ELECTIVE (SSC5a) REPORT (1200 words)

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

1) What are the prevalent medical presentations to emergency services in Tasmania? How does this differ to the UK?

I am writing this report from a personal perspective, not a research perspective.
There were a few notable differences between the ED in Hobart compared with ED in London:

- The reduced access to GP services meant an increased number of patients presenting with problems that would be better situated to a primary care environment.
- There was a significant prevalence of "ice"/crystal methamphetamine use in Tasmania, compared with London where the most prevalent drug presentations I have seen in the ED are opioids, crack and cocaine. They both had a high prevalence of cannabis users.
- They both have a high prevalence of alcohol abuse – however in the UK I have experienced a higher level of acutely drunk individuals presenting to the ED, vs. in Tasmania where I saw a higher level of chronic alcohol abuse (people not presenting specifically for alcohol-related reasons, but who were marked as at risk for alcohol withdrawal).
- There was a high prevalence of trauma and orthopedic presentations in both locations, especially from MVAs. There was a higher prevalence of presentation in Tasmania of accidents related to mountain biking/dirt biking.
- There was a high prevalence of cardiovascular disease and cerebrovascular accidents in both locations.

2) How are the emergency services structured in Tasmania? How does this differ to the UK?

The Tasmanian healthcare system is two-tiered. For each consultation there is a 'schedule fee' which is the base cost for any consultation. For each consultation there is a set rate that is subsidized by the government's Medicare – 100% of the schedule fee for general practice, 85% for inpatient consultations, and 75% for outpatient consultations (and other price points for certain investigations, treatments or procedures). There are also some things that are not covered at all by Medicare. After this point, the provider can decide how they would like to charge the patient, bulk billing or not:

- Bulk billing is when the provider sets the cost of the consultation to match the amount of rebate they receive – this means that the consultation is free at point of care.
- The other option is that providers can charge a 'gap fee'. This covers the gap between the rebate and the total scheduling fee, and any money above this that the provider would like to charge. This extra fee is not externally governed. Over time providers have pushed this up, and as a result free primary care access has become reduced. This has led to the increased number of people attending ED with primary care issues, as discussed above.
- The Australian government also encourages people to get private health insurance, which allows patients to access private healthcare providers, private care at public hospitals, or public healthcare.

3) How do the differences in demographics and natural environment affect medical presentations?

I found that the natural environment had a big impact on medicine in Australia. Unlike the UK, there are large swathes of Australia that are very remote, and not easily accessed by road. As a result there is a large portion of training that is geared towards air outreach medicine and pre-hospital care. This covers both general practice, and acute and critical care provisions. The closest comparison I have for the UK is medicine in remote corners of Scotland and pre-hospital care respectively. This kind of medicine differs from my experiences so far in London hospitals, as doctors are often working completely alone, giving them much more autonomy over the situation. This also means that there is an element of 'making do', as access to investigations and management provisions are much more limited. I do not have any personal experience of how this affects medical presentations, but having spoken to many clinicians who manage these roles, the management can be quite variable from hospital care, where you are supported by a team, and have a wealth of resources at your fingertips. I found this difference was also reflected in hospital practice, where the majority of ED anaesthesia was managed by ED clinicians, not anaesthetists.

In relation to demographics I found there was a lot of similarities and a lot of differences between Hobart and East London. Most similar was the socioeconomic spread I saw – there was a wide disparity between patients, and many people whose social situation was a directly influencing factor on their medical presentation. Namely, there was a lot of mental health issues; recreational drug abuse; an intersection between the two; and a portion of the patient population who were homeless. There were also a large number of medical presentations influenced by smoking; obesity; chronic alcohol use etc. which are incredibly prevalent in the UK. On the converse there were a number of patients who were presenting in the ED due to a lack of free primary care provisions, which is less common in the UK, and largely limited to immigrant communities. There was much less ethnic and racial diversity in Hobart

4) Do you feel comfortable clerking and coming up with a basic management plan for any patients coming through ED?

I think this was a misguided objective – I don't think any doctor will ever be completely comfortable managing *every* patient that comes into their ED, but I think what is important is being able to clerk and manage the things within your remit, and knowing when something is outside your limitations. I have solidified my understanding that this is one of the more essential skills for a newly graduated doctor, and I am confident and comfortable that I can take a safe initial clerking for most patients that come into the ED, and am comfortable enough with my own limitations to know when to ask for help and recognise when I am out of my depth. I have also been reassured by this placement that all the information I learnt for finals has not just fallen out of my head, and I am still capable of coming up with reasonable management plans. This revelation came with the reminder that while recognising my limits is incredibly important, having confidence in my capabilities is also a very important skill, and essential for me to work on going forward if I want to be a helpful and contributing member of a medical team in the NHS.