NEUROSURGERY

SSC 5C: ELECTIVE REPORT
Hospital Kuala Lumpur, Malaysia – Neurosurgery

Samir Mehta – ha06102@qmul.ac.uk

(09/04/2012 – 11/05/2012)

Objectives:

1. **What are the neurosurgical conditions in Malaysia? How do they differ from the UK?**
2. **How are neurosurgical services organised and delivered in Malaysia? How does this differ from the UK?**
3. **Describe the extent of patient choices and education with regards to common neurosurgical conditions and their management in Malaysia.**
4. **How did the experience of neurosurgery in Malaysia improve and expand your communication skills? What are the main challenges of integrating into a different culture?**

Hospital Kuala Lumpur is one of the largest government tertiary referral centres in Malaysia, and is located in the Chow Kit district of KL. It is one of only two government hospitals in the Selangor state of Malaysia which has a neurosurgical department. Though there is no neurosurgical ward per se, one bay of 8 beds in the HDW is dedicated to neurosurgical patients, with other patients being placed in the ICU. The neurosurgical team I was placed under was headed by Mr Safari, the main consultant neurosurgeon of the hospital, his registrar, Mr Hafiz, and Dr Faizi, the SHO. I mainly spent my time on the ward shadowing Dr Faizi, who had graduated from St Andrews medical school, and had completed his foundation years in England. In addition to this I attended the daily 8am team meetings and ward rounds which were conducted by Mr Safari, as well as attended Mr Hafiz's weekly operating theatre and outpatient clinics.

1. What are the neurosurgical conditions in Malaysia? How do they differ from the UK?

Having spent time on the ICU and HDW, as well as also attending clinics, I observed a wide variety of different inpatient and outpatient neurosurgical conditions including traumatic head injuries, subarachnoid haemorrhages, and tumours of the brain and spinal cord.

The most common neurosurgical condition in Malaysia was due to trauma following a road traffic accident. In 2007, the WHO published results which showed that Malaysia had one of the highest estimated road traffic mortality rates at 23.6 per 100000 people. In comparison, this is on average approximately 8 people per 100000 more than the estimated RTA mortality in other Asian countries. Subsequently, during the 5 weeks that I was at the hospital approximately 70% of the patients I saw were inpatients that had acquired an extradural or acute subdural haemorrhage. The majority of the remaining inpatients that were on the ward

were post-surgical patients, many of whom had undergone emergency surgery following a ruptured berry aneurysm. Due to the regular influx of RTA victims, the vast majority of resources at Hospital KL were used for acute and emergency neurosurgical conditions, and therefore there was consequently less elective neurosurgery for chronic conditions.

In contrast, in the UK where RTAs are relatively uncommon, acute haemorrhages following traumatic head injury are rarely serious enough to warrant neurosurgical admission, and are hence usually managed in A&E. Similarly subarachnoid haemorrhages are frequently being done by the vascular surgery team. In England, the majority of neurosurgical patients are outpatients that undergo elective procedures for chronic illness. Thus, the most common neurosurgical procedures that take place here are median nerve releases for carpal tunnel syndrome, discectomy for vertebral disc herniation, creating burr holes to alleviate chronic subdural haemorrhages, or surgical resections of a glioma or meningioma.

2. How are neurosurgical services organised and delivered in Malaysia? How does this differ from the UK?

The provision of healthcare in Malaysia is very similar to the UK in that there exists both government-funded hospitals, which are under the Ministry of Health in Malaysia, and private hospitals. Government hospitals are free at the point of use, and there is only a one of charge of RM 2 (the equivalent of 50p) which is required for administration of patient records. After this, the entire duration of a patients stay in hospital, including drugs, procedures and imaging, are completely free.

In comparison, private hospitals charge for each day a patient stays in hospital, with extra money for each item of equipment used. Subsequently, 90% of locals use the government hospitals, whilst the ever increasing numbers of private clinics are used by the elite of Malaysia, and by foreigners who come to Malaysia for health tourism.
Unfortunately however, many of the private hospitals in Malaysia have attained a bad reputation with many stories of private hospitals reusing equipment to save costs. In fact, whilst I was at Hospital KL, there were two neurosurgical patients on my ward that had been transferred from their private hospitals after contracting thrombophlebitis from needles that were reused between different sites on their body. As a result, many patients end up eventually going back to the government hospitals, thus placing an increasing amount of preventable burden on hospital such as Hospital KL.

In Hospital KL, the management of neurosurgical patients was based on a strict daily routine. Every morning, there is a consultant-led team meeting that is attended by all the MDT members that are involved in treatment and rehabilitation of a neurosurgical patient. Here, each of the 20 inpatients is reviewed in detail, and their latest investigation results and bloods are discussed to come up with the management plan for the day. This is different from the UK, where due to the sheer number of patients and lack of time, it is only practical to do this on a once weekly basis. Also unlike in Hospital KL where there is only one consultant who oversees all the patients, In the UK, there are multiple consultants, each with their own team and neurosurgical patients. Hence in the UK, it makes more sense for the consultant to talk to his small team more informally on a daily basis, whilst in Hospital KL it is easier to have a formal meeting so that all the many members of their MDT can discuss the patient each day.

In both Malaysia and the UK, there are multiple daily ward rounds, with at least one in the day that is conducted by the consultant.

3. Describe the extent of patient choices and education with regards to common neurosurgical conditions and their management in Malaysia.

The majority of the Malaysian population is well educated and literacy rates are similar to that of the UK. Subsequently, younger patients are very curious about their conditions and are actively involved in the management. Thus, to take advantage of this, there were many posters around the hospital about potentially life-threatening conditions, such as meningitis, which promoted health awareness by educating patients on the symptoms that they should look out for. Similarly, to combat the increasing number of road traffic accidents, there have been many campaigns on the radio and television regarding road safety, and recently a law has been passed make it an imprisonable offence for any passenger on a motorbike to not be wearing a helmet. Overall, the multitude of health and safety campaigns across Malaysia have been successful in educating the public on important, and potentially stigmatised medical conditions, and have therefore encouraged patient to be more actively involved in their management.

Despite the recent advances in health awareness in Malaysia, the older generation of patients still believe that it is the doctor's responsibility to dictate the management of the patient. Hence many older patients do not want to discuss their management plan, and rely on the doctor to act on their best interests. In the neurosurgical department in Malaysia, it is generally not practical in most cases to discuss choices with a patient, just because of the urgency of most acute presentations of road traffic accidents, where the patient may also have reduced consciousness.

However, there have also been many cases of patients refusing standard therapy, and opting for a more traditional approach to therapy. For example, one patient on the ward had decided that he wanted an integrated approach to his management, and so his neurosurgical procedure was done under hypnotherapy and acupuncture, instead of general anaesthetics. Though this was a rare case, it does demonstrate the flexibility of the neurosurgical team to accommodate a patient's choices and cultural beliefs in their holistic treatment.

4. How did the experience of neurosurgery in Malaysia improve and expand your communication skills? What are the main challenges of integrating into a different culture?

Due to the high tourist influx in Kuala Lumpur, language was generally not a problem in the more urban areas of Malaysia. However, on the neurosurgical ward this was not the case because as previously stated, Hospital KL has one of only two neurosurgical departments in the entire state of Selangor, and hence as KL is one of the only urban areas in this state, the majority of patients lived in rural areas, and thus had a very limited English vocabulary. This was further compounded by the fact that the majority of patients had pathology of their brain which had affected their Broca's or Wernicke's areas, therefore causing dysphasia. As a result I found it extremely difficult to communicate with the patients on my ward, and needed

a nurse to be present with me at all times to help ask the patient questions, and also to request informed consent to carry out examinations and bedside procedures on the patient. Unfortunately, I feel this greatly dampened my overall experience of neurosurgery in Malaysia. However, one good thing to come out of this situation is that my non-verbal communication skills have thoroughly improved, and I feel this will have a positive impact when I deal with my patients as a future doctor.

Aside from the obvious language barrier, understanding the Malaysian culture also took some time to adapt to. As patients and their relatives had a significantly more spiritual and religious view of death than had encountered before, I spend some time researching various Malaysian customs on the internet, so as to gain a better understanding of the patient's social history when the nurse translated it for me. I thought that this would be important to overcome the greatest challenge of integrating into the patient's culture, which is the fact that as a foreigner, the patient does not believe that you will understand their situation and consequently, does not open up to you. Fortunately, by the end of the elective I had a reasonable understanding of many Malaysian customs, and as a result I was able to better express empathy towards the patient, which I hope the patient sensed and felt more at ease in my presence.