出國報告（出國類別：短期研習）

主題：UCLH ENT 短期實習

服務機關：國立陽明交通大學醫學系 114 級
學號：10801081
姓名：刁子淇
派赴國家：英國倫敦
實習機構：University College London Hospital
實習科別：耳鼻喉科
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- 摘要
  - 關鍵字：英國倫敦、UCLH、耳鼻喉科
  - 摘要:UCLH(University College London Hospital)是隸屬于 NHS Foundation Trust 的一家醫院，他同時也是 UCL 的教學醫院，位於倫敦市中心，靠近倫敦大學學院主校區和埃斯頓車站（Euston Station），倫敦大學醫院以多學科綜合服務聞名，包括但不限於以下領域：癌症治療（UCLH Cancer Centre 是歐洲最先進的癌症治療中心之一）、神經科學、兒科（提供綜合兒童健康服務）、急診與重症監護、婦產科與生殖醫學。Royal National ENT and Eastman Dental Hospitals 則是一整棟完全致力於耳鼻喉科門診病人和牙科病人的大樓，因為耳鼻喉科的門診業務很多，實習期間我也很常會在這裡觀摩學習。
- 目的
  - 作為一名醫學生，到英國倫敦進行為期一個月的醫院短期實習將是一個極具價值的學習與文化交流經驗。在這段時間，我希望能透過親身參與，深入比較台灣與英國的醫療體系與制度，從病人角度探討兩地在資源分配、服務模式與患者滿意度上的差異，進一步理解不同制度對病人福祉的影響。
  - 此外，此次實習也將是我提升英文醫療溝通能力的絕佳機會。通過與病人進行問診和與醫療團隊協作，我希望能更自信地以英文進行專業交流，特別是在病史詢問與診斷溝通中熟悉國際標準的表達方式。
  - 英國的公醫制度（NHS）是全球公認的典範之一。我期待觀察其在實際運行中的優勢與挑戰，包括醫師的工作量、醫療環境以及醫療資源的運用效率，這將為我未來的職業選擇提供參考。同時，我也希望藉此機會了解英國醫學生的教育流程，例如課程安排、臨床實習內容及評量標準，探索不同教育模式對醫療人才培養的影響。
  - 倫敦作為一個國際化大都市，匯聚了來自世界各地的多元文化。透過與不同種族的病人、同儕及醫療專業人士交流，我期待學習不同文化背景對疾病看法與醫療期望的差異，進一步開拓我的國際視野與文化敏感度。
  - 這次的實習經歷不僅是專業技能的鍛煉，更是對全球醫療與文化理解的一次深刻探索，為未來成為一名優秀且具國際觀的醫師奠定基礎。
- 過程
  - 在 UCLH 的四週實習中，我有一個固定的指導老師 Mr. Hannan，我會在臨床教學課中遇到他、學習怎麼問診和報病人給其他人聽。其餘時間我每週會到一個新的團隊中學習，分別觀摩了耳科、鼻科、喉科和頭頸癌的運作方式，每週 Mr. Hannan 都會寄給我一個行程表可以稍微規劃什麼時候哪裡有門診、手術可以觀摩，但實際上我都可以自行調整，想在喉科的實習週裡面回去看有興趣的鼻科手術也是沒問題的，這給了我相當大的自由度去觀摩自己

感興趣的主題（我去了一個專門看暈眩的門診三次！）。因為實習月份的關係，大部分時間都只有我一個學生，所以十分仰賴願意教學或熱情的學長姐或老師才能知道自己在看什麼手術，好險大部分的人都非常好，也常主動問我有沒有問題想問，甚至有遇到一位耳科醫師從動物演化的觀點來講耳朵構造解剖，非常特別！倫敦的種族多樣性自不在話下，不管是診間還是日常生活中，都會遇到形形色色的人，除了訓練自己的英語溝通能力，我也對各國文化有更多的了解，尤其在門診時，老師可能會因為一些事情暫時離開，此時我就需要獨自和病人交談，也讓我覺得成長了不少。

- 心得

I. Reflecting on this past month, I’ ve been able to compare the differences between the healthcare systems of two countries.
   A. Patients in the UK tend to have a strong sense of autonomy. They are often aware of the names of their medications, the progression of their conditions, and they can discuss treatment directions with their doctors. This is quite different from Taiwan, where, perhaps due to language barriers, the public often lacks detailed knowledge about the medications they are taking and tends to rely more on doctors’ recommendations, adopting their decisions without asking more advanced questions. However, this patient autonomy can also bring challenges—I observed that patients sometimes have so many questions in consultations or wards that it significantly prolongs appointment times.
   B. Regarding patient communication, London’ s diverse population means nearly half of the patients are non-native English speakers, which can occasionally lead to communication difficulties. Once, during Dr. Joseph’ s clinic, I had the experience of helping translate into Chinese for an elderly couple.
   C. The UK’ s tiered healthcare system is very well-established, where everyone has their own GP (general practitioner) for initial consultations on all health issues, who decides if further specialist referrals are needed. I see this as a double-edged sword: it ensures that medical centers are not overwhelmed, yet it also sometimes leads to delayed treatment for certain patients. In Taiwan, the National Health Insurance system can achieve very short consultation times and good care quality, but this often comes at the expense of healthcare staff. I feel that both sides could learn from each other to achieve a better balance.

II. The other experience that left the strongest impression on me was a class I attended with Mr. Hannan and other third-year medical students. Each of us was assigned a patient, given ten minutes to take a history, and then returned to present a brief summary to the class. I was impressed by the students’ ability to describe and understand their patients' conditions—at

their age, I couldn't have done half as well. It really made me rethink how we teach medical knowledge.

A. At my university, we have a class called PBL (Problem-Based Learning) for each major system we study (e.g., pulmonology, cardiology). We split into groups of 9-10 students and engage in three-hour discussions over three sessions. We're introduced to a short case description that provides enough information for us to deduce the illness and explore treatment options based on what we've learned. After the discussion ends, our teacher gives feedback, and we each choose a topic to research and present in the next session. Reflecting on this, I improved my ability to search for medical knowledge, enhance my communication skills, and practice differential diagnosis. However, after finally experiencing a real hospital environment over the past year, I believe that real-life patients are the best teachers. The class with Mr. Hannan was a great example of this. Each student had to ask patients about their history rather than just reading it on paper. This real-life interaction creates a strong memory of the illness through conversation. Afterward, we summarized what we'd just heard along with our prior knowledge. Additionally, we got to learn about ten different conditions from our classmates without burdening the patients too much. At the end, the teacher also provided additional information to spark our curiosity for further study.

III. During my time in the ENT ward rounds, surgery rooms, and clinics, I found that the way doctors taught and guided me was not much different from my experience in Taiwan. (However, some doctors showed immense passion for teaching and even provided me with additional reading materials, for which I am very grateful !!!) Ultimately, I think the goals for interns are universal: to help them consider whether they might pursue a particular specialty and to learn the key topics in that field. I feel that I achieved both of these goals perfectly during my time at UCLH.

IV. Rhinology Clinic

A. 9/24 with JJ ：The most memorable case was a young man who underwent R.maxillectomy because of cancer. He also did proton beam therapy in 2023. However, he complained bleeding from the other side of the nose and yellow/redish discharge with bad smell coming out. There are few possibilities to his symptom: 1. infection 2. post PBT damage to tissue, causing infection and necrosis 3. post PBT cancer, mostly soft tissue cancer like sarcoma. The patient was very sad about the possibility of another cancer. JJ needed to comfort the patient and tell the bad news in the most gentle way possible. I learned how to build a strong and trustable relationship with the patient, and that post radiation therapy follow-up is very important. On the other hand, I asked JJ

about why he needed a PBT rather than a regular therapy. He explained since the cancer site is very close to skull base, PBT could bring less damage to the surrounding area including eyes and the feeding vessels, which were very fragile to radiation energy damage.

B. 9/27 with Sammit and Guled

1. Nasal cycle: 4h because of turbinate enlargement one side at a time

2. Empty nose syndrome: original laminar flow in the nose being alternated to turbulent flow, causing noisy sound, inefficient fullness. However, if the lesion or the defect was in the back of the nose, it wouldn't cause this effect since the flow tract was straight and thus unaffected.

C. 9/26 with Iona

1. Most of them were otology case. But I had a great time using the microscope to observe! She also taught me about the differential diagnosis of OE and the treatment.

V. Ward round

A. 9/25 and 9/27 with Viranga

1. Viranga was very keen on introducing patients and asking questions about them. Although I couldn't get the full answer most of the time, she was very happy to teach me. We discussed about tracheostomy indication, septum perforation etiology, glandular fever, GPA evaluation and so forth.

VI. Theatre

A. 9/23 with Guled, Ramya, Ashwini and Ritika

1. Since it was my first day in the GWB, I was very lost. Thanks to them for guiding me and showing me how to go to the theatre and change clothes. It was the first time I saw FESS, they taught me about the anatomy under the scope and the surgery goal.

B. 9/25 with Sammit and Viranga

1. Sammit was very professional in rhinoplasty. I watched the full process of a septorhinoplasty including the allograft rib cartilage pruning, which was very cool to see! He was very kind to teach me too.

VII. Otology clinic

A. 10/1 with Dr. Cillian Forde

1. Cholesteatoma removal surgery follow up: DWI MRI for 1,3,5 years :When evaluating the middle ear, we often use a CT scan to assess its structures. However, since fluid accumulation is frequently present in a pathological middle ear, it can sometimes be difficult to differentiate between granulation tissue and cholesteatoma.

In such cases, DWI MRI proves to be particularly useful.

2. Bilateral sensorineural hearing loss at 40 years old, medical history of neurofibromatosis type 1 and aortic regurgitation : Acoustic neuroma is more often seen in NF2 patients rather than NF1. However, Dr. Cillian said it’ s still possible to grow.

VIII. Vertigo Clinic with Dr. Surangi

A. Dr. Surangi was one of the best doctors I’ ve met. I learned so much during the two observations I had in her clinic. Since almost all the patients presented with severe vertigo, it was very useful to compare their symptoms, severity, and disease progression. For example, vestibular migraine was something I wasn't familiar with, but after Dr. Surangi’ s thorough history-taking, I grasped the concept of the disease well. Additionally, she always performed physical exams on the patients, and we got to see some dizziness provoked by the Dix-Hallpike maneuver. We also observed a vestibular function test (VNG), which helped me understand nystagmus and its relation to the vestibular system.

B. We met a gentleman with severe vertigo symptoms. He could barely turn his neck and had visual motion sensitivity. When asked to look up, he couldn’ t do it because he felt so dizzy. We also evaluated his migraine, and he fit all the criteria (having aura, throbbing headache, photosensitivity, etc.). Dr. Surangi also gave me some papers to read, which I found very interesting. To sum up, I really enjoyed this clinic because it focuses on the patients' experiences and can greatly improve their quality of life by reducing their symptoms.

C. Painkiller Overuse Problem: We encountered a patient who took paracetamol every day to relieve headaches. However, this could lead to medication overuse headache. Her treatment was to stop paracetamol immediately and use NSAIDs for pain control for two weeks. After two weeks, she could start using triptan for background control and Naproxen for acute symptoms.

IX. Otology surgery

A. 9/30 with Dr. Mehta: tonsillectomy, explorative revision of stapes, cochlear implant

1. Dr. Mehta performed a cochlear implant surgery using a post-auricular incision, which provided him with a broader view compared to the transcanal approach. A key landmark during the procedure was the chorda tympani, a branch of the facial nerve that supplies taste to the anterior two-thirds of the tongue. It lies over the incus and behind the malleus. It took me several surgeries and double-checking the textbook to fully understand this later. Once everything was secured, he carefully made a small hole in the round window and inserted the wire with great precision. After the surgery, the patient will receive the external component of the hearing aid

later in the clinic.

2. Dr. Mehta was fantastic! He taught Iona and me the anatomy of the ear, starting from its embryology. He explained everything, from why we have ossicles to how hair cells function. The tympanic membrane is also a fascinating structure, composed of all three germ layers. He explained how it plays a vital role in the development of cholesteatoma and why grafts can never fully replicate the original structure.

B. 10/2 with Dr. Mehta :

1. Butterfly tympanoplasty
    a. good for central perforation(naturally better than marginal perforation though), small to middle size perforation for kids
    b. graft: tragus perichondrium, with the fascia to filling the gap later (it' s vital for preventing iatrogenic cholesteatoma!)
    c. caution: need sandwich technique to secure the graft(oftentimes anterior perforation can be affected by intact Eustachian tube more)
2. High riding jugular bulb
    a. This was the first time I truly delved into this subject. It can cause pulsations from the jugular vein bulb to transmit to the middle ear, resulting in pulsatile tinnitus. Dr. Mehta was very kind and guided me through each step of the procedure.

X. Ward Round with H&N Team: Dr. Jack and Dr. Shun

A. We saw a post-operative laryngeal SCC patient who was in extreme pain. However, since he also had liver function problems, we needed to change his pain medication to oxycodone (morphine is metabolized in the liver, while oxycodone is metabolized in the kidneys).

B. There were a lot of people joining the H&N ward round. At first, I felt overwhelmed by the large team, but Dr. Jack was very kind and took the time to explain the patients' conditions and the reasons for the treatment choices.

C. Hemorrhagic Thyroid Cyst

1. We saw a 37-year-old woman with a hemorrhagic thyroid cyst. The cyst had central hemorrhage with eccentric hypervascular papillary wall thickening. During the ward round, she was already intubated and sedated. Since she was breastfeeding, the doctors wanted to address the issue as soon as possible. Treatment options included ultrasound-guided cyst puncture, ablation, or surgical removal.

XI. MDT Meeting with H&N Team: Dr. Shun, Dr. Paul

A. The format of the meeting was very similar to the ones in Taiwan. Pathologists provided pathological diagnoses, radiologists answered questions regarding MRI or CT scan

reports, and the primary care team asked for treatment advice. MDT meetings were always difficult to comprehend at first, but as I listened to more cases, I became better at understanding the key information. I vividly remember one case: a man had cancer that had spread throughout his mandible and surrounding tissue. It was shocking to see his scan. After discussion, everyone agreed that the case was inoperable, and he was recommended for palliative radiotherapy.

XII. Surgery with Dr. Shun, Dr. Paul

A. Oropharyngectomy, Partial Pharyngectomy, and Left Neck Dissection

1. The patient had a tongue base cancer growing on the left lateral side of the oropharynx. The doctors were very kind and explained the patient's history and the details of the surgery to me. They used robotic surgery to remove the tumor, and I also got to see the 3D view on the monitor. During the neck dissection, we identified many structures: SCM, omohyoid, CN11, digastric muscle, CN12, IJV, carotid bulb, and more. It was very impressive to see the doctors remove lymph nodes right next to the carotid sheath.

XIII. 倫敦生活分享

A. 食：眾所皆知倫敦是個高物價消費的城市，出去吃一餐台幣 500 跑不掉，一般普通的餐廳則大概 500-1000 元不等，想吃完整的套餐或是加杯飲料肯定破千，為了省錢，我選擇自煮大部分的平日餐點。因為只有一個月的時間，我沒有什麼亞洲胃的問題，所以都在當地超市買食材而非亞超（普遍還是比較貴），這裡的超市有分不同等級，最便宜的 Lidl 和 Aldi 非常經濟實惠，選對食材煮其實備餐起來非常方便又好吃，有時候我也會去 TESCO, Sainsbury's 等買食材（中等價位），M&S 和 Waitrose 就比較貴了！但都可以去逛一下挖寶～善用 google maps，倫敦的餐廳並沒有想像中難吃，有時也會挖到寶藏餐廳！如果有需要美食地圖可以再詢問我

B. 衣：9-10 月的倫敦已經轉涼，有幾天又刮風又下雨的一定要帶防風防潑水的外套，但是還是有幾天可以在太陽出來時穿短袖感受夏天的尾巴。另外室內暖氣、倫敦地鐵也蠻熱的，建議洋蔥式穿搭！

C. 住：我在學長建議的 homestay 平台配對找到了一位非裔的中年女性同住，當時選擇的考量以可以步行到醫院為主，也住的非常市中心，就算一個人晚上回家也不至於太恐怖，選地點時建議詢問在當地長居的親朋好友附近的治安，人流多寡等，不然會很大的限制你下班以後還能不能出去探索倫敦哈哈，建議住在 zone1-2，頂多 3 的範圍，不然會浪費太多時間在交通上。

D. 行：這裡的大眾交通分為火車、地鐵 tube、公車、腳踏車，網路上都有很多介紹跟攻略可自行查詢～我就住在醫院旁邊，所以就沒有買交通月票，都是直接用有回饋的信用卡付 apple pay，非常方便，但是坐一次就是 80 元以上所以後來也蠻習慣走路的。火車的話如果週末要出遠門可以去買 Railcards，搭配早鳥票應該可以省不少錢

E. UCL 資源：在這裏的一個月會拿到 UCL 的學生證，如果需要學生證明的地方也都可以拿出來打折（書店、少數付費博物館等等），我有參加學校的一些國際學生 welcoming tour 跟 gathering，認識了很多國際學生！

F. 小紅書：非常建議可以下載來查吃喝玩樂的內容，甚至連免費廁所的位置都能在上面找到，超好用，如果要搭配玩歐洲其他國家一定用得到。

G. 倫敦景點：

1. 網路上都有超多介紹，一定夠你玩哈哈，建議加入 FB 社團「台灣人在英國」、「台灣歐洲交換學生」等等，可以找旅伴、問問題。
2. 倫敦有非常多的劇院，非常建議下課以後去看，我看了回到未來和歌劇魅影都十分精彩，可用搶票平台買到比較實惠的票價，也可以先準備望遠鏡

附錄