

Francesca Yeldham (Medicine). Clinical Elective, Sarawak Malaysia

I spent 2-3 weeks in the capital of Malaysian Borneo, Kuching, in Kuching General Hospital, a large tertiary referral centre. I then spent 4-5 weeks in a range of healthcare services including several regional hospitals in the towns of Bintulu, Belaga and Kapit. Additionally I went to rural clinics in Tatau and Daro. Finally I joined some community health teams on the visits via long boat to very distant communities on multiple islands off the coast and also up river in the rainforest.

I chose Borneo as my elective destination because it fulfilled my two major requirements. Firstly I wanted to go to a country with a developing health system where I would encounter tropical disease not typically seen in the UK – particularly Dengue which I wrote my dissertation on - and different challenges to those in Cambridgeshire such as provision of services despite limited resources. Secondly, I wanted to go to a country where the medicine was carried out in English as I wanted to get the most out of my elective and the ability to understand the language was therefore key.

I had planned to split my time between the general and 1-2 regional hospitals focussing my time upon obs and gynae, paediatrics and accident and emergency medicine. Instead I spent far more time in much smaller and so more generalised clinics and hospitals. This meant that not only did I get to see the specialities that I was interested in but I also saw far more than I had expected in the areas of general medicine and community health care. For example I helped run cooking courses in the island clinics as part of the basic child nutrition education courses which the government was running. The time spent in the tertiary referral centre meant that I had the opportunity to go to some interesting specialist clinics, notably the burn unit/ clinic and trauma orthopaedics (which was mainly supplied by scooter RTIs), which I was unaware of when I planned my elective.

One of the best aspects of my elective was the range of healthcare services which I got to see and I gained a lot of different experiences including;

The value of clinical communication skills was emphasised to me. In Malaysia the veneration of doctors combined with a poor standard of education held by the majority of the patients resulted in a noticeably paternalistic practice of medicine – this was predominantly in the speciality clinics in larger hospitals. Patients seemed unable or unwilling to ask questions and the concept of a two way discussion was not encouraged. The result was often difficult consultations where the patient's ideas and concerns were not explored and they often seemed to leave dissatisfied. Yet given the pressure on the clinics which often had 50-60 patients per doctor it is understandable why the doctors rushed their consultations. Specifically, our session focusing on breaking bad news helped me when I had to explain a diagnosis of Langerhans Histiocytosis in a 2 year old to his extremely anxious mother. She had been sent the histology report but no further information or explanation had been given. I found it was possible to use skills we had been taught even through the language barrier. Although she seemed bewildered by the idea she did have multiple questions when asked whether there was 'anything else' she wanted to know.

I was continually impressed by the ingenuity and adaptability of staff when faced with challenges arising from limited resources and I also saw their frustration, as typically there was funding available but it was being handled poorly. Malaysia is a relatively wealthy country in SEA yet Sarawak is its poorest province and there is an obvious lack of correct funding, especially in staff and equipment (in terms of the health provision) and also in basic

infrastructure – electricity, water and sanitation and roads. The majority of towns/ villages we visited were only accessible by river as there were no roads, and if there was piped water it was not potable. If I had spent time only in Kuching the state capital I wouldn't have noted this. Examples include Tatau, in the equivalent of a GP surgery, where the US machine was routinely used yet was so old that there were no buttons left and the roller ball had been lost yet the empty socket was used for controlling the images instead. They had been promised a new X-ray machine yet the clinic's electricity supply was insufficient to run it. There was also obvious wasting of funds for example in Belaga there is currently a brand new hospital complete with multiple US machines, operating theatre and dentist yet none of the local people visit it because the doctor assigned to it left and he had no replacement. The rest of the staff of nurses, midwives, paramedics etc are present but are effectively superfluous without patients. This highlighted to me the necessity of accurate health expenditure and the basic requirement of co-ordinating new technology with underlying infrastructure and staff.

The challenge of providing basic healthcare to very distant communities was also something I got to experience. There is only a certain amount of equipment and drugs that can be carried/ pushed up river on a single longboat, the doctor had to adapt his treatments/ investigations accordingly. For example, given the limited number of lancets, he had to be selective based on the history as to who he would sample for blood glucose, blood films etc. This was a requirement given the circumstances yet the sense to only run necessary and not superfluous tests is something I hope to continue in my future practice.

I did see a huge range of tropical diseases including Malaria, Dengue and Tb. The most memorable was a 19 year old woman who had atlanto-axial subluxation due to Tb spine. We also saw a vast amount of 'Western' disease Diabetes Mellitus, Hypertension, Chronic Renal Failure. I had the opportunity to see extreme cases – which I would not have seen in the UK - as these patients often presented late with advanced disease and severe complications due to their poor access to healthcare. Also, the specialist clinics cover a huge area meaning in a few days I saw virtually a whole textbook of cases for example on paediatric cardiology in Bintulu.

The impact of other health care professionals SALT, Physiotherapists, Dieticians etc was also highlighted to me due to their absence. Therefore, patients in rural communities with relatively common conditions, typically those arising from perinatal complications e.g. Cerebral Palsy, had a degree of disability far greater than similar patients in the UK or those in the cities able to pay for such services. They had very poor outcomes with severe contractures, poor mobility and malnutrition etc

Overall my elective surpassed my expectations in terms of the range of healthcare provision and the different diseases which I had a chance to witness. I would have preferred to have gained more hands on experience and thereby have developed my practical skills further. Had I spent longer in one larger hospital focusing on a specific speciality I am sure that I would have achieved this yet I feel the breath of specialities, health care facilities and places I was able to experience more than compensate for this.