Aamenah Hawash Elective Report and Reflection

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 other countries or with the UK
3. Health related objective: to improve radiological skills and help build skills for future patient care
4. Personal/professional development goal: to compare the healthcare systems within the Western world (UK v USA), and the East (Malaysia)

I carried out an Anaesthetics elective at Hospital Kuala Lumpur (HKL), Malaysia, and a Thoracic Radiology elective within University of California, San Diego (UCSD), United States of America.

I was very lucky to have the opportunity to carry out my first elective placement at HKL, one of the largest departments of Anaesthesia and Intensive Care in Malaysia, as part of one of the largest government-funded hospitals in Malaysia. Upon arrival, I felt very at home, as they were renovating part of their hospital - so it felt like being back at the Royal London Hospital! Very quickly, I realised that the structure and format of the healthcare delivered in Malaysia was also very similar to the UK. The modern anaesthesia machine is the exact same machine that I have seen being used in our London hospitals, and I was surprised that the general equipment, such as the venflons and Tegaderm was the same as well. I however noted that there was a superior observations machine used in theatre, which automatically saved the patient observations, instead of them having to be written out by hand as is in the UK. With regards to the procedure, although the patient was anaesthetised in the main surgical theatre, as opposed to in an adjoining anaesthetics room, the same precautions, i.e. the WHO surgical safety checklist, were carried out, as well as the use of the universal triangle of anaesthetics (propofol anaesthesia, analgesia and a muscle relaxant). The main differences I noticed though, was the use of reusable surgical clothing that then get re-sterilised and repackaged. This felt very foreign for me, having being used to single-use scrubs, but I appreciated the cost-effectiveness and the reduction of waste.

Due to the diversity of the Malaysian community, there are multiple languages spoken, including Malay, many different Chinese dialects, and Tamil. English is therefore the common language for the doctors to communicate, both with each other and with patients. This was an unexpected surprise, but allowed me to gain a fuller experience, both within the hospital and in the country as a whole. When on a rare occasion I

encountered someone that spoke no English at all, I found the communication skills teaching we have received to be invaluable in using non-verbal body language in communicating with patients.

A major difference that I was expecting was of course the different structures of healthcare. My placement at UCSD allowed me to compare both the British and US healthcare models and provided me with a a practical understanding of these differences. The US healthcare system is often based on clinical guidelines from the respective specialties' national organisation and evidence-based practices. Unlike the UK, there is no nationalised service; therefore this system should favour best practice as opposed to cost cutting, often seen in the National Health Service (NHS), but unfortunately I felt it tended to favour defensive medicine. Ultimately, I believe it is the poor and elderly who suffer from this approach to healthcare, although now with the introduction of Obamacare, this may all be completely different within a few years, and only time will tell whether or not this initiative will be successful.

Malaysia was a perfect comparison as it has a 'national system' in which nationals only pay 5 Ringgets (MYR) - equivalent of £1 GBP - to be seen in the hospital, which is affordable for all, but also has a private healthcare system which is opt-in. Similar to the rest of the world, access to healthcare for international patients is a lot more expensive.

Arriving at UCSD, I could see that the set-up of the department was different to both the UK and Malaysia in that it was much more sub-specialised. We were placed within Thoracic (chest) radiology. The benefit of this system, of course, is that the readings become a lot more accurate as they are being made by specialists experienced in reading imaging of that area of the body, not just in radiology. I was also amazed to realise how much time and effort goes into reading radiology, which is something I had not truly appreciated before. We were given the opportunity to sit either with the attending, or one of the residents, who are the more junior doctors who read through the images alone, then go through them all again with the attending.

I was also surprised to see a lot more liaison there was between Radiology and General Medicine. Phone-calls were always being made between the different departments in the hospital, and also within the different sub-specialities within Radiology, both for consults, and to report back urgent findings. Requests for imaging were rarely rejected, even though they were carried out a lot more frequently than I have seen in the UK - I even saw a couple of repeat x-rays being done within the hour after a dose of furosemide had been given! This again is in part due to the fear of litigation - the majority of physicians I spoke with were of the thought that it's better safe than sorry if something is

missed. However, this again was something I was not used to, for example in the intensive care unit, ICU, patients had daily chest radiographs, regardless of any clinical indication or changes.

A similarity I noted between the US and Malaysia was the fact that all the doctors seemed really happy within their profession and with their job in the hospital. This was a refreshing change from the UK, where the majority of the doctors seem disgruntled working within the NHS. Another similarity that we do not have in the UK is the provision of food within the hospital. At HKL, breakfast and lunch is provided in departments to staff, and is eaten together in the departments, really promoting a sense of community. At UCSD, an 'icecream social' was set up, where ice-cream was being served to everyone at the hospital, free of charge, by the administrators of the hospital. Again this promoted a great sense of community as well as increasing morale.

One thing that came as a bit of a culture shock was the differences in infection control procedures. No clinician, either in the US or in Malaysia were bare below the elbow, and both countries still employ white coats. In addition, in Malaysia, the patients are partly or completely seen by different members of the team, who each wrote up their interpretation of that part of the history or examination. In addition, although we are used to hand-writing notes in the UK, in Malaysia, 2 carbon copies are also made, meaning that there are many pieces of paper around the bedside, not organised into one set of notes, and not always coherent together. What shocked me most though is that a lot of the time the date was omitted, and as it was not organised into one set of notes, it was very easy to not be able to place when a certain set of notes or part of the history were taken.

Since my intercalated BSc, I have always been interested in public health, and carried out many projects back in the UK. From the first day, I realised that Hillcrest had a very large HIV positive population. I was lucky enough to be given the opportunity to become involved in a project related to radiological changes in Immune Reconstitution Inflammatory Syndrome (IRIS) secondary to the use of antiretroviral medication in HIV positive patients, which has yielded interesting results and allowed me to have some interesting intellectual discussions on the subject.

Overall, I feel that my electives have taught me a lot of clinical knowledge in areas that we have limited exposure to during our medical school teaching, as well as allowing me to experience Medicine across the world. I have become a lot more confident in recognising a normal chest radiograph, and being able to orientate myself around x-rays and

computed tomography imaging, putting me in a better position to identify abnormalities and pathology. This will be invaluable when I start work as a doctor in August.