A Reflection on Clinical Decision-Making Between Vietnam and the UK: Medical Elective Report

AUTHOR:
Lucy Cardno

a. *Final Year Student Doctor, University of Sheffield, UK.*

Keywords
Critical Care | Decision Making | Medical Elective | Paediatrics | Patient Autonomy |

Abbreviations

MDT	Multidisciplinary Team
UK	United Kingdom

All author(s) made substantive intellectual contributions to this study by making substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content; and giving final approval of the version to be published.

Accepted for publication: 21st November 2025

Address correspondence to: Lucy Cardno, School of Medicine and Population Health, The Medical School, University of Sheffield, Beech Hill Road, S10 2RX

E-mail: lhcardno1@sheffield.ac.uk

Editor: Dr Neil Chapman, School of Medicine and Population Health, The Medical School, University of Sheffield, Beech Hill Road, S10 2RX.

AJPP@kent.ac.uk
https://journals.kent.ac.uk/index.php/ajpp/index

ISSN Number: Online 2059-3198.

FINANCIAL DISCLOSURE: The authors have indicated that they have no financial relationships relevant to this article to disclose.

Abstract: This article was written following a period of elective study by a fourth year (now final year) medical student in both a hospital in the Northern region of Vietnam, and a hospital in Yorkshire, UK. It gives an insight into the influence of contrasting approaches to clinical decision-making on the provision of healthcare services and patterns of disease. The article aims to highlight the benefits of conducting a period of elective study, particularly in terms of personal and professional development.

Reflection on my Elective

The Elective

My elective provided exposure to contrasting healthcare systems, resources, and cultural attitudes towards patient care. In Vietnam I spent time on the stroke ward, getting involved with ward rounds, Multi-Disciplinary Team (MDT) meeting and collecting patient cases. In the Yorkshire-based hospital, I observed a variety of specialties, but this reflection focuses on my time in critical care. Both settings offered unique opportunities to observe differences in clinical decision-making, patient autonomy, and multidisciplinary team involvement.

Elective Objectives

The main objectives for my elective

were:

- Gain a deeper understanding of how resource availability, cultural influences and multidisciplinary collaboration shape clinical decision-making.
- Explore how different healthcare models in two contrasting healthcare systems influence patient outcomes.
- Reflect on how differing approaches to care can inform and adapt my own future clinical reasoning and practice.

Reflection

In Vietnam, patient care evidently took a much more paternalistic approach compared to care in the UK. Treatment decisions were made solely by doctors, often without input or even a discussion with patients and their families to explain what treatment they would be receiving and why. Whilst multidisciplinary discussions and meetings did exist within the department, they were a much smaller part of practice, and it was common for doctors plans to be put into place immediately without any wider discussion. This approach made me reflect on the implications of such autonomy. While the decisiveness and individualistic approach prevented delays to patients receiving care and treatment, I felt that the absence of collaborative input from both colleagues and patients potentially increased the risk of errors or oversights. A literature review highlights that increased time spent in discussion of care between the doctor and patient resulted in improved patient satisfaction (1). However, I also recognise that the paternalistic approach to patient care is related to cultural values and systemic constraints. Patients in Vietnam expected the doctors to take charge of their care and appeared to have a lot of trust in the decisions that were being made. There were also more limited resources in Vietnam compared to the UK, which could further influence the involvement of multi-disciplinary discussion and patient-centred care.

In contrast, during my time on critical care in the Yorkshire-based Hospital, I experienced how shared decision-making can introduce a range of complexities to patient care. A previously well child presented with rapid deterioration and multiple organ failure of unknown cause. Many consultants from various departments were involved, yet there was clear hesitancy and delay for anyone to take on responsibility of her care due to uncertainty about how to approach treatment in such a complex and serious case. Despite frequent multidisciplinary team meetings, a clear treatment plan was slow to emerge. I appreciated that the hesitancy was ethically cautious however I also felt that it had potential to be detrimental due to delayed interventions. This contrasted with Vietnam's more individualised but rapid approach.

Conclusion

Both approaches raise important ethical questions around autonomy and professional responsibility. The UK's emphasis on patient involvement and MDT collaboration can result in

defensive medicine and risk aversion. Alternatively, while Vietnam's approach may be more efficient, it risks undermining patient autonomy and accountability.

These experiences broadened my understanding of the complexities of "best practice" and how there is not always a clear path to follow when it comes to patient care and medical ethics. Both systems have benefits and limitations and recognising these will enable me to adapt my clinical reasoning and balance timely action with collaborative practice in my future career.

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