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GASTRO

ELECTIVE ASSESSMENT PART 1

Objectives:

1. Describe the prevalent gastro-intestinal diseases in Tokyo, and explore the differences with those in London.
2. Describe the pattern of health systems and patient management in Japan, and compare with the NHS in the UK.
3. Describe the differences in use of investigations and management measures for a given disease in Japan and in the UK.
4. To be able to take history in Japanese competently, with use of appropriate medical terminology and language.

1. I was under the Gastroenterology, Endoscopy and Hepatology unit at the Jikei University Hospital, Tokyo, Japan. I was under the liver specialist so predominantly saw many liver patients, along with the common gastrointestinal presentations. Liver pathologies included viral hepatitides (A/B/C, EBV, CMV), autoimmune hepatitis, primary biliary cirrhosis (PBC), alcoholic liver disease, non-alcoholic steatohepatitis (NASH), drug-induced acute hepatitis, and hepatocellular carcinoma (HCC). Of note, Japanese medicine includes use of traditional Chinese herbal medicine, and these commonly contain 8 to 10 different ingredients mixed in, so drug-induced hepatitis caused by herbal medicine was a relatively common presentation. Gastrointestinal presentations included large bowel polyps (and elective polypectomies), diverticular diseases (sigmoid and ascending colon), gastroenteritis, peptic ulcer disease, gastro-oesophageal reflux disease (GORD), cancers of the GI system (mainly large bowel and stomach), inflammatory bowel diseases (IBD) and acute / chronic pancreatitis. Compared to the UK, ascending colon diverticular disease and gastric cancer are far more common in Far-East Asia region. The diversity of liver patients was new to me, as liver patients are rarely cared for in East London hospitals. Seeing cancer patients managed by medics and not by oncologists were also a difference from the placements I have been on.

2. The Japanese health system is very complex, and is very different to the NHS in the UK. The Japanese system can be divided into Public and Private health insurance systems. The Public health insurance scheme is further divided into Employees' health insurance run by companies' health unions and other groups' health unions, National health insurance run by the local authorities and National health insurance unions, the Elderly healthcare system, and lastly social welfare. The majority of the working families are covered by the Employees' health insurance, which covers their dependants. For the self-employed and the unemployed, the National health insurance covers them. The Elderly healthcare system covers for the population over 75 years of age (and some over 65 year olds), and the Social welfare is self-explanatory. These four systems cover the majority of Japanese citizens and overseas nationals with a right to remain for over 1 year, and is a mandatory requirement to join one of the four insurance systems, with monthly payment (except for the welfare). The Japanese health system works that the Employees' and the National heath insurances cover the 70% of medical payments, and the individual contributes with 30% of payments. The Elderly healthcare system covers for 90% of the cost and the individual covers for the remaining 10%. These insurances are limited to standard treatments and do not cover for new and innovative treatments. The Private health insurances are regarded as supplementary system to cover what is not covered by the Public insurances, and is not a mandatory requirement.

   Compared to the NHS in the UK, it poses major risk of health inequality between the rich and the poor. The cost of treatments may be overwhelming so even the 30% of the original payment may be unpayable for the less well off, and they may not have been able to afford the private insurances in the first place. For the individuals receiving welfare the treatments are free, but receiving welfare in the first place in Japan may be tricky, with a considerably small budget compared to the UK. As for the unemployed, there is no support for them and they are almost always unable to pay for the National insurance, so are liable to pay 100% of the medical fees when they fall ill. The burden of

healthcare costs deters patients away from healthcare services, and the poor cannot receive the treatments that they would otherwise be able to receive with the NHS, and suffer as a consequence.

3. The use of investigations and treatments in Japan is somewhat contrasting to the NHS in the UK. There are many reasons for this, including the payment system differences and the healthcare budget in Japan and the UK. In Japan, they use extensive blood, radiological and interventional investigations as routine. For example, prior to patient admission to a ward, they receive a full range of blood investigations (FBC, U+Es, LFTs, TFTs, glucose and other metabolites, viral assays, CRP, standard set of inflammatory and rheumatology markers, etc) and a chest X-ray as a minimum. They offer routine liver biopsy investigations daily on the ward that I was on. This is very contrasting to the philosophy of "Primum non nocere (First, do no harm)" that is followed in the UK. All investigations and treatments have risks and complications, and should not be taken lightly. Furthermore, they offer investigation and treatment methods that are rarely heard or seen in the UK, for example Percutaneous Ethanol Injection Therapy (PEIT, for sclerosing blood vessels leading to liver tumours) and small intestine colonoscopy and were interesting to see.

4. Taking a history in Japanese was a challenge, with medical terms that were difficult to understand, bearing in mind that I speak Japanese fluently. Furthermore, Japanese language is complex with use of various types of polite language for different situations and individuals, and added to the difficulty. When observing Japanese doctors clerk patients, I had the impression that they don't spent as much time taking history and examining patient as in the UK. They rarely go through the history thoroughly and use the previous clerking notes as their main basis. I had the impression that the history and examination has been simplified and the extensive investigation supplemented their gaps in the clerking. Coming back to the polite speech, I felt that this was sometimes in the way of history taking, when asking intimidating questions. This mentality of politeness and good manners I felt has prevented the doctors from asking vital questions. For example there was a teenage female patient coming in with a suspected gastroenteritis, and had received chest and abdominal X-rays but there were no mention of pregnancy testing or any questions of possible pregnancy prior to the radiological exposure. I felt that this politeness embedded within the Japanese society prevented the doctors from asking these questions or consenting to pregnancy testing.

   This elective was very interesting in terms of the contrast and differences in the way they practise medicine, and was fortunate to be able to speak Japanese fluently. Obviously I would not recommend anyone to take this elective if they are not able to speak any Japanese, as the doctors in Japan are not very fluent in English and neither are the patients. I have gained a good experience and insight into how the doctors work in Japan and will help me decide my future career path.