ELECTIVE (SSC5a) REPORT (1200 words)

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

This elective placement in emergency medicine at Humanitas Research Hospital in Milan was very interesting and an excellent opportunity to improve my clinical and communication skills. The emergency department at Humanitas is a modern, well-staffed and well-organised unit, looking after a large and varied patient population. Even though I was born and raised in Italy, I attended higher education in the United Kingdom and my knowledge of the Italian healthcare system had been limited attending hospital as a patient or relative. At the end of these three weeks, I feel in a position to draw more significant comparisons. Before I delve into the provision of emergency medical services in Milan, a brief digression on medical training in Italy will provide the necessary context to interpret my observations. Medical school in Italy is a six-year-long course centred on pre-clinical teaching with some hospital placements from in the final two years. After graduating, doctors enter specialist training, lasting four or five years. Following postgraduate training, they are employed as trust grade registrars, "strutturati" under the guidance of a lead consultant, "primario". Each ward is managed by a lead consultant, with a few of the trust grade doctors acting as their assistants, "aiuto" or "assistente", depending on seniority. I was surprised to learn that a large proportion of the trust grade doctors working in emergency medicine at Humanitas are not originally trained in emergency medicine, but rather have undergone higher training in an internal medical specialty such as gastroenterology or rheumatology, then electing to work in emergency medicine. These training pathways provide a useful window into the structure of emergency medical services in Italy. While emergency medicine is one of the newer established specialties globally, Italy – like most European countries – has a recognised professional regulatory body in this field. They offer training programmes which focus primarily on medical emergencies and acute internal medicine. Surgical patients presenting as emergencies and trauma patients are generally assessed by junior surgical trainees, whose procedure-prone skillset complements the diagnostic ability of their medical counterparts. Patients are assigned to either pathway by a triage nurse as they present to the department. This implies that emergency medicine trainees will not see what is deemed to be a surgical case and are generally more comfortable assessing medical patients rather than conducting procedures such as chest drain insertion, fracture manipulation and reduction, and suturing. Inevitably, some patients will necessitate intervention from both physicians and surgeons, in which case whichever doctor is looking after the patient will ask for help from another specialist colleague. For example, I saw a few patients who had fallen for medical reasons and dislocated their shoulder or lacerated their forehead in the event. Whereas in the UK I would have expected the A&E registrar to reduce the shoulder and suture the wound themselves, their Italian counterparts relied on an orthopaedic consultant and a surgical registrar to manage these problems while they focussed on the medical aspect of their fall and consequent presentation. From what I could observe and infer, this leads to predictably different outcomes. While the patient will benefit from having their shoulder or wound managed by a specialist, they will have to wait longer and interact with more healthcare practitioners. Depending on the acuity and severity of their presentation, patients coming into the emergency department at Humanitas are assigned to ambulatory care, majors or a resuscitation room. In March 2020, norther Italy was badly affected by Covid-19 ahead of many other European countries. This led to a part of the emergency department being devolved to Covid positive patients, effectively generating Covid and non-Covid parallel patient pathways. Thanks to the vaccination campaign, lockdown and social distancing, the Covid situation had improved drastically in Italy and there is now just one room dedicated to Covid patients. On the single occasion I went into this room, only two patients were there and Covid doesn't seem to be as concerning as it was just a few months ago. However, patients are still screened for symptoms and swabbed for Covid as they come into hospital, and this is unlikely to change anytime soon. Throughout the three weeks I shadowed a trust grade doctor mostly working in ambulatory care and majors. I was there for a total of ten six-hour day shifts and two twelve-hour night shifts. At the beginning of each shift, each doctor is handed over some patients from every zone of the department, in addition to the list of new patients to be seen, prioritised according to a traffic light system of severity. While the majority of my shifts were in ambulatory care, we often left the cubicle to review or discharge the patients handed over to us from the previous shift. It is not unusual for patients to stay in the emergency department overnight or for twenty-four hours, either because of diagnostic uncertainty or bed shortages in the upstairs inpatient wards. This management resembles that of a clinical decision unit or acute admissions ward, as many of these patients present with acute exacerbations of chronic disease and – as previously said – are looked after by internal medicine specialists with sub-training or experience in the emergency setting. This is where their physician's approach is most valuable. Humanitas is a renowned cancer centre in Italy. As such, many emergency department admissions are for oncological emergencies or complications of treatment. This was very interesting, as these complex patients are

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perhaps those who benefit most from a physician's holistic and integrated approach to their care, rather than a strictly that of an emergency doctor. For example, I saw a middle aged woman with type 2 diabetes mellitus and rectal cancer who'd had a few days of bloody diarrhoea and presented in diabetic ketoacidosis as a result. This was a very challenging case but well handled by the emergency physicians at Humanitas.
Many other patients come, however, with relatively uncomplicated problems which could probably be managed in the community setting, such as urinary tract infections in systemically well people. Sadly, like in many other countries, the primary care infrastructure is unsuited to deal with a large volume of patients, and hospital practitioners struggle to contact general practitioners to arrange shared care of patients. Consequently, many patients turn to the emergency department as their only port of call for the healthcare system, which inevitably contributes to the heavy workload of the doctors working in this specialty. Throughout these three weeks I had the chance to practice taking histories and examining patients in Italian, which was a new and rewarding experience for me. I acquired a lot of medical jargon and I was surprised at how quickly I picked up the shorthand used by Italian doctors and nurses when clerking patients. I was exposed to a wide patient population with problems varying vastly in acuity and specialty, which allowed me to learn some specialty-specific terminology as well as improving my general communication skills. Overall, I had an excellent time at Humanitas, felt very welcome and I will consider emergency medicine as a career option in my professional future.

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