ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Objective 1: Describe the underlying causes for acute medical admissions to Borneo Medical Centre and discuss this in the wider context of global health.

Acute admissions to medical wards in Borneo Medical Centre differ greatly from complaints that are seen in clinics in the same hospital. Examples seen in patients admitted to the ward include influenza, cellulitis, HIV/AIDS and associated complications, alongside a suspected secondary bacterial pneumonia and dermatomyositis. In contrast, many patients seen in clinics at the Medical Centre complain of problems associated with hypertension, diabetes, obesity and depression. Also seen in an outpatient setting were patients with a chest lump and query tuberculosis. This is reflective of common communicable and non-communicable diseases that are seen in Malaysia.

Tuberculosis is a significant public health concern in Malaysia, however the incidence has been decreasing over the years. Particularly in rural areas, many people live in crowded conditions which makes it very easy for TB to spread. Like many countries with high TB rates, Malaysia has implemented vaccination programmes to try and curb the spread of disease. Meanwhile Malaysia is experiencing a concentrated HIV-epidemic with higher-than-average rates among at-risk populations. Many patients seen in Borneo Medical Centre were admitted with complications associated with AIDS and a low CD-4 count including cerebral toxoplasmosis and febrile illnesses. Many other ward patients were admitted for simple or supportive treatment of influenza or pneumonia. Malaysian doctors are working hard to drive uptake of influenza vaccinations within their population.

Meanwhile, hypertension, cardiovascular disease and diabetes are leading causes of morbidity and mortality among the population of Malaysia and are a common reason for attending outpatient appointments. Similarly, obesity and COPD/respiratory diseases are common among a population where smoking is common and sedentary lives are becoming the modern norm. Much time in outpatient clinics is spent on giving lifestyle advice for patients, including exercising, smoking cessation and portion control.

In the wider context of global health, these diseases reflect common issues seen in developed countries and is not dissimilar to what is seen in parts of the UK. Tackling these concerns requires a multifaceted approach from government public health strategies. At the heart of this lies the promotion of healthy lifestyle from a young age, vaccine programmes for preventing communicable diseases and enhancing data collection systems to monitor disease trends. By addressing the underlying causes of admissions, overall better health outcomes are within reach.

Objective 2: Describe the pattern of health provision in relation to private vs public healthcare in Malaysia.

Healthcare in Malaysia is divided into private vs public care - much like the system in the UK. When seeking care, many people turn to the public hospitals which will provide treatment that is free or heavily subsidised by the ministry of health. There are fees for certain services or medications however these are usually readily affordable for most of the population. These public hospitals tend to be busy and crowded and diagnoses can be slow, leading many Malaysians to look for private healthcare as an alternative.

In private hospitals, patients can book medical and surgical appointments or try their luck for a walk-in assessment. They will be seen relatively quickly, and many investigative and diagnostic tests can be performed with the results and reporting sometimes occurring within the same day. Patients can then be counselled on the diagnosis and discuss the management with their physician. Patients that require

© Bart's and The London School of Medicine & Dentistry 2024

hospitalisation can be admitted by attending the A&E department of the private hospitals. In contrast to the public hospitals, the patients will foot the bill for their appointments, investigations and management plans. This can lead to interesting conversations with patients about the depth of investigations that they are willing to pay for, as well as what treatment they would like. Many physicians can present their recommended management plans, but may also state the cost and, in situations where it is suitable, can provide alternative, cheaper, treatment options. Indeed, some patients opt to undergo a more rapid diagnostic process privately, and then take their results for treatment in a public institution. Healthcare insurance also comes into play, but often requires authorising signatures from consultants before the companies are willing to cover the costs.

Objective 3: To compare and contrast the similarities and differences in the diagnosis and management of medical conditions in rural and urban Malaysia, compared with the UK.

With a healthcare system that closely mirrors the UK, medical care in urban areas of Malaysia is very similar to those back home. Patients have access to primary and secondary care relatively easily, and many private facilities offer walk in appointments depending on the capacity of the physician's diary. In secondary care, much of the process of diagnosis and management of different medical conditions is reflective of the UK while management of certain conditions varies slightly. For example, there may be different antibiotics recommended as first line treatment for some infections which differ to those that are recommended in the UK. Overall, however, the process of receiving healthcare for citizens of urban areas is very similar to the UK.

In rural Malaysia, this is a completely different story. Many villages and settlements lie hours away from more urban areas with GPs and hospitals. The road network in Malaysian Borneo, while recently improving, is very lacking which makes it difficult and lengthy to travel by bike or car. Many travellers elect to fly to more rural parts of the country, however this may not be a viable route for less affluent local people. Charities exist which offer medical outreach programmes to bring medical and dental care to isolated villages. All equipment, medication and food supplies are ferried by volunteers and set up in front of local longhouses. Villagers can then queue to be seen by a GP and/or a dentist which will provide them easy access to diagnosis and treatment of medical problems. This system works very well with more stable, chronic conditions (e.g. OA or hypertension) which can be managed with simple medications that are carried by the charities pharmacy team. However waiting weeks to months for a doctor to attend the village would not be suitable for acute conditions or emergencies. In these situations, villagers are forced to tackle a journey to a hospital under their own power - possibly on the back of a motorbike or in the back of a 4x4 car if they are lucky. In contrast to the UK, even the most rural areas often aren't too far away from some form of healthcare providers. The most suitable comparison to these rural areas of Malaysia would include remote islands that border the UK, but many of these will have boats and infrastructure to transport patients to hospital relatively quickly, if the situation requires.

Objective 4: To gain a deeper understanding of different healthcare provisions globally, by attending clinics and ward rounds in Malaysia and comparing this with the UK.

A private hospital in Malaysia supplies much the same provisions as public hospitals in the UK - there are A&E and outpatient departments, as well as wards and theatres. Shadowing a general medicine consultant allowed exposure to patients in outpatient clinics and in the wards.

Ward based patients were treated in a very similar way to the UK, as demonstrated on ward rounds. Rounds are attended by the responsible consultant as well as the nurse who is directly in charge of patient care. Ward patients review their daily reviews and doctors are kept up to date on their patient's condition. It is here where the patients and their families/friends also have an opportunity to have input into their

© Bart's and The London School of Medicine & Dentistry 2024

care via conversations with doctors, and, in private hospitals at least, patients may decide to what level of care and expense they wish to receive. Ward round consultations are often undertaken in different languages, including Malay, Mandarin, and English. All documents and charts are dictated in English.
Outpatient clinics also operate similarly to the UK - patients may receive appointments or attend a walk-in session, where their basic observations, including height, weight and blood pressure are measured by a nurse/healthcare assistant before being seen by a doctor. In the clinic, they can discuss recent test results and future management plans. Many patients are followed up with further appointments occurring within a few months' time. Walk in patients can quickly be reviewed and sent for tests, many of whom will receive results within an hour and can be seen again by the doctor for further management. This speed of reporting is the biggest difference to public hospitals in the UK, where outpatients will usually be sent for investigations in the weeks prior to their appointment.
Interestingly, doctors in private hospitals may only charge a set amount per patient seen. This limits the burden on patients and regulates private doctor's pay. This, however, leads to some doctors' cherry picking less complex patients to see, so that they can see more patients per day to be able to earn more money. This can lead to more complex patients potentially struggling to find private healthcare providers. While not directly comparable to the UK, this goes to show the more discriminatory aspect of private vs public healthcare worldwide.

© Bart's and The London School of Medicine & Dentistry 2024