ELECTIVE (SSC5b) REPORT (1200 words)

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

As a soon-to-be junior doctor in the UK in 2017, it's hard to know how to feel about working in government. On one hand, for somebody interested in international work, the UK is the third largest funder of World Health Organisation, and a force to reckoned with on the international stage. On the other hand, the mere mention of our secretary of state in most hospitals or clinics gives such a reaction to call into question whether any good can come of entering the halls of government.

But enter I did. As someone who is passionate to change the systems that govern you, you have to make a choice: either to be outside, free from constraint and banging on the door, or to be inside, frustrated by protocols but perhaps in a better place to affect change. For the last 2 and a half months I chose the latter, and worked in the international team in the UK's Department of Health, in Richmond House, Whitehall. Across the street from the Foreign Office and just down the road from the houses of parliament, you couldn't really be much closer to the action that is hushed up behind these walls.

Starting work was overwhelming. People gave me instructions in a language I didn't understand, not realising my confusing when they told me to send something 'up' or 'liaise with private office' or to 'ask SCS'. It was certainly a different pace of life to the wards, and - dare I say it – much more comfortable. Every day I came in and had my own desk, my own computer, and even my own technology, being kitted out with a blackberry and laptop within a week of joining. On the wards, you are lucky if you even find a chair! Hospital computers are fought over and even pens can be precious commodities. The project I joined for was cross-governmental (or X-HMG in many undecipherable emails) so not only did this add to the list of names to remember but added a myriad of different working structures, different priorities and different cultures.

Both medicine and the civil service have their hierarchies, but they work in different ways. As far as clinical decisions go, the top of the hierarchy is the consultant, the most experienced and highly qualified doctor on the ward, to whom you turn when things get difficult. Civil servants can also turn to their seniors, but at the top of the hierarchy is the minister who, dare I say it, might have no expertise in the area whatsoever. Where then is the accountability if something goes wrong? Using medical terminology, does the minister really give their 'informed consent' for a decision if they don't understand the implications of what they are signing? Consequentially, after a decision has been made and things have gone amiss, in clinical medicine we have morbidity and mortality meetings (M&Ms) where unexpected deaths are discussed, in order to improve future care. I wonder how often meetings like this are held in government projects that have failed, and how much the decision-makers engage with them, before a change of leadership sends officials off on another mission.

Briefing was a part of government work that I found particularly interesting. Namely, how a relatively junior member of a team might concisely and accurately slim down important information to a few key points to be used by a senior. For me, the obvious medical comparison was a medical clerking, where on admission a full history and examination of a patient is taken. As a medical student, we are told not to cut corners, and make sure that we ask every question, and examine every system. Our more senior colleagues can condense such a history to a few lines, knowing exactly what is important to the consultant in charge of their care, but as a junior doctor you should not be expected to do so, as it would be a concern that you would miss something. I often felt in government that things could be missed in such ways, and that perhaps tools like the 'swiss cheese model', so effective in clinical practice, could also be applied in the civil service.

One area I fully appreciated during my time in the civil service was the sense of teamwork and support. The International team met every few weeks, and I had a one on one meeting with my line manager every week. This gave ample opportunity to air any issues, to gain feedback and to ask questions. In hospitals, it can be difficult to feel much team spirit or support, given the large number of different professionals moving through, high numbers of locum staff and shift patterns making it difficult to meet. Having a one on one meeting every week was a great way to feel grounded and directed in your work, and I wish there was some way to create a similar system in hospitals.

At a time when our health system is a political football, it is more important than ever that doctors take an active interest in the decision-making processes of our health system. Interpretation of evidence and policy decisions can change our hospital, workforce and process structures, unlike other countries such as the USA where private ownership precludes government interference. The Department of Health is working towards better interdisciplinary collaboration between clinicians and civil servants, through programs such as the Masters in Public Policy at Imperial, but a great deal more must be encouraged to rebuild trust in the ability of government to appropriately manage the NHS. Even though much of day to day implementation is now the job of NHS England, the Department of Health still has an input on strategy and the power to influence and set policies. Building relationships at all levels – including pairing junior doctors with junior civil servants or encouraging more spaces for mixing, such as conferences or journal clubs, might be a low-cost place to start.

Leaving the civil service is hard. Behind these walls and security gates there is a sense of safety and support that you certainly don't have on the wards. However, yesterday, as I started back in hospital, I met a young heavily tattooed Polish patient in a Metallica T shirt. He had become acutely unwell over the weekend with jaundice and nausea, and had been admitted query hepatitis. Looking at him as he tried to understand me, in his second language and far from home, I felt his fear, and tried to comfort him. Realising that he is just one of thousands of patients I will treat in my medical career, I appreciate that as a doctor, almost every interaction in your day has the chance to make someone's most difficult days that much easier. Effort on preserving life, or easing death, never feels like effort wasted. For him and for every patient and person who uses our health services, it is our combined duty to create the best possible health system. Civil servants, doctors, managers, nurses, technicians, accountants and drivers, we are all in this together, whether we are those seeing the patients every

day or not. It is always worth reminding those not on the front line, that despite not being in sight, the people of the UK are their patients as much as ours, and that at the end of every decision that they make is a patient somewhere in a bed feeling afraid and far from home.