Lothian Colorectal Unit Year 6 teaching

Western General Hospital, Edinburgh

Year 6: Preparation for Professional Practice

> "He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all"
> (Osler)

You will receive a timetable of clinical sessions during your 2-week attachment. However, it is not infallible and you must be prepared to seek out another opportunity for clinical experience if a particular session is cancelled. Peripheral hospitals (Roodlands in Haddington, St Johns in Livingston) will have fewer students than RIE and WGH, so can provide excellent learning opportunities, usually directly from a consultant.

Ward rounds

The surgical working day starts at 8am. 'Green' and 'blue' team ward rounds usually begin from the doctors' room on Ward 24. The emergency team is based in ward 57. It is important to note that these are busy working ward rounds and direct student teaching is rarely possible. However, that does not mean there is nothing to learn. You should participate in assisting the team in their work: write in the electronic patient record, prescribe fluids, volunteer to collate the results of blood, radiology or other tests from the day before etc (anything documented/prescribed by you needs signed off by a doctor).

Make sure you know why a particular test is being requested, how a particular complication is diagnosed and treated, and how communication takes place both from team to patient and within the team itself.

On one morning of the attachment you should shadow the FY1 on ward 58 (Surgical high dependency unit).

Clinics

Clinics are good for student learning, with lots of pathology gathered into one place at the same time and the opportunity to observe a highly-trained practitioner at work. Key learning points:

- common referral symptoms;
- taking a history and coming to a differential diagnosis;
- abdominal and anorectal examination;
- common anorectal disorders;
- communication including informed consent.

You should try to see and present a new patient, remembering that this is a focused assessment, not an exhaustive clerking.

The outpatient clinics take place on the Lower Ground Floor of the Anne Ferguson Building.

Theatre lists
There are colorectal operating theatre lists at WGH every day. Getting to theatre means being proactive: obtain a copy of the theatre lists for that day (Lynda Imery or any of the secretaries in the unit will be able to produce one), meet the registrar at 7.45 in DOSA (Day of Surgery Admissions unit, Ground Floor Anne Ferguson Building) to see the process of consent, then stick with the registrar so they can let you into the theatre changing room.

Introduce yourself to the theatre team, help move and position the patient, volunteer to put in the urinary catheter, scrub in for the case. Ask questions: how did the patient present, how were they diagnosed, what is the important anatomy etc

On 3 out of 4 Fridays there is a joint gynae-oncology/colorectal laparotomy for advanced pelvic malignancy in Theatre E.

The main theatre complex (Theatres A-E) is on the 2nd Floor of the Anne Ferguson Building. Theatre H (day surgery) is on the ground floor Anne Ferguson Building and is a good place to see common anorectal disorders/surgery.

Colonoscopy
The endoscopy unit is on the ground floor of the Anne Ferguson Building. Endoscopy lists take place every day. These are opportunities to observe, question (and be questioned by) a senior doctor on the pros and cons of the investigation, management of polyps, bowel cancer screening etc.

Colorectal Surgery attachment: emergency team
The colorectal emergency admissions unit is located in Ward 57 (2nd Floor Anne Ferguson Building, WGH). Each day starts with a consultant ward round at 8 am. Also on the team are 2 FY1s, an FY2/ST trainee referred to above, and a registrar. It is a 24/7 service. Emergency admissions come via the Surgical Assessment Unit after urgent referral from primary care or transfer from RIE. This a great environment for getting experience and students should spend as much time as possible seeing new patients and shadowing/assisting the admitting doctors/specialist nurses in SAU.

Students should participate actively in ward rounds to assist FY1s. The emergency team FY1s are very busy and there will be ample opportunity to perform practical procedures such as venepuncture and venous cannulation.

The nature of colorectal emergency admissions means that a relatively high proportion need surgery. Each student should shadow the duty registrar for a part of the attachment and scrub in for an emergency case.
We will try to cover all tutorials but there will be times when we are short staffed and these may be rescheduled or cancelled at short notice.

Teaching
Colorectal tutorials: Tuesday 11.30-12.30 and Thursday 11.30-12.30.
These will focus on discussion of common clinical presentations in colorectal surgery: acute abdomen, lower GI bleeding, altered bowel habit, GI obstruction etc. A working knowledge of common colorectal diseases is advisable (colorectal cancer, diverticular disease, perianal disorders, the acute abdomen).
Bedside teaching will take place on Friday morning 11.30-12.30.

Case-presentations: Friday 2-3pm
Attended by year 4 and year 6 students.
Year 6 students will present cases (4-5 per session) in 4 slides (symptoms + relevant PMH/SH; findings on examination; investigation results; management) as a vehicle for discussion of some of the following conditions/presenting complaints:

Anaemia
Altered bowel habit
Abdominal mass
Perianal symptoms
Bowel obstruction
Abdominal pain
Rectal cancer
Inflammatory bowel disease
Palliative surgery
Stoma
Rectal bleeding
Complications of surgery

Ideally you should present a short case study of a patient you have seen. This works much better if you have followed the patient's journey. This is an ideal opportunity to summarise cases and refine your presentation skills and obtain feedback for a Clinical Observation upload (PebblePocket) . You can ask members of the surgical team to assist you in using screenshots of scans for your talk but **neither images nor slides should contain patient sensitive information (CHI numbers; DOB, name, address etc).** *Students should liaise to avoid repetition of the same topics from the above list.*

Simulation session
These will focus on managing clinical scenarios (post-operative haemorrhage, sepsis, respiratory failure etc).
Location: Clinical Skills unit, WGH
Abbi Jenkins (Year 6 coordinator) will liaise directly with dates/times

Intensive care tutorials
Given by Dr Stuart McLellan, Consultant Intensivist, WGH
Dates: Usually Wednesday afternoon fortnightly, dates/times to be confirmed
Location: Ward 23 Seminar room

Radiology
Imaging is a key component of modern surgical practice and students should try to become familiar with plain and contrast radiography and CT scan interpretation as they spend time on the wards.

Colorectal Surgery Radiology meeting: Mondays at 1pm Radiology seminar room

Radiology tutorial: Wednesdays 11.30am with Dr John Taylor (meet in Ward 57 doctors' room). *This is an interactive session, and students are expected to identify suitable inpatient cases for discussion.*

Each morning there is an interventional radiology session which students are encouraged to attend (maximum 2 students per session). Year 6 students are also welcome at radiology trainee teaching on Friday 8.30-9.30am

MDTs
Colorectal cancer MDT 8-9.30am Oncology Seminar room
Inflammatory bowel disease MDT 1.30-2.30pm Pathology Seminar room

Feedback/assessment
Please upload completed logbooks to PebblePad for review and sign-off. We will also request feedback from you- please fill in a form.

The following are considered "must see" for all students during their colorectal EMERGENCY team attachment.

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1) Observe at least one **emergency laparotomy**
2) Patient assessment /management of at least **one acute abdomen**
3) Patient assessment /management of one **bowel obstruction**
4) Assessment /management of patient with **lower GI bleeding**
5) Involvement in management of one patient in the first 3-5 days following laparotomy
6) Assessment /management of patient with **appendicitis**

The following are considered "must see" for all students during their colorectal ELECTIVE team attachment.

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1) Observe at least one **colonoscopy** session
2) See and present a new outpatient referral
3) Assist in theatre at an elective colorectal cancer resection
4) Involvement in management of one patient following laparoscopic or open colectomy using ERAS principles
5) Recognise and discuss management of different types of stoma