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GENERAL MEDICINE

Elective Report

I undertook my 5 week elective in Sarawak which is an east Malaysian state situated on the northwest side of the island of Borneo in Southeast Asia. My placement was in Sarawak General Hospital (Hospital Umm Sarawak), the largest hospital in Sarawak and the main tertiary and referral centre in East Malaysia. I chose to do my elective in Malaysia because it is a country that is undergoing rapid socio-economic growth which has meant that the country has a mixture of health issues which are can be seen in both developing and developed countries. Also in areas of Malaysia, particularly in Borneo regions like Sarawak, there is a combination of urban living in main city areas but still areas of rural living. Therefore I was able to see a broad range of conditions and was fortunate enough to meet patients with different social circumstances.

Access to healthcare in Malaysia is rather similar to accessing healthcare in the UK. In the UK, patients see their GP first when seeking medical advice and are responsible for overseeing the long term management of chronic diseases and to ensure referral to the correct specialist services. In Malaysia, residents seek non-emergency medical care by attending a polyclinic for a minimal fee and the doctor they see at the polyclinic will refer them to specialist as needed. If referred to the hospital, then the hospital doctor is responsible for overseeing follow ups and prescription. The difference between the UK and Malaysia is that there is not the continuity of care in Malaysia that is found in the UK from having an allocated general practitioner.

In the UK, GPs are usually local to the patient so it is more convenient, however in Sarawak General Hospital (SGH), as one of the main referral centres, patients may have to travel long distances for appointments. There are parts of Sarawak which lack easy access through poorly maintained roads which can make it even harder for patients to present at the hospital. This can sometimes mean patients present later and with more complication. To tackle this problem, doctors and volunteers from the hospital travel to rural areas for rural clinics and also to set up medical camps. This helps those patients with chronic problems but poor maintenance and lack of roads in rural area poses a problem for access for emergency services. This contrasts to the UK as fortunately, even in the most remote areas of the UK there is access to emergency services.

Malaysia use a dual system of both government led and also private healthcare, however unlike the UK, the government led healthcare requires patients to pay a small fee of 1 – 5 RM when they attend outpatient clinics in hospital which includes the consultation, investigations and prescriptions. There are also charges for inpatient care of 3 – 5 RM a night plus the charges for investigations. Those that have a problem with paying the fee are referred to a social worker to be assessed and in genuine cases the fee is reduced to a more affordable amount. Similarly to the UK, vulnerable members of the population like the elderly, disabled and those on welfare get free treatment and prescription. In Malaysia, government workers and their families also receive free treatment. Some of the investigations are outsourced

to centres in peninsular Malaysia which means there can be long waiting times for results which leads to people preferring to go via the private route if they can afford to.

Even though SGH may be the largest hospital in Sarawak, it still cannot cope with the large numbers of patients which come through its doors. Therefore, the hospital has had to adjust to try and accommodate for this. One way which I observed is by seeing two patients in one room during clinics, this enables more patients to be seen however as I learnt this also compromises medical ethics by the prospect of breaching of confidentiality. This was quite shocking as this is a scenario which I cannot imagine would occur in the UK and patient confidentiality is one of the cornerstones of ensuring a good doctor – patient relationship.

In Malaysia the conditions facing the population is changing as their country grows, the rate of communicable diseases is reducing with better healthcare and sanitary conditions however there has been a rise in non-communicable diseases as seen in other western countries like the UK. While the prevalence of communicable diseases is falling in Malaysia, it is still higher than the UK with more deaths from communicable diseases in Malaysia than in the UK. Common infectious diseases seen are typhoid, malaria, hepatitis, diphtheria and Japanese encephalitis. These diseases are higher in the population living in rural regions where there is poorer sanitation and lack of preventative measures. Also there is a large migrant population in certain areas of Malaysia which also contributes to the prevalence of infectious disease.

Surprisingly, I found that conditions such as hypertension, hypercholesterolemia and diabetes are common in Kuching with cardiovascular diseases being one of the leading causes of death in Malaysia which is a reflection on their evolving lifestyle. This fact was even more apparent when meeting the patients attending the hospital and the various public health posters around the hospital in a bid to tackle the problems of obesity and other metabolic risk factors which are contributing to the raised prevalence of ischaemic heart disease and cerebrovascular diseases. Malaysia also has a high incidence of respiratory conditions like asthma and COPD. It was clear to see that one problem that Malaysia needs to tackle is the high incidence of tobacco use, with more than 50% of their population smoking cigarettes. During my time in Malaysia I observed a lack of public awareness of the risks associated with smoking and poor enforcement of the legal age limit of buying cigarette. Smoking is socially accepted and is allowed in almost all area in Malaysia except government buildings. Other common reasons for admission to the hospital are accidental causes especially RTA.

I was able to attend grand rounds and conferences with speakers from various other countries which both helped consolidate my learning and improved my understanding of the workings of the healthcare system in Malaysia. Also the grand rounds enabled me to see the working relationship between the doctors and how they communicate. I was able to improve my communication skill through conversing with patients despite the language barrier, especially improving my non-verbal communication skill as sometimes when patients could not speak English, non-verbal skills could still help build a relationship with the patient. My elective taught me a great deal about local customs, cultures and health beliefs of the people of Malaysia. It also broadened my perspective of health care on a global level and I believe has enriched my understanding of the importance of the health system and patient care.