GENERAL MEDICAL
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Vancouver General Hospital- elective report

Clinical Teaching Unit – Internal Medicine
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1. *What are the prevalent conditions in Canada? How do they differ from the United Kingdom?*

Both Canada and the UK are developed countries with similar health issues. The biggest cause of mortality in both countries is heart disease with a reported 100'000 deaths per year in the UK and over 60'000 deaths per year in Canada. Chronic conditions such as diabetes, hypertension and hypercholesterolemia are also prevalent in Canada. These are potent risk factors for heart disease and a huge burden on Canada's health care system.

Canada has also responded to the global HIV/AIDs crisis by testing all patients admitted to hospital on an opt-out system. A similar strategy has been devised for hospital patients in the UK.

2. *How are the health care services organised and delivered in Canada? How does it differ from the United Kingdom?*

Health care in Canada is delivered through a publicly funded system which is mostly free at the point of use and guided by the Canada Health Act of 1984. This system is more commonly known as 'Medicare' and is designed to ensure that all Canadians have reasonable access to health care services. This is similar to the UK where the National Health Service uses taxes to ensure that services are free of charge upon use with prescriptions having a small fee regardless of the cost of the drug. In Canada, medications are covered by public funds for the elderly or through employment based private insurance.

Canadians can choose their own family physician that can make a referral for a patient to see a specialist, which is the same system as in the UK. In the UK there is also the 'choose and book' system whereby patients can decide which hospital they want to be treated.

3. *How did the members of the healthcare team interact at the Canadian hospital? Was it different to the way in which they interact in the United Kingdom?*

During my placement at Vancouver General Hospital each day began with a meeting where all teams in Internal Medicine attended to discuss patients who were admitted overnight. Only doctors and medical students attended this meeting. Following this, each team then went to review their in-patients. Team members within each team usually split to review the patients they were following and if any issues arose the attending would be notified.

This format of reviewing patients individually was very different to my experience in hospitals in the UK where a ward round usually took place where all the team members would be present to review the patients. The system in Canada did have its advantages in that it was much faster to review patients individually so that important issues could be attended to promptly. But these solo ward rounds may result in lack of communication between teams. This was prevented by teams meeting up to touch base on all patients at noon but this was not practical every day.

Doctors only interacted with members of other healthcare professionals on the wards. The nurses only communicated with the doctors if they experienced any difficulties with the patients. This was different to the UK where the nurse looking after the patient was normally present for the ward round.

The pharmacists usually did their morning rounds to check the patients 'medication reconciliation' forms and any outstanding issues relating to patients' medications. The 'medication reconciliation' form was a list of all the medications that each patient was taking. The job of the pharmacist or admitting doctor was to go through the form and ask the patient if they were taking these drugs and addressing any discrepancies with regards to dosing or any other medications not on the list. The aim of this form was to prevent errors in taking a drug history and I felt that it was really helpful in that it was a form of communication with the pharmacist.

In contrast to the UK there were no multidisciplinary team meetings during my stay at Vancouver General Hospital. This was surprising to me as some patients had complex cases requiring input from other healthcare professionals. In many cases this prolonged inpatient stay as there was lack of communication between different specialties.

4. How has this experience helped me in becoming a better Doctor?

I feel that I was very much part of the Internal Medicine team at Vancouver General Hospital. The team was very welcoming and treated me as a fellow colleague. Every other day our team was admitting patients from the emergency department and I was seeing patients individually. I was taking the history, performing the examinations and formulating a management plan. I would then present my findings to the senior who would then review the patient and complete the admission forms with me. This process of seeing patients presenting to the emergency with acute problems certainly gave me the confidence with regards to my history taking and examination skills. I also feel that being able to formulate a management plan helped me to think more like a doctor and bring together all my findings.

After I had admitted the patient my job was to follow these patients on the wards and assess their progress. I would review these patients daily, check their vitals, laboratory results and examine them. I will also review any new imaging such as chest x-rays or ECGs. I would devise a problem list, recording all the components of the patient's care. I would then discuss the list with my senior and make the necessary orders based on the recommendations. Since I knew these patients from when they presented to the emergency department I felt keen to follow their progress. This responsibility helped me to appreciate my position and give me best each day I arrived in hospital.

When it was time for my patient to be discharged it was my duty to complete all the discharge paper work and dictate on behalf of the attending. I would speak to the patient first and let them know that the will be discharged in advance so that they can make arrangements. If they are living at a care home I would contact them and discuss transport. I would also call the GP to inform them that the patient was in hospital and make an appointment for the patient to be reviewed. If the patient required involvement of other services I would make referrals as an outpatient. The discharge process requires good communication not only with the patient but all the other people involved in their care. This helped me to appreciate the importance of a good discharge letter and effective communication with other professionals to prevent unnecessary readmission.