James Hywel Beynon, 2013

ACCIDENT + EMERGENCY

Reflection on Elective Aims

1) To increase my understanding of alcohol related liver disease. What services are available to these patients at Prince Philip hospital?

During this placement I was able see a large number of patients who had been admitted with acute symptoms of chronic alcohol abuse. Through Consultant-led ward rounds and shadowing junior members of the team, I was able to gain an understanding of the common investigations ordered to monitor patients' progress, and came to appreciate the many complex needs involved in their care. I observed that, as a patient cohort, they can often be difficult to manage as they can be reluctant to engage in health services, despite having the serious potential to deteriorate further causing them to become critically unwell. I observed acute withdrawal of alcohol, and how distressing it can be to the patient and their relatives, and learnt how to prescribe a detox regime.

Discharging these patients can also be more complex than other patient groups; I noticed that social services are often involved early on, and specifically at PPH I learnt about the PRISM service. This is an outpatient service run by an experienced Clinical Nurse Specialist and is based in the community in a less threatening environment than hospital. Patients can attend for emotional and social support, and in some circumstances to discuss medications that may be available to them which can help them to abstain from alcohol.

In a number of specific cases I was able to fully realize the importance of this social aspect of care for chronic alcoholics in how it would shape their management back in the community and hopefully prevent or delay any alcohol related readmission to hospital. A patients home circumstances, employment status and work environment are often the route of developing alcoholic dependence and tackling these problems at source in the community is the way forward in treating these patients and will lead to decreasing the frequency of acute alcohol related admissions and overall reducing the strain on the NHS.

2) Increase my experience of the management of an intoxicated patient in an A&E setting.

I spent some time at the start of my elective in A&E, both during the day and at night. Unsurprisingly perhaps, most of the alcohol-related attendances I saw were later into the evening and at night, and were often associated with trauma, such as falls or assault. I was very impressed with the management of these patients by the A&E doctors and nurses; these patients were often very uncooperative and generally demanded more staff involved in their care. The A&E staff were quick to recognize the acutely withdrawing patient, and by addressing and treating withdrawal, it was then much easier to treat their other medical problems, from suturing to obtaining an ECG. From direct observation I also learnt that it's sometimes difficult to look beyond the alcohol and listen to genuine symptoms that patients are describing; a nurse commented that a frequent alcoholic attendee 'always came in complaining of chest pain,' and that

there was never anything wrong. The doctor treating the patient nonetheless took bloods and treated the case as suspected ACS as fitted the symptoms– the Troponin of this patient came back as over 370; I will always take this lesson with me when working in an acute setting that intoxicated patients can also be acutely unwell from something unrelated, and to take their symptoms seriously.

3) Gain a patient perspective of their disease and how it affects their day to day life.

I spoke with an intoxicated patient in A&E who was brought in with symptoms of acute withdrawal from police custody. Whilst the doctor was taking bloods and gaining IV access for medication she asked me to talk to the patient about his alcohol abuse, and whether he had thought about stopping drinking. The patient surprised me by saying that he was desperate to stop drinking, and had tried once before through the PRISM service, but ended up relapsing because of peer pressures from his social group who were all heavy drinkers. He felt that alcohol 'had ruined his life,' saying that it had cost him regular employment, and that he believed without alcohol he would have probably never ended up in trouble with the police to the extent that he was currently. Most upsettingly, it had cost him the rights to see his children. The doctor was very good at suggesting alternatives to PRISM, such as his seeing hid GP, and suggested he may want to think about an elective admission for detox at some stage.

4) Improving my clinical skills and general medical knowledge.

Throughout my elective period, I feel that I have gained considerable knowledge and confidence in the clinical skills necessary for FY1 year, through my work both in A&E and with the Gastroenterology team on the wards. I have taken every opportunity to build upon my examination technique, and appreciate the doctors I have worked with taking the time to show me gastroenterology patients with good clinical signs, including hepatic flap and hepatomegaly. On the wards I was able to hone my venepuncture and cannulation skills, the bread and butter of the junior doctors workload as well as observing multiple ascitic tap and drain insertions.

This elective gave me the opportunity to begin learning how to be an effective junior doctor and I changed my outlook from that of a medical student to that of an effective cog in the medical team where I would be documenting consultant ward rounds, writing discharge summary's and referring patients for radiological investigations , all new skills which I have gained more experience in during my time. In A&E I gained plenty of experience and confidence in examining and treating minor injuries and trauma. I appreciated having multiple opportunities to suture wounds, as I had only sutured synthetic skin as a medical student. I also feel that I have furthered my communication skills and I have had greater opportunity to deal with difficult patients and in particular I have had more exposure in dealing with paediatric patients in an acute setting which can be difficult for even the most experienced doctor. Trauma medicine is a specialty that I had had little exposure to at medical school, so I think it is safe to say that

the first arrest I participated in was initially very daunting! However, I was shadowing the FY1 and both he and the medical registrar leading the arrest encouraged me to get involved, and I had plenty of time to ask any questions I had afterward.