SALMAAN SALEEM

GENERAL MEDICINE

Elective report – Kuching, Sarawak. Malaysia

Statistics:

Total population	**27,468,000**
Gross national income per capita (PPP international $)	**13,740**
Life expectancy at birth m/f (years)	**71/76**
Probability of dying under five (per 1 000 live births)	**6**
Probability of dying between 15 and 60 years m/f (per 1 000 population)	**175/95**
Total expenditure on health per capita (Intl $, 2009)	**677**
Total expenditure on health as % of GDP (2009)	**4.8**

"1. Describe the pattern of disease/illness of interest in the population with which you have worked and discuss this in the context of global health."

What are the most prevalent conditions in Sarawak, Malaysia? How do they differ from the UK?

In Sarawak, the population is a mix of urbanites and tribes who live far outside cities. Although the tribal villages are relatively modern with running water and sewage systems, electricity and satellite tv there is no escaping the tropical infectious diseases. Many travel websites adivse to take malaria prophylaxis however the locals had a much more relaxed impression of such infectious diseases. Education and healthcare seems to be lacking in the more remote villages, which may be a factor in these figures.

However, recent rapid socio-economic development has led to a reduction of this form of disease with sporadic outbreaks occuring (e.g. recent hand, foot and mouth outbreak.) There is a much greater prevalence of communicable disease in Malaysia in comparison to the UK. There are 762 deaths per 100,000 people in Malaysia as a result of communicable disease whereas there are only 36 deaths per 100,000 in the UK. Important communicable diseases present in Malaysia include infectious and parasitic diseases (malaria, leptospirosis), tuberculosis, HIV/AIDs and diarrhoeal disease. Deaths from lower respiratory tract infections are almost three times higher In Malaysia also.

In regards to HIV/AIDs, speaking with the healthcare professionals it appears that the illness is greatly underreported due to the reluctance of possibly affected individuals being tested. Although there are no precise statistics regarding this issue, speaking to physicians it was apparent that there is a great deal of stigma which is something that isn't dealt with by the governing bodies.

Non communicable diseases show similar death rates per 100,000 in the UK and Malaysia (400 and 526 respectively.) Diabetes has a death rate of nearly four times as high in Malaysia, even though the overall totals are relatively low (19 deaths/100,000 compared to 5/100,000 in the UK.)

Both the UK and Malaysia have cardiovascular disease as a leading cause of death in both countries – although, more so in Malaysia. Ischemic heart disease and cerebrovascular disease comprise a large proportion of the pathology in both countries.
Respiratory disease is very similar to the UK with COPD and Asthma being the two major conditions. However due to the general populations' perception of smoking and it's wide social acceptance (smoking being allowed indoors in most restaurants), as well as low tax on cigarettes has given rise to greater numbers of smokers, hence COPD rates in Malaysia.
Unintentional injuries have a much higher prevalence in Malaysia with road traffic accidents accounting for much of this. This is likely due to a number of reasons such as a high number of motorcyclists, the terrain and maintenance of rural roads and laxity of law enforcement regarding helmets and speed restrictions contribute to this statistic.

Reasons for visiting a general practitioner are much the same as the UK with the top 10 conditions all being prevalent in both Malaysia and the UK (see table 1)

Reason for visit	Number of patients
1. Upper respiratory tract infection (URTI)	6867
2. Soft tissue disorder	2033
3. Hypertension	1873
4. Dermatitis, eczema	1473
5.Acute gastroenteritis	1432
6. Diabetes mellitus	987
7. Medical checkup	825
8. Immunisation	681
9. Hyperlipidaemia	570
10. Fever	493

Table 1. Top 10 reasons for Malaysian Primary Care Visits (National Medical Care Survey 2010)

		Malaysia	United Kingdom
	WHO Country code	**3236**	**4308**
	Population ('000)	*27,014*	*61,231*
Cause of death			
All Causes		**762.4**	**462.1**
Communicable conditions		***185.3***	***36.1***
Infectious and parasitic diseases		**114.5**	**6.7**
Tuberculosis		**17.8**	**0.4**
HIV/AIDS (f)		**23.1**	**0.4**
Diarrhoeal diseases		**1.4**	**1.9**
Lower respiratory infections		**65.1**	**23.7**
Noncommunicable diseases		***526.0***	***400.5***
Malignant neoplasms		**103.2**	**137.0**
Mouth and oropharynx cancers		7.7	2.4

Oesophagus cancer	2.2	7.6
Stomach cancer	8.4	4.8
Pancreas cancer	2.3	6.8
Trachea, bronchus, lung cancers	17.9	31.0
Breast cancer	7.9	12.9
Prostate cancer	3.2	8.2
Diabetes mellitus	**19.0**	**5.0**
Cardiovascular diseases	**263.3**	**141.7**
Hypertensive heart disease	**7.6**	**3.7**
Ischaemic heart disease	**138.7**	**68.8**
Cerebrovascular disease	**75.8**	**36.9**
Respiratory diseases	**58.7**	**34.4**
Chronic obstructive pulmonary disease	**19.1**	**21.5**
Asthma	**5.3**	**1.1**
Digestive diseases	**30.9**	**26.7**
Peptic ulcer disease	**3.5**	**2.5**
Cirrhosis of the liver	**2.4**	**9.5**
Injuries	**51.1**	**25.5**
Unintentional injuries	**48.0**	**17.4**
Road traffic accidents	**34.5**	**4.8**

Table 2. Burden of disease – death rates per 100,000 (WHO 2008)

"2. Describe the pattern of health provision in relation to the country in which you have worked and contrast this with other countries, or with the UK."

How is the health service delivered in Sarawak, Malaysia? How does it differ from the UK?

The organisation of healthcare in Sarawak, Malaysia is very similar to that of the UK. There is static healthcare delivery which are hospitals and family doctors. However family doctors (general practitioners) are not free to access, whereby people have to pay for this service. The referral system is much the same – someone sees their family doctor and if the pathology is deemed severe enough, they will be referred to specialist clinics at the hospital. This would explain the high number of patients present in clinics (up to 200 patients) as these were free to access. There are also 187 rural health clinics which include basic medical assessment and management along with maternal and childcare services. This from of static healthcare delivers care to around 70% of the population in Sarawak.

For more remote regions of the province there are mobile health units, which include units such as the Village Health Teams and the Flying Doctor Service. These teams can access areas by road, river, foot or by helicopter. With these additional services healthcare is provided for up to 90% of the population.

Flying helicopter service

3. Improve confidence in performing basic practical skills e.g. cardiovascular examination, venepuncture

I had the opportunity to perform various clinical examinations and practical procedures on patients throughout my placement. History taking proved to be difficult at times due to language barriers, as even patients who spoke some English did not understand what I had asked of them. I resolved this issue by trying different sentences for the same question and using fewer words. I also asked for help from the nurses who were free to act as interpreters. This was much like many patients I have faced in East London which I felt had equipped me with techniques to take a decent history. These experiences have helped further develop my communication and clinical skills which I'm sure will pay off in the future. Examining patients was also difficult to perform due to obvious

barriers in communication, however I was still able to perform examinations to a good standard and elicit clinical signs like crepitations and murmurs.

4. Learn to work in an MDT in an unfamiliar environment to prepare for my FY1 job

This was not easy as the team was often busy and I could only help by performing usual student tasks such as clerking, which often took a long time due to reasons stated earlier. However I witnessed lots of examples of teamworking during ward rounds where the doctors would communicate patient details between each other and the nursing staff, asking for eachothers' input and feeedback. Asking for help from seniors and nursing staff helped me learn how to negotiate for their time and communicate in a friendly yet authoritative manner.

Reflection

Was it what you expected?

I was surprised at the similarities in the healthcare systemin Sarawak, Malaysia and the UK. The ward structure and daily routines were much the same, with morning ward rounds followed by the juniors carrying out jobs needed to be done for the patients. There were afternoon clinics run by senior doctors much like the UK system.

Clinical experience?

Much like firms, the medical teams were very busy and learning was very much self-organised. I gathered some clinical experience examining and clerking patients, however, the ward had many elective students with suitable patients becoming scarce. Teaching was also limited.

What did you learn about the people and the country?

The people in Sarawak were very friendly and willing to help. They displayed a genuine interest in you and made you feel welcome and comfortable. There is a strong cultural presence and people are proud of their tribal heritage, which we observed at the cultural village and long houses.

What did you learn about the health care professionals you worked with?

They were very friendly and knowledgeable. Most of the staff were multilingual and showed a genuine interest in us, going out of their way to help us find our way or help us get started.

What did you learn about the health care system in that country?

It was very similar to the UK, with the health team communicating with each other in English. There are many foreign doctors working there with most of them having attained their MBBS in the UK. Because of this I believe that doctors from here could easily settle there and practice medicine with ease. The patient notes were identical to the UK system as well as other aspects of record keeping, with everything being written in English.

Speaking with the doctors we also learnt that the health minister of Malaysia is a firm believer in alternative and herbal medicine, which is why it was available through the state. Malaysians have a strong sense of tradition and alternative medicine seemed to fall under this category, which was difficult for doctors to deal with as they had to be tactful in discussing its flaws without causing offence.

Also junior doctors were required to week much longer shifts than in the UK, being allowed only one day off with long hour shifts.

What were the best bits?

Experiencing the local attractions and package tours, such as kayaking near in the rainforest and visiting Bako national park to witness rare wildlife was great fun. At some clinics we were lucky to get some one-to-one teaching and had the opportunity to ask questions. Discussing topics specific to Sarawak and the general healthcare was very interesting. There was an interesting clinical case whereby a patient presented with community acquired pneumonia, yet had completely different pathological cause, due to the different organisms present in that region.

What were bits you least enjoyed?

It was often difficult to follow what was happening in consultations as patients did not speak English, making it difficult to keep interest.

Were there any shortcomings?
Although we had sorted all the paperwork for our placement before arrival, there was a somewhat slow administrative process in regards to getting our ID cards, it took the best part of the week to finalise which subtracted from our clinical experience. There were many English elective students there which made socialising out of hospital easy. The negative aspect of this meant that wards were busy with students and individual teaching was rare.

Would you recommend it to another student?
I would highly recommend this elective to another student as there is a lot to do locally, with a wide variety of activities, sights and culture. The hospital staff were very friendly, however, clinical experience can sometimes be difficult to obtain with the numbers of students on the ward.

Would you do anything differently?
I would attempt to sort out ID cards before arrival to prevent the delay in starting our placements. Attending the rural clinic would also be interesting, however due to the high number of students this was not possible.

What did you learn about yourself?
I learnt that being a medical student from East London has equipped me with many communication and clinical skills, the depth of which I was not fully aware of. I also learnt that in the most part healthcare systems are very similar in other countries, with just minor differences.

Were there any deviations from risk assessment?
No

How was your accommodation?
We lived in a local hostel (lodge 121) which was clean and well taken care of. The highlight of our accommodation was the extremely helpful and kind owners who treated us more like family than visitors. I cannot recommend this place highly enough, every other accommodation paled in comparison, we still keep in touch via social networking and email.

How were your travel arrangements?
In order to save money our flight to Sarawak, Malaysia was somewhat long winded with a 13 hour flight from London to Kuala Lumpur, a 1 hour flight from Kuala Lumpur to Singapore and finally a 1.5 hour flight from Singapore to Kuching airport (Sarawak.) It was not particularly enjoyable, so if you don't enjoy long flights, this may not be your thing. From the hostel to the hospital, it was only a 10 minute walk, however the heat makes this difficult and taxi service is abundant and relatively cheap if shared between 3 or more people (which was the case for us)

Other experiences and information useful to future students
Try to sort out ID badges beforehand. We underestimated how long this would be.