From too little to too much

The perspectives of a multinational physician on two different worlds of medicine

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As I unwind on my first free weekend, I find myself reflecting on the events of the past week in the surgical service. I hear myself sigh and mutter under my breath, "I have come from a place where we did too little for patients, and I am now in a place where we do too much."

My journey began with medical school in a West African country, where residency training was characterized by limited resources. Both doctors and patients frequently lamented the challenges posed by this scarcity. Patients who needed a computed tomography (CT) scan often had to bear the cost out-of-pocket, a financial burden many could not afford. In response, physicians relied heavily on clinical signs and examinations to guide patient management. For instance, confirming acute appendicitis without a CT scan was commonplace; instead, we trusted in our clinical acumen and would, at most, order an abdominal ultrasound. Moreover, appendectomies were typically open procedures, lasting no more than 30 minutes, with patients often discharged within a day or two, experiencing favorable outcomes.

Upon transitioning to Canada, the contrast in healthcare provision was stark. When I did my general surgery rotation, the emergency department doctors only called us after a CT abdomen had been completed and the diagnosis of acute appendicitis confirmed. Armed with the diagnosis, we would then be called upon to "poke" the belly and obtain informed consent for a laparoscopic appendectomy. Here, the abundance of resources was evident; CT scans, magnetic resonance imaging machines, and other advanced diagnostic tools were readily available, transforming medical practice into a technologically driven endeavor; however, I couldn't help but question the necessity of such interventions, particularly when they didn't significantly change the diagnosis or course of treatment.

Particularly in the field of uro-oncology, disparities in healthcare access became increasingly apparent. While patients and staff in Canada closely monitor slight increases in prostate-specific antigen levels, back in my home country, such concerns were uncommon. Instead, most cases presented in advanced stages, often requiring palliative care due to limited access to screening and advanced therapies.

This disparity in healthcare access and utilization has left me grappling with a fundamental question: How can I leverage my experiences to advocate for more equitable healthcare systems? While campaigns such as Choosing Wisely and Greening the OR address issues of unnecessary investigations and waste, the real challenge lies in bridging the gap between worlds. How can we ensure that those with limited access to care receive the support they need, while also encouraging a more balanced approach to healthcare delivery in resource-rich settings?

As I continue my journey as a multinational physician, I ask myself what I could do to encourage those doing too little to do more. I also wish to remind my colleagues in Canada that while we are racing to a future of advanced and sometimes superfluous medicine, we may be doing too much. Through increased funding for research and advocacy efforts, I hope to address the disparities that persist and foster collaboration between healthcare systems worldwide.