ELECTIVE (SSC5b) REPORT (1200 words)

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

I carried out my elective with the Dr Caroline Methuen and Dr Chloe Beale. Dr Methuen is a Primary Care Liaison Consultant which means that she works in the community to assess patients that have been referred by GPs. She then can allocate patients to different services so that they can receive appropriate care. Dr Methuen also acts as an independent doctor for the purposes of Mental Health Act (MHA) assessments, and I was able to observe her making those assessments both in an out of the hospital setting.

I was able to sit in on the City and Hackney Adult Mental Health Referral and Assessment Service referrals meetings. These took place at Homerton Hospital. All referrals from GPs in the area were reviewed in this meeting, and the patients were allocated to various teams. For example, Dr Methuen might decide to assess some of the patients in clinic, while others might be referred to psychology services. In many cases patients had to be discussed at length and occasionaly patients may have been rejected by one service and had to be reallocated to another one. It really showed me have over-stretched the services are. At times it felt quite frustrating that the team did not feel that patients were being offered the appropriate care because it was not available to them.

I accompanied Dr Methuen for MHA assessments. The first assessment was done in the community. The patient had a history of aggression and therefore the police were also present for the assessment. I had never seen an assessment before and I found this quite difficult. The patient was clearly unwell and required intervention as he had not been engaging with services for many months. As well as his mental health, his physical health was also suffering. However, the patient did not feel that he was unwell and did not wish to go to hospital. He was very young and seemed vulnerable. Although all the professionals were working in the patient's best interests, it was still very hard to see someone taken to hospital against their will. The patient did not become physically aggressive but was taken to hospital in handcuffs. The hope of everyone involved is that with treatment he gets well and gains insight into his condition and how to manage it.

The second assessment was undertaken in hospital, where a patient had been detained under section 2 MHA but was to be considered for detention under section 3 MHA. Again, the patient did not wish to be kept in hospital any longer and did not feel that she was unwell. The case as to what to do was not at all clear cut. The patient was eloquent and calm and it did not seem that she posed an obvious risk. However, as she did not have any insight into her condition it was likely that she would not continue to take medicaiton once out of hospital and would become unwell again. The psychiatrist decided to detain the patient in hospital, though not without a lot of thought. I realised what a great responsibility it is to have to make these decisions, sometimes several times a day, and what a huge impact they have on patients.

Dr Beale is a consultant liaison psychiatrist who works within the emergency department at Homerton Hospital. She heads a team which includes two other more junior doctors and several specialist mental health nurses. The team offers support to patients presenting to A&E in crisis as well as covering the medical wards. As such the team works closely with the medics. Whilst with them, I saw a wide variety of patients presenting with many different difficulties.

Many patients present to A&E as they are feeling suicidal and have feel they have nowhere to go. Most often these patients will not seek advice from their GP first, indeed this crisis may be their first presentation to health services. During my elective I saw a few patients like this and the psychiatrists had to make a detailed risk assessment. I thought it was very difficult for the doctors to accurately assess the immediacy and seriousness of the risk, and I learned that as a profession, doctors do not carry out risk assessments very accurately. The responsibility is great and I did wonder how I might cope with making decisions like this if I were ever to become a psychiatrist. It would of course be easy to decide that every suicidal patient should be brought into hospital, but of course resources cannot stretch to this. Some patients were discharged home to the care of their GP.

I was also able to observe the assessments of some of the patients on the medical wards who were being treated for medical conditions. Dr Beale's team would go and assess them by the bedside. The assessments that I saw were very thorough and detailed, taking over an hour in most cases. I saw some really interesting cases in this way. I was able to meet a patient with bipolar disorder who was having a manic episode, which I had never seen before. It made me realise that mania is not always very obvious - it took at least half an hour of conversation for me to notice that some of the patient's ideas were grandiose in nature. He was very eloquent and had an explanation for all his actions. The patient lacked insight and I found this a particularly challenging aspect of the assessment as the patient became quite upset and agitated when he realised that the psychiatrist felt that he was unwell and should remain in hospital under section. I could sense his frustration that the medical staff were not understanding him I did think that this must be a terrible feeling for a patient.

I also met a very interesting patient with medically unexplained symptoms. I understand that medically unexplained symptoms are a common presenting complaint but I had not seen this before. The patient was unable to move the left side of her body but all medical tests had come back as being normal. The psychiatrist I was shadowing took a very thorough history, starting from the patient's childhood and ending at the present day. It was clear that the patient had had several traumatic periods in her life that would have put her under a lot of stress. However, the patient had not connected these life events to her current symptoms. She seemed unwilling to do so, rather revisiting possible medical tests and explanations. It was very surprising to me that the patient would be having physiotherapy to help with her movement when doctors believed that the symptoms were psychological in origin. However, she was also likely to be offered talking therapy alongside her other treatments.

I very much enjoyed this part of my elective. All the teams were very welcoming and keen to get me involved. I really love psychiatry but I have come to learn a lot about the seriousness of the decisions that psychiatrists make. I hope I will continue to think about this when considering a career in psychiatry.