DERMATOLOGY VIRDEE Karina

Bali Sanglah Hospital Elective experience

What are the prevalent dermatological conditions in Bali? How do they differ from the UK?

How are dermatological services organised and delivered? How does it differ from the UK?

How is alternative medicine used by clinicians and how does this differ form the UK?

How did this experience improve and expand your communication skills? What challenges were there in integrating into a different culture?

My placement was in the Dermatology clinic in Sanglah hospital, Denpasar, Bali. I observed consultations for adults in there area, who came for short or long-term treatment of their ailment. This did not include emergency treatments or cosmetic treatments. From the clinic, I was able to witness the most prevalent dermatological conditions first hand. These included fungal infections such as Tinea Corporis, Tinea Capitis and Tinea Pedis, which accounted for approximately ten per cent of all patients seen at the clinic. The second most common condition was scabies, which was also seen on a daily basis and accounted for approximately seven per cent of patients seen. Other conditions attributable to poor hygiene were also commonplace including impetigo and intertrigo. This differs greatly from the most prevalent dermatological conditions seen in the UK. Whilst the majority of conditions seen in Denpasar were related to poor hygiene and infectious conditions, a health care report by the University of Nottingham in 2005 shows that the mostly highly reported skin complaints were 'minor wounds' (28%) followed closely by 'skin rash allergies and irritated skin' (26%) as well as eczema (13%) and athletes foot (13%) **(Schofield et al.,2005).** Infectious dermatological conditions were too few to be significant in the report.

There were also significant differences to the way in which the dermatological services were provided at the clinic, when compared to the UK. The clinic comprised four doctors, two nurses and variable numbers of students. Two consultations would take place in each room due to a lack of space in the clinic, which reduced the level of confidentiality for each patient. This was also the case in the sexual health room, which was part of the dermatological clinic. Consultations usually included between two and four students who would act as observers and occasionally clerk patients for their seniors. Students were encourages to photograph conditions for their learning. Altogether this created quite a busy, crowded environment. The pharmacy onsite is then used to collect medications, which all patients must pay for. If the doctor requires use of the laboratory to aid the diagnosis, they will commonly do so themselves as there are no staff that work specifically in the laboratory. The lack of resources when providing care for patients was also evident from the clinic. Gloves are used rarely or disinfected due to their lack of supply and there was no air conditioning. All documentation is by hand, which contrasts greatly to the UK where much is computerised.

As a Hindu country, Bali has an abundance of spiritual healers and alternative medicine sources. These healers are abundant and highly respected by the people. Patients are often encouraged to visit healers and to use alternative medicines when western medicine is insufficient. Although not provided in the clinic, patients may be referred to medical doctors elsewhere who provide both western and eastern methods of treatment. This is widely practiced and accepted by the Balinese as it compliments their culture and beliefs. This contrasts the UK greatly where doctors

are discouraged to advise medications that have not been scientifically investigated or proven effective.

Overall this I believe that this experience greatly contributed to my communication skills. On several occasions I was asked to clerk patients that had no English language ability, and had to find innovative methods for identifying their primary complaints. I was able to combine limited Indonesian with pictures from textbooks to decipher problems. This I found to be extremely difficult and ultimately I was paired with an Indonesian student to make clerking more manageable. This experience demonstrated the importance of being able to fully understand what a patient is saying when describing symptoms and how it affects the ultimate diagnosis. I believe that these challenging scenarios were helped by good team-work between fellow students and colleagues. As a completely different culture from the UK, I made efforts to get to know members of the medical team by discussing their traditions and beliefs. I found this to be a great method of getting to know individual members and a way in which to reduce culture barriers. I was fortunate to be able to attend celebrations at the homes of several doctors, and witness Hindu rituals and festivities. In this was I was able to integrate into the Balinese culture and work life.

References:

Julia Schofield, Douglas Grindlay, Hywel Williams. 2005. SKIN CONDITIONS IN THE UK: a Health Care Needs Assessment. Centre of Evidence Based Dermatology, University of Nottingham. 11-12