ELECTIVE (SSC5c) REPORT (1200 words)

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

1) During my time in Vancouver General Hospital ICU Departement I was exposed to an aspect of medicine that I have not had much experience in before. I was only placed in ITU during my course at Barts and the London for no more than a week but during this time I developed an interest in intensive/critical care medicine. Before my elective in Vancouver I did not realize how great a role the intensive care team plays in the treatment of major traumas. In London, I was not exposed to that much trauma during my training even during my time in ITU and A&E however during my 2 weeks in Vancouver, I saw a large proportion of trauma cases particularly those dealing with head trauma and traumatic brain injuries. In the UK I noticed that many of the ITU admissions were post-surgical cases. Though this also makes up a large number of ITU admissions in Vancouver I noticed that it seemed to be less so than in London and the UK. I found that my knowledge of trauma and head injury was not as extensive as I had hoped. This prompeted me to focus on this aspect of critical care medicine. Over the 2 weeks I greatly improved my knowledge of of trauma and traumatic brain injury diagnoses, relevant investigations, acute management, long term management, and protective measures whilst the patient is in the Intensive Care Unit. In addition to this , I saw a large number of rare and complex conditions. This was mainly due to the fact that Vnacouver General Hospital is a tertiary centre for the entire province of British Columbia. Many conditions that cannot be managed in the district hospitals are transferred to Vancouver General. During my time I saw conditions such as autoimmune hepatitis, pulmonary arterial hypertension, on top of the large variety of trauma cases.

2) Many of the therapies that I saw used in the Intensive Care Unit in Vancouver General Hospital were identical to those that are used in the United Kingdom. Vancouver Genereal Hospital was very well resourced. This was evident not only with the equipment that was available but also in the staffing in the unit. During my 2 week rotation I noted that there was a very high ratio of clinicians to patients. For a unit of approximately 30 patients 2 teams divided the patient list with one consultant, one fellow (equivalent to UK Registrar), and 5 residents (equivalent to FY1-SHO rank in the UK). This greatly reduced the workload that was placed upon each clinician with each resident being responsible for 3-4 patients a day. This allowed for much more efficient completion of jobs for the day with everyone who was not on call finishing at 530pm. On calls were also different from what is common in the UK. In the ICU at Vancouver General Hospital on calls were 1 in 4 and were for 24 hours. Though these on call shifts were extremely tiring I found them very useful as being present for the entire day shift meant that there was good continuity of care with jobs that needed to be handed over to the on call team. Finally I noted that economic cost of treatments was as great a factor in deciding treatments for patients as it is in the UK. For example VV/VAECMO was widely used for almost all critically ill patients that I saw who were not achieving adequate gas exchange via the pulmonary route, even those who's outcomes were extremely poor.

3) Prior to my placement at VGH I had not been exposed to much Intensive Care Medicine. Therefore I was unable to directly compare protocols that are used in the UK to however I did notice that there were extensive local guidelines and protocols that were used in the Intensive Care Unit at Vancouver General Hospital. For every new admission into the intensive care unit an ICU admission order form was required to be filled out. These admission forms I found were very

effective to ensure that all patients who are admitted are given necessary care upon admission. This includes daiily feedinig rates, maintenance fluid therapy, oxygen requirements, electrolyte balance, multivitamin, supplementation, sedation, and daily bloods and imaging. This ensured that all patients received not only the necesssary interventions but also the necessary investigations required for close monitoring whilst in the intensive care unit. I was very impressed with the proforma that was used for this admission process and it is something that I would very much like to incorporate into my work as I will be starting my Foundation Programme in the Intensive Care Unit in Conquest Hospital, Hastings, East Sussex. Another major difference in the practice in Canada compared to the UK pertains to drug perscription. In Canada, all drugs are prescribed using trade names rather than using generic names. I found this to be very difficult to follow since here in the UK we are taught generic names for drugs. Another difference in drug perscription was that in Canada there is no drug chart that is used, at least in ICU where I was placed. Instead of a drug chart system patient drugs are written on a order sheet which is similar to a history sheet with the drug name, dose, and route on it. This is then checked by a pharmacist and then faxed to the pharmcy where the drug is then dispnesed. Though this process is more time consuming s to what is done in the UK it requires more people to safely dispense the drug which results in fewer prescribing errors.

4) I learned a great deal about medical practice in Canada. In the end it was not so different from what medicine is in the UK. The main differences that I noted were the fact that the hospital seemed to be better staffed and resources were much more readily available. In addition the support that for nights seemed to be much more extensive. I was able to undertake a large number of practical procedures during my placement which I thoroughly enjoyed. I was able to do a number of central lines, arterial lines, as well as other procedures. The skills that I developed with the procedures will be very helpful for me particularly as y first FY1 job is Intensive Care. I was also involved in a number of crash calls and this helped me with my recognition and management skills of an acutely ill patient. My time in ICU also helped me realize that this is a field of medicine that I am very interested in and would very much like to work in one day as a long term career. I was amazed with the techniques and interventions that were used to help the most ill patients in the hospital recover. My time in Vancouver has motiveated me to one day become an ICU/Critical Care doctor as well as to practice in Canada.