

ELECTIVE (SSC5b) REPORT (1200 words)

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

The start of my elective was spent on the neonatal ward, before this placement I had had very little experience of a neonatal ward so I had little idea of what to expect. The structure of the day was similar to that of other wards, the ward round comprised most of the first half of the morning. The night team would stay to hand over the red room patients in order to describe and major events that had taken place in the night. My first patient had an interesting hand over from the night team, he was a premature baby who overnight had some pulmonary haemorrhage and blood in his ET tube. There was then discussion about management, adjustments to the ventilator, blood results and fluid adjustments. This management conversation was quite difficult to follow, the adjustments to the ventilator were confusing and the normal range of blood results for neonates were off from what I was accustomed to. The blood gas results were especially lenient, the ranges for pH and CO₂ were not explained to me initially and so I was concerned by every patients ABG result, more concerning was that no one else seemed to be worried.

I was able to see an echo done on a baby with tetralogy of fallot, the operator was a very nice registrar who took the time to explain what he was seeing and why they were scanning. He explained to me that it was important to assess the patency of the pulmonary artery, he explained there was a risk of the baby's pulmonary blood supply being compromised when the ductus arteriosus closed. This scan was to determine whether or not the child should be allowed to go home.

Many of the patients on the ward were not acutely unwell and were only there as a result of being premature. A majority of the medical care provided was an attempt to keep the patient breathing and well hydrated until they grew. I could see that the role of the nurses in the care of these babies was often more relevant than what the doctors were doing. The high involvement of the nurses meant that there had to be effective communication between the teams which was well displayed on this placement. All changes made on the ward round were communicated to the nurses and the doctors were very open to questions from the nurses.

I quickly came to realise that there were very few practical things that I could do on the ward because working with neonates requires a skill set that I did not yet possess, so I was pleased when the consultant suggested that I take one of the more interesting patients and review their case and produce a small presentation on the condition. As well as this I observed the doctors performing procedures to gain some insight and confidence.

The patient I was asked to review presented as pre-term delivery with difficulty maintaining sats, was brought to the ward and managed on ventilation. It was later noticed that she had reduced tone and abnormal facies. Researching the causes of a floppy baby as well as chromosomal conditions that lead to facial changes and reduced tone showed me that there are wide gaps in my neonatal knowledge, and I even came to realise that even my examination of a floppy baby was lacking. The initial suspected diagnosis was spinal muscular atrophy, after further chromosomal investigations it was discovered that the child had Prada Willi syndrome.

Having been given the time to find the flaws in my knowledge regarding neonates has left me feeling more confident about starting my foundation job as I have a paediatric placement first with neonates.

Once I finished my neonatal placement I began my paediatric surgery placement, my knowledge of paediatric surgery was just as limited as neonates. The ward round was quick and to the point, much like I would expect on a surgical ward. Again, much like the neonatal ward there were very few jobs available for a medical student. The exception was Wednesday when we had to do pre-surgical assessment, I found that during these assessments I could get involved, examine the patients, practice taking a succinct surgical history and practice making good notes. The independence I was afforded during these assessments gave me some confidence for starting my foundation job.

During this placement, I was also lucky enough to be able to attend and occasionally scrub into a number of surgical procedures. This incentivised me to research what was involved in these procedures and what the indications were. I realised, while looking into these procedure, that it would be important to understand at least some of the surgical options available to patients so that in the future I am able to properly advise them on their options for treatment.

The surgical procedures I was able to attend included, correction of malrotation (open Ladds procedure), antegrade colonic enema, correction of hypospadias, abdominal hernia repair as well as others.

During this placement, I was also asked to give a presentation, this time on the ACE procedure and the Mitrofanoff. I was very apprehensive about giving this presentation because I was quite assured that a majority of the people I'd be presenting to would know more about the procedure than I could hope to in the time I had. Even though I wasn't really looking forward to giving the presentation, the positive I took from it was a chance to practice presenting confidentially in front of my senior colleges which is an important skill for a foundation doctor as presenting is a day to day occurrence on the ward. The advice given by the consultants, both during and after the presentation, was very useful and I feel like it will help me give better presentations in the future.

During my time in Hull I have been able to compare the population visiting hospital and the clinical practice within the hospital. From this I have seen that there are many similarities and a few differences. Both being under the NHS the structure of care and practice was unchanged from what I had experienced in London, and patients came in with similar complaints. The population was slightly different in that they were a slightly poorer population and on average were slightly less educated. This meant that in terms of communication you had to be both clear and ensure that they had understood, I found that patients would often agree to what you said even if they didn't understand it and were less likely to question than patients in London, so getting them to feedback what they understood was very important. In terms of ethnic and religious diversity in Hull, it was less complicated than London from which I had seen a higher diversity of patients, I ran into a few hurdles with patients that didn't speak English, mostly from eastern Europe, but this is a common problem in London also and requires good organisation and communication with translators to ensure the patient gets the best care.

In summary I have very much enjoyed my time at Hull Royal Infirmary, I think it has had a positive effect on my learning and has given me an insight into hospital paediatric medicine.