ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

What are the prevalent dermatological conditions in New York? How do these differ from the UK?

Having a consult based placement in New York, I understood that nature and presentation of the conditions I saw would differ from my experience of dermatology clinic in the UK. From speaking to the residents on the clinic service in New York, they were indeed involved in treating similar, everyday dermatological complaints that I had seen in clinic in London. Had I been in the clinic setting in New York therefore, I predict that I would have seen many patients with psoriasis, atopic dermatitis and acne, much the same as I saw routinely in London. Dermatology consult in New York offered me a wider learning platform for my elective, building on what I had seen in the 15 weeks I spent in the dermatology clinic setting in the UK.One of the most common dermatology consults was for drug eruption. Several times a week, this would be suspected by a team and then proven or disproven by the dermatology team using examination, tests and clinical deduction. However, the benefit of being on the consult service was that I had the privilege of seeing many conditions that I had not seen before. I saw rare conditions, which I may never see again in my career. Even if the diagnosed condition was common, the list of differentials provided many esoteric diseases that required hours of research. I do feel like the conditions that I saw on consult were conditions that could occur in the UK even though I haven't necessarily seen them. Occasionally, the differential diagnoses did include conditions that are specific to America such as a spider bite from a brown recluse spider but this was a more unusual occurrence.

Healthcare services are very different in the USA compared to the UK. How do they differ and what impact does this have on patients?

The greatest difference between healthcare in the USA and UK is how the provision of healthcare is funded. The NHS provides the vast majority of healthcare in the UK, which is free at the point of use for people born in the UK and 'permanent residents' of the UK. In America, patients are required to have insurance to cover medical fees, or pay directly for their care. Occasionally, on placement at Columbia, I was required to send a patient specimen for testing at an external lab. This required the inputting of insurance details before the samples could be sent. In the UK, non-British nationals are required to pay for their healthcare. However, I haven't ever seen a patient actually being asked about payment for medical treatment regardless of their nationality. It remains a fact that many foreign visitors do not pay for their NHS treatment. Figures quoted state that healthcare tourism is widespread in the UK and costs the economy millions of pounds every year, although the figures are controversial given the potential benefits to the economy by other means. However, as a result in the UK, use of resources within the NHS has to be heavily rationalised. Frequently, doctors are asked to justify their choice of investigation both economically and from a standpoint of patient wellbeing. This is unlike America where ordering extensive lab work ups/ imaging studies appears to be standard practice. This has its benefits but may not be the most economical way to diagnose patients. It could also be argued that patients in America are subjected to excessive tests because the insurance company is paying it for the tests, there is a bigger potential impact with this approach however for patients who don't have sufficient health insurance cover. Ordering routine, extensive lab work ups and imaging is expensive and significantly impacts patients if they lack the required level of health

insurance; this is especially true for patients from lower socio-economic groups. Alternatively, in the UK, patients may be under diagnosed or treated as a result of the rationalisation of such tests.

Dermatology care in New York; what does it offer that isn't available in London? I don't see that dermatology as a speciality in New York offers anything that isn't also currently available in London. In fact, I think that there are many similarities between the two cities. Some of the most accomplished doctors gravitate towards each city to become the experts of their field, working in the prestigious hospitals on offer; which in turn encourages people to travel long distances seeking opinion and treatment from these medical leaders. Both cities have numerous excellent hospitals, offering state of the art facilities, which afford patients extensive options when selecting a treatment location. The notable difference between US and UK hospitals is the provision of investigative testing. It could be argued that the extensive testing practiced in the US allows for quicker, more thorough diagnoses, but without any data it is impossible to say with any degree of certainty. I was surprised at the number of tests performed, but I didn't necessarily surmise that this was to be viewed negatively. In the UK, far fewer tests are ordered, especially initially, but this possibly saves valuable funds to be put into other avenues of care. On the whole, I see the 2 cities as offering equivalent services to patients and patients as a result receive world-class care in both New York and London.

How has this elective affected my career choice? What have I gained?

I feel that this elective has been a milestone in my career. When I arrived at Columbia, I was unsure whether I wanted to continue persuing this career as I had become slightly apathetic whilst working in clinic in the UK. I had found clinic to be routine and I didn't feel completely engaged. I feel that the consult experience has completely revitalised my passion for dermatology and has given me motivation to continue building links with centres of excellence, such as Columbia and St John's Institute. I also have new drive to continue building my CV in preparation for applying to dermatology in 4 years time. Surprisingly, I have also discovered that I would like to work in America at some point in my career. I have already begun to research options that would allow me to work in America, whether that would be a long-term or a short-term move. One of the aspects of dermatology in America that appeals to me the most is the training. I find it frustrating that I will have to wait a minimum of 4 years practicing general medicine in the NHS before I can apply for dermatology training. In America, after an intern year, dermatology training starts properly. This allows for residents to become highly skilled in their area of interest at a much earlier point in their career. There are pros and cons with both systems but I feel that the American system would better suit me and my focussed nature which is a real attraction to their training pathway.