DERMATOCOGY

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Elective Report 2013

Sanglah Hospital, Denpasar, Bali

Word count 1169

Elective report

I spent my elective period in a government run hospital in Bali, Indonesia. I undertook placements in the dermatology, sexual health and neurology departments. I picked these specialities both because I had an existing interest in them, and also because I felt that I would see most tropical disease within these specialities. It turned out to be a fascinating experience.

There are many fundamental differences between the healthcare systems of Indonesia and of the United Kingdom. The National Health Service provides services to everyone, which is free at the point of care. In Indonesia, although government run hospitals exist, free healthcare is actually very difficult to access. Most Indonesian citizens have some form of health insurance, which enables them to access comprehensive medical care. The poorest citizens, who cannot afford insurance, have only limited access to basic care. They are able to obtain essential care, for example emergency life-saving treatment, or antibiotics for serious infectious diseases. However, they are not entitled to care beyond basic management. They are not automatically entitled to medical follow-up in outpatients, and medications they might be prescribed are not free.

Personally, I found it difficult to assess who was, and who was not, entitled to free healthcare. I also struggled to understand the full role of the medical insurance cover. I feel that the British system of healthcare is financially far more transparent. I think that the Indonesian system can make it difficult for people to access the resources they need, and without a good understanding of how it works, can be difficult for patients to understand. I sometimes felt that patients were not clear about what they had the right to ask for, and what they were entitled to. This really reinforced to me that patients in the UK are fortunate to have an inclusive health service for everyone.

Although I am not in any way an expert, and had only a short time there, I felt that the Indonesian health services often perpetuated health inequality. I noticed differences in the quality of the care provided for people of different economic backgrounds. Richer people were, for example, able to pay prescription charges for medication that they were prescribed. Poorer patients were often unable to pay for medications – this was particularly a problem if the medications were advised to be taken long-term (such as anti-hypertensive medications, or cholesterol-lowering drugs). On several occasions, I saw patients who had come in with complications of illnesses which may have been preventable with prophylactic medications, which they could not afford.

Due to the economic restraints the hospital faced, I think doctors were often more reluctant to prescribe medications, especially ones designed to be taken long-term. I think this occasionally was harmful to some of the poorer patients, but it meant that very few patients had problems with polypharmacy. Patients that I met in the hospital seemed very wary of taking medications, especially prophylactically. I think this may reflect the different health beliefs held in Indonesia. Most patients seemed to associate taking medications with being unwell, not with the prevention of future illness. I am not sure if the concept of primary

prevention is widely understood outside of the West. I will take this on board when trying to explain the idea of primary and secondary prevention to patients back in London.

I was fascinated by some of the health beliefs held by Indonesian patients. Many patients had a belief that disease was not caused by a pathophysiological process, but rather as a curse, or ill-wish. This was particularly true of diseases with a high-level of stigma, such as leprosy. The understanding of leprosy in Indonesia is variable, despite it being the country with the 3rd highest incidence of the disease in the world. People with the illness tend to come from the rural areas of the country, and generally rarely visit urban areas or cities. It is unusual for people from these areas to pursue a higher education, and often understanding of illness is poor. These cases tended to present late, often when the signs of leprosy were pronounced, which compounded the stigma attatched to the disease. Leprosy is so feared, that the doctors in the hospital referred to it not as leprosy, but as Morbus-Hansen disease, so that patients would not be stigmatised by others. The doctors were careful not to mention the word leprosy at any time. Those diagnosed with leprosy/Morbus-Hansen disease were often very upset by the diagnosis. The negative attitudes towards the illness means that many people are not aware that it is curable with antibiotics. It sometimes proved difficult to convince people that they would not die from the disease, but would make a full recovery with medication.

Another disease with a high level of stigma in Indonesia is HIV/AIDS. Again, poor understanding of the illness has led to many myths and horror stories springing up about it. This is not too dissimilar to attitudes in the UK. However, attitudes in the UK towards HIV seem to be changing, partly due to the advent of successful antiretroviral treatment regimes. The hospital which I was based in in Bali did not have adequate resources to fund treatment for all HIV patients, so as far as I saw, they tended to have poorer outcomes.

Illnesses that are common in Bali, however, such as Dengue fever and malaria, had very good outcomes in the hospital. These diseases are seen all the time by the doctors there, and are rapidly and easily diagnosed. The local protocols for management are comprehensive, and seem to be very effective.

Medical training in Bali has many similarities with the UK. After graduating, medical students spend two years doing general training, and then can choose to specialise. I only spent time in the hospital, but I would have enjoyed to go to a community care centre, to see what sort of services they provide.

Medical ethics was very different to the Western model. Confidentiality is not especially valued in Indonesia. Clinics are run with multiple patients in the same room, and people are constantly wandering in and out. The patients did not seem to mind or be surprised by this, and I do not think privacy is especially valued within the health service. The doctors also continually took photographs of interesting signs on their personal phones, and encouraged me to do the same. I found this quite uncomfortable, as it is so different to what we would do in the UK, and raises a lot of issues around confidentiality. I think possibly medico-legal law is not as developed in non-Western countries.

My experience in Sanglah Hospital, and in Indonesia as a whole, was a very positive one. I felt I learned a lot about a very different healthcare system, and about my own capabilities and limitations as a doctor. I hope I can apply some of the things I learned to my work back in the UK.