GASTRO

Elective Reflection- Columbia International Exchange Programme

For my final year elective I was honoured to be selected by Bart's and The Royal London as one of four candidates undertaking an elective in New York with hospitals in the prestigious Columbia University.

I was assigned under the team of Dr Donald Kotler and Dr David Carr-Locke, Chief's of Gastroenterology at St. Luke's Hospital and Beth Israel Medical Centre, respectively.

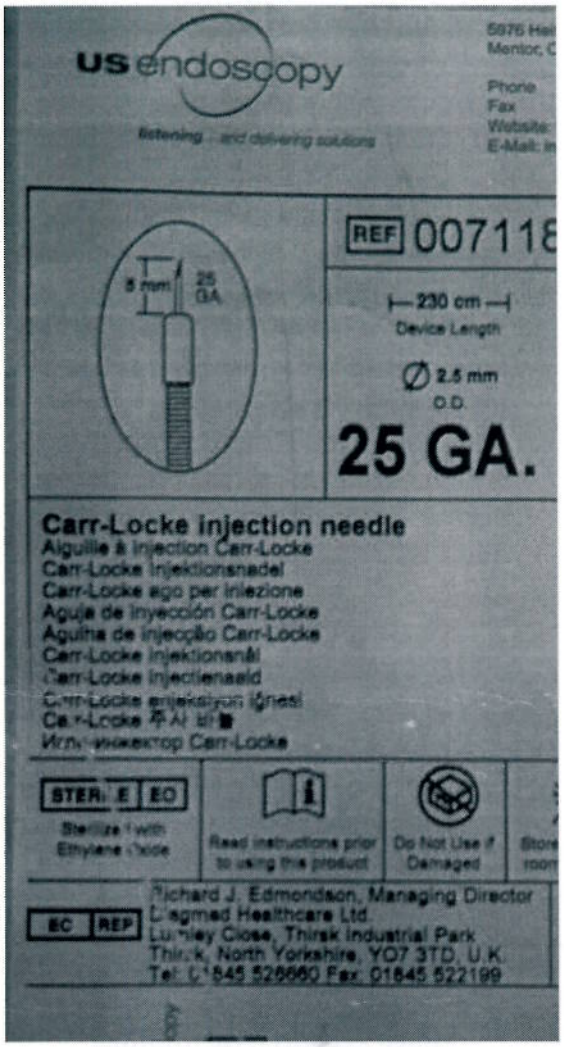
The placement was well organized and coordinated by the medical school and the administrators at Columbia's medical school body, the college of Physicians and Surgeons.

My first day began by being introduced into the Gastroenterology (GI) departments. I was attached to a first year GI fellow- Zheng Lin. Immediately as per my objectives; I was able to identify a difference in the way medicine is practiced in the USA. Core medical specialties such as GI and cardiology are not given a full ward in which patients are seen. In the USA the internal medicine team is responsible for the majority of patients on the ward and they request consults for GI patients who are difficult or require special procedures provided only by the GI team.

This concept of a consult service was completely new to me, and gave me a unique insight into how structure is different in the USA. The GI fellow have already completed a 3 year internal medicine training, and are completing a further 3 year fellowship training on procedures such as colonoscopies, endoscopies and PEG tube insertion.

> One benefit to this system is that the medical team can assess the GI cases with general complaints, with serious or difficult cases being reserved for the specialists. This also frees up time for procedure work. Over the course of a year, the fellows are able to account for hundred of procedures, meaning they become extremely proficient in these essential techniques.

Every Thursday I shadowed a GI celebrity, Dr. David Carr-Locke. He is known throughout the Gastroenterology community for his work in research as well as being a pioneer in GI techniques. During my placement, he casually tossed aside a 'special' injection needle wrapper. On closer inspection this was actually a needle he had developed, that was named after him, about to sell 1 million units at the end of this month under US endoscopy.



During my elective placement he suggested I attend one of the biggest Gastroenterology conferences in the world, DDW, Digestive disease week, Orlando 2013. I managed and throughout the journey from take off to landing was in contact with an abundance of Gastroenterology Clinicians. One of the senior Professors I sat with in a Tuesday morning grand round, Dr. Peter Holt, graduated from The London in 1954. It was wonderful to speak to someone who went to the same medical school as myself, and he enlightened me on his research on obesity and its links with cancer.

(S Pendvala, L Neff , M Suárez-Fariñas, P Holt Diet-induced weight loss reduces colorectal inflammation: implications for colorectal carcinogenesis Am J ClinNutr. 2011 February; 93(2): 234–242.)

The conference itself was absolutely fantastic; 4-days are not enough to be able to encompass all of the fantastic topics that were show cased. There were multiple speakers, a huge exhibition hall, and stations for video based teaching modules, training courses and poster presentations available. Every evening had a social engagement related to the various GI specialties. I even managed to bump into to some familiar faces from London in the event attend by 16,000 persons. I was overwhelmed at the opportunity and research and this has further emphasized the importance of these meetings and events in medical education. They were a fantastic update style course for the clinicians. Many networking opportunities and the ability to socialize with like-minded people was fantastic. I will definitely try to take part in more events like this in the future.

A major difference I have yet to comment on, was how a privatized health case system, is different from a nationalized system, such as the UK. This was an issue I was prepared

to observe. In the United States, due to the nature of health insurance, if someone can afford it, these patients are more likely to undergo medical procedure (some unnecessarily). Screening guidelines require every patient above 50 to have colonoscopies every 5 years, depending on the results. Patients were pushed more into procedures than I have ever seen in the UK. This is partly due to the nature of litigation in the USA, where they are afraid of missing diagnoses. However equally, the threat of perforation and infection is also high, where such complications can be serious for both the patient as well as the hospital.

In addition, the hospital in which I was working was not an exclusively private hospital. In the USA, clinicians usually operate either privately or with teaching/district hospitals. This means that only certain private hospitals have the elite services that are often talked about. Both St Luke's and Beth Israel was a hospital with budgets stretched to provide services for patients with poor insurance and some with none at all. The patients were mostly Hispanic or African American with most of the clinicians able to converse with them fluently in Spanish. These hospitals were very much similar to the NHS standard, understaffed, overworked but certainly still much better paid than in the UK!

In conclusion, my experience in this medical placement was fantastic; I worked with all levels of fellows and attending and made many friends along the way. I was able to integrate myself into the medical team, seeing consults and reporting to seniors. I will truly cherish this experience and would like to thank all of my mentors on this journey.

Hira Naqvi