A glimpse of women's health in China

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Danni Wang is a final-year medical student studying at The University of Auckland. She was born and raised in China. In 2017, she went back for her fifth year selective in Obstetrics and Gynaecology at Peking Union Medical College Hospital. She describes it as a very educational experience and hopes to inspire more students to go on elective attachments in Asian countries.

Introduction

In 2017, I had a fantastic opportunity to go back to my homeland China for a six-week selective in Obstetrics and Gynaecology at Peking Union Medical College Hospital (PUMCH) in Beijing. I was involved in many rare cases in different subspecialties during the clinics and surgeries. It was eye-opening to observe the impacts of culture and a different health system on women's health in China. Hopefully, my selective experience described below is helpful for those considering an elective in China.

Background – Comparison of the health care systems between New Zealand and China

Unlike New Zealand (NZ), primary health care does not play a very important role in China as many patients would present straight to tertiary centres to book specialist appointments available that day. Therefore, the outpatient department is always full of patients starting to line up for appointments very early in the morning. The advantage of this type of system is that people with serious conditions get attention and treatments on the presenting day. However, it is a very inefficient way of spending health care resources if people present with minor illnesses that could be easily managed in the primary setting.

The government provides partial funding for the costs of health care if the patient is eligible (taxpayers and people receiving special benefits). However, patients still need to pay for the majority of the cost they spend in hospitals, such as the medications, investigations, and treatments. Therefore, it is not surprising to see how some patients refuse life-saving treatments, purely because of the high cost.

Selective clinical experience

Week one – delivery suite/inpatient obstetrics

The obstetric centre at PUMCH is a tertiary centre that looks after women with complicated pregnancies referred from other centres all over China. There are no midwives in this hospital as each patient is assigned to a resident during labour. Each day began with a handover of all patients and then a ward round with every one of the department present (including all the junior doctors, nurses, and medical students). The system was very efficient as residents pre-rounded the patients prior to senior review. During this week, I had the opportunity to assist in many vaginal deliveries, caesarean sections, and life-threatening obstetric cases such as amniotic fluid embolism.

What I found interesting during this week was the impact of Chinese culture on the management of pregnant women. Many people, especially the older generations are influenced by the Chinese culture, which believes the birth process should have as little intervention as possible. As a consequence, I noticed a number of patients avoided any form of analgesia during labour. An extreme example of this was recently reported in the media, about a pregnant woman who signed divorce papers during labour because her husband's family was strongly against the idea of an epidural. The health professionals were aware of the impacts of culture on maternal health. PUMCH has held several public tutorials in order to reduce misconception on analgesia used in labour as well as clinical indications for caesarean sections. However, most doctors did not feel very opportunistic in seeing a significant change at this stage due to the long history of the cultural beliefs.

The pressure of having a healthy baby is very high on Chinese women due to the birth control policy. In Chinese culture, boys are preferred as they are considered to be the continuation of the family, so many women were forced to abort or abandon female babies. In some rural areas, it is still not surprising to see women who gave birth to girls getting blamed or abused. To reduce the stigma of this, the government has legislated that it is illegal for doctors to disclose the gender of the fetus unless there is a clinical implication such as a positive family history of a sex-linked condition. We have been promoting gender equity all over the world, yet I still hear tragic stories happening to women in my motherland. The gender inequity highlights the negative aspects of the traditional culture, and there is an urgent need to discourage gender selection in China. In rural areas, the government has been promoting respect and gender equity during pregnancy to protect women from perinatal abuse.

Week two – maternal-fetal medicine clinics

During my second week of selective, I was attached to the maternal-fetal medicine team. I observed many prenatal counselling sessions

on the diagnosis of chromosomal disorders and genetically-linked defects. Due to the strict one-child policy, there is a comprehensive screening programme in China. Pregnant women over the age of 35 are recommended by the government to receive diagnostic testing (rather than screening) for Down syndrome by either chorionic villus sampling or amniocentesis. I assisted my supervisor in three procedural clinics with 40 amniocenteses and 25 chorionic villus samplings.

I was excited when my consultant asked me to 'perform' one amniocentesis with her hands over mine. My hands were shaking and sweating because I was terrified of going in too far into the abdomen. I was holding my breath the whole time until I finally felt the 'loss of resistance' my consultant had mentioned. I thought it would be easy after seeing my consultant doing it so many times in the clinics, however, it was only when I was the person next to the patient that I realised – it is always easier seen than done! I have learned that seeing how things are done is not enough in clinical medicine. We gain skills from hands-on experience and practise makes perfect.

I also went to an antenatal counselling clinic with the medical genetics team. It was for couples who have had a child with a genetically-linked disease and were considering genetic screening before having a second child. In order to break the child control policy, parents must obtain the confirmed results of a genetic disease in order to be eligible for a second child.

There was one child, which attended the clinic, with a rare condition called mucopolysaccharidosis. It is an autosomal recessive condition characterised by connective tissue damage from the defective lysosomal enzyme. The parents of this child were embarrassed because of his distorted facial features and short stature. This is another example of the impact of Chinese culture, where people in some rural areas of China perceive that the parents who have disabled children are being punished for sins in their previous lives.

I felt sad. The health literacy in China is poor in some rural areas and amongst the older generations. Many people go to temples to pray for the cure of their diseases and some older people are strongly against Western medicine. For example, they think they would lose the 'internal energy' if the abdomen is being cut open in surgeries. The young generations of doctors in China are aware of the collision between Western and Chinese health views and have initiated educational programmes on social media. Some examples include sexual health in schools, the efficacy of western medicine, and the research evidence on traditional Chinese medical practice.

Week three/four – general gynaecology ward and theatre

I was placed in the general gynaecology ward for two weeks. Some of the common conditions I saw on this ward included endometriosis, ovarian cyst, fibroids, congenital agenesis of the female reproductive tract, and urogynaecological conditions. The ward was very busy with 30 beds, three assigned operating rooms, and various clinics run daily by different consultants.

On my first day, I was shocked by the efficiency of my consultant seeing 60 patients in one afternoon clinic. Patients from all over China travelled to PUMCH to have appointments with my consultant because she is an expert in performing hysterectomies and endometrial ablations. My consultant asked me to help her prepare patients for speculum exams so we could save time for each patient. I was very nervous in the beginning because of my limited experience in NZ. However, I knew that one of the main objectives for me doing the selective in China is to gain more hands-on experience, so I took a deep breath and did the first one successfully. My consultant was happy with my skill and even asked me to do the swabs and smears for most of the patients. I had a lot of practice that day, and I felt more competent with speculum exams. A bit of pressure made a difference.

The gynaecology department at PUMCH receives referrals from all over China, so I had the opportunity to observe and assist in many rare gynaecological surgeries. I was very lucky to be involved in the care of an 18-year-old patient who had an extremely rare phenotype of Mayer- Rokitansky-Kuster-Hauser (MRKH) Syndrome. Unlike other MRKH girls with absent uterus, this patient had two moderately sized uteruses with functioning endometrium. After suffering for four years of monthly abdominal pain, she finally had the opportunity to receive the hysterectomies and vaginal reconstruction at PUMCH. I scrubbed in her surgery and was surprised to see the two uteruses connected by a cord in between, surrounded by a pool of menstrual blood in the pelvic cavity.

The post-op care was critical in this patient as she had to insert a penile model every day to keep the vagina patent. This caused embarrassment and concern for the patient as she was about to start university with other girls living in the same dorm. Her concerns highlight the significance of psychological impacts of congenital gynaecological conditions. Most girls are diagnosed in their teens, and they often experience emotions such as fear, sadness, anger, and hopelessness.[1] The information and consequences that come with the diagnosis can be overwhelming and devastating for some girls. Therefore, psychological support systems such as counselling service and peer support groups are important for adolescent gynaecology patients as parts of their long-term gynaecological follow ups. Unfortunately, I was frustrated to see that youth mental health services are not readily available to these girls in China as most of them travelled to PUMCH solely for the surgery. With most of the prestigious specialists working in bigger cities such as Beijing and Shanghai, the doctors in China are used to this 'migratory' method of seeking medical advice. The lack of follow up (both medically and psychologically) and poor handover of care to local hospitals are the downsides I see in the Chinese health system.

Week five – colposcopy clinics

During my fifth week, I attended colposcopy clinics with the cervical oncology team. Similar to the outpatient clinics I went to in the previous weeks, there were 30 patients in each half-day clinic. The registrars had to work on a 'streamline' and I was responsible for speculum insertions and the sterilisations for all the patients before my consultant began the procedures. I even had the opportunity to apply the stains in some of the patients.

According to the World Health Organisation statistics from the human papillomavirus (HPV) information centre, cervical cancer ranks the eighth most frequent cancer among women in China with a crude incidence rate of 9.4 per 100,000 women per year and mortality rate of 4.5 per 100,000 women per year.[2] Therefore, I had the opportunity to observe many large loop excision of transition zone procedures and cone biopsies. Unlike NZ, there is no national cervical screening programme in China. Patients have to pay for their smears and pathology analysis (costing approximately 200 NZD in PUMCH). Therefore, the frequency of screening depends on the income and health literacy of the patients. The government has been implementing public health campaigns on cervical health, so the majority of women in China have had at least one cervical screening at some stage. However, the follow-up rate for most women is very low, and unfortunately, the diagnosis would have already deteriorated to high-grade lesions or cancer by the time they come back with bleeding. Furthermore, the HPV vaccine is not readily available in most parts of China. People would have to go to Hong Kong or major cities for the vaccine, and the total cost, including transport and accommodation, would be about 10,000 RMB ($2000 NZD). The majority of the general population could not afford it.

From this week's experience, I realised the huge benefit of health screening programmes. The rate of cervical cancer in NZ has dropped significantly since the introduction of national screening programme

in 1990 – ranking 13th most frequent cancer in women in NZ with a crude incidence rate of 6.4 and mortality rate of only 2.4.[2] It will continue to decline after our new guidelines in 2018 with boys also included in the vaccination programme. Health screening programmes are affordable and effective ways to detect early abnormalities of the screened conditions with the aim of preventing serious health events in individuals as well as minimising the economic burden of those conditions.

Week six – gynaecology endocrinology outpatient clinics

I spent my last week of selective in gynaecology endocrinology clinics. It is a subspecialty of gynaecology looking after women with hormonal or developmental problems. Some of the common conditions I saw were infertility, amenorrhoea, polycystic ovarian syndrome, and puberty-associated problems.

There was a special patient with congenital adrenal hyperplasia that I saw during one of the clinics. It was a 16-year-old girl who came in with her older sister for results of her initial investigations. Her sister was also diagnosed with 21-hydroxy dehydrogenase deficiency. She was found to have a malformed uterus and absent ovaries on the ultrasound scan. My consultant explained the necessity of the clitoral reduction plastic surgery if she were to consider having sexual relationships in the future. To our surprise, she burst into tears in the clinic. It was a lot to take in for the patient because her family was too poor to afford the surgery and medications for both her and her sister. My consultant sighed. I asked if there was any form of funding for the treatments or financial aids she could get from the government. Sadly, she explained that it was impossible to fund for everyone due to the population size and limited resources. Many patients leave the hospital after being diagnosed with cancer because they know they could not afford the surgery and adjuvant therapies. Some desperate patients seek help from families, friends, or public fundraising programmes.

I felt so helpless seeing her leaving the clinic. It was frustrating for us because we had the skills to help her but her socioeconomic situation was beyond our control. If she were in NZ, she would have received hormone treatments earlier on without suffering from all the complications. There are millions of patients like her in China who are desperately seeking money for their medical treatments. It was hard to know what we can do for them. I feel grateful that I will be working in a country where my patients do not have to worry about the bills for life-saving treatments. Moreover, I will utilise the precious resources I have in NZ wisely and with gratitude.

Conclusion

It was interesting to observe the differences in the health care systems between China and NZ. Due to the large number of patients in China, doctors in China had to sacrifice communication in order to increase efficiency. In my opinion, the health care in China is more like running a Kentucky Fried Chicken, because it is fast, efficient, and with the whole team streamlined. This may have adverse impacts on the doctor-patient relationship, accurate clinical judgements, and informed consent, as there is less time to build rapport and obtain detailed histories. In NZ, the health care is more like dining in a restaurant with excellent communication, favourable environments, but slower turnovers. Every clinician is required to comply with the Code of Health and Disability Services Consumer's Rights, which ensures the quality of health care each patient receives. However, the downside of the more patient-focused care is the long waiting time for specialist appointments in the public system. It is demanding to achieve both efficiency and quality simultaneously. I believe each system has its own value to be more adaptive to the population it serves.

Overall, I had a fantastic selective experience in China. I had a much broader view of the obstetrics and gynaecology specialty, as I was able to observe clinical practice in the different sub-speciality areas. I also had the opportunity to gain practical experiences such as doing a countless number of speculum exams and assisting in amniocentesis and rare gynaecological surgeries. It was a fulfilling selective experience that reinforced my pursuit of becoming an obstetrics and gynaecology specialist.

Tips for students who are interested in an elective in China

China is definitely a good place to do an elective in if you want to gain more clinical or practical experience. The conditions we consider as rare in NZ may be the bread and butter presentations in China. It would be helpful if you know a little bit of Mandarin, especially when you interact with the patients. But you will still get a lot of teaching as most of the consultants were very fluent in English with the other international exchange students.

Most hospitals that host international elective students have accommodation available on site. There are a lot of places to visit during the weekends if you are interested in exploring ancient Chinese culture. The public transport is very cheap and convenient. And most importantly, you will not be disappointed with the authentic Chinese food!

Reference

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