GENERAL MEDICINE

SSC5c – Medical elective report

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Elective supervisor: Professor Dato' Dr KL Goh

Elective subject: Public health/Gastroenterology, and Ophthalmology

Elective location: 1 week in Kuching, Sarawak, Malaysia

4 weeks in Kuala Lumpur, Malaysia

Elective objectives:

1.) **Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health.**

2.) **Describe the pattern of health provision in relation to the country in which you will be working and contrast this with the UK**

3.) **Compare and contrast the practice of gastroenterology in the Malaysia and the UK**

4.) **Reflective assessment of elective experiences**

Introduction

I organized to spend my fifth year elective in Malaysia. With 1 week in Kuching, in the eastern state of Sarawak, and four weeks in Kuala Lumpur, the capital of country.

Malaysia is a country in South East Asia that lies across the equator. Geographically, Malaysia is formed of Peninsular Malaysia in the west and Malaysian Borneo in the east (Fig 1).

Fig 1: An overview of the geography of Malaysia

Malaysia is a common wealth country that was formally known as Malaya, which gained independence in 1957. In 1963, Malaya united with Sabah and Sarawak to form Malaysia. Malaysia is a diverse country with many ethnic groups. The largest ethnic group in Malaysia are the Malays, whom form 50.4% of the population. This is followed by the Chinese (23.7%), the Indigenous island populations (11.0%), and the Indians (7.1%). Of religion, the official state religion is Islam; however the Malaysian constitution guarantees freedom of religion, and many different religions are in practice.

The political organization of Malaysia is somewhat similar to the United Kingdom. A system of a federal constitutional elective monarchy is in operation. With the system of government based on the Westminster parliamentary system, and the legal system based loosely on English common law.

Interestingly, I was fortunate enough to be in Malaysia during the 2013 general elections, which afforded me some extra insight into the political landscape of Malaysia. Briefly, the incumbent party successfully retained power, continuing their unbroken reign since the formation of Malaysia as a country. The elections however were plagued with controversies, involving allegations of corruption and unfair voting practices.

Healthcare provision in Malaysia is somewhat different to the UK. In the UK, healthcare is free from the point of access for all British citizens. Whilst in Malaysia, healthcare is not free at the level of individual patient, instead, the government subsidises the costs that are involved in healthcare, but in most cases, the patient will still be expected to contribute financially in his/her treatment with a nominal fee. Malaysia also has a much larger private healthcare industry than the UK, catering for those in middle and upper classes of Malaysian society who fund their healthcare needs through means such as insurance or individual savings.

Kuching – Public health

For the first week of my elective, I was attached to Sarawak General Hospital in Kuching. This is a governmental tertiary referral centre for the state of Sarawak and its population of approximately 2,400,000.

The pattern of disease seen in Kuching was very different from what I am used to in the NHS indeed. Firstly, compared to the NHS, the patients that were admitted to the wards in Kuching tended to have diseases that were at a much more advanced stage when compared to the NHS. From speaking to local doctors, it seems that low income of the population and restricted resources were the main contributing factors in the advance presentations of diseases in Sarawak. Secondly, I encountered conditions that are uncommon in the UK, namely infectious diseases such as malaria, and dengue fever, this was not entirely unexpected as Malaysia is a tropical country with higher rates of infectious diseases.

With regards to the practice of public health in Kuching, there was much emphasis placed on the modification of lifestyles that could predispose to disease. The two areas that were targeted in Kuching were smoking and the contributory risk factors for type II diabetes, as both smoking and diabetes are very common amongst the population, 1/2 of the population smoke and 1/5 are diabetic. Needless to say this contributes to a significant public health burden, and this is immediately noticeable on the medical wards were COPD and complications due to diabetes (e.g. MI and stroke) are very prevalent indeed. Awareness

campaigns were the main public health intervention that the local authorities used to address this problem, Fig 2 shows an example.

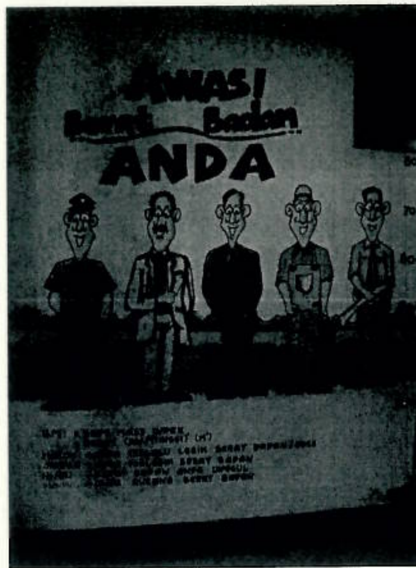

Fig 2: A public health awareness campaign on obesity

Kuala Lumpur – Gastroenterology

For this part of my elective, I was attached to the University of Malaya Medical Centre (UMMC), a national tertiary referral centre for the whole of Malaysia. The practice of medicine and the resources at UMMC were more akin to what I am used to in the NHS when compared to Kuching.

For my time at UMMC, I was attached to the department of gastroenterology, an international centre of excellence for endoscopy that carries out a high volume of endoscopic procedures (Fig 3).

Fig 3: The plaque denoting the department of gastroenterology as an OMED international centre of excellence for endoscopy.

I was able to observe many endoscopy procedures during my time in the department of gastroenterology. Examples of procedures I observed include PEG insertion, ERCP, and the endoscopic management of varices.

Asignificant amount of patients that were admitted to the ward had liver diseases that were of varying stages and severity. In the UK the main cause of cirrhosis of the liver is usually attributed to alcoholic liver disease and non-alcoholic fatty liver disease (NASH), in Malaysia, there is also the added burden of hepatitis B and hepatitis C, which is far more prevalent when compared to the UK. In fact hepatitis B and hepatitis C are the most common cause of liver disease in Malaysia, as opposed to NASH which is the most common cause in the UK. Interestingly, in the Indian populations, the incidence of alcoholic liver disease is higher than in the Malays and Chinese. Another difference between the UK and Malaysia that I have noticed is that the rate of IBD is far lower in Malaysia when compared to the UK, it is very uncommon to see a patient with Crohns disease or ulcerative colitis in Malaysia. Whereas IBDs are more common due to the population risk factors that are present in the UK.

Kuala Lumpur – Ophthalmology

For the remainder of my elective, I was posted to the department of Ophthalmology at UMMC. Here, I had the opportunity to observe eye clinics, and also to observe procedures such as cataract surgeries, glaucoma surgery (e.g. laser iridectomy, trabeculectomy), and some vitero-retinal surgery (e.g. Vitrectomy, retinal detachment repair).

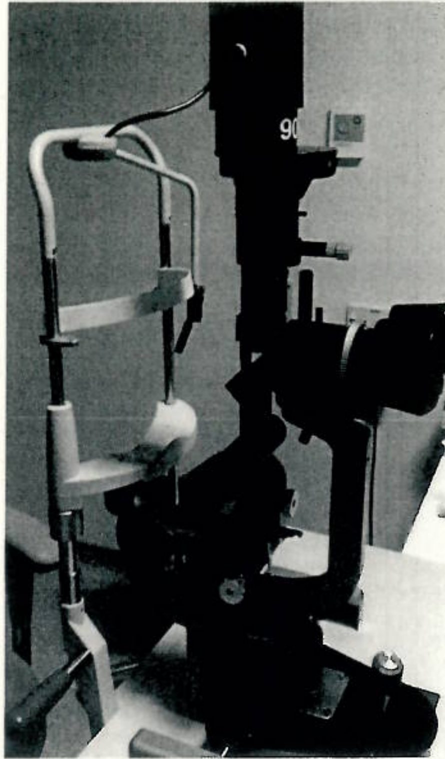

Fig 4: One of the slit lamps at the Department of Ophthalmology, University Medical Centre Malaya

During the latter part of my fifth year, I did an SSC in ophthalmology, so I was able to compare and contrast the differences between the UK and Malaysia. The main difference between the UK and Malaysia is that patients tend to present later during the course of their disease in Malaysia, for reasons that I have already explained in the above sections. This was somewhat emotionally difficult, as I saw many patients with sight lose that was entirely preventable if they got the help they needed sooner. One particular patient comes to mind, he lost one eye in an industrial accident when he was younger, and developed acute angle closure glaucoma in the other eye, but did not seek medical attention immediately and was thus rendered blind.

Another aspect of ophthalmology in Malaysia that I've noticed is that the public hospitals are chronically understaffed, as many trained specialists are lured to the massively lucrative private ophthalmology sector in Malaysia. From speaking to members of staff in the department, it transpired four out of six of their consultants left in the past month, leaving the department very understaffed at the senior level and facing immense pressure. This is in direct contrast to the way that private practice is conducted in the UK, were consultants usually do both NHS and private work.

Reflective assessment of elective

This elective has most certainly been an eye opener. Although there are similarities in the practice of medicine in Malaysia as compared to the UK, there are also significant and sometime dramatic differences. These differences include the limited resources that were most obvious in Kuching, and the different pattern of diseases in both Kuching and Kuala Lumpur.

The difference that has struck me the most is the difference in the public funding of health care. As mentioned, public healthcare in Malaysia is subsidised by the government with the patient expected to make some financial contributions. Also a large private practice medical sector is in operation in Malaysia to cater for those who can financially afford it, with a payment for service model that generates income, this usually means that the resources in the private sector are almost unlimited, as long as you can afford it or have insurance. The NHS is not without its problems, however, at a fundamental level it provides free healthcare from the point of entry for all British citizens, in an environment that is very well funded compared to Malaysia.

The one thing that I realise on reflection is that I am really grateful for the NHS providing a socially just and well delivered health service that is available to all, irregardless of income and social class.