Thomas H Saunders and Peter J Basford

Tips for GP trainees working in general medicine

TH Saunders, MRCP, specialist registrar in geriatric and general medicine, Western Sussex Hospitals Trust, Department of Medicine for the Elderly, Worthing Hospital, Worthing. **PJ Basford**, MRCP, gastroenterology clinical fellow, Portsmouth Hospitals NHS Trust, Department of Gastroenterology, Queen Alexandra Hospital, Portsmouth.

Address for correspondence

Thomas H Saunders, Department of Medicine for the Elderly, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH, UK.

E-mail: tomsaunders@doctors.org.uk

Submitted: 2 March 2011; **final acceptance:** 15 March 2011.

DOI: 10.3399/bjgp11X613296

During your GP training you will spend time as a medical SHO, a period that may daunt you. Ward rounds can be long and patients may be complex, have multiple problems, and often be seriously unwell. Remember you are part of a team and people are there to help you. The majority of the skills that you need will have already been developed during your foundation years, and the idea is to expose you to common conditions that you will encounter during your career as a GP.

You will also learn leadership and management skills. As the firm SHO, it's your job to ensure the ward round is smooth and that things get done. Lead and look after your house officers — they will probably come to you first with any problems. Try and remember what it was like when you first arrived from medical school.

An area in which you can make a real difference to your patients' care is communication — this rotation is, alas, an opportunity to practice your breaking-bad-news skills. It is also good training in explaining procedures, diagnosis, and management, all of which are common fodder of the clinical skills assessment.

No-one expects you to make a diagnosis of Rocky Mountain Spotted Fever, but simply to develop your skills as a clinician, and become confident in differentiating the sick from the well. Make the most of your general medicine placement: ask questions and absorb as many pearls of wisdom from the consultants as you can.

THE BASICS

1. It's all about the history. As in all specialities history taking is the most important part of the admission, but more so in general medicine where patients are often complex. A focused, thorough history will mean the patient's problems are identified from the start and appropriately investigated and treated.
2. Knowledge of endless medical minutiae is all very nice but the most important skills on the ward are being efficient, knowing your patients, and recognising if they deteriorate.
3. Ward clerks and ward sisters. Remember they tend to have been in their job for years and have seen it all before. Upset them at your peril, but get on the right side of them and your medical placement will be a breeze.
4. Most of the things you'll see will be variations of the same common medical themes, but always expect the unexpected. If something doesn't seem quite right, it probably isn't.
5. Radiologists. Hunt them out early and go armed with the facts. Once they've disappeared into a darkened room, they tend to get a bit elusive.
6. Serum rhubarb! Every consultant has one thing they always want to know about, find out yours before you start and impress them from day 1.
7. Deep vein thrombosis prophylaxis. A hot topic in hospital medicine. Remember to do a risk assessment for every patient.
8. In the anaemic patient always send haematinics before transfusing.
9. Patients should have their statin withheld while taking a macrolide antibiotic — there is a significant risk of severe rhabdomyolysis if taking both.
10. Learn some trusted sources on the web. As a general rule the following all have good guidelines:
    - http://www.brit-thoracic.org.uk
    - http://www.bsg.org.uk
    - http://www.escardio.org
    - http://www.bcshguidelines.com
11. Learn who your consultant's secretary is. They will always be able to track them down and ask that question that has been bugging you.

ON-CALL SURVIVAL

12. You will see a lot of acute coronary

REFERENCES

1. Sullivan JT, Sykora K, Schneiderman J, *et al.* Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). *Br J Addict* 1989; **84(11):** 1353–1357.
2. British Thoracic Society Pleural Disease Guideline Group. *British Thoracic Disease Pleural Disease Guideline 2010.* http://www.brit-thoracic.org.uk/guidelines/pleural-disease-guidelines-2010.aspx (accessed 9 Nov 2011).
3. Kumar A, Roberts D, Wood KE, *et al.* Duration of hypotension prior to initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. *Crit Care Med* 2006; **34(6):** 1589–1596.

Provenance

Freely submitted; externally peer reviewed.

Discuss this article

Contribute and read comments about this article on the Discussion Forum: **http://www.rcgp.org.uk/bjgp-discuss**

syndrome (ACS) on call. Know your local ACS protocol. However, remember not all chest pain is ACS, the first step is to make the correct diagnosis.

13. Anticipate alcohol withdrawal, but beware over-treatment of those without symptoms. The CIWA-Ar[1] score is a useful tool for assessing the severity of withdrawal and guiding treatment.
14. When asked to write up intravenous fluids always ask why the patient is receiving them and check their most recent bloods.
15. Hypernatraemia. Usually the cause is dehydration and the treatment is fluids. Remember not to drop the sodium too quickly as this can cause cerebral oedema. In a dehydrated hypernatraemic patient the initial fluid of choice is normal saline.
16. Bilevel positive airway pressure (BIPAP)/non-invasive ventilation. When on ward cover you will frequently be asked to take blood gases from patients with COPD on BIPAP. Learn what type of machines your hospital uses and how to adjust the settings. Know how to interpret the blood gas result and adjust settings appropriately.
17. Insulin sliding scales. Does the patient really need one? If they are eating and drinking and not significantly unwell or ketotic it's better to just adjust their usual diabetic regime.
18. The majority of acute kidney injury (acute renal failure) is due to a pre-renal aetiology. However, a renal ultrasound is essential to rule out a treatable obstructive cause. Remember to dip the urine and stop any nephrotoxic medications.
19. Have a basic framework for managing 'fast atrial fibrillation'. Remember to treat any precipitating causes, ensure the potassium and magnesium are in the normal range. A 15–20 minute crash course from a friendly cardiology registrar is worth it's weight in bisoprolol.
20. Never let the sun go down on an empyema. If a patient with pneumonia develops a pleural effusion they need a diagnostic pleural aspiration — frank pus or a pH <7.2 equals an empyema and requires a chest drain.[2]

COMMUNICATION AND DOCUMENTATION

21. Problem lists. Initially a pain to write but they make your ward rounds flow, your consultants love them, and you'll look super efficient.
22. When taking referrals on-call, if in doubt ask the referrer to speak to your registrar.
23. If you order a test, remember you are responsible for chasing the result and acting upon it.
24. Sedating patients. Try to avoid at all costs. Try to work out why a patient is agitated and look for other options. If you absolutely have to sedate someone, be aware of your local guidelines, and clearly document why.
25. If you think a patient should be made 'do not attempt resuscitation', make sure you pin your seniors down to make a decision, it's you, not them who has to run to the arrest call.
26. Be proactive when talking to relatives, especially if the patient is sick and there is a chance they may not survive. Never assume relatives realise the gravity of the situation. Communication at an early stage can prevent angst later on. Document discussions thoroughly.

MEDICAL EMERGENCIES

27. Revise advanced life support. www.resus.org.uk
28. Medical emergency guidelines. Certain conditions have to be treated urgently and aggressively, but to complicate matters there may be variations in guidelines between hospitals. Read through your local ones before your first on-call.
29. If you think there may be ST elevation on the electrocardiogram, don't delay, show it to your registrar immediately.
30. Treat severe sepsis early and aggressively. Mortality increases by 8% for every hour that passes without antibiotics in a hypotensive patient.[3] Send cultures but do not delay antibiotics while trying to identify a definite source of infection. Ensure the first dose of antibiotics is given in A&E. Refractory hypotension after fluids (for example, 2L crystalloid) should prompt an ITU referral if appropriate. Read the surviving sepsis guidelines for further details www.survivingsepsis.org.
31. Neutropenic sepsis is an emergency. As soon as you suspect it, treat it, even before you have any results back.
32. Beware of the young septic patient, from the end of the bed they can look well but can deteriorate dramatically.
33. Hypokalaemia can kill in diabetic ketoacidosis. Be vigilant checking and replacing the potassium in the first few hours, at least until the acidiosis has resolved.