Elective report 2017

Mr El Mahdi

I had the pleasure of being based in Barts NHS trust for my elective after my final examinations. I was based at Royal London and newham university hospitals in Medicine and thoroughly enjoyed the work experience I got there.
I now realise that I am at the crossroads of being a medical student and a junior doctor- a very serious time in ones career but also very enjoyable and exciting.

During my elective I took an active role in the medical specialties I have an interest in pursuing. But I realise that at this stage I should keep my options open and decided to get involved in the Medicine side of things, I am not cut out to be a surgeon.

I feel that my objectives were met and I learnt a lot about the practice of medicine, and about myself during this elective period.

I would spend time in the Emergency department at RLH and participate in the post take ward round in NUH aswell. I learnt that the post take ward round is an invaluable teaching opportunity. I assisted the junior doctors in clerkings, and presenting cases to more senior doctors.

I recall a case involving an infection exacerbation of COPD which was treated with clarithromycin. However a detailed drug history was missed and so it wasn't noted that the patient was on warfarin too. Their INR rose and help was sought. This taught me the importance of always listening to patients and following a logical schema when taking histories from patients. I learnt about the importance of taking a holistic approach to patients aswell which is illustrated in the following case.

I recall being involved in the discharge of a patient suffering from pulmonary fibrosis who had severely limited exercise tolerance. This particular patient was receiving housing benefit and was in council accommodation. However their flat required him to climb 4 flights of stairs. – no easy task for someone like myself too. The patient was medically fit for discharge but didn't want to go home. Due to language barriers and time constraints the detailed reason for home avoidance wasn't elucidated so this bought more anguish to the patient and delayed issues further. This bought home to me the importance of taking a biopsychosocial approach to patients and always inquiring further to their concerns. Often in a hospital environment patients are scared and vulnerable and need a listening ear, it is difficult to do that in a hectic work environment but if you make time it can go a long way to helping a patient in their journey home.

Another patient case really struck me and I learnt a lot from it. I recall clerking a diabetic patient who said they “didn’t quite feel right” and had a “strange chest sensation”. They were diverted to the minors dept of A&E and clerked by nurses, me, and my supervising registrar. I took a history and there was no history of smoking, family history of IHD, no high cholesterol, but they were a diabetic 75 year old. So we decided to do a 12 lead ECG and saw a massive inferior STEMI. They were rushed to resus and then plans made for them to go to the Cath Lab for angioplasty. This case was particularly pertinent for me. It reinforced the idea of a silent MI- found in elderly and diabetics. It also taught me to be on high alert and always consider the risk factors a patient has for a serious medical emergency- MI, VTE, variceal bleed etc. I learnt how taking a good chest pain history on a real patient is very hard and differentiating GI causes of CP and ischaemic causes, particularly in a primary care setting must be very challenging. Thus we need to consider the risk of IHD in patients and order troponins and 12 lead ecgs accordingly. I also learnt how exercise ecg is no longer used in the diagnosis of angina, rather patients are risk stratified and if high risk it can even be the case that they are sent for angiography straight away, its all about risk and the appropriate necessary investigation.

The final case is a case which highlighted to me the importance of experience and wisdom in medicine, not just reading textbooks. It taught me how medicine is best learnt by the bedside. A patient came in with a NOF and was operated on. A few days later they were getting better but just didn’t seem right, their sats were also getting quite low. They complained of slight tightness in chest and had mild dyspnea. We were unsure of what was happening but suspected PE, thrombolysis was arranged. This was at night so there wasn’t access to CTPA that night. However, the patient then deteriorated further and their abdomen became rigid. The surgical registrar was called but was very angry that the patient had been in hospital with a rigid abdomen and they were not called earlier. Another senior doctor suggested atypical presentation of GI bleed, investigations were done and indeed it was a GI bleed, and they were given thrombolysis. This case was very serious and taught me a lot about medicine. Diseases can present in atypical ways, we as doctors need to take our own histories from patients rather than following previous clerkings and differentials which can prove to be erroneous, but mainly we should treat patients with respect and dignity.

I thoroughly enjoyed my elective and look forward to working life.