European Option Report: Morgenfrühe im Krankenhaus

I clearly recall the meeting held in first year for students thinking about applying to the European Option- a whole PowerPoint slide was devoted to why we should apply, yet the only one really that stuck with me was a study which quoted how those who learnt a foreign language could delay the onset of Alzheimer's disease by up to 15 years. So I suppose it was fear that drove me to study with European Option. In actual fact, I remember at the time having cold feet about applying, worried my German wasn't up to scratch having only studied it to AS level. It was my linguist flatmate Emma who convinced me in the end to at least apply, and I'm so grateful she gave me that little push I needed.

Travelling Asia during my gap year, I noticed how easy English speakers have it. Something about that made me want to pursue learning a foreign language. Moreover, I'm almost certain that following my time here in Germany, I will pick up my Year 9 French and see where that takes me. Spanish is apparently similar to French, and then there's Portuguese…

Having thoroughly enjoyed a Student Selected Component in Berlin in third year, it was a simple decision as to where to complete my fifth year placement. As it happened, a friend of mine was moving out to Berlin for work, so we attempted to be nice and organised and arrange our accommodation beforehand. Sadly we fell into the hands of a fraudster, which meant not finding a permanent address for a few weeks. Luckily, through our own stupidity, we didn't lose a single dime throughout the entire ordeal. On reflection I now feel much more aware of fraud and hope I don't fall victim to it again.

Eventually we found a hostel which was taking guests on a long-term basis until it was properly up and running, which was a fantastic experience. We were able to get along easily with our landlord, which led to us socialising outside of the hostel. This gave us a wider view of what residents of Berlin got up to.

I was fortunate enough to achieve all of the placements in Berlin which I had asked for. The first of these was neurosurgery, which I had opted for having had no prior experience of this specialty. It wasn't until I started that I realised how far people had travelled to see what happened at Professor Vajkoczy's neurosurgical unit: doctors and trainees from Japan, Peru and Brazil joined me and many others as part of the team.

My induction to the unit comprised being led next door to the MDT room which hosted both morning and evening neurosurgical meetings. It was following this meeting, after all of the doctors had filed out where I was taken under the wing of a student in his final year working on the ward, who had taken it upon himself to orientate those just starting. For this I was eternally grateful, as with no timetable of how the neurosurgical unit operated and with my German not quite back to its pre-finals revision self, I'm sure it would have taken much longer to get the hang of things.

The unit itself was very fast-paced, with morning ward rounds beginning at 0700 (but be there for 0650 to get a patient list printed out). Following this ward round which left little time for the patient to ask questions, there was a ward round on the intensive care unit (Intensivstation) which was equally as rapid. It was on this particular ward round where I once counted upwards of twenty attendees all straining to hear what was being whispered between the team leaders. Needless to say it was important to see what the neurosurgical work-load comprised of.

Following this our duties as ‘Famulanten’ (which might I add was a particularly unfamiliar term to patients) began on the ward. A typical day would comprise blood taking, inserting venous cannulas, and the removal of wound drains following surgery. Removing drains was not a skill I had learnt before, but under careful instruction of the students in final year and the junior doctors, I was able to complete this task independently by the end of the placement.

Besides practical tasks required of students on the ward, there was also the opportunity to go into theatre to observe and partake in operations completed under the neurosurgical team. This I relished, having never witnessed such surgery beforehand. During my time in theatre, I was able to witness removal of brain tumours, insertion of intraventricular shunts as well as deep brain stimulation (DBS) implantation. During my final week I was also fortunate enough to scrub in for a patient having a trans-sphenoidal resection of a pituitary adenoma, which had caused the patient to develop acromegaly. The combination of the classical phenotype plus the fairly straightforward procedure undertaken right in front of me made it an unforgettable case.

Whilst there was always something occurring in theatres, there wasn’t always a new operation which I hadn’t seen before, which led to students having a fair amount of free time on the wards. During this time I took it upon myself to offer some teaching to the younger medical students on the ward.

During one such session I taught a Brazilian student how to take a venous blood sample. I tried to remember how it was for me taking blood for the first time and I remember being quite nervous. The old adage of see one, do one, teach one (although quantitatively now insufficient for training) correctly identifies the learning process when learning a new skill. So I tried to adopt this method in teaching my colleague. I began by taking blood from a patient having asked if my colleague could observe. I explained each of the steps involved as I went, including the crucial first step of vein selection. Following this I got the student to select a vein himself next time around. When he had seen enough to have a go, I explained this to the patient who was more than happy- fortunately the majority of patients in my training have been conscious of the fact that students ‘need to learn somehow’. I was pleased when the student finally managed to collect a sample by himself- I felt that this was the first of many experiences where I would be teaching medical students in my career.

It was during my time on the neurosurgical ward where I realised the differences between the experiences of medical students in the UK and in Germany. In the latter, students spend the majority of the first five years studying, learning the theory behind the medicine. Following this they complete a ‘Praktisches Jahr’, where they spend 4 months at a time working (unpaid) on different wards. The jobs they were busying themselves with seemed very close to what foundation doctors would do in their first year, such as taking bloods and inserting cannulas, ordering investigations and attending ward rounds with the doctors. They were also expected to follow the shifts of the more junior ‘Assistenzärzte’ on the ward, starting at 0700 and finishing when required, sometimes staying until 1900 to make sure everything was complete. Whilst I did not envy the German students, I was fairly sure that such a format would prepare students well for starting work as a doctor. I can liken the ‘Praktisches Jahr’ to my Student Assistantship; though only for four weeks, I gained a real insight into life as a junior doctor, and I suppose this is essentially what the German students do if only for longer.

Overall I found myself needing to be assertive on my neurosurgical placement, which I believe is a requirement of many if not all of the surgical specialties- the more you put in, the more you get out of it. Many of the doctors mentioned this during my time there, which I think helped me to seek out opportunities, including scrubbing in for an operation during my last week, for which I'm grateful.

My second placement was gastroenterology and hepatology, which was a welcome change from the fast-paced neurosurgical department. I was introduced to everyone adequately on my first day, including the consultant of the ward, who provided teaching during his ward rounds.
The placement provided ample opportunity to prepare me for my foundation years. The morning began with blood taking and cannulation, which I was already confident at having done several on neurosurgery. However, the quantity of bloods that needed taking was somewhat different. With roughly fifteen rooms on the ward, most of which containing two beds, there was plenty to keep us busy. Fortunately there were several others students on the ward, including a 'PJler' in her final year, which meant we could get the bloods done within a few hours.
Following bloods, there were ward rounds three times a week, where the consultant would see all of the patients in turn, providing teaching as he went. This was helpful, and contending with students from not only Germany, but Spain and Italy too, I'm pleased to say that I answered at least one question correctly.
After ward round, there was the chance to clerk new patients onto the ward, which involved taking a full history, examining the patient and inserting a venous cannula for both bloods and intravenous access. This was quite a neat little package for students, and once I had learnt all of the relevant terms in the 'Anamnese', I was able to conduct them wholly by myself, which I found very rewarding. Students then had to present the patients to the corresponding doctor for that side of the ward, and then would accompany the doctor in reviewing the patient.
The remainder of the day comprised completing any tasks that arose on the ward as well as 'Fortbildungen', which were prearranged lectures lead by doctors from around the hospital.
Ascitic punctures were fairly frequent procedures undertaken on the ward owing to the high number of patients with alcoholic liver disease and gastrointestinal malignancy. I was fortunate enough on my last day to complete two of these with the aid of the other students and an overseeing doctor. This involved firstly locating free fluid in the abdomen using ultrasound guidance. The point with the deepest amount of fluid was marked using a stopper to make a temporary mark on the skin. Then under sterile conditions, local anaesthetic was injected, before using an ascitic needle to drain the fluid, which as it turned out was normally a luminous green. Once the needle was secured, the drain could be left for around fifteen minutes before the three litre container needed replacing, and following drainage of six litres the tap could be removed. It was great having the opportunity to learn a new skill on this placement, particularly one that provided an immediate benefit to patients.
It was also possible to spend time in endoscopy on this placement, which I managed a couple of times. During this time I was able to see an endoscopic retrograde cholangiopancreatography (ERCP), which was previously something I had only heard about, and seeing one really reinforced its indications.
Being a daily attendee of the ward, I found I really got to know the patients well. One particular encounter stays with me- an English teacher from Sweden who was being visited by his wife. She was a dental nurse, and they had travelled Europe together,

educating their children partly at home. As I was leaving the ward, she was waiting just outside by the lifts. We got chatting, and she told me the story of her husband, who had been diagnosed with a hepatobiliary cancer.

The reason this memory stays with me is twofold. Firstly, I was pleased by how detailed a conversation I was able to have in German, having been a bit rusty when I first started at the beginning of February. Secondly, through her recounting her travels, I learnt that she had visited Lyme Regis, a small coastal town on the English south coast. It was here that as a young whippersnapper I had pursued my passion for palaeontology, and to this day have a remnant of rock in my left ring finger after I smashed a chisel against a piece of chalk with a little too much enthusiasm. Needless to say, the world felt a very small place following our conversation.

My logic for selecting this placement was that it was quite a general medical specialty, which would be useful for my foundation years, and I stand by this having completed the placement.

The following placement was tropical medicine, which as a Manchester Medic was not something I had spent a lot of time learning. The placement was clinic based, and essentially functioned as a walk in centre for both future and returning travellers. Two clinics ran side by side- one for vaccinations, and the other for returning travellers. During my placement I was fortunate enough to see a variety of patients, including ones with giardia, Dengue fever, typhoid fever, cutaneous leishmaniasis, larva migrans and an amoebic liver abscess. The difficulty for the doctors was sifting out the simple traveller's diarrhoea from the serious pathology.

Harder still was dealing with patients with delusional parasitosis, who firmly believed that they were infected with a parasite and were requesting every investigation under the sun to prove it. Patients would go to extreme lengths to 'help' doctors with their diagnosis, including bringing in samples identified in their stools, with such practice having tragically become part of their daily routine. One of the doctors I was shadowing had actually been on German television on several occasions talking about his such patients, as they weren't that rare.

The clinic also provided health checks for people seeking asylum in Germany, which was a reminder of the lengths people go to when faced with adversity in their home country.

My placement had quite a relaxed feel to it, and with new patients no longer accepted after 1400, doctors would normally assemble in a room for a post-work chat.

As luck would have it, there happened to be a spring conference on Ebola held by Doctors without Borders (Ärzte ohne Grenzen) which I attended during my placement. The meeting gave a real insight into the Ebola crisis, and highlighted a lot of issues of which I was previously unaware. The importance of understanding local cultures and beliefs could not have been further emphasised, with stories of locals believing that Nescafe or onions had caused Ebola, or that the people in the white suits were injecting everyone with it. Moreover, the alleged failure of the World Health Organisation to respond to the crisis was also raised, and I could feel tensions rising between representatives of different groups. Fortunately there was some good news, with Liberia having had no new cases for a good few weeks.

What I found interesting was that more people died in the same amount of time from malaria and HIV. However, Ebola gained so much attention was because of how quickly it kills patients. This leads to a state of panic, and combined with a lack of knowledge about the disease it is understandable how the outbreak spread further. Overall the conference provided a wider perspective on healthcare in a global setting and how groups need to work together in times of crisis.

My final placement was in the emergency department, this time in a Vivantes clinic (rather than with the Charité). I'm glad this placement came last, as it was a chance to tie together the German I had honed over the last three months with my clinical knowledge from the last five years, and seemed a good way to finish medical school.
I completed the 'Frühdienst' shifts which ran from 0730 until 1600. Although long hours, I found that the more I got involved with patients, the quicker the time went. With the right doctors on shift, I was able to take histories and examine my own patients before presenting the patient's case, which was a really useful exercise.
I was fortunate enough to see some of the classic presentations to the emergency department too, including ACS, PE, pneumothorax and GI bleeds. Besides the medical cases there were many social cases too. One doctor who was particularly busy one day asked me to ring an elderly couples 'Hausarzt' and have their past medical histories and medication lists faxed to the emergency department. The doctor in A+E was so grateful he bought me a Club Mate, a unique soft drink which every visitor of Berlin should try at least once- this was definitely one of my high points.
One of the key differences I noticed in the emergency department between the UK and Germany was the job allocation- who did what. The nurses would be the first to see the patients, but following triage would also record basic observations, insert a cannula, take a basic set of bloods and perform an ECG, all before the doctor had seen the patient. The rationale behind doing this was to speed up the process of having patients discharged, as waiting for blood results could take up to two hours. It also meant that a baseline set of blood results and observations were available, and could be referred back to later if necessary. As a non-invasive investigation, I felt the routine recording of ECGs was in no way detrimental to the patient's care.
There were of course disadvantages to using this system. If the correct blood samples were not taken, doctors would have to ring up the lab and have them add on results, providing the blood was taken in the correct blood tube. Sometimes this wasn't possible, which meant taking blood from the patient again.
In the UK it is done slightly differently: patients are triaged, but following this the doctor inserts the cannula and takes the bloods in accordance with their differential diagnosis.
Over the course of all of my placements, one key difference between the UK and Germany was highlighted- 'Diagnostik'. It came across that in Germany, doctors would order tests just to check that nothing was awry, rather than having a clinical suspicion, which could then be confirmed with that investigation. The disadvantages of this approach become more evident the more invasive or damaging the investigations become e.g. with CT scans. That's not to say all doctors were like that- I learnt from one radiologist that one CTPA scan was equivalent to four thousand chest radiographs, and as a result he was not happy to send a patient with an US-confirmed deep vein thrombosis for the investigation.
Regarding my linguistic development during my time there, I feel the real difficulty was converting from 'Hochdeutsch' which I had learnt for the C1 to German which was more 'umgangsprachlich', which was how most people spoke. By the end of my four months I felt I had gained back what I'd lost from the previous summer having focussed mainly on passing finals, and had improved in my verbal fluency as well as my vocabulary. As everyone has consistently told me regarding learning a language, the best thing to do is to be in a country where it is spoken. I feel this has some sort of osmotic effect whereby constantly hearing, seeing and talking the language, you

can't help but learn. Staying in a hostel meant I was constantly doing this, although we were very fortunate to find a 'future hostel' like we did.
The challenge now will be to maintain my German whilst in England- I plan to do this by keeping up with German news through Der Spiegel, watching German TV online and by keeping in touch with the friends I have in Berlin (in German of course).
Whilst in Berlin I made sure to see as much of the touristy stuff as possible, and I would recommend all students to do likewise. I found Berlin's history really interesting, and with so many museums (many of which are free), parks and events it's hard not to get sucked into it all.
One trend I noticed regarding young people's view of the war, which was not a sore topic, was that although they didn't feel guilty about it (thankfully), they felt it was their responsibility to make sure nothing like that ever happened again. I shared their views on this, but also felt the responsibility is not Germany's alone.

Practical issues for future students

I have collated what I feel would have been most useful to know before embarking on my trip for Berlin below:

- Accommodation: DON'T SEND ANY RENT MONEY BEFORE YOUR ARRIVAL. It is much better to meet the owner in person than send them money in advance and have them 'send you the keys'- this is a common scam and I was very nearly fooled by it!
    - Liaising with Charite students is a good starting point
    - Staying in a hostel for a while before finding somewhere would be a good alternative
    - Living with Germans or German speakers is definitely the best way to get the most out of your language development.
    - **You have to register as living in your accommodation in order to receive your full Semesterticket from the Charité- this you do at the 'Bürgeramt'. There are multiple offices across Berlin where you can do this, and although you can book appointments online, you can turn up early (an hour before the opening time) and get an appointment on the day.**
- Placements: on your first day you'll need to get some 'Kittel'- essentially a white lab coat. Try and get a name badge as well as it lets people know you're part of the team- introducing yourself to everyone will help this process.
    - At the end of each placement you will need to get a 'Zeugnis' saying you attended that placement- these will be collected at the end of your time in Berlin to confirm your overall stay.
    - there is a fair bit of paperwork involved, but providing you make copies of everything to give to them, you'll be fine
    - A folder is a must to ensure you don't lose anything important!
- Food: food is cheap, but shopping and cooking with others will make your Euros go even further. Food/ drink you have to try as a Berliner:
    - Club Mate (caffeinated drink)
    - Berliner/ Pkannenkuche- jam doughnuts
    - Döner kebap- the best donner you'll ever have
    - Currywurst- German sausage
- Events: Berlin.de has most upcoming events in your area

- Clubs: look on residentadvisor.net for the best club nights
    - Best time to get in to Berghain: Sunday morning

Addresses, phone numbers and contacts:
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