

The British Student Doctor Journal

BSDJ

VOLUME 1, No.1
31 January 2017
ISSN 2514-3174
bsdj.org.uk

A photograph of a hospital hallway. The hallway is dimly lit, with a window on the right side showing a view of trees outside. A white radiator is visible under the window. A dark door is open on the right, revealing a glimpse of the room beyond. The floor is dark and reflective.

Are the elderly our silent generation?

Experiences of older
people in hospital



The British Student Doctor is an open access journal, which means that all content is available without charge to the user or his/her institution. You are allowed to read, download, copy, distribute, print, search, or link to the full texts of the articles in this journal without asking prior permission from either the publisher or the author.

bsdj.org.uk



[/thebsdj](https://www.facebook.com/thebsdj)



[@thebsdj](https://twitter.com/thebsdj)



[@thebsdj](https://www.instagram.com/thebsdj)

Journal DOI

10.18573/issn.2514-3174

Issue DOI

10.18573/n.2017.10117

This journal is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License. The copyright of all articles belongs to **The British Student Doctor**, and a citation should be made when any article is quoted, used or referred to in another work.



Cardiff University Press
Gwasg Prifysgol Caerdydd

The British Student Doctor is an imprint of Cardiff University Press, an innovative open-access publisher of academic research, where 'open-access' means free for both readers and writers.

cardiffuniversitypress.org

Contents

EDITORIAL

- 1 *James M. Kilgour and Shivali Fulchand*
Editorial: Welcome to *The British Student Doctor*
- 4 *Andrew Y Finlay*
How to succeed in medicine
- 7 *Eleni Panagoulas*
Four steps to a successful original research article

DISCUSSION

- 9 *Peter Jonathan Edwards*
Why I am pursuing a career in general practice

EDUCATION

- 11 *Laura Jane Cunliffe and Ian Renwick*
Valley Fever in the UK? The importance of a travel history

- 15 *Ffion James*
Ode to an ulcer

REFLECTIONS

- 17 *Sohini Chatterjee*
Psychological phenotypes associated with the rare skin disease X-linked Ichthyosis
- 19 *Caitlin Louise Young*
The silent generation: Experiences of older people in hospital
- 21 *Caitlin Bass*
Watchful waiting

Editorial

James M. Kilgour

Co-Founder & Editor-in-Chief
The British Student Doctor
School of Medicine
Cardiff University

ORCID: 0000-0001-8067-2306

Shivali Fulchand

Co-Founder & Editor-in-Chief
The British Student Doctor
School of Medicine
Cardiff University

ORCID: 0000-0003-2918-3931

Address for Correspondence:

Editor-in-Chief, The British
Student Doctor, PO Box 430,
1st Floor
30-36 Newport Road
Cardiff, CF24 0DE

Email: editorinchief@thesdj.org.uk

No conflicts of interest to declare

Welcome to the first issue of *The British Student Doctor*. The BSDJ is a peer-reviewed, diamond open-access, medical student journal, which was founded in March 2016, after securing funding from Cardiff University School of Medicine. We recruited and trained an editorial and management team of 15 students, as well as enrolling over 170 peer reviewers from across 4 continents. Within this time frame, *The British Student Doctor*, has reached over 20 UK medical schools, including several internationally. Between September and December, submissions were opened for this first issue, and we received many high-quality submissions. We have also created a YouTube channel, and have currently released two videos, which provide a general overview of the ethos and vision of *The British Student Doctor*. The journal was also presented at the Academy of Medical Educators' conference in London. It was very encouraging to receive such a positive response from medical educators from across the country.

In 2011, a study of over 500 medical students at 7 UK medical schools found that only 14% submit their work to peer-reviewed journals. (1) This statistic is poignant, as this reflects a lack of engagement by medical students in scientific publishing. Evidence-based medicine is the responsibility of every doctor, as it ensures that patient care and management coincides with the latest scientific developments. As medical students, we initially found it difficult to engage with the publication process, because the traditional medical school curriculum provides limited guidance in this field. The complexity of medical journals, and the high-level of expertise required for submitting manuscripts to journals, can be a barrier to participating in academic publishing.

The vision of *The British Student Doctor* is to create a platform for sharing the critical thought and creative flair of medical students, packaged in a simple, modern and accessible way. The aim of the journal is three-fold; firstly, to provide editorial board opportunities to medical students; secondly to engage students with the peer-review process; and finally, to give students the opportunity to publish their work into a journal that has a beautiful, modern and accessible design, whilst still maintaining its scientific rigour. *The British Student Doctor* aims to set the standard for journals moving into the future, which is evident through our marketing and social media presence.

Looking forward, one of our goals for The BSDJ is to obtain a PubMed ID. The reason for this requirement, is that indexing in PubMed is a sign of quality - that the journal's editorial process is credible, objective and transparent. Furthermore, that the research and discussion published within that journal has the rigour and originality necessary to impact on the field of research, and in turn, on clinical practice. PubMed indexing is also important to UK medical students, as it provides up to an additional 2 extra points on the Foundation Programme application. Once a PubMed ID is obtained, all articles previously published in The BSDJ will also be indexed, retrospectively, meaning that the benefits of a PubMed ID will not be missed by authors published in these initial issues.

Currently, the editorial and management board of *The British Student Doctor* is constituted solely of Cardiff University medical students and staff. In due course, we would like to have these positions filled by individuals from a variety of institutions, as we hope to have a diverse editorial board. It is also our aim to increase the multimedia presence of the journal through a YouTube series, to educate students on the editorial and publication process. Finally, we are working to design a smart phone application, so readers can access articles with greater ease from their devices.

The article featured on the front cover of this issue discusses a subject that is increasingly pertinent to health policy discussion - our ageing population. The author, a medical student at Cardiff University, Caitlin Young, discusses the experiences of elderly people in hospitals and provides a reflection on the changes that need to be seen, given the changing demographics of hospital wards. She poses the question; are the elderly "the silent generation", whose views are often not asked for, or are maybe forgotten?

Medicine can be a rewarding career, and there are diverse opportunities open to all medical students. However, with the intense competition that medical students face, it can be difficult for them to find their place within a medical career. In this issue, Professor Andrew Y Finlay discusses how to succeed in medicine. As a Professor of Dermatology, pioneer of the Dermatology Life Quality Index and co-founder of the *Journal of Dermatological Treatment*, alongside many other achievements, his career demonstrates the breadth and variety a career in medicine can offer. His editorial provides valuable insights and practical advice for career development, as well as methods for contributing to the improvement of clinical care.

One of the key aims in founding *The British Student Doctor* is to encourage more medical students to publish their work, and by doing so, improve patient care. Eleni Panagoulas, our Senior Original Research Section Editor, gives a simple four step process to publishing a successful original research article.

It is well known that there is a recruitment crisis in General Practice. Dr Peter Edwards, an Academic Foundation Year Two doctor in Bristol, presents an interesting discussion on this crisis, and why medical students should be wary of the negative stigma and attitudes towards this important, but often undervalued, speciality. Finally, Ffion James, a final year medical student at Cardiff University, provides the unique opportunity in medicine to combine revision alongside creative literacy.

Acknowledgements

Founding *The British Student Doctor* has been the result of a culmination of efforts, and there are a number of people that we wish to extend our gratitude to. Firstly, we would like to thank Professor John Bligh, the former Dean of Cardiff University School of Medicine, for his enthusiasm and support for The BSDJ. By providing our initial funding, it allowed us to align The BSDJ with our vision of a high-quality journal. We are also indebted to the continual efforts and support of Mrs Julie Browne, Senior Lecturer in Academic Practice at Cardiff University. She is not only one of our Faculty Advisory Board members, but also a mentor who has helped and guided us through every step of the process of establishing this journal. Her experience and knowledge is an invaluable asset to our team, and we are grateful for all the time that she has generously donated to us. We would also like to thank the rest of our Faculty Advisory Board, Dr Steve Riley, Dr John Ingram and Dr Debbie Cohen OBE, for their advice and support throughout the year, and their efforts to review all of the articles published in this issue.

Additionally, we would like to thank our publisher, Cardiff University Press, who have helped to guide the development of The BSDJ, as well as providing the Open Journal Systems software that powers our editorial process. We would also like to give a special thank you to Hugh Griffiths, a PhD student in the School of Journalism, Media and Cultural Studies. Hugh has been instrumental in creating the design and branding of *The British Student Doctor*, including our logo.

Thank you to Cardiff University School of Medicine, who have provided support on many different levels; thank you to the Finance Team for managing and processing our accounts, Caitlin Golaup for her encouragement and advice on promotion and posting on social media, and the Health Library staff for creating a space for our promotional materials.

Finally, we would like to thank all of the authors who have contributed to this issue, our peer reviewers, as well as the editorial and management team of *The British Student Doctor*. The publication of this issue is the achievement of a team effort to review the many quality submissions that we received.

We hope you enjoy reading this first issue of *The British Student Doctor*. If you have any ideas, thoughts or comments about any of the articles published in this issue, then please do get in touch via email, or through our social media pages. You can also submit a letter to the Correspondence team, and this will be considered for publication in our next issue, which will be published in June.

REFERENCES

1. Griffin MF, Hindocha S. Publication practices of medical students at British medical schools: Experience, attitudes and barriers to publish. *Medical Teacher*. 2011;33(1):e1-e8.

<https://doi.org/10.3109/0142159X.2011.530320>
PMid:21182368

Guest Editorial

Andrew Y. Finlay

Professor of Dermatology
School of Medicine
Cardiff University

Address for Correspondence:

Professor Andrew Y. Finlay
Department of Dematology
Cardiff University
3rd Floor, Glamorgan House
University Hospital Wales
Heath Park, Cardiff, CF14 4XW

Email: finlayay@cardiff.ac.uk

ORCID: 0000-0003-2143-1646

No conflicts of interest to declare

HOW TO SUCCEED IN MEDICINE

What are the secrets of success in medicine? One of them is making sure your CV is as strong as possible as early as possible, for example by getting an article published in this new journal. But there are lots of other ways, (1) that some successful doctors might not want you to know...

Listen, listen, listen

Right from the start of your clinical experience, let your patients tell you what is wrong with them, uninterrupted. Actively listen and you establish a more effective relationship. And don't avoid examining a patient properly. The art of high quality clinical medicine depends on high quality history taking and examination: without that, investigations are a waste of time.

Ask and act

Don't feel shy about admitting you don't know something. Look up things, even in front of patients, who appreciate you taking an interest. Put the patients' needs ahead of your own. Whatever your problems, put on your actor's mask, smile, carry on. All doctors at all levels sometimes feel nervous or unsure in clinical practice. Try to act confidently: it inspires confidence.

Rehearse!

Before giving a presentation, even if it's to a small group of other students, rehearse, rehearse, rehearse. Speak out loud in a room by yourself, time yourself, and be ruthless over cutting out stuff in order to keep to your allotted time. Then rehearse in front of a friend: ask them to check and criticise your slides. You will then wow your audience.

Be generous with your time

You are a professional. Take a professional attitude to time and your responsibilities, both in learning and in caring. If you will learn best from a patient at an awkward time for you, or if a patient needs your advice, try to oblige. You will be the ultimate gainer.

Speak face to face and be there!

Speak face to face. Personal regular meetings establish and oil daily professional relationships and later pay big dividends. As a student, go to all your timetabled events, contribute, ask questions, and get involved in student activities. You may feel that at the time no one notices whether or not you are there, but people take more note of this than you may imagine, and a keen and positive student is always appreciated. When you qualify, regularly attend local administration meetings, grand rounds, and national meetings. However out of place you might at first feel, you will gradually integrate and eventually become essential.

Lead change

Change is inevitable: lead it. Don't reject new ideas just because they seem mad. Opportunities arise all the time, often unexpectedly. Many aspects of medicine will radically change during your career, you can influence and be part of this.

Get a mentor

Someone more experienced can guide difficult decisions and give invaluable personal advice in your career. Friends and mentors are important.

Don't expect "them" to do it

"They ought to..." How often do you hear that? There is no "them". If you want to change something, you have to do it yourself! Lobby, join a committee, get elected so that you can make the changes that you can see are needed.

GETTING INVOLVED IN RESEARCH

Find something that excites you

Pick and develop a theme that you are genuinely interested in and feel ownership of. Follow your own star. You will quickly be considered an expert!

Be clinically relevant and question dogma

Choose clinically relevant research topics. Ask simple questions. Don't accept the status quo. Don't be overawed by your seniors – it's not long since they were students too.

Be original

Don't try to reinvent the wheel. Get aware of what others are doing in the area that interests you, with Google Scholar or PubMed literature searches.

Develop ideas – think outside the box

If you have an idea, work on it yourself. Don't expect others to do your work. If you think of a new angle to research or clinical practice, stick with it until you prove that it makes sense and get it established. Medicine constantly changes. Areas you can't understand are often ripe for a rethink. But not all your ideas will be good ones: learn to be self-critical and when to accept direction change. Expect research plans to sometimes go wrong: failure helps you learn.

It's easier to publish than you think

Plan your research to be publishable in as high ranking a journal as possible, but be realistic. The chances of getting into, say, the BMJ or Lancet are pretty small (even for me). So match your manuscript quality realistically to a journal. Get a "critical friend" to comment. Delete verbosity. Follow slavishly any suggestions from the editor. Don't be put off by an initial rejection, these are totally normal in the academic world, you just have to have the staying power to improve the manuscript and resubmit until you get an "Accept".

LATER IN YOUR CAREER (OR EVEN NOW)

Administration tips

Choose your battles, only fight the battles you are likely to win. Sacrifice unimportant issues to secure your main objective. Offer solutions, not just problems. Understand your administrators' pressures.

Crisis management

Sometimes you have to cancel everything and deal with a crisis, medical or personal. Most routine things can wait. Colleagues are nearly always understanding and supportive.

Every doctor gets complaints

Its one of the most horrible things, either as a student or as a doctor, to get a complaint from a patient. But sooner or later it will probably happen to you. So be prepared. Do all you can to avoid patient complaints. Try to neutralise them early. Drop everything to deal with them. Apologise early. Along with the doctor in charge, meet the patient, explain how it happened and how you will prevent it happening again. After a clinical mistake, take steps immediately to protect the patient. Remember your duty of candour.

Log it all

Keep a hard copy “logbook”, that can’t get lost or deleted, of your personal achievements. Update it regularly, in your own writing. You will find this incredibly helpful when you need to update your CV, and for lots of other purposes as well. E-formats change and eventually may become inaccessible but a hard copy notebook is super reliable.

Look after yourself

Develop friends and interests outside medicine. Give yourself “protected time”. Keep fit. Although immensely rewarding, medical careers can be tough, so you must look after Number 1. By caring for yourself you will be better equipped to care for others.

The ideas in this article are mostly based on the Twenty Top Tips (1) that I aimed at trainee dermatologists, but they apply equally well to you! Don’t worry, no one could follow them all perfectly, but some may be helpful. (2)

Medicine is a great career, with multiple possibilities to have an interesting and fulfilling life. There are always challenges, management structures are always changing, things have never been easy. Every generation of doctors faces different problems and tries to meet them. Read a little medical history and get things in perspective! Rise above today’s problems and concentrate on the unique and extraordinary relationship that we are privileged to have with our patients.

Acknowledgement

I wish to thank Dr Sarah E Finlay, Imperial College Healthcare NHS Trust, for helpful suggestions. This editorial includes verbatim quotes from reference 1.

REFERENCES

1. Finlay AY, Griffiths CE, McGrath JA. Twenty top tips to triumph in dermatology. *Br J Dermatol*. 2012;167:445-6.
<https://doi.org/10.1111/j.1365-2133.2012.10865.x>
PMid:22292932
2. Azad M. How to succeed as a junior doctor. *Clinical Medicine*. 2016;16:448-50.
<https://doi.org/10.7861/clinmedicine.16-5-448>
PMid:27697807

Guest Editorial

Eleni Panagoulas

Original Research Section Editor
The British Student Doctor
School of Medicine
Cardiff University

Address for Correspondence:

Eleni Panagoulas
School of Medicine
Cardiff University
The Cochrane Building
Heath Park, Cardiff, CF14 4YU

Email: originalresearch@thesdj.org.uk

ORCID: 0000-0001-5920-1024

No conflicts of interest to declare

FOUR STEPS TO A SUCCESSFUL ORIGINAL RESEARCH ARTICLE

The importance of research and publication during your undergraduate years at medical school has been highlighted many times, after all many important discoveries such as insulin have actually been made with the help of undergraduate medical students. (1) Furthermore, getting involved in research from the early stages in your career shapes a positive attitude towards academia, and allows individuals to make more informed career choices. (2) Therefore, it is important to challenge yourself and put pen to paper, and not let anything sit in the draw. A great amount of satisfaction will result from it, and by following some systematic steps, success will soon follow.

Thousands of articles get submitted every day to journals, and never make it past the peer review process, this can be due to a multitude of reasons, but it is important to be aware of certain requirements in order to give your manuscript the best possible chance at getting published. *The British Student Doctor* aims to give students the opportunity to start their publication careers, and through the following advice in this article, I will discuss the process of submitting an original research article.

Originality

Original research is about what it says on the tin. The work needs to be an innovative study in any aspect of clinical medicine, biomedical science or medical education. The research could range from experimental lab based work to a systematic review and meta-analysis; any established methodology is acceptable. Original research also includes revisiting topics, but providing a new perspective, or researching something which has already been published, but from a new angle. Students are often involved in very interesting research, but due to multiple reasons, which include a lack of publication experience or producing research with a smaller nature and narrower scope, this research ends up never being published.

Ethical and professional

It is pertinent that all research has proper ethical approval from the relevant regulating bodies. However, though it may be obvious when a study requires ethical approval, there are subtleties when conducting research. If in doubt, it is always possible to speak to your local ethics committee.

It is also important to uphold a professional manner. When submitting a piece of research, it is vital that all parties that were involved in the research are informed. This includes, first and foremost, your supervisor, who needs to give full consent for you to publish the research. Furthermore, anyone who has worked with you and advised you needs to be acknowledged, and considering how much their involvement was, perhaps they may even merit inclusion as an author. This, for example, could be a PhD student who taught you a technique or proof-read your work, whose contribution should be acknowledged at the end of the paper. Additionally, studies that are a part of a collaboration, or constitute the first stage of a multistage trial, also require the full consent from whoever is responsible for overseeing the study. Remember, just because you did all the footwork for a study, this does not make the data exclusively yours. It also goes without saying that if you use anyone else's data, then their consent needs to be gained, and they should be included as an author.

During the publication process, you will often be in contact with different parts of the editorial team, and you will also receive feedback from at least two peer reviewers. It is important to always maintain a courteous manner in your communications. Often, receiving criticism can be challenging, but you must remember that reviewers put in the effort to review your work out of genuine interest and good will, and they are not paid to do so. Therefore, their time and effort needs to be appreciated.

Transparent

Research is often difficult, requiring many hours sacrificed staring into a microscope or critically appraising countless articles or analysing patient notes. So it is not surprising that cutting corners would seem like a solution. However, the scientific community relies on the transparency and probity of the researcher. This is why papers undergo a stringent peer review process to ensure that only the highest quality of data is published. Furthermore, deliberately trying to mislead the reader is unethical, and if this is discovered, it may lead to serious professional consequences for the author.

Well written

Think of your audience and try to draw them in. Research does not have to be displayed in a dry manner. Please do read the author guidelines. Submitting a piece of work without having read and followed the author guidelines is like setting off on a road trip without a map or destination. It sounds like fun, but you will get lost, or in this case your article will be rejected. Furthermore, it is important that your manuscript follows a standard set order, and this is usual for most research journals. The background usually places your research into the context of what the current literature says, and ends with your aims and hypotheses. Methods need to be detailed, outlining the relevant steps taken, as well as the statistical tests or programs used to analyse the data. The results section is a platform to display your results, and it is important not to start analysing or explaining results at this stage, only simply stating them in an objective manner. In the discussion, you must consider the clinical implications of your results, and analyse the strengths and limitations of your study. It is also informative to include directions for future research. Lastly, proofread your manuscript very carefully, and ideally have a fresh pair of eyes to look over it before submission. Having many spelling and grammatical errors will put your editor in a bad mood, and detract from your overall manuscript.

Starting off may seem like a daunting task, therefore it is easier to break things down into manageable chunks and to work consistently at your manuscript. Furthermore, there are online resources that can help you. (3) At *The British Student Doctor*, to help streamline the submission process and aid future authors, we have created a pre-submission checklist, which is included as part of the copyright agreement, and needs to be completed and submitted alongside the manuscript.

Good luck with your research and publication endeavours.

REFERENCES

1. Metcalfe D. Involving Medical Students in Research. *Journal of the Royal Society of Medicine*. 2008;101:102–103.
<https://doi.org/10.1258/jrsm.2008.070393>
PMCID: PMC2270240
2. Amgad M, Man Kin Tsui M, Liptrott SJ, Shash E. Medical Student Research: An Integrated Mixed-Methods Systematic Review and Meta-Analysis. *PloS ONE*. 2015;10:6
<https://doi.org/10.1371/journal.pone.0127470>
PMID:26086391 PMCID:PMC4472353
3. Kallestinova ED How to Write Your First Research Paper. *YALE Journal of Biology and Medicine*. 2011;80:181–190

Why I am pursuing a career in general practice

DISCUSSION

AUTHOR

Dr Peter J Edwards

MBBCh, BSc(Hons)

Research Associate / Academic

Foundation Year 2 Doctor

Centre for Academic Primary Care

School of Social and Community

Medicine, University of Bristol

Address for Correspondence:

Dr Peter J Edwards

Centre for Academic Primary Care

School of Social and Community

Medicine, University of Bristol

Office G06.d, Canynge Hall, 39

Whatley Road, Bristol, BS8 2PS

Email: peter.edwards@bristol.ac.uk

No conflicts of interest to declare

General practice is in a recruitment crisis. 2015 saw 28% of UK GP training posts unfilled after the first round of recruitment, with some of the worst affected areas reporting vacancy rates of over 60%. (1) The question is, why has general practice become so unpopular?

When I told some of my colleagues at medical school I wanted to become a GP, I received several negative responses. “Oh really?” and “but you have such potential”, are prime examples of such reactions, playing to an assumption that becoming anything other than a consultant surgeon or consultant physician is somehow taking ‘the easy route’. This misconception that general practice is a ‘lesser’ career than other specialities appears to be widespread throughout UK medical schools, (2) and is likely to be contributing towards the recruitment crisis in the field.

Personally, I feel that general practice has a lot to offer. As a GP, all manner of symptoms, conditions and patients can present themselves to you in the space of a morning, and distinguishing between minor ailments and serious pathology takes great concentration and attention to detail. The variety of clinical care that GPs offer is also immense: you could be dealing with a paediatric cardiology case in the morning, a middle-aged sports injury in the afternoon and finally reviewing an end of life patient in the evening. This diversity in workload, combined with the continuity of caring for an individual patient over a prolonged period, and often through multiple disease processes, are some of the main reasons why I want to become a GP. Additionally, I am attracted to the excellent opportunities to develop in-depth knowledge in a field of my choosing through becoming a GP with a Special Interest (GPwSI), enabling me to run dedicated clinics in primary care, while still retaining the breadth of care that general practice offers.

GPs are masters of multitasking and many spend part of their working week fulfilling supplementary duties. As all UK medical students will have a GP placement, there are vast opportunities for involvement in medical education. Research into primary care is also an ever-growing field. With reports that 90% of all NHS contact occur in general practice, (3) the discipline offers great scope for contributing to research that will improve patient care on a massive scale. There are also opportunities to sit on commissioning boards, helping to decide how we allocate our limited NHS funds and influencing national policies. Furthermore, there are plenty of opportunities for out of hours work and dealing with acute medical issues within the emergency services, for example, as an ambulance doctor. General practice also offers greater autonomy over how, where and when you work compared to other specialities. Whereas there might be only one training post for paediatric cardiac surgery in one part of the country, GP recruitment occurs throughout the UK. Considering this wealth of opportunity, general practice, to me, appears far from an 'easy route' towards a dead end, but rather a springboard into a fulfilling, diverse and stimulating career of my own shaping.

Undeniably, there are tough times ahead for all medical professionals, but I am proud to be pursuing a career in general practice and I encourage all medical students to give it some serious thought. Irrespective of whether general practice is the right option for you or not, it is essential that we maintain our professionalism and refuse to buy into myths about one field being superior to another. It is imperative that we enable one another to feel confident in our career choices and empowered to base them on what, ultimately, works best for us as individuals. In essence, we must respect and support our colleagues, no matter what speciality they choose to train in.

REFERENCES

1. Rimmer A. A third of GP training posts are vacant after first recruitment round. *BMJ Careers*. 2015 [accessed 30 Nov 2016]. Available from: http://careers.bmj.com/careers/advice/A_third_of_GP_training_posts_are_vacant_after_first_recruitment_round.
2. Health Education England and The Medical Schools Council. By choice - not by chance. 2016 [accessed 30 Nov 2016]. Available from: <https://www.hee.nhs.uk/sites/default/files/documents/By%20choice%20not%20by%20chance%20web%20FINAL.pdf>.
3. Irish B, Purvis M. Not just another primary care workforce crisis. *British Journal of General Practice*. 2012;62(597):178-9.
<https://doi.org/10.3399/bjgp12X635985>
PMid:22520894 PMCID:PMC3310012

Valley Fever in the UK? The importance of a travel history

EDUCATION

AUTHOR

Laura J. Cunliffe

Hull York Medical School

Dr Ian Renwick

MBBS, FRCR

Consultant Radiologist

Scarborough General Hospital

Address for correspondence

Laura Cunliffe

Hull York Medical School

John Hughlings Jackson Building

University of York

Heslington, York, YO10 5DD

Email: hyljc@hyms.ac.uk

No conflicts of interest to declare

Special thanks to

Dr Craig Bratten

Consultant Histopathologist

York District Hospital

ABSTRACT

Summary

Coccidioidomycosis, also known as Valley Fever, is a fungal infection caused by the inhalation of spores, and is endemic in the Southwestern United States, regions of Mexico, Central America and South America. (1) It therefore came as a surprise to isolate this infection from a patient in a seaside town in North Yorkshire, UK. Coccidioidomycosis is caused by either *Coccidioides immitis* or *Coccidioides posadasii*, and once inhaled they are highly infectious, and can cause a wide variation in clinical manifestation and imaging findings. (1) Most infections primarily involve the lungs, and are self-limiting and resolve over a period of weeks to months. (1) Occasionally the infection can spread to cause a very serious disseminated disease. The radiographic findings can be nonspecific and variable, often raising concern for many differential diagnoses such as malignancy, other infections or granulomatous conditions. (1, 3)

Relevance

This was an interesting case of a female patient in the UK presenting with nonspecific respiratory symptoms, and eventually being diagnosed with a fungal infection typically found in the Southwestern United States.

Take Home Messages

It highlights the importance of enquiring about a travel history, and conducting appropriate imaging, even when the initial picture points towards a less exotic, more sinister diagnosis.

INTRODUCTION

Coccidioidomycosis, also known as Valley Fever, is a fungal infection caused by either *Coccidioides immitis* or *Coccidioides posadasii*, which are dimorphic fungi found in the soil in endemic areas; commonly the San Joaquin Valley in California, USA, Southwest USA and Northern Mexico, but increasingly commonly found in non-endemic areas, as in this case. (1,2,4,5,6) The hyphal form of the organism proliferates in the soil as a mycelium during the rainy season and dies in the dry period. (3) The highly infectious spores, called anthroconidia, are released into the air when the soil is disturbed by agricultural work, landscaping or windy conditions. (1) Once in the air these spores can be inhaled, and are so infectious that one spore is enough to cause clinical infection. (6) Once inside the airway, they swell to produce spherules that rupture to release endospores, which perpetuate infection and inflammation with the lungs being the primary site of infection in 95% of cases. (1,7) Clinical manifestations include a flu-like illness with fatigue, cough, fever, headache, shortness of breath, night sweats, myalgia and arthralgia. Misdiagnosis is common; therefore awareness should be increased to allow for inclusion in the differential diagnosis. For immunosuppressed patients, the disease can be more serious, ranging from the above mentioned Primary Pulmonary Coccidioidomycosis to Chronic Coccidioidomycosis (which develops months to years after contracting the initial disease and can lead to lung scarring) or disseminated Coccidioidomycosis. (1,2,7)

CASE REPORT

A 54 year old lady with no significant past medical history presented to Accident and Emergency with a one week history of feeling generally unwell and lethargic, with 3kg weight loss and diarrhoea. This was accompanied by a two day history of shortness of breath, fever, petechial rash on fingers, and swelling and tingling of the lips. The chest X-ray showed a 3cm diameter rounded soft tissue lesion in the right mid-zone with some faint consolidation and no hilar or mediastinal lymphadenopathy (Fig 1). This was thought to be a round pneumonia, but a tumour could not be excluded. A CT of her chest and abdomen with contrast showed a 2.7cm diameter solid spiculated lesion in the apex of the right lower lobe, against the oblique fissure, with no air bronchogram through it (Fig 2). There was some ground glass shadowing elsewhere in the lower lobe, and a subcentimeter node in the right hilum, along with some minor lymphadenopathy in the mediastinum, all <1cm. Simple liver cysts were noted but no evidence of metastatic disease. Appearances were therefore suggestive of a primary bronchial malignancy. A referral to the respiratory physicians for consideration of a PET, CT and biopsy was suggested. In a roundabout way, it came to the knowledge of the reporting consultant radiologist that this lady had recently been to the Southwestern United States, and had spent some time underground in caves. Consequently, an

addendum was added to the report to suggest that histoplasmosis should be included in the differential. The working diagnoses were now; primary malignancy, histoplasmosis, fungal infection, tuberculosis or another granulomatous process. A CT guided biopsy and bronchoscopy were completed and the specimens were sent for histological and microbiological opinion. Lung biopsy showed spherules containing endospores, suggestive of a diagnosis of Coccidioidomycosis (Fig 3). After discussion with the Tropical Disease specialists, she was commenced on 400mg fluconazole daily for six months. Two months later she had almost completely recovered with only some residual fatigue. Follow up chest X-ray at eight weeks showed considerable improvement, with only a small amount of residual shadowing, with no effusions or hilar/paratracheal lymphadenopathy. Follow-up at 2 months revealed that the patient was almost completely recovered.

DISCUSSION

In endemic areas Coccidioidomycosis causes 15–30% of community acquired pneumonia, and there are vast differences in the appearances on imaging. (8) The most common finding on chest X-ray is a dense homogenous consolidation, occurring in 75% of cases, and can be solitary or multiple areas, suggesting a diagnosis of bacterial pneumonia. (1) Ground glass appearances are common, along with nodular lesions and mediastinal/hilar lymphadenopathy in 20% of cases, again as seen in this case, suggestive of metastatic disease. (1,3) Other findings can include cavities, which in the acute form can look like *Mycobacterium tuberculosis* infection. (3) Pleural effusions are seen in 15–20% of cases, whereas no abnormalities can be found in 20% of other infected individuals. (1,2) Other differential diagnoses to be considered include lung abscesses, lymphoma or a rheumatological condition. (9) CT findings are just as varied, including subtle opacities, lymphadenopathy, and discrete lesions. (1) Common findings include intralobular septal thickening, cavitation, ill-defined nodules and endotracheal or endobronchial Coccidioidal granulomas. (1,5,7,10) CT can also show pericardial disease, pneumatoceles, hydropneumothorax, bronchiectasis and granulomas. (3) MRI images are more useful when assessing the extent of bone, joint and soft tissue involvement in disseminated disease, mainly demonstrating high marrow signal intensity. (3) Other modalities include radioisotope bone scanning and PET-CT scans to indicate bone involvement and active fungal invasion respectively in disseminated disease. (11)

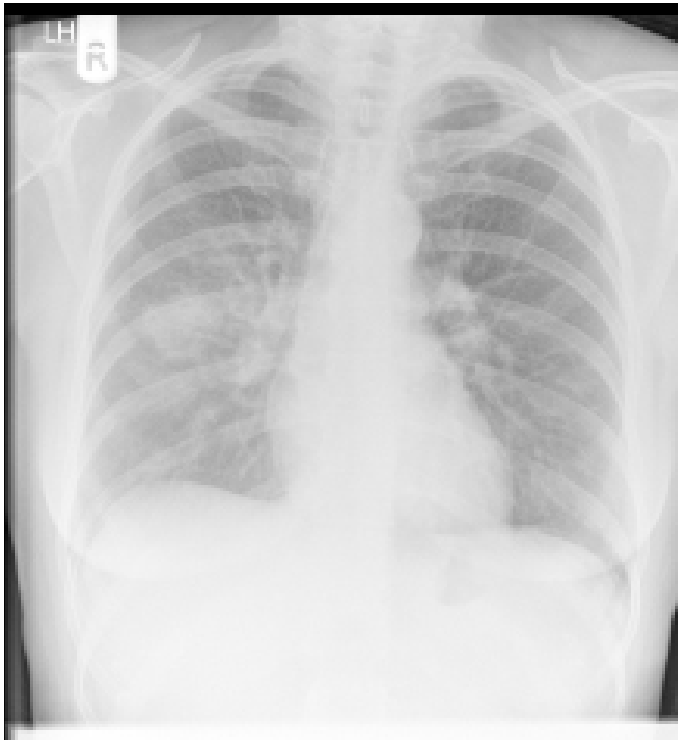


Figure 1
*PA Erect Chest X-Ray, showing
right sided round consolidation*

Figure 2
*CT Thorax, showing spiculated
lesion in right mid-zone*

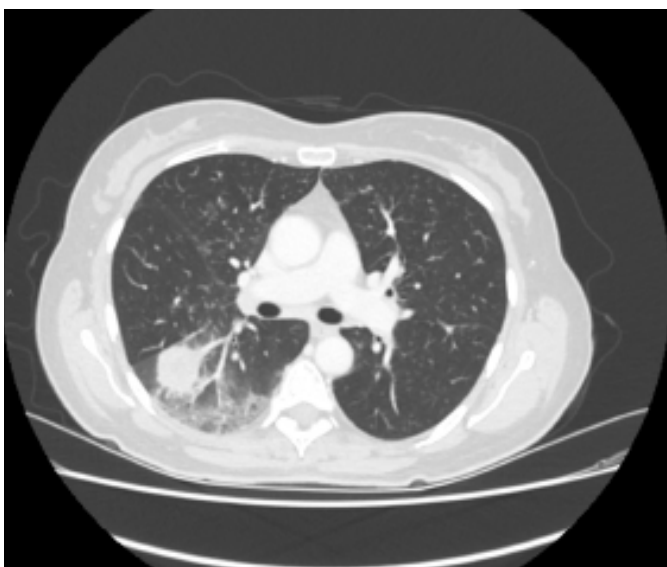
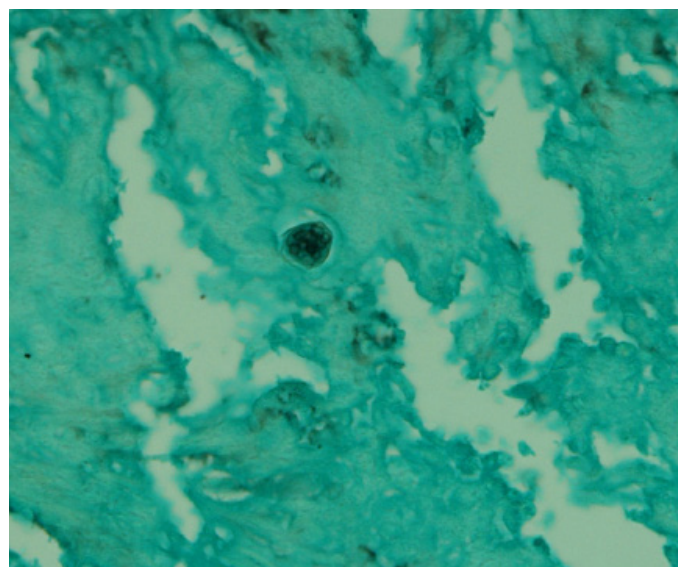


Figure 3
*Grocott Stain 40X, showing
Spherule containing endospores*



CONCLUSION

Coccidioidomycosis infection is very common in endemic areas, but not commonly seen in the UK. However, with the increase in travel, immunocompromise and the use of immunosuppressants, it is becoming more frequently seen in non-endemic areas, including other countries. (1) Therefore familiarity with the imaging characteristics, along with a comprehensive travel history is necessary to be able to consider such exotic diagnoses, obtain biopsies, and initiate appropriate treatment. It is also vital to remember that many tropical diseases can mimic malignancies both on imaging and clinically; thus the importance of rapid biopsy and treatment is essential to avoid delay and subsequent deterioration.

REFERENCES:

- Jude CM, Nayak NB, Patel MK, Deshmukh M, Batra P. Pulmonary coccidioidomycosis: Pictorial review of chest radiographic and CT findings. *RSNA RadioGraphics*. 2014;34(4) [accessed 7 Nov 2016]. Available from: <http://pubs.rsna.org/doi/ref/10.1148/rg.344130134>
- Musil IL, Gilbertson-Dahdal D, Elliott SP. Disseminated coccidioidomycosis in an immunodeficient 16 year old female. *Radiology Case Reports*. 2008; 3(4) [accessed 7 Nov 2016]. Available from: https://www.researchgate.net/publication/244937509_Disseminated_Coccidioidomycosis_in_an_Immunodeficient_16YearOld_Female
<https://doi.org/10.2484/rcr.v3i4.237>
PMid:27303563 PMCID:PMC4897600
- Sharma S, Maycher B. Coccidioidomycosis Imaging. *MedScape*. [accessed 7 Nov 2016]. Available from: <http://emedicine.medscape.com/article/2137779-overview>
- Gupta NA, Iv M, Pandit RP, Patel MR. Imaging manifestations of primary and disseminated coccidioidomycosis. *Applied Radiology. The Journal Of Practical Medical Imaging Management*. 2015 [accessed 7 Nov 2016]. Available from: <http://appliedradiology.com/articles/imaging-manifestations-of-primary-and-disseminated-coccidioidomycosis>
- Centre for disease control and prevention. Valley Fever Awareness CDC features. 2016 [accessed 7 Nov 2016]. Available from: <http://www.cdc.gov/features/valleyfever/>
- Hospenthal DR, Arsura EL, Oppenheimer AP, Thompson GR. Coccidioidomycosis. *MedScape*. 2016 [accessed 13 Nov 2016]. Available from: <http://emedicine.medscape.com/article/215978-overview>
- Skalski M, Weerakkody Y. Pulmonary Coccidioidomycosis. *Radiopaedia.org*. [accessed 7 Nov 2016]. Available from: <https://radiopaedia.org/articles/pulmonary-coccidioidomycosis>
- Centre for disease control and prevention. Valley Fever (Coccidioidomycosis) statistics. *CDC fungal disease*. [accessed 4 Jan 2016]. Available from: <http://www.cdc.gov/fungal/diseases/coccidioidomycosis/statistics.html>
- Hospenthal DR, Arsura EL, Oppenheimer AP, Thompson GR, Bronze BE. Coccidioidomycosis differential diagnoses. *MedScape*. 2016 [accessed 13 Nov 2016]. Available from: <http://emedicine.medscape.com/article/215978-differential>
- Capone D, Marchiori E, Wanke B, Dantas K, Cavalcanti MAS, Filho AD, Esucissato DL, Warszawiak D. Acute pulmonary coccidioidomycosis: CT findings on 15 patients. *The British Institute of Radiology*. 2008; 81(969) [accessed 7 Nov 2016]. Available from: <http://www.birpublications.org/toc/bjr/81/969>
- Hot A, Maunoury C, Poiree S, Lanternier F, Viard JP, Loulergue P, Coignard H, Bournoux ME, Suarez F, Rubio MT, Dupont B, Lecuit M, Faraggi M, Lortholary O. Diagnostic contribution of positron emission tomography with fluorodeoxyglucose for invasive fungal infections *Clinical microbiology and infection*. 2011;17(3) [accessed 7 Nov 2016]. Available from: <http://www.sciencedirect.com/science/article/pii/S1198743X14638775>
<https://doi.org/10.1111/j.1469-0691.2010.03301.x>
PMid:20636432

Ode to an ulcer

EDUCATION

AUTHOR

Ffion James

Finance and Advertising Manager
The British Student Doctor
School of Medicine
Cardiff University

Address for Correspondence:

Ffion James
School of Medicine
Cardiff University
Heath Park, Cardiff, CF14 4XN

Email: jamesfs@cardiff.ac.uk

Conflicts of interest: Ffion is the Finance & Advertising Manager of The British Student Doctor. As a result, the decision to publish this work was taken by a member of the journal's faculty board.

ABSTRACT

Summary

This poem highlights the different clinical presentations, investigations and management of arterial and venous ulcers.

Relevance

Ulcers are a very common condition seen across primary and secondary care with serious health implications for the patient. They are a common exam and OSCE question and are frequently seen on placement.

Take Home Messages

Using creative ways to learn about different medical conditions makes revision a little more bearable, and may help it stick in your memory for longer than just exam time!

Oh ulcer, ulcer, festering there,
Tell me what you are, be fair.
My student, look closer, come, less haste.
For the answer is staring you in the face.

Venous problems are the main cause,
with arterial and diabetic being less common flaws.
Your patient must be committed for the long haul,
For management options vary for all.

Venous drainage issues started the doom:
Blood got lazy, sat there and pooled.
It seeped out of the vessels and dirtied the skin,
Right and left legs are no longer twins.

Where on the leg is the cause of distress?
The inside ankle, it's not looking its best.
It's swollen and puffy, red white or blue.
One thing's for certain – it's not good for you.

If your ulcer has been there a while,
You may have noticed it has developed a style,
It's harder, it's darker, and it's fatter and red
With a leg like a champagne bottle turned on its head.

If your ulcer is painful and hurts when you walk,
Then we need to digress from this venous talk.
You're not helping your feet if you like a smoke,
Got diabetes mellitus or had a stroke.

The top of your foot is the scene of the crime,
A punched out appearance, with a long cap refill time.
If you're unlucky, your pulses are lacking
And bits of your foot may be slowly blacking.

What can we do about this terrible sight?
Before we treat, we need to get the diagnosis right.
We need confirmation of a leg blood supply,
Otherwise your foot may be saying bye-bye.

How do we accomplish such an important task?
A simple procedure, don't worry, relax.
Blood pressure is measured in your arm and your leg,
All you do is lie on the bed.

Depending on the score you achieve,
We'll give you the best treatment that you can receive,
Venous ulcers need a compression bandage
To prevent worsening of the leg damage.

Wrap them tighter at the bottom than the top,
You'll force fluid into vessels, preventing them go pop.
Cleaning your wound and preventing infection,
Will try and regain a bit of perfection.

Another thing that you need to know,
Is that the bandages are bulky and may make you slow.
When they're on, it's a struggle to shower,
But please persist; you've got the willpower.

Arterial ulcers, we haven't forgotten about you!
You've been put into a different queue.
Vascular surgery is your ultimate quest,
To clear out your blood vessels, they know what is best.

Whilst you're waiting to go under the knife,
Pain management will improve your quality of life.
Cleaning your wound and preventing infection,
Will give you an added bit of protection.

Improving the leg supply through an operation
Which enables wound healing, may sometimes be your only
option.
Control of your weight, and stop smoking you're told,
Otherwise your foot will be covered in mould.

Greater care of your feet and toes must be taken,
Otherwise your foot will be forsaken.
Good footwear, exercise and examining the feet,
Will get you back walking on the street.

Don't worry if this is too much to take away,
Nurses are with you every step of the way.
Advice and tips to make you succeed,
Their guidance and expertise is guaranteed.

Psychological phenotypes associated with the rare skin disease X-Linked Ichthyosis

REFLECTIONS

AUTHOR

Sohini Chatterjee

School of Medicine
Cardiff University

Address for Correspondence:

Sohini Chatterjee
Cardiff University School of
Medicine, The Cochrane Building
Heath Park, Cardiff, CF14 4YU

Email: chatterjees@cardiff.ac.uk

No conflicts of interest to declare

In my intercalation year, I undertook a project looking at behavioural and psychological symptoms in a very specific group of patients affected by the rare skin condition X-linked Ichthyosis (XLI), caused by deficiency of the enzyme steroid sulfatase (STS). (1) The project was based upon previous, limited, research showing that STS plays a role in both skin and brain function, and that its deficiency can cause behavioural abnormalities. Prior to this study, evidence had only been collected from boys with XLI and animal studies. (1) I aimed to comprehensively characterise the behavioural profile for both adults and children with XLI, with the main hypothesis being that they would exhibit higher rates of symptoms related to Attention Deficit Hyperactivity Disorder (ADHD) and autism-related conditions than controls.

As XLI is a rare disease (with a prevalence rate of 1 in 3000–6000 males, (1) I undertook worldwide recruitment and testing of participants by means of an online survey. The survey link was circulated through XLI support groups and dermatological charities, taking advantage of the recent boom in using social media, such as Facebook and Twitter to obtain clinically-relevant information. We obtained ethical approval for the project through the School of Psychology, Cardiff University Ethics Committee. The study highlighted to me how even a rare, relatively inaccessible, group of patients from around the world can be recruited for a study and questioned relatively easily. (2) Overall, patients seemed keen to engage in the survey, although one of the caveats of such recruitment was response bias. Behavioural issues are not inevitable in XLI patients, but it is likely that those responding to this survey are the most affected, or over-concerned parents who may exaggerate their child's symptoms, emphasising the behavioural

issues. However, the rates of ADHD diagnosis we found were comparable with those previously seen in a sample of boys with XLI, who were ascertained based on hormonal levels and not behaviour; hence there is probably not a large response bias issue. There were also some concerns raised by affected individuals and those running support groups regarding the purpose and clinical utility of the study. Some had suspicions that this was a 'Big Pharma study' run by a pharmaceutical company for profitable intentions, which emphasised to me some of the views that the general population may harbour about online research surveys. To overcome this degree of mistrust, we explained some of the benefits of the study e.g. should the study highlight an increased prevalence of behavioural disorder traits in individuals with XLI, this may facilitate cross-speciality referrals from dermatologists and GPs (who typically diagnose XLI). Additionally, this may improve genetic counselling for the condition. With technological progress, recruiting participants internationally through online surveys will only become more prevalent, so it is our responsibility as researchers and students to make the public aware of the purpose of such research and remove any scepticism.

Our results showed that there was a substantially higher risk of neurodevelopmental disorders (particularly ADHD and autism related conditions) and associated symptoms in boys with XLI relative to unaffected controls (consistent with previous data). There is also a higher risk of both neurodevelopmental and mood disorders and associated symptoms in adults with XLI compared to unaffected controls. (3) These findings suggest that individuals with XLI are at heightened risk of psychopathology, and support the concept that the enzyme STS plays a key role in normal brain function. (3) Therefore, affected individuals may need to be referred to a multidisciplinary team including psychologists and psychiatrists, and for genetic counselling.

Importantly, our findings emphasise that there may be non-intuitive links between conditions or specialities. Many genes and proteins, including STS, act within multiple tissues of the body, and their dysfunction can elicit multiple diverse phenotypes, all of which need to be documented and treated.

I presented our results at the Ichthyosis Support Group (ISG) UK family conference, to a non-specialist patient audience consisting mainly of parents and their affected children. I acknowledged that there was a lot of complex terminology and detail involved in this project and its findings, therefore I had to take the time to explain everything clearly to help the lay audience understand the results. It was important to make parents and affected individuals aware of our results, whilst not making them overly-anxious; this was a difficult balance to achieve. We aimed to reassure participants that an XLI

diagnosis was not inevitably associated with behavioural problems, but rather an increased predisposition; we emphasised that our data might allow specific impairing symptoms, such as inattentiveness and extreme hyperactivity, to be recognised early, enabling early diagnosis and treatment.

It was interesting to see many families questioning why there has not been much research on developing potential cures for ichthyotic disorders, particularly given that many are debilitating. This highlighted to me the lack of awareness and funding for rare diseases as well as the importance of support groups and charities such as the ISG in lobbying for, and providing, information and resources. The Ichthyosis Support Group itself provides research grants and is currently funding research into gene therapy for certain ichthyotic disorders. (4)

Of course, whilst I appreciate the importance of allocating limited resources to the most common conditions and those associated with the highest morbidity or mortality, just raising awareness of rare conditions amongst the GP community, specialist clinics and the general population would help greatly with diagnosis and management, and would facilitate the multidisciplinary care of those affected.

REFERENCES

1. Trent S, Davies W. Cognitive, behavioural and psychiatric phenotypes associated with steroid sulfatase deficiency. *World Journal of Translational Medicine*. 2013;2(1):1-12.
<https://doi.org/10.5528/wjtm.v2.i1.1>
2. Davies W. Insights into rare diseases from social media surveys. *Orphanet Journal of Rare Disease*.
<https://doi.org/10.1186/s13023-016-0532-x>
3. Chatterjee S, Humby T, Davies W. behavioural and psychiatric phenotypes in men and boys with x-linked ichthyosis: evidence from a worldwide online survey. *PLoS One*. 2016;11(10):e0164417.
<https://doi.org/10.1371/journal.pone.0164417>
4. Ichthyosis Support Group. Research. 2015 [accessed 18 Dec 2016]. Available from: <http://www.ichthyosis.org.uk/category/research/>

The silent generation: Experiences of older people in hospital

REFLECTIONS

AUTHOR

Caitlin Young

School of Medicine
Cardiff University

Address for Correspondence:

Caitlin Young
School of Medicine
Cardiff University
The Cochrane Building
Heath Park, Cardiff, CF14 4YU

Email: youngc9@cardiff.ac.uk

No conflicts of interest to declare

Our population is ageing and two thirds of those admitted to hospitals are now over 65. (1) The complex medical and social needs of older people place a unique and growing load on healthcare resources. In return, hospital admission can take its own toll on older people, fostering functional decline and development of geriatric syndromes. For older people, hospital stays can be lengthy; I recently came across a patient on their two-hundred-and-twenty-second day in hospital, marooned in a private room with dementia and a femoral fracture. Meeting patients such as this often makes me wonder how older people would describe their experience of hospital. I expect the patient felt lonely – I know I would – though regrettably, I didn't ask.

I recently completed a study into the impact of hospital environment on clinical outcomes for acutely ill older people with dementia, investigating differences in outcomes between those admitted to single rooms and those placed in traditional, multi-bed wards. During this project, I began to question the extent to which hospital environments truly reflect the preferences of older people. In recent years, there has been a shift in NHS hospital design favouring the development of 100% single room wards. This is thought to offer more privacy, dignity, and possibly reduce the incidence of hospital-acquired infections. (2) Whilst these new ward designs are often impressive, fresh, bright and a far cry from their predecessors, their sweeping introduction suggests the potential consequences of inpatient loneliness and social isolation appear not to have been considered.

Many older inpatients are frail and infirm, and with staff fearful of falls, they may spend most of their days in bed. If these patients are in private rooms, the only social interaction they have may well be with

healthcare professionals. A peaceful alternative to traditional wards? Perhaps: if patients can walk easily and unaided to see others, if there is a smartphone at their fingertips, and if they can rely on relatives to visit when they are feeling low. It is not difficult to imagine this becoming a rather lonely experience. Despite this, it may be true that patients in single rooms sleep better, have more dignity, and are free from other potentially disruptive patients. In Scotland, where the government have pledged to build exclusively single-room hospitals, forty-one percent of surveyed adults said they would 'definitely prefer' to stay in a single room. (3) One of the few studies focusing on preferences in older people yielded mixed results over the two different years that data were collected. (4) As such, the preferences of older people, not least those with dementia and cognitive impairment, remain to be more fully explored.

Hospital design must prioritise patient safety and dignity, but what of social interaction? Standing at the foot of the bed of a sleeping, open mouthed and motionless patient with dementia, it is easy to conclude that they are incapable of conversation. They may also be frail, infirm, and suffer from hearing and visual impairment. Spending time in geriatric medicine, I have recognised my own tendency to draw such conclusions; ones that have repeatedly been proven wrong. It has been humbling to observe how talkative and animated some older people, both with and without dementia, can be despite the upheaval of acute admission and the tiresome monotony of lengthy hospitalisation. Older people might repeat themselves, those with dementia might do so even more, but conversation brings mental stimulation. I believe that this is vitally important for older people in hospital. I fear that by introducing 100% single room hospitals we risk minimising patient choice, especially for older people, for whom having a little company may be a priority.

I was recently challenged for suggesting that single rooms could be lonely for older people with dementia. The surgeon in question suggested that I only thought that because I might feel that way, and questioned whether those with dementia can really feel loneliness at all. I don't doubt for one second that people with dementia can and do feel lonely frequently in UK hospitals. I believe it is time that we start to ask older people, those of the rather aptly named "Silent Generation", these important questions.

Hospitals should cater for everyone and every generation. We are likely to see more older people in hospital, some of whom will stay for a long time. Therefore, if their preferences differ from those of policy-makers, we really ought to know.

REFERENCES

1. The Royal College of Psychiatrists. Improving the outcome for older people admitted to the general hospital: Guidelines for the development of Liaison Mental Health Services for older people. 2005. Available from: <http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf>
2. Pennington H, Isles C. Should hospitals provide all patients with single rooms? *BMJ*. 2013;347. Available from: <http://www.bmj.com/content/347/bmj.f5695>
<https://doi.org/10.1136/bmj.f5695>
3. Scottish Government. Single room provision steering group report. 2008. Available from: www.scotland.gov.uk/Resource/Doc/253500/0075129.pdf
4. Reid J, Wilson K, Anderson K, Maguire C. Older inpatients' room preference: single versus shared accommodation. *Age & Ageing*. 2015;44(2),331-33.
<https://doi.org/10.1093/ageing/afu158>
PMid:25349152

Watchful waiting

REFLECTIONS

Caitlin L. Bass
School of Medicine
Saba University

Address for Correspondence:

Dr Caitlin L. Bass
16727 NE 83rd Place, Hawthorne,
Florida, 32640 USA

Email: cbass2688@gmail.com

No conflicts of interest to declare

His name on my patient census that morning was John Doe. The admitting note said he was found unresponsive in a bodega. The paramedics said they had been called by the bodega's manager. The manager found Mr. Doe alone and unresponsive on the floor by the milk. No one in the bodega knew how long he had been there or what had happened to him. The paramedics said his vitals were stable during the ride to the emergency department, but beyond that, they had nothing.

By the time he arrived in the emergency room (ER) he was alert, but no one in the ER could get him to say anything. The nurses tried questioning him in English and Spanish, but he wouldn't give them anything, not even a name. They searched for clues on his person, but he had nothing in his pockets, except for some completely ordinary keys.

He was a small man, wiry, and well-kept. He looked to be older, dad or grand-dad aged, but his age was hard to pinpoint. He was nondescript. He could have been anyone.

We went through his bag of personal effects to try to find some identification, though why we thought we'd be able to when neither the paramedics, police, nor ER staff had been able to, I don't know. His clothes were clean— a pair of well-worn jeans, an old leather belt, a faded button down shirt, and a pair of sturdy leather shoes. He seemed well taken care of and I felt sure that there must be people missing him.

Mr. Doe was a mystery. Not only did we have no idea who he was, we also had no idea what had happened to him.

By the time I saw him, the morning after his admission, no one had

been able to find anything medically wrong with him, except his continued inability or refusal to answer questions. His vital signs remained stable. He had no drugs in his system. His labs were perfect. The radiologist reported his brain scan showed a completely normal and perfectly healthy-looking brain.

When I asked Mr. Doe basic questions like “What’s your name?” “Do you know where you are?” “What happened?” he would answer me in nonsensical Spanish.

In order to do something, anything, we decided to search through his belongings again. Again, we only found keys.

Why would he go to the bodega without his wallet? Maybe, we thought, he was confused when he left home... Maybe he had some sort of underlying dementia? Maybe he had wandered off from where he belonged? Maybe someone was searching for him?

All we had were a bunch of maybes and some nonsensical mumblings. He kept mentioning “m’ija,” which means “my daughter” in Spanish. However, we couldn’t get him to tell us his daughter’s name- we couldn’t get him to tell us anything useful at all.

He looked so incredibly frustrated and scared and helpless. We were feeling all those things too. It’s not often in a hospital that the entire team- attending, residents*, medical students, everyone- feels quite as lost as we did that day.

As clinicians, we’ve spent years training, learning how to fix, to remedy, to prescribe, and to work through complex problems to find solutions. With Mr. Doe’s case I felt like my training hadn’t prepared me quite enough. We didn’t know what to do, so we did the only things we could: watch and wait.

The hospital neurologist happened by as we were discussing Mr. Doe’s case one more time. We briefed him on what was happening. He did his own thorough exam and attempted to speak with Mr. Doe. He stepped back and looked at us as though we had missed something obvious and said “He is aphasic. He’s had a stroke.” We quickly agreed in regards to the aphasia, but told him that the radiologist stated that the brain scan was normal. He replied “We must read it for ourselves.”

As we crowded around to look at the scan over the neurologist’s shoulder it became apparent he was correct. There was a subtle defect in the temporal region of Mr. Doe’s brain. Mr. Doe had a stroke, and a recent one at that.

The neurologist explained that the way Mr. Doe was speaking was a classic presentation of Wernicke’s Aphasia. For a moment, our entire team was elated. We had a diagnosis! Now there was something for us to do!

Except, there wasn’t anything for us to do. All we could do was continue to watch and wait. I was horrified. I couldn’t

wrap my head around the fact that we couldn’t help him. It was unacceptable to me that we couldn’t “fix” this situation. This poor man was basically locked in his own brain and we weren’t going to do anything. There was nothing for us to do. Time was his only hope.

Mr. Doe helped me realize that there are some mysteries in medicine that we’re not going to be able to solve. Even the best medicine can’t always provide us or our patients with the answers we so desperately want. There are going to be those patients we can’t fix. Sometimes the only thing we can do is *watch and wait*. Our impulse is to help, to heal, to do something- anything- all the time. But I think it’s important for us to be able to recognize and gracefully accept those situations where watchful waiting is the most appropriate plan. We can’t fix everything; sometimes the best course of action is no action at all.

It took days, but in Mr. Doe’s case, the watching and waiting paid off. We all got our answers. The local police discovered his identity; he wasn’t Mr. Doe anymore- he had a real name and a family. His “m’ija” had been looking for him and was relieved to know he was safe. Eventually, he was even able to answer questions and speak meaningfully.

He was a mystery that solved itself with a little time.

Ethical Statement

This work is a piece of creative writing inspired by several real patient encounters. No patient identifiable information is contained within this work, and the personal details given represent a fictional person.

**The use of the term "attending" here refers to the equivalent of a UK consultant, whilst "residents" refers to junior doctors.*

The British Student Doctor Journal



To discuss an article published in this issue, please contact:

editorinchief@thesdj.org.uk

The British Student Doctor
Cardiff University Press
PO Box 430
1st Floor, 30-36 Newport Road
Cardiff, CF24 0DE
United Kingdom

bsdj.org.uk



/thebsdj



@thebsdj



@thebsdj

To submit an article for publication in **The British Student Doctor**, please visit: bsdj.org.uk/author-guidelines

EDITORS-IN-CHIEF

James M. Kilgour and Shivali Fulchand

FACULTY ADVISORY BOARD CARDIFF UNIVERSITY

Professor John Bligh (Honorary Editor)
Former Dean of Medicine

Julie Brown
Senior Lecturer in Academic Practice

Dr Steve Riley
Dean of Medical Education

Dr Debbie Cohen OBE
Senior Medical Research Fellow

Dr John Ingram
Senior Lecturer and Consultant Dermatologist

EDITORIAL AND MANAGEMENT TEAM

Original Research Section Editors

Eleni Panagoulas

Rachel Cichosz

Pakinee Pooprasert

Discussion Starters Section Editors

David Evans

Owen Meurig Jones

Education Section Editors

Shafqat Batchelor

Susruta Manivannan

Reflections Section Editors

Thomas Coope

Stephanie Wentzel

Correspondence Section Editors

Vidhi Unadkat

Oliver Denton

Design Editors

Nor Farzana Abdul Aziz

Anthony Wijaya

Finance and Advertising Manager

Ffion James

Social Media and Marketing Manager

Angelica Sharma

SDJ