Mithun Unadkat

GENERAL MEDICINE

Medical Elective Report
Sarawak General Hospital, Malaysia.
General Medicine.

Sarawak General Hospital(SGH) is the largest hospital in the state of Sarawak, Malaysia, and the main tertiary and referral hospital in East Malaysia (i.e. the Malaysian territory of the island of Borneo). Since Borneo is an isolated island, with patterns, causes and effects of health and disease that are very different to West Malaysia and the rest of the world, SGH was an ideal choice of location to undertake an elective and learn about a different healthcare system.

The 2.5 million population of Sarawak is a mix of Malays, Chinese and indigenous groups such as Bidayuh, Iban, Melanau and Orang-Ulu.There are few Indians here unlike West Malaysia. The main languages are Malay and Mandarin Chinese, but many people can speak English depending on their education and upbringing. This unique population faced challenges affecting healthcare outcomes such as rural living, health beliefs and costs of healthcare.

The training of doctors in Sarawak appeared to have a similar standard and structure to the UK. All Malaysian medical schools teach using English as the primary language. In addition, the government grants a large number of scholarships for local students to study for MBBS in Western countries, with conditions tying the graduate into working in Malaysia. Graduates undertake a similar training structure through foundation and middle grade levels, with completion of MRCP (UK) being the standard most trainees to.

Both public and private healthcare sectors exist to serve the population of Sarawak. Public services are highly subsidised and affordable for the local population. Patients are charged a nominal RM 1.00 (£0.20) for general outpatient clinics and A&E visits, with specialist clinics costing RM 5.00 (£1.00). Rural health services (e.g. popup day clinics in remote areas) are free of charge. Inpatient charges are capped at RM 500 (£100) for specialist treatment although many patients in receipt of government subsidies do not pay this.

The organization of public services at inner city hospitals somewhat resembles the organization of NHS services in terms of there being primary, secondary and tertiary levels of care. However the quantity and quality of services falls short. For example, SGH is the only public general hospital in the region and waiting times can routinely be many months. The hospital has only 800 beds for a population of 2.5 million. There are around 20 smaller district hospitals providing a further 1500 beds but these hospitals are limited in the services they can provide. The doctors I met on my elective unanimously agreed this is a major problem acing the state.

A major contrast to the UK was a lack of long-term management, post discharge rehabilitation and social services. Such care was not provided, even in urban settings. I believe that this is due mainly to financial reasons as the doctors I

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spoke to, many of whom has trained in the UK, clearly understood the importance of long term management and health promotion.

I was impressed by the clinical skill demonstrated by the senior doctors at the hospital. They were exceptional in picking up subtle clinical signs and confidently making an interpretation without the use of specialist equipment and investigations. I initially thought this high standard was due to having frequent exposure to unusual clinical signs that are infrequent in the UK. It was only after discussing the running of the infrequent rural healthcare clinics that it became clear that having a high level of skill in clinical examination was a necessity rather than choice - when the same doctors would do a shift in the rural clinics they would not have the option of confirming a diagnosis with specialist tests and equipment. Instead they would have to make a diagnosis solely based on history and examination.

The burden of infectious diseases faced by SGH was much higher than I had initially expected. I soon learned that the surrounding rainforests were host to a range of pathogens. The five most common infections I encountered in admitted patients were malaria, leptospirosis, dengue fever, meliodosis and tuberculosis. This is an incredibly different picture to the UK where these infections are unlikely to be at the top of a differential diagnosis. Common things being common world over, I also witnessed a lot of diabetes, hypertension, arthritis and asthma in outpatient clinics. The dermatology clinics were particularly interesting with a variety of cases including tuberculosis of the skin and leprosy.

The concept of confidentiality,a basic duty doctors mustprovide for theirpatients, is far from the UK. I was remarkably shocked and confused when attending my first outpatient clinic. In a typical room two doctors would share a desk, one sitting on either end. Each of the doctors would have their patient in the room at the same time, sitting on chairs back to back! The clinic rooms were interconnected with open doors, which nurses and medical students would walk through freely. Any conversation was open to anyone present in the room. I was surprised that the patients did not once complain – most seemed grateful to be seeing the doctor after waiting weeks for an appointment and travelling from a very rural area. It was explained to me that the situation is a result of a lack of resources and is a compromise. The doctors were indeed upset about the situation but out of options for the time being.

My overall impression of healthcare in Sarawak is that the state, and its body of doctors, understands how a good healthcare system should ideally be structured and delivered. However, due to a lack of resources the state has someway to go before the quality and quantity of healthcare provision is adequate and on par with the western countries. I feel that the hospital uses its limited resources in very efficient manner and excellent diagnostic clinicians treat the patients.