My Clinical Elective Experience in St. Bartholomew's Hospital's Department of Oncology

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Why I Chose SBH:

As a medical student from NYCU, we were given a 12-week window to participate in at least 8 weeks of a clinical elective program worldwide. I have always been curious and fascinated by the cultural and ethnic diversity of London, and the NHS is renowned globally for providing exceptional patient care and covering novel drugs for cancer treatment. I narrowed my options to the Department of Oncology because the prospect of seeing patients from diverse religious, cultural, and ethnic backgrounds facing various cancer types promised a unique experience – and it indeed was.

A Diverse yet Specialized 4-week Course:

Trained at Taipei Veteran's General Hospital, a medical center with over 3000 beds and approximately 8000 outpatient visits per day, my experience at SBH was markedly different. In Taiwan, a medical student shadows a "team" comprising a visiting staff, a senior resident, and a junior doctor, following the team's activities with minimal interaction with other doctors. However, at SBH, I had the opportunity to shadow in different clinics and participate in various ward rounds, enhancing my understanding of UK medicine and avoiding a biased perspective. Additionally, I engaged in surgeries, radiotherapy treatment planning sessions, and a visit to Maggie's Center, which I will detail below.

Culture Shock for a Taiwanese Medical Student:

In Taiwan, masks are always worn, except during meals or physical examinations, with N95 masks mandatory in COVID-affected wards. It was surprising to see the lax mask usage at SBH, even among potentially immunocompromised patients or those at risk of neutropenia during chemotherapy cycles. Dr. MJ Devlin explained that maskless interactions could enhance physician-patient communication, as facial expressions are vital for understanding. Recognizing subtle facial changes is especially important in delivering difficult news. Furthermore, in a city like London, where diverse accents are common, masks can hinder clear communication.

Doctors Went on Strike:

Due to the excessively long working hours faced by UK residents, often reaching around 60 hours per week, and insufficient compensation, the residents initiated a two-day strike. As a result, clinical consultants were required to take over the residents' duties in the wards. Subsequently, the clinical consultants themselves went on strike, protesting against inadequate salaries provided by the NHS. In Taiwan, the concept of doctors going on strike is quite unexpected; however, in the UK, doctors indeed took this drastic step to advocate for fair compensation. During the strike days, students were barred

from attending the hospital. As a form of compensation for this disruption, I received 70 pounds from Queen Mary University of London.

Theatre Observations:

My time in the operating theatre was limited, but it included observing a breast fibroadenoma excision and a sebaceous cyst removal. The patients received thorough informed consent from Dr. Fahmy during ward rounds. I learned the criteria for adenofibroma excision, such as a 4 cm size under breast sonography.

Clinics: physician-patient communication, and novel drugs

Understanding the treatment of various cancers in a short period was a formidable challenge. My primary objective during my shadowing experience in clinics was to observe the physician-patient interactions, as well as to learn about novel drugs and clinical trials in oncology. I will summarize some noteworthy cases.

- **Dr. Slater's GI Cancer Clinic:**
  Met a 70-year-old male with esophageal cancer, who had comorbid COPD managed with BiPAP for 6 hours daily, T2DM on multiple medications, and dementia. The clinic visit's primary goal was to evaluate the timing and appropriateness of initiating chemotherapy. Key takeaways: First, the uncertain efficacy of chemotherapy, its delayed onset, and potential side effects make treatment decisions particularly challenging in terminally ill patients. Second, a patient-centered approach in consultations, especially with new patients accompanied by family, is crucial. This involves prioritizing the patient's narrative, followed by family input, and ensuring agreement between the patient and his family on the treatment plan. This method, contrasting with some practices I observed in Taiwan, where patients, particularly frail ones, might be overshadowed by their families, was particularly enlightening.
- **Dr. Steele's Lung Cancer Clinic:**
  He taught me to always ask patients if they are in pain, and always expect them to know less than what we are explaining to them. Always examine patients to gather PE information while making them feel secure. I saw a 72M with mesothelioma, a palpable lump in the right chest wall was noted, and the patient is on immunotherapy and palliative radiotherapy.
- **Dr. Greenberg's Breast Cancer clinical oncology clinic:**
  60F with triple-negative breast cancer (common in black and Asian communities), with brain and L spine metastasis. The patient is currently tapering steroids to restart immunotherapy. RT of 30Gy/10Fr in the brain was done 8/10 Fr; 20Gy/10Fr on the L spine was completed. Diplopia needed to be corrected.
- **Dr. Rashid's metastatic melanoma clinic:**
  NHS offered complete coverage for immunotherapy on metastatic melanoma, almost all patients in this clinic are on Nivolumab, some combined with Ipilimumab if satellite lesions were found. Those on Ipilimumab usually have more IRAE.

- **Dr. Khan's One stop breast clinic:**
  I was grateful to have the chance to palpate breast lesions and perform breast examinations, which I could hardly do in Taiwan due to my gender. I palpated several fibroadenomas on the bilateral sides of a 35F patient, then I saw her receiving US guided biopsy for pathology diagnosis.
- **Professor Gerlinger's GI cancer clinic:**
  75M with colon cancer, had his ascending colon removed, and the left supraclavicular LN was stable. The patient was on Dorstarlimab. This was my first time encountering a patient using this drug, which had a legendary 100% success rate in clinical trials. Also, I saw a 68M with Cholangiocarcinoma and performed a biopsy for FGFR and NTRK testing. The patient might be on Larotrectinib.
- **Dr. Prerana's GI cancer clinic:**
  44F with metastatic colorectal cancer. The unique part was that I was the interpreter for this patient. Since the patient understood little English and spoke Mandarin. Therefore, I became her interpreter. Real-time interpretation was challenging despite having a decent score in IELTS.
- **Dr. Shamash's Seminoma clinic:**
  44M with seminoma, had a great response after BEP (Bleomycin, Etoposide, Platinum) chemotherapy. Many patients in this clinic had decent responses to chemotherapy.
- **Bladder & Kidney tumors clinical trial:**
  I never expected this to come, a clinic specialized in the clinical trials of GU cancers. I saw a 64M with Bladder cancer on the Durvalumab EV301 trial.
- **Dr. Tipple's Prostate Cancer clinical oncology clinic:**
  The first time I heard about the concept of Prostate Cancer SBRT. I saw a 60M with prostate G3+4, prescribed with 5 fraction Saber. Also, there was a 56M with prostate cancer, he was worried about erectile dysfunction and considered brachytherapy.

Ward Rounds – Learning from Patients

The wards in SBH differ significantly from those in Taiwan; they are more sunlit, and the atmosphere appears more serene. My initial patient encounter involved taking the history of a woman with metastatic breast cancer who presented with a headache. This 50-year-old patient exhibited classic symptoms of photophobia, and her headache intensified when lying down. Surprisingly, within a week, she lost her vision, with the underlying cause still under investigation. In her case, leptomeningeal metastases were initially suspected. Another memorable case involved a 70-year-old Urdu-speaking male with non-small cell lung cancer (NSCLC) metastasis in the bilateral lungs. He was continuously on a nasal cannula and receiving high-dose steroids. I observed him receiving palliative care while in pain. We facilitated real-time interpretation between Urdu and English to ensure communication. This case underscored the importance of ensuring the patient comprehended the treatment objectives, and the medical team understood his needs, despite his critical illness and language barriers. Informed consent was diligently executed. I am deeply grateful to Dr. So and Dr. Alden for imparting knowledge in internal medicine and medical oncology, grounded in the cases we encountered.

Maggie's Centre – To comfort, always.

The visit to Maggie's Centre was an eye-opener. The center, an architectural marvel, provides a welcoming space for cancer patients seeking prehabilitation, rehabilitation, consultation, and comfort. The medical adage "To cure sometimes, to relieve often, to comfort always" was brought to life here. While doctors often focus on curative aspects, the emotional and psychological needs of patients can be overlooked, especially in high-volume settings like Taiwan. At Maggie's Centre, a holistic approach is taken, engaging patients actively in their care and addressing the needs of both patients and caregivers.

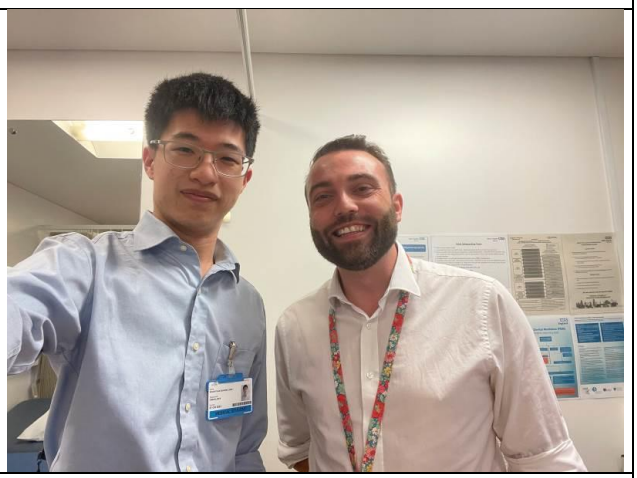
Radiotherapy – A Seed Sown for Future Aspirations:

Initially, I had a limited understanding of "clinical oncology" in the UK context, mistaking it for a subspecialty distinct from medical oncology. However, I quickly learned that it refers to "therapeutic radiology" or "radiation oncology." My week in clinical oncology and radiotherapy was enlightening, laying the foundation for my future interest in radiation oncology. Although concepts like "dose-volume-histogram" and "dose fractionation" were new to me, they became clearer during my subsequent experience in "therapeutic radiology" at Hokkaido University, Japan. This experience solidified my ambition to pursue a career in radiation oncology. Shadowing in Clinical oncology clinics observing patients receiving radiotherapy, including SBRT for prostate cancer, learning about the PERALs trial, and observing the cooperation between medical and clinical oncologists in the UK made me interested in Clinical Oncology.

Key Takeaways:

I traveled to the UK to gain insight into how patients are treated under the NHS system and to understand the impact of cultural and ethnic diversity on physician-patient interactions. The NHS has its advantages and disadvantages. With substantial budgets funded by income tax, it provides free immunotherapy as a first-line treatment for patients with metastatic melanoma. The NHS is also capable of adapting to the latest clinical trial results, covering the costs of new drugs like Dorstarlimab for patients. However, a significant drawback of the NHS is its inefficiency in healthcare delivery, often resulting in long waiting times for surgeries. At St. Bartholomew's Hospital, the diversity of patient ethnicities necessitates real-time on-site or telephone interpretation services. In contrast, in Taiwan, interpretation largely depends on patient families or multilingual doctors, which can lead to miscommunications due to language barriers. Overall, my four-week clinical elective in the UK was an enlightening experience. While no healthcare system is perfect, we can learn from the strengths of others and strive to mitigate their shortcomings.

Photos with the doctors at St. Bartholomew's Hospital Department of Oncology.

	
Photo with Dr. Tipples, my clinical supervisor.	Photo with Dr. Alden, FY1 doctor in the ward.
	
Photo with Dr. Steele, at his Lung Cancer Clinic.	Photo with Dr. Devlin, at the GYN Cancer Clinic.

Group photo of me with the other medical students doing the oncology rotations.