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essay

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Sent: 24 May 2014 19: 39PM
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Natasha Goh Elective Report

As a contrast to my South African experience, I wanted to do the second half of my elective in the setting of a highly advanced healthcare system. The United States of America was my first choice, and since I am absolutely fascinated and adore the American culture!

The specialty that I picked was intensive care medicine. Although I wish to do surgery at this stage, I find intensive care medicine extremely fascinating and abstract with all the complex patients and unfamiliar machines and procedures. .

Unlike the United Kingdom, the intensive care service is highly specialized. Firstly, intensive care is divided into either medical or surgical units. Within each category, there is further division according to various specialties (e.g. pulmonary, liver and cardiac diseases). From what I've been exposed to so far, the intensive care units in the UK treat both medical and surgical patients (although some trusts have specialized units devoted to cardiac or neurological disease). Another important difference is that the doctors that run the ICU in the USA specialize in internal medicine while the ICU doctors in the UK mostly have a background in anesthetics. Like the UK, the patients in the US have one-to-one nursing. But the US patients all had nice large rooms of their own, which would obviously help to enforce contact precautions/barrier nursing more effectively than shared wards.

The intensive care unit that I was attached to was a pulmonary and critical care unit. A large majority of the patients had pulmonary conditions although we saw some patients from the liver/cardiac/surgical service whenever they ran out of beds. Even though it was a pulmonary unit, the patients had many comorbidities, e.g. immunosuppression from cancer or transplants, heart, liver, renal diseases. It was an excellent exposure overall!

In terms of provision of intensive care services, the USA has more available beds than the UK. It is estimated this can be as high as seven times as many beds available. Additionally, the threshold of admitting a patient is lower. According to a review by Murthy et al, the average APACHEII score of a US ICU patient was 15.3±8 while that of a UK ICU patient is 20.5±8.5. This could be attributed to the fewer number of beds available, hence reserving the beds for the sickest of the sick.

The interventions used in the ICU were similar to that in the UK, although I felt that the US doctors ordered more investigations and more readily that in the UK. When covering infections, the 'big guns' like meropenam and vancomycin were given more easily, and a wider variety of agents was used to cover multiple pathogens when there infection was still unidentified.

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However, what I found really interesting was that there wasn't an arterial blood gas machine on the unit. Specimens had to be sent on ice to the lab if any analysis was to be carried out. Although my attending explained to me that the rationale behind was because it was not part of standardized guidelines, intuitively, I found it hard to believe as I felt that ABG machines would be useful for rapid assessment of respiratory patients, as well as give an immediate analysis of oxygen and carbon dioxide levels, lactate and electrolytes in cardiac arrest patients.

Another fascinating aspect was how the patients and their family had a heavy weight in influencing the direction of treatment especially for the decision to resuscitate and/or to intubate in the event of deterioration. In the USA, the decision to resuscitate is seen as the right of the patient/family, while this decision is made by the medical team (with consideration to the patient's wishes). I often saw many terminally/severely ill patients in the ICU get full code status, who I felt were likely be denied resuscitation back home.

As part of my personal developmental goals, I definitely felt that I have gained a lot more experience and confidence in patient care. This is especially true in terms of formulating a workup and management plan for the patient, which I believe would be the most challenging aspect of being an intern. I was given the opportunity to present during the ward rounds, which was initially daunting. However, I found that the more I did it, the less challenging it felt.

Since this was the intensive care unit, it was definitely much more cerebral than other medical firms I had. The multiple comorbidities of the patients enabled me to integrate the various systems to appreciate an overall picture, which was previously difficult since we did our firms according to specialties. There was a good mix of bread and butter cases (e.g sepsis, acute kidney injury, liver disease) as well as rarer conditions (e.g. coccidioidiomycosis, pulmonary hypertension). I also appreciated being able to gain a greater understanding of how more complex cases are managed, in terms of the additional procedures/interventions that can be applied and the complications encountered.

I look forward to utilizing the knowledge gained from this rotation in my future career. This would definitely come in handy for the future as I have rotations in geriatrics, pulmonary medicine and critical care during my internship years. I would definitely seek to develop what I have gained from this experience; in particular, by focusing on the technical aspects of the adjuncts used (e.g. ventilator, dialysis machine, central and arterial lines) and getting a hands-on experience where possible. Furthermore, I hope to be better at formulating management plans independently, while taking into consideration the role of evidence-based medicine.

This has been a very satisfying experience as I was encouraged to be involved in patient care and was given a lot of teaching by all members of the medical team. Being able to compare and contrast between both systems has broadened my horizons, and has brought attention to alternative/additional ways of patient care.