ACCIDENT + EMERGENCY

Nur Aliya Mustapha
Barts and The London

Columbia University Medical Center – Barts and the London Student Exchange Programme

EM06R: Emergency Department, St Luke's and Roosevelt Hospital

Tutor: Dr. Jennifer Stratton & Dr Jonathan Wassermann

Learning objectives

1. What are the pattern of disease/illness of the population with which you will be working and discuss this in the context of global health.
2. Describe the pattern of health provision in relation to the country which you will be working and contrast this with other countries or with the UK
3. Personal/professional development goals

Medical Elective report

On my first day, I was told to meet the course director, Dr Jennifer Stratton and the other medical students at Roosevelt Hospital for our induction. During that session, we were told to arrange 14 shifts, including 2 overnight and 1 weekend shifts at the St. Luke's-Roosevelt Hospital and 1 ambulance ride-along. We were also told that we will be working with a different Attending every shift, and they will provide feedback on our performance each day. I appreciated the fact that I am allowed to choose my own shifts and I will be receiving constant feedback on my performance. We were also taught how to use the computer system and given a quick tour of both hospital sites.

One of my learning objectives for this elective is to compare and contrast the differences between the UK and the US health care system in general and specifically in the Emergency Department. Having written a paper previously titled, "Epidemiology and Public Health Strategy of HIV/AIDS in the United Kingdom and United States of America", I had a basic understanding of how the American healthcare system works. However, getting a first-hand experience working in the system shed more light on the topic.

Contrary to my previous belief, no patients are refused from the ED. Most patients are either covered by Medicare, Medicaid, their own personal insurance or self pay. During my 4 week experience, I have not heard of patients being refused of treatment because of financial reasons. However, I feel that patients are not subjected to extensive and sometimes unnecessary investigations. In contrast, in the UK since everything is paid for by the NHS, most patients in the A&E department are rigorously investigated. For example, almost all patients in the UK will have continuous monitoring, an IV access and routine bloods, while asthmatic patients will definitely be subjected to a chest xray and an arterial blood gas (ABG). Both have its pros and cons but I do feel that sometimes the NHS system is abused because of this.

Since most of my time was spent in the ED, I was able to observe and learn a great deal of how the system works. I am amazed at how organized the system is. From the moment a patient arrives at the hospital, everything is documented and computerized using the EMSTAT system. All the paperwork is done digitally. In a way, this system is environmentally friendly as they reduce the amount of paper used. This system has not been introduced in the UK yet, but I do feel that it should and hope that it will be implemented soon as it definitely more organized.

From talking to the medical students and fellow doctors, I learned that medical students start applying for a residency placement in their chosen speciality programme straight after graduating. In contrast to the UK, medical students do not have to pick a speciality until after their second year of being a junior doctor. As a result, US medical graduates become a consultant or an attending much faster and at an earlier age compared to UK medical graduates. In the US, doctors become highly specialized at their field at an earlier age as compared to the UK, but they definitely have to decide their career paths much earlier which may or may not have adverse outcomes.

Based on my working experience in the Emergency Department (ED), patients are filtered into the main ED or the Fast-track, similar to a majors and minors unit in the UK. In the main ED, there will be around 3 teams led by an attending working at the same time. So at one time, there will be at least 3 attending on duty as opposed to the UK where there is only one consultant. The ratio of the attending to a resident is also almost equal. Whereas in the UK, 5 to 6 junior doctors and 2 to 3 registrars work with one consultant in a shift. I feel that the Americans have a better system as there is more support and teaching opportunities between colleagues. Plus the atmosphere here is also friendlier to encourage

learning and teaching since the age gap here is not too big. However, this system may not be feasible in the UK considering the tight NHS budget.

One of the requirements of this elective is to ride along with the paramedics for a day. I had the pleasure to shadow paramedics Angel Franco and George Lincoln for a day while they serve the citizens of New York. This was my first experience following a paramedic team and it was definitely a memorable one. This activity gave me a different view of the medical service, as we went into people's homes around Harlem to attend to the sick. It was definitely an eye opening experience for me seeing patients out of a hospital setting, in their own environment and not just merely as a medical student or a tourist. The friendly paramedics also shared amazing stories of their experience working in the field including their experience on duty during the tragic event of September 11.

Another interesting thing I noticed is the importance of mastering the Spanish language in communicating with patients as there is a big Hispanic population in New York. From my observation, almost 1 of every 3 patient attending the ED speaks Spanish as their mother tongue, with variable command of the English language. As a result, it is almost a pre-requisite for residents and attendings working in New York to be able to speak Spanish. As someone who does not speak Spanish, at times I felt I was at a disadvantage when trying to take a history from Spanish speaking patients as I had to rely on an interpreter. Similarly in London, there is a big Asian (Pakistani, Bangladeshi, Indians etc) population but the majority do speak English except the older Asian population. It is almost impossible for the doctors to learn the language as there are many different Asian language and dialects, so an interpreter is usually used when needed.

I did not notice any major difference in terms of patterns of illness and diseases here compared to the UK. Common diseases in the UK such as diabetes, hypertension, hypercholesterolaemia, asthma and cardiovascular diseases are commonly seen here. I was not expecting it to differ considering the similarities between the two countries in terms of population demographics, lifestyle, eating habits and culture. However, I was able to see a number of trauma cases including motor vehicle accidents and gunshot victims since St.Luke's and Roosevelt are one of the trauma centres in New York. It was definitely an amazing and educational experience to be involved in managing trauma patients.

My personal goal from this elective is to improve myself as a medical student in preparation to become a junior doctor. I wanted to improve my history taking and presenting skills, procedural skills

and most importantly to learn how to manage patients. From this experience, I can confidently say that I have improved tremendously from the training and teaching I received from the attendings I have worked with. I was given many opportunities to practice phlebotomy, insert IV cannulas and foley catheters. I was also taught suturing skills, inserting a nasogastric tube and performing lumbar punctures which I did not get to do back in London. All in all, I had a fabulous time doing this medical elective and I would highly recommend it to my other colleagues back in London.