ELECTIVE (SSC5c) REPORT (1200 words)

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

Over the course of the last four weeks I have been attached to the gastroenterology unit at Hotel Dieu Hospital in Kingston, Canada, I have seen a range of GI conditions. It is important to note that Kingston is a fairly affluent city, even compared to other cities in Canada. The average income is approximately $80,000, $6,000 more than the Canadian average. Neither is it a particularly diverse city, with over 90% of the population being Caucasian. Thus, as a relatively wealthy, homogenous population, the range of diseases seen is rather limited compared to the borough of Tower Hamlets in London where over 40% of the population is of Asian origin and only 30% is White British. It must be said Tower Hamlet's position in the U.K. is unique compared to the rest of the country. Kingston's demographics are therefore probably not drastically different from cities in other parts of the U.K. and it would follow that the common conditions seen here are probably quite similar to what is seen in a town in Essex like Colchester or Southend. As a result, from my time in a Canadian GI clinics there seemed to comparatively fewer cases of infectious diseases such as viral hepatitis or intestinal parasites. An important exception is the large aboriginal population who live in remote communities in northern Ontario and present to Kingston for specialist care. Many of these areas suffer from high rates of deprivation, excess alcohol and drug use (Kingston also used to have a large prison population but this has shrunk considerably over the last few years). Some of the more common diseases that I saw included autoimmune conditions like inflammatory bowel disease, conditions related to high rates of obesity like non-alcoholic fatty liver disease and gastro-oesophageal reflux disease, and functional disorders like irritable bowel syndrome.

Like most countries in the western world, Canada has universal healthcare, however it is organized slightly differently as compared to NHS. There is extremely limited scope for private healthcare due to the limitations imposed by the Canada Health Act that forbids private health providers offering the same services as the public service. Healthcare in Canada is the responsibility of the province and while it is technically free at the point of care, one does require to have coverage from the taxpayer funded Ontario Health Insurance Plan (OHIP) for this to apply. This requires the insurance holder to live in the province for at least 153 days a year and have Ontario as their primary place of residence. Unfortunately OHIP does not cover prescription medications, meaning I saw some patients who were unable to afford some of their prescriptions due to a lack of private/employer coverage; in most cases however, they should be able to get some coverage from the Ontario/Trillium Drug Program. Like the U.K. most patients are referred to the GI clinic by through primary care, either in the form of their family physician or via the emergency department. The clinic I worked in would probably feel alien to most British doctors, since patients are brought to empty rooms and then clerked by available staff that uses a separate office as a place to check previous clinic letters, investigations and procedures. These differences, however, are mostly skin deep and the respective systems of the U.K. and Canada are more alike than they are dissimilar.

Over the course of my time with the GI unit in Kingston, one of the more common conditions I saw was irritable bowel syndrome (IBS). I became interested in it due to the seemingly complex interplay between the symptoms of alternating bowel habit, abdominal bloating and abdominal pain with neuropsychological issues like stress. It sometimes appeared as though the diagnosis of IBS was unsatisfactory to certain patients who wanted an apparently more tangible disease with an organic cause such as IBD. It thus seems apparent that explaining the diagnosis of IBS to a patient requires a good deal of skill. I was especially impressed by one of the attending physicians explanation to a patient about how that when someone feels has a strong emotion, they develop a "sensation in the pit of their stomach". He then told the patient that this sensation was in fact real and that while the gut is a very intelligent organ system as it is own enteric nervous system, this intricacy makes it prone to dysfunction. Outside, he told me how the prevalence of IBS is much higher amongst young women than any other group and many of them are highly stressed. I had also learned that a diagnosis of IBS can be positive based on the Rome III criteria, meaning it no longer needs to be a diagnosis of exclusion, reducing the number of patients who need to be subjected to a barrage of investigations. However, the faecal calprotectin test (which hitherto I was unaware of), that detects inflammatory proteins in stool, is a promising investigation for IBS, as negative result will should exclude IBD from the list of differentials. Prior to working at the GI clinic, my view of treatment was also limited; anti-diarrhoeals for those with diarrhoeal symptoms, fibre for those with constipation and anti-spasmodics if abdominal cramping was an issue. I learned about the low FODMAP diet that reduces the amount of fermentable carbohydrates in the bowel, thus reducing GI symptoms. Since I have four months of dedicated GI research time, as part of my academic foundation programme, investigating the role of certain diets in IBS could be an interesting avenue to further explore.

Due to the nature of medical school and postgraduate training in Canada, I believe final year medical students here operate at a more advanced level than their respective counterparts in the U.K. Whereas in Britain, a medical student will typically start their training after high school at 18 and continue until at least 23, most Canadian medical students will do four years of medical school after obtaining an undergraduate degree. After medical school, Canadian students will immediately start residency in their chosen specialty (e.g. internal medicine, family medicine, general surgery etc.). From what I have observed, 3rd and 4th year medical students are treated like British foundation doctors; expected to rigidly adhere to clinic schedules and on-calls; even in the face of upcoming final exams. In that sense there was a learning curve, which was steepened by certain differences in terminology and technique (becoming proficient with a dictaphone took longer than I had hoped). Happily though, the steady stream of histories, examinations and presentations that I have been doing at the clinic has improved my knowledge of GI conditions and ability to synthesize a coherent differential diagnosis and management plan. I believe this will serve me well in the near future as I start my career as a first year doctor.

ELECTIVE (SSC5c) REFLECTION

This information will be used to monitor placements for safety and to provide useful information that we can pass on to students for the future. (Please complete the sections below).

Was it what you expected?
Essentially yes, but with more general GI medicine and less of a focus on hepatology. Also little inpatient work; all my time was in clinic or watching endoscopy.