European Option report - Rennes

My parents are English, I was born in Portugal, I went to a French school in Lisbon and studied Italian at A levels. As soon as I heard about the European Option I was interested. I loved the thought of spending four months in one place to really get to know it and get a feel for what life is like there, I loved the opportunity to speak French on a daily basis again and the chance to work in a foreign health care system was really incredible. It also means you can spend five of the seven fifth year blocks abroad which is pretty exciting!

I chose Rennes as my destination for several reasons – I had heard great things about Brittany, I love being by the coast, I much prefer small towns, no one else was applying there and it looked beautiful in pictures. It lived up to all my expectations!

There was a slight hitch with my application so two weeks before I was due to leave, and one week before sitting finals, I still hadn't heard from Rennes University and was starting to get a bit worried. I hadn't booked travel or accommodation in case it fell through and I was more concerned by finals than what came after so I didn't organise anything at all until the week before I was due to start. As such I got an overpriced and frequently changing train to Plymouth then an expensive overnight ferry to St Malo. I also didn't have time to find an apartment so booked three nights with a Rennais family online as a stopgap measure. Despite my slightly disorganised beginning I was incredibly lucky and ended up having a pretty perfect placement. The University in Rennes organised my placement into four blocks – geriatrics, internal medicine, rheumatology and respiratory medicine, which gave me breadth as well as an opportunity to spend time at each of the three hospital in town. My second placement turned out to be so interesting that I asked to stay on instead of moving to rheumatology and they very helpfully obliged. As for the stopgap family, I never moved out and they were the people I had the most trouble saying bye to. 1. Living in Rennes

Rennes has a tiny beautiful town centre with ever sprawling built-up outskirts fringed by wonderful French countryside. Tiny villages with huge stone churches, bakeries never further away than the length of a deliciously golden baguette, old men in stripy shirts with a beret and a bicycle, Calvados and Cidre-producing apple farms everywhere.

I was so lucky with the family I picked – from a stopgap house to sleep in while I found an apartment they became my closest friends in Rennes and provided me with an authentic and welcoming and thoroughly enjoyable four months. Through the couple who I lived with, Claude and Mano, both now retired, I met their family, their friends, their neighbours. I introduced them to my parents, to my boyfriend, to the friends I made in Rennes. By the end of the four months I felt like I had a second home and would have been perfectly happy there for much longer, just loving life in France eating lots of patisseries and hearing all the local gossip.

Another great thing about Rennes for me was the sport – I lived right outside the biggest park in town which leads onto open countryside, perfect for long runs. I was also a five minute walk from a brand new indoor swimming pool. And there are lots and lots of cycling and triathlon clubs around Rennes who were really welcoming and helpful. There is also kayaking and canoing on the river, watersports at the beaches from May onwards (so slightly too late for Erasmus placements sadly)

and a great network of university team sports. A nearby town called Cesson was voted the sportiest town in France two years ago by L'Equipe newspaper.

Every Saturday in Rennes there is a huge and wonderful farmer's market – cheaper and infinitely more varied than any supermarket, it was packed with fresh produce of all colours and shapes and varieties, the displays changing as the months went by to bring in what was in season. From earthy purple and pink and yellow beetroots in January to piles of proud green artichokes and stumpy thick, pearly white asparagus in March, to table upon table laden with bright red strawberries in May. And there were dozens of butchers and fishmongers – displaying freshly caught Oysters from Cancale, just 50km away on the coast - cheesemongers and dairy farmers. Bakers with rustic loaves and dainty macaroons, butter laden Kuign Aman (a cake from Brittany that is delicious yet very very heavy) and locally milled bags of flour. After a morning shopping around you can then have lunch at any of the half dozen Galette stalls – food trailers that attend every market and football match in Rennes serving buckwheat pancakes unique to Rennes, typically rolled around a thick barbecued sausage. Followed of course with a Crêpe for pudding, topped, if being truly local, with salted butter caramel. These were my very favourite Saturday mornings.

If you have a car I would take it with you, on the ferry, because the surrounding area is really incredible, especially along the coast. I didn't explore it as much as I should have because not all places are accessible by train or bus so having your own form of transport is definitely a plus. But not essential at all!

2. Geriatrics in Rennes

My first placement was in geriatrics at the Tauvrais hospital – a small and slightly dilapidated building from the 60s which has two short stay geriatrics wards, a rehabilitation department and a 'unité de soins de longue durée', which is like a nursing home for patients with relatively advanced medical needs. I was on the short stay unit and I really enjoyed my month although I actually want to be a geriatrician unlike most people so I was probably quite biased.

The main differences I noticed compared to my geriatrics' placement in Manchester were that they use a lot more cognitive testing than we do – not only do they use the MMSE but also the Bref (which assesses frontal lobe disfunction), the test de l'horloge (where patients are asked to draw a clock face at ten to two) and the Dubois (which looks at immediate and deferred recall). They then go into the clinical differences between varying types of dementia much more than we did on my English geriatrics placement. As a whole throughout my time in France I realised they go into a lot more pathophysiological detail than we do, learning very very intricate cascades, mechanisms, interactions and so on. However they don't learn to do examinations as thoroughly as we are taught, they don't take blood, do cannulas or place catheters and they have no communication skills teaching at all. So I think a balance between the two would be ideal but if I had to choose one model of medical education I would stick to ours. Speaking to a friend who did a placement in Paris she told me a funny story which illustrates this quite well I found – during oncology teaching the students engaged in detailed molecular markings discussions with the professor, going into genetics to an absurd level which left the English student feeling distinctly unintelligent. However when asked how bowel cancer presents they were unable to come up with an answer, with things such as 'weight…loss? No gain…yes weight gain?' being proposed. So great knowledge but little clinical application.

3. Internal medicine

I had never come across this specialty in England but I did my StEP in Lisbon in Internal medicine so thought I knew what to expect. There I had dealt with a bit of everything, some stroke, some anaemia, a few geriatric patients, a bit of oncology. Nothing especially out of the ordinary. Here again we had a bit of everything but it was anything but ordinary. I saw patients with conditions I barely remembered reading about, from Still's disease to mastocitosis and an atrial myxoma. We had systemic sclerosis, sarcoid, lupus, Hodgkin's lymphomas, polymyoscitis. When someone came in for falls or confusion the juniors would grumble a bit and try to get them home quickly to make room for 'real' patients.

This is one of my patients that I included in my patient log –

*She presented with a two week history of progressive weakness, mainly in the lower limbs, but affecting the arms as well. It had culminated with an inability to walk the day before admission, and her husband had been carrying her up stairs for a few days before this. She also complained of pain in her lower legs, from the knees downwards but was fairly inconsistent in her accounts of this. On admission she was well in herself albeit very distressed at her condition, she was unable to stand without using her arms, power in her lower limbs was at 2/5, upper limbs 4/5, no neurological symptoms, cardiac, pulmonary and abdo exams were normal. She had no dermatological signs. She was well oriented. Her past medical history included breast and ovarian cancer for which she had a left sided mastectomy and a total hysterectomy and oophorectomy. There was also a possible similar episode 30 years ago for which she had been taking 5mg of steroids ever since and a Steven's Johnson's-like syndrome (we only saw photographs – they showed a full body, peeling, red rash) following ingestions of an antibiotic, but I forget which one.*

*Initial bloods revealed a myopathic picture – CK 4330, Trop T 635, AST and ALT also very raised. FBC, UE and inflammatory markers were normal. No metabolic abnormalities, TSH was normal.*

*The day after admission she had improved somewhat and was able to stand without using her hands, power in her proximal lower limb muscles was 3/5, distally it was 4 to 5/5. Upper limbs were 4+/5. She was unable to get in and out of bed unaided but otherwise admitted she was noticeably stronger. Over the course of her admission her clinical picture remained unchanged.*

*Polymyositis, possibly as part of a paraneoplastic syndrome, was the top differential. We couldn't discount steroid-induced myopathy although it seemed unlikely due to her low dose and the sudden onset of her symptoms. Due to the rapid recovery of some strength we also considered a viral myositis.*

*However, further bloods showed that she had no auto antibodies (although we later found out they had not performed a DOT myositis – specifically searching for antibodies involved in inflammatory myopathies which require different screening techniques and could therefore be missed) and serology for HIV, HepB and C, CMV and EBV were negative.*

*Tests she underwent:*

*- TTE and ECG in case of polymyositis to screen for conduction abnormalities: normal*

*- Mammography: showed ACR 3 so follow up at the breast clinic with possible biopsy is required*

*- Lung function tests: normal*

*- ENMG: normal - Muscle MRI*

*- Muscle biopsy*

I had never seen such a barrage of tests being performed on one patient and we still didn't reach a diagnosis. It truly was a fascinating placement and one that I would highly recommend! If you don't want to feel really thick like I did though I would recommend learning the coagulation cascade by heart as well as getting a very good grasp on detailed auto immune antibodies.

Another really great opportunity that came from this placement were new and exciting clinical skills. Leaving my first placement I thought French students didn't have any practical knowledge but I was quite mistaken. They may not know how to cannulate but bone marrow aspirates, lumbur punctures, pleural taps, cutaneous biopsies…no problem!

This is my reflective piece on one procedure that really excited me –

*Today was a day of firsts – a punch biopsy and a suture. I had practiced stitching on a Saturday morning above a pharmacy in Eccles once. On a pig's trotter. But I couldn't remember it very well since I had never had an opportunity to practice since. On my AE placement I had been to the minor injuries department several times a week for a month to ask to suture someone and never had the chance presented itself.*

*This morning the junior turned to me and asked whether I knew how to perform a skin biopsy. Until a few days ago I had barely even heard of a skin biopsy. It had somehow stayed entirely off my radar. And now I was being told to accompany the other medical student to observe her perform one before carrying one out myself. Usually new skills, or even old skills, pretty much terrify me. I can chat to patients, take a history, perform an examination, that's so easy. But handling instruments in a skilful manner in order to carry out a particular procedure is hard. I get shaky if I am nervous or I think someone is watching me. The other day doing an ABG I managed to start shaking as soon as I saw the blood enter the syringe. Why on earth would that make me tremor? I had just succeeded!*

*Anyway, today I was surprisingly keen and calm. It sounded quite easy and I was really looking forward to learning a new skill. I was also looking forward to being able to get my suturing UPSA signed off at long last! If I could get a French doctor to understand my form well enough to be willing to sign it.*

*I accompanied Emilie, my student tutor, to her patient and she talked me through the kit and the procedure. I handed her things and watched as she cleaned, anaesthetised, punctured and then carefully lifted and cut the small sample to send to the lab. Her specimen was taken from a furuncle so the skin was hard and fibrosed and would have been impossible to stitch so it was packed with haemostatic gauze.*

*And then it was my turn. I prepped my trolley and asked what kind of suture material I would need. I really didn't have a clue.*

*I gained the patient's consent and didn't contradict Emilie when she told the patient we had done this lots of times before and that he didn't need to worry. It was half true.*

*I chose my target, a small bulla on the patient's left shin, about 1cm in diameter. Once both it and I were clean and my sterile field was in place I anaesthetised the skin. This was only the second time I had used sub cutaneous Lidocaine, the first being during the bone marrow aspirate a few weeks ago, but I had seen it done so many times that I felt confident. I injected at two or three points and pressed it firmly with gauze to spread it. Then I got my punch tool ready, I'm not sure what the correct term for it is in English, and pressed gently against his leg to check sensation. None. So following the instructions I had read online as well as what I had seen Emilie do just a few minutes previously, I gently started to twist the cutter down into his skin until it was in. I could feel his tibia and thought that was probably deep enough. Gently withdrew and got a quick glimpse of the perfect circle I had drawn on his leg before blood wooshed out and covered it. I had read that it could bleed a lot so although this was in fact the very first time I was performing what could arguably be called minor surgery, and there wasn't even a doctor present to supervise, I felt very calm. I dabbed at it with gauze until I could get a clear view and then picked up the little flap with tweezers. It was still attached so for the very first time in my life I reached for the scalpel and cut. It came away perfectly and there I was, holding a tiny piece of skin and subcutaneous fat in my left hand, a scalpel in my right, and watching blood ooze rather quickly out of a wound that I had inflicted. I put everything down and dabbed again. Now it was time for the stitching. This made me more nervous because I hadn't seen it done by Emilie and the pig trotter was now only a faint memory. It was only a tiny hole though so one stitch would be enough. Needle holders held rather hesitantly in my right hand I grasped the needle and pulled the stitch out of its container. Following Emilie's guidance, 'go in about 2mm from the hole so you get a good purchase', I went in. It was tougher than expected. I then couldn't remember where to bring the needle out. Luckily E was there and calmly told me carry on until about the same distance away on the other side. Out came my needle and suddenly it came back to me – roll it around the needle holders like I've seen countless surgeons do and tie a knot. Then again in the other direction. And one last time the same way as the first. And there it was – one stitch, holding closed the perfect little hole I had punched.*

*To cement it all firmly in my mind I got to perform a second biopsy and stitch immediately – this time on the patient's arm. No instructions were needed this time and my needle holders were held slightly less hesitantly.*

4. Respiratory medicine in Rennes

This was my last placement and also my shortest, lasting just three weeks and including two bank holidays. Nevertheless the team was welcoming and since I was so so close to finishing medical school they gave me a lot of responsibility and let me have my own patients which was great. It was a good mix of really interesting, I was on a more oncology based resp ward and so learnt a lot about chemotherapy and different types of lung cancer (doing my StEP abroad meant I missed my Christie block but this allowed me to catch up a little so I found it really useful) and very exciting with yet more practical procedures to be done. I got to assist in and then perform pleural taps for symptomatic relief of effusions which was really useful to learn.

5. So was studying medicine in France all that different?

I think the biggest difference between the two medical school systems is that the whole six years in France are gearing towards the ECN – a national exam undertaken by all the medical students in France. Their results are used to rank them, no account is taken of continuous assessment or performance throughout medical school, and they select a job and a region based on their position. It means that any specialty in Paris is closed to all but the very few at the top of the ranking, and most specialties like cardiology or neurology, irrespective of city are virtually inaccessible. I am so glad we have a different system!

Being in such palpable competition with each other from the get go breeds a very cut throat attitude. Students aren't told about teaching sessions by colleagues hoping to gain the upper hand, patients are fought over on the wards, 500 pound subscriptions to revision websites are commonplace. Of course that's a generalisation and there are some lovely French medics!

Another big difference is that because they get paid from fourth year onwards, I think around 200€ per month, they're sometimes treated more like assistants than students. It's their job to put away all the patients' test results in chronological order, to fetch and deliver folders to the secretaries, to perform every single ECG that needs doing, to cover the ward on Saturdays, to do a compulsory minimum number of night shifts per semester. They don't have university holidays like we do and instead have to arrange amongst themselves to take time off and making sure there are always at least two students left on the ward. It's a really different role than the one we play.

Overall I am incredibly happy to have spent four months in Rennes – both for the opportunity to work in a French hospital as well as for the wonderful town and a chance to enjoy the French lifestyle. A lot of sitting in cafés, amazing food, and best of all, students there only have morning placements. That's a lot of afternoons to explore Brittany!

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