patients first. There were few seniors- 'Medical Officers' – (These equate to UK Registrars) that would rotate between the junior doctors to authorise their decisions. Patients requiring investigations would be sent elsewhere to have them done as this area did not have the relevant facilities. This is in sharp contrast to the UK where baseline investigations such as bloods, ECG and cannulation would be carried out within minors itself. Also the request for any radiological investigations would have to be done in person through the radiology department (which had a desk in A&E) as there was no computerised method for ordering these investigations.

Patients requiring more focused attention from specific specialties would usually be taken to the ward from A&E and managed there.

A striking difference I also observed was in the role of paramedics. Unlike in the UK, paramedics here are actively involved in the continuing care of their patients and have greater medical knowledge input into patient care. In the ambulance other than clerking, monitoring and instituting initial management, they continue to treat the patients alongside the doctor in the hospital. Secondly, the paramedics are responsible for performing procedures in the 'procedures room' located within A&E. This includes any procedures from cannulation to chest drains and suturing – which are usually done by the A&E doctors in the UK. Although the A&E doctors generally manage the patients, the paramedics stay with them and assist in their continuing care.

A key difference I noted was with young girls seeking abortion. As the pill is readily available over the counter at pharmacies, these situations are never seen in the hospital. I conversed with the doctor about the sensitive issue of this nature and he explained since the country is predominantly muslim and the country's law reflects this, abortion would not be offered to any girl of any age irrespective of her circumstances. But this is generally not an issue due to the widespread availability of the pill.

The treatment of asthma is also very different. There is a treatment bay on the side in minors dedicated specifically to patients coming in with acute exacerbation of asthma which is not life threatening (this would be treated in resus). The bay contains oxygen masks and nebulisers which are attached via ports to the wall. Patients would be brought straight here and managed accordingly. The bay also contains cabinets with all the necessary medications that may be needed. This bay accommodates both children and adults. Doctors will reside in the bay all day and focus solely on managing these patients.

In general the Accident and emergency department was equipped and functioned very similarly to A&E in London.

Every Tuesday and Thursday ward rounds were conducted at 10am with the consultant on duty. This involved all the doctors (20-30) gathering around a table and discussing their patients. It was usually junior doctors that presented patients. Any patients with concerning issues were then visited by the group. This was also utilised as an opportunity to provide/gain bedside teaching as junior doctors would often by quizzed by their seniors.

Overall I feel the medicine was very similar in both countries. The main problem encountered here is lack of education. Many patients found it difficult to grasp a firm understanding of their medications. During my time shadowing doctors in minors, a common reason for visits was patients complaining

their medications weren't working. Most commonly they were taking wrong doses or mixing up doses of different drugs. Many patients did not know what their diagnosis was and carried their files for their doctors to see. Some patients did not take medications due to concerns over their side effects having never tried them and were insistent on alternative or herbal medications. Having read medicine in East London, I found communication to also be among the main barrier to effective medical practise here. With migration now becoming a global phenomenon, I realised how difference in language is now a universal barrier.

A third crucial difference I learnt was the local paper based record keeping which was in sharp contrast to the national computerised database employed by the UK NHS faculty. Following a consultation, the events of the consultation were documented on a special form. A copy was filed away within the department and a second copy given to patients for their own record. The patients kept a file of all their consultations and all investigation results which they would carry to all their subsequent appointments.

It was through this file alone doctors were able to communicate with eachother. In the instance the patient did not bring his/her file, there was no way of acquiring the patient's past medical history. The only other way would be to retrieve the original copy from the department itself, which was not always possible. Similarly any investigational results such as XRay films or other reports were kept in this similar way. I believe this crude method of patient record keeping was key in limiting communication both between professionals and between the doctor and patient.

Despite these vast differences in administration, I felt the services and format of the Accident and emergency department was nearly as good as that in the UK. This is largely owing to the vast number of doctors gaining training abroad and brining back skills/qualities and knowledge from various parts of the world and then incorporating them into their own health service. I found this very inspirational and during my time there I spoke to many doctors who had studied abroad and either returned to Malaysia which was there native land, or were here on temporary work permits. I learnt gaining experience in different settings would allow me to interact with a wider diversity of patients, variable situations and ways of dealing with it (e.g. abortion) and ultimately improve the quality of care I provide to my patients. I live in one of the most metropolitan cities in a world with patients from all walks of life.

My experience of working at Sarawak General Hospital has been very memorable and educational. I learnt the skills required for good medical practice are universal. Effective communication both written and verbal, and listening to patients forms the foundation for a comprehensive consultation. The integral role of teaching was also very evident.

I learnt to practice international medicine, I must be versatile as each country has its own challenges. I learnt walking around and speaking to different doctors allowed me to gain some understanding of certain aspects especially the patient population being treated, which is something I cannot obtain from literature. Unfortunately the problem of language barrier greatly limited my direct interaction with patients. As there is no language line, or translation services available such as in the UK, knowing some of their language is very beneficial. From this I have learnt attending short beginners' courses in languages might help in this situation.