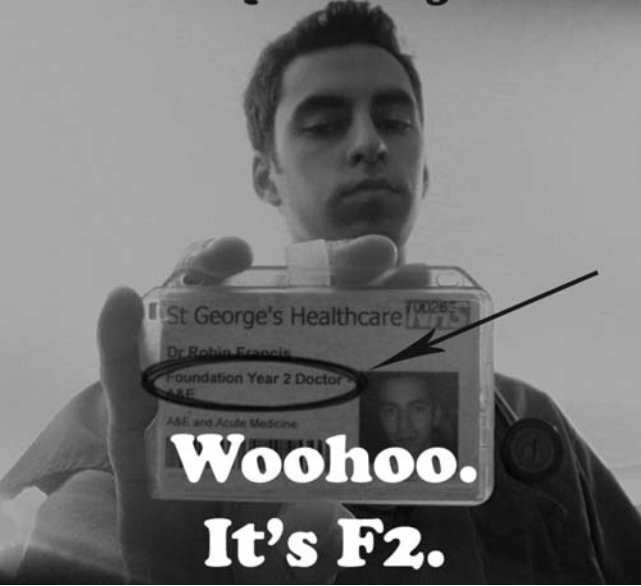


Still practising...



Robin Francis
FY2 Doctor

Guardian Student Media Awards
Diversity Writer of the Year
Runner-up Columnist of the Year

HO HO HO. HO HO HO HO HO HO HO HO HO. Ho. Hoho. (ho). Mairhry Christmas! MAAIRHHRY CHRISTMAS! Can you TELL I'm happy? But why you ask? Why? I'll tell you why! It's Christmas!

No not really I hate all that shit. The real reason I'm brimming with sheer mania is that I finish A&E in two shifts' time. Two stinking nights and I'm free of this pus-ridden bubo of a job. Well, until the son of MTAS screws me over and I have to take a non-training A&E post like the poor suckers I work with.

These last few days I have

been sitting quite squarely on my laurels and getting slack. To demonstrate my attitude to this obscene job, I am currently sitting in the middle of the department writing a column for a student newspaper instead of seeing patients. Don't worry, I doubt any of them are ill.

Something jarred about that last paragraph didn't it? I bet you thought "what laurels?" You astute bastard. The one thing that has kept me from lapsing into a coma whilst at work is intense competitiveness. Thankfully, in our A&E department we use a programme that allows you to track how many patients you have seen.

I am number two in the department. In four months I have seen near 750 patients, whereas the average F2 has seen about 120 less. I spit on

Robinplasty

the average F2. The only person ahead of me is a Chinese senior SHO called Ben, who was actually mass-produced in a large factory-town outside Shanghai. He was designed to process and eject patients at break-neck speed without rest. He is my hero.

Yesterday I was glad to be able to spend a bit of extra time with the patients, safe in the knowledge my figures are respectable. One of the nurses asked me if I was busy. I looked at my computer screen, which showed the results of a google search for giraffe brain valves. "Yeah I can spare a minute."

"Could you just clear the C-spine of this lady? She's quite far down the queue."

"What's the history?" As I walked over to a dark room with a woman strapped down in bed with a cervical spine block. She was wailing with pain. I'll call her Annabel.

"This lady was found collapsed in the street. She's complaining of bad head and neck pain, we don't know if she's had a head injury." I removed the block to examine her and she howled all she wanted to do was turn over and go to sleep. The lady was 60 years old and her 30-something daughter was with her.

She did not appear to have any bony tenderness nor signs of a head injury. But she was clearly in intense pain. One of the criteria to clear a cervical spine is that the person must have no drugs or alcohol on board. I did not expect this to be the case in a respectable 60 year-old lady, but had to ask. "Have you had any alcohol today?" No. "Have you taken anything else?" Pregnant pause. I looked at her daughter, who was getting more anxious. "Have you taken anything Annabel?"

"I've had a bit of coke." Her daughter's jaw dropped and my alarm bells went off. When questioned, Annabel agreed this headache was the worst of her life and hit her like a thunder-clap. Her neurology and fundoscopy were normal and she was maintaining a GCS of 14, but she was photophobic, meningitic and hypertensive.

I called the radiologist and as I left the cubicle I heard daughter scream at Mum. "You were baby-sitting, you're sixty years old, what the hell are you taking cocaine for?"

Sometimes arranging a night time CT can be a challenge but luckily no opposition was met. I sat in front of the computer hitting F5 when the first few slices appeared. There was more blood than brain. She had bled *everywhere*. The radiological classification of this type of bleed was the most severe. All her ventricles were completely filled with blood. Clinically she wasn't that bad, yet.

By the time she returned to the department with her daughter I had already arranged a bed on neuro ITU. Her daughter looked at me and read my worry. Even though I've now had a year's experience of breaking bad news, I still find myself mentally reciting the steps I'm supposed to take.

I followed the technique I had been taught and explained the diagnosis to Annabel's daughter, who was inconsolable. Her Mum's GCS was slowly dropping. I was able to spend some extra time with her and her sister, who arrived soon afterwards. I stayed with them until their mother was taken over by the neurosurgeons.

However, sometimes one can not afford a patient very much time, especially if your shift is about to finish. We are instructed to "do whatever we can" and hand over. I had fifteen minutes left and saw a solitary card in the box. I thought it would be nice not to hand over any waiting to be seen, so grabbed the card. He was a 19 year-old Afghani fellow, whose friend had to translate. He had 'man-flu'. Nothing worse. He had a temperature, a sore throat and a headache. He was shivering (as one does when they have a virus) and sweaty.

He came the day before and had bloods done at triage. The triage nurse gave him some painkillers and he felt so much better he went home before seeing a doctor.

Once he got home, he took just one 500mg paracetamol

tablet during the day and - surprisingly - felt bad when evening came.

His bloods from 20 hours ago were normal. I cannulated him for a litre of fluid and as his exam was also fine, I handed over to a fellow F2 that he should have his fluid and go home. I explicitly said his temp and tachycardia need not settle.

When I came in the next day I checked what happened. After I left, he had been bled, cultured, X-rayed, gassed, dipped and given antibiotics. The diagnosis had been revised from innocent virus to tonsillitis.

I challenged the F2 responsible, who will no doubt earn more than me as a GP dishing out antibiotics in a few years' time, who felt he was dreadfully unwell. His bloods, ABG and chest radiograph were normal, but she thought he needed amoxicillin. This despite advice that antibiotics should almost always be avoided for simple tonsillitis *and* that amoxicillin is contra-indicated. "His creatinine was also up." It was 130. Cockcroft-Gault gives a 100kg chap like him a healthy GFR.

When you're at home with the 'flu, you have honey and lemon, you rest and get better. If you have the misfortune to be in hospital, you are over-investigated and falsely labelled as seriously sick.

The patient will probably think his second doctor was better as she gave him drugs. But hey, she's seen 140 less patients than me, so she sucks and I rule.

Attack of the one-weekend wonders

It's a truth universally acknowledged that "The Fear™" urges legions of finalists to sign up for revision courses every year. But are they worth the money? *MS* went along to *Finalmed* to find out why it's marketing itself as different to the rest

Emma-Jane Smith
Consultant Editor

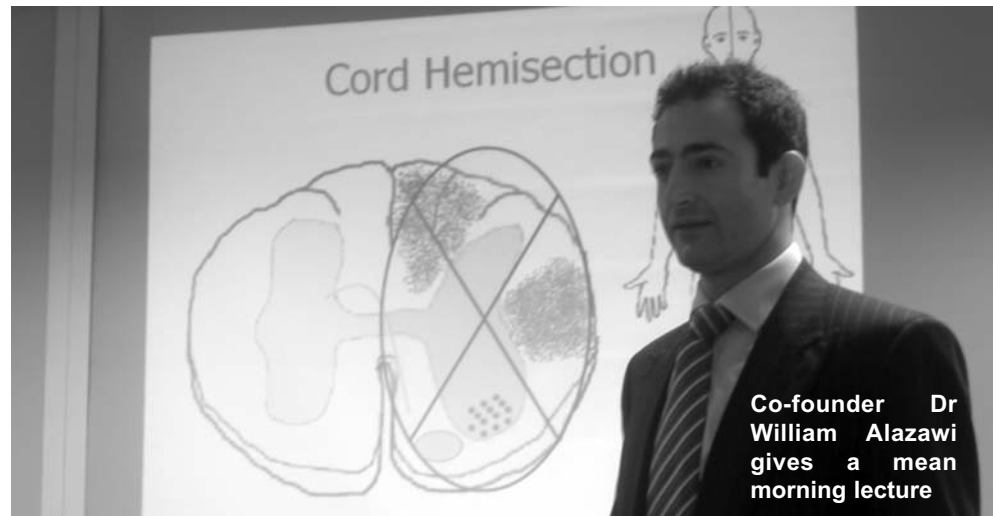
FINALMED sells itself as "a unique weekend revision course offering superior preparation for clinical finals" - but unlike other courses which concentrate on practical and examination skills, its focus is on learning to "present cases like the doctor you are about to become". This, the co-founders Drs William Alazawi and

Patrick Byrne claim, is the key to OSCE excellence and setting oneself apart from the merely competent. Think honours, not bare pass.

Consisting of an intensive ~8.30am-6pm timetable both days and with a tendency to over-run, *Finalmed* is not for the faint-hearted. The mornings are packed with revision lectures in medicine and surgery by keen lecturers: a useful memory-jogger for the content of the afternoon, with many

containing handy tips on approaches to common OSCE stations, all supplemented by copies of the presentations in a course handbook.

But it's the afternoons which are the main event of *Finalmed*: multiple self-styled 'carousels', consisting of groups of eight students rotating around different tutors and specialties to practise logical consolidation and presentation of clinical signs shown on slides. The idea is that these signs have just been elicited in an OSCE station, and the candidate is turning to the examiner to present the findings. Each member of the group presents once or twice in each carousel, each time receiving feedback from the tutor on their performance and tips for improvement, and then having another stab at it. The emphasis is not on knowledge, but on effective presentation. By the end of the weekend, the average student present-



Co-founder Dr William Alazawi gives a mean morning lecture



A *Finalmed* carousel in action

tation of several minutes of rambling and trailing off into cringe-worthy silence had been transformed into 3-4 sentences of concise clinical information - success! The teaching technique clearly works, although the organisers emphasise that without regular practice of the skills learnt, the use of the weekend is limited. It's also important to be able to elicit signs in patients as they won't

be on slides in the exam, of course.

Priced at £147 (-10% discount with early booking), *Finalmed* is admittedly dearer than its counterpart courses run by the MDU, MPS, BMA and others - but its emphasis on active participation, small group teaching and personalised feedback means you're getting far more attention than on the average cramming week-

end. The focus on presentation of signs rather than knowledge or examination skills also makes *Finalmed* stand out from the crowd: to our knowledge and that of the organisers, there is no other course with the same bent. It may not be the cheapest 'weekend wonder', but if you want to look slick in the OSCE and build your confidence at presenting, *Finalmed* comes highly recommended.