ELECTIVE (SSC5c) REPORT (1200 words)

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

Working with the infectious disease team within a clinical setting was an extremely valuable experience. Initially the rotation seemed relatively daunting. The team doesn't have a specific ward due to it consulting patients all over the hospital, so initially it felt slightly isolated - I was surprised how different it felt to being on a normal team ward round. There were a whole host of differences between the day to day affairs of a junior doctor / resident. I initially found the orders system confusing, and was surprised that the residents didn't do lots of the minor jobs that UK foundation doctors do: such as taking bloods from a patient if they required it urgently. Starting and discontinuing medications was also interesting, as it was ordered by the doctor and then the clerk would check this and update the medications to the intranet. I feel that I prefer the English drug chart system which you can edit yourself on the chart, as it feels as though you have more control when there is no middle man. Working in the Canadian system made me appreciate how much knowledge I have about the small things that concern patients. I struggled occasionally with questions from patients with regard to things such as social support structures in the community, or the ancillary healthcare services. I know that when I move to a new area of the UK, I shall have to make sure I check out all the local services available so that I'm fully clued in as soon as possible. One more thing that I found slightly alien was the extent to which each hospital, and indeed every physician has more flexibility with regards to guidelines. There seems to be much more of a literature review culture in Canada, with regards to deciding on treatment. I think it has its advantages: namely that there is more autonomy amongst doctors and this leads to more discussion with regards to treatments / investigation, which I believe benefits the patient.

The investigation of infectious diseases by Canadian doctors typically follows a similar approach to that of the UK with regards to working up disease. However, in the UK we tend not to have an infectious disease team, and many of the suspected infectious diseases are worked up in the emergency department or under general medicine. Because there is an infectious disease team within the hospital setting in Vancouver, patients with any suspected infection are seen by a specialist, who has a much more extensive background of infectious etiologies. I found that this made a difference in the treatment of certain infections that are more likely to be treated empirically in the UK. AS an example, for a number of soft tissue infections, the team would decide to hold off empirical therapy until an organism is isolated. This would most likely be supported by experience of seeing many previous skin infections and weighing up the pros and cons of empirical therapy. In the UK, we tend to treat more empirically from the outset and will generally follow NICE guidelines with regards to a broad treatment regime, without weighing up the severity of the infection. This appeared to be of benefit in the Canadian healthcare system and should help to reduce the chance of antimicrobial resistance from extensive broad-spectrum antimicrobial therapy, as well as reducing side effects. A further note about the infectious disease team that helped it work effectively was the early request for consultations. With much more experience and knowledge in an extensive range of infections and pathogens, I found they tended to think a lot broader with regards to the typical infective organisms. When rounding on patients, it was good to discuss the possibilities of infections that may not have been considered originally by other medical teams looking after the patient, and keep a very open

mind with respect to the possible etiology. In the UK, I don't think that we tend to do this as much, and we are more likely to investigate the more common causes of infections without considering the weird and wonderful causes.

One thing that was noticeable in Vancouver was the common infectious diseases seen in the local community. Downtown Vancouver has a surprisingly large homeless population, due to it being the warmest city in Canada. Throughout the year, homeless people from other areas of the country are given one way tickets to Vancouver, to prevent them freezing to death. The hospital I Was working at is closest to Downtown so deals with a large number of this population. Within this population, there is a huge amount of intravenous drug use and alcohol abuse. This has resulted in much of this population having hepatitis C and HIV. There are also high rates of TB. This is similar to the same population demographic in the UK.

In summary, I have thoroughly enjoyed my experience working alongside the infectious disease team at Saint Paul's Hospital. It has given me the opportunity to work within a system that is different to the NHS, which I feel will set me up well for starting new jobs in the coming year. I am glad to have spent my time within this specialty, as it has given me a better understanding of microbiology, antibacterial therapy and infectious organisms which I know will be invaluable for my years as a foundation year doctor in the NHS.