Exchange Programme
Final Report

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5th Year Internal Medicine Resident,
Centro Hospitalar de São João,

Tutors:
Dr. Blanca Pinilla Llorente
Dr. Pedro Conthe

June 2015
Vivir no es sólo existir,
sino existir y crear, saber gozar y sufrir,
y no dormir sin soñar.

Gregorio Marañón
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1. **Introduction**

Internal Medicine is complexity and diversity. I believe that every working/formation experience can improve our practical skills, as much as they put us in contact with distinct realities and allow us to exchange knowledge with peers. I have always tried to get to know different working environments during my medical practice, in order to better understand the multiplicity of ways through which the best for our patients can be achieved.

The Exchange Programme of the European Federation of Internal Medicine (EFIM) promotes short internships of one month among European specialist training centers in Internal Medicine Units. It aims to provide opportunities for gaining knowledge and skills for the Young Internists taking part. The Exchange Programme constitutes a chance to become more confident and self-reliant in professional life and to better understand the realities of others European countries.

Being on the last year of my Residency, I considered that having the chance of accomplishing the Exchange Programme of the EFIM would constitute a tremendous enrichment on my formation, not only in Internal Medicine but also as a future specialist and as a European citizen.

My Exchange Programme took part at Hospital General Universitario Gregorio Marañon (HGUGM) in Madrid, Spain, during the month of June 2015, and was supervised by Dr. Blanca Pinilla Llorente and Dr. Pedro Conthe.

*Figure 1* – Main principles of the Exchange Programme of the European Federation of Internal Medicine. (http://www.efim.org/sites/default/files/2015_exchange_brochure_web.pdf)
2. **Hospital General Universitario Gregorio Maraño**n

HGUGM is a member of the Madrid Health Service public, tertiary and university hospital, located in the centre of the city and spread over several buildings. It is noted for its technological strength and teaching and research capacities, as well as high qualifications of its professionals, being a national and international reference in various specialties.

*Figure 2 – Location of Hospital General Universitario Gregorio Maraño.*

2.1 **Internal Medicine Department**

The Internal Medicine Department of HGUGM is divided as presented in figure 3.

*Figure 3 – Organogram of Internal Medicine Department.*
2.1.1 Ward B – Section 4200

During the first three weeks of my Exchange Programme, I worked at the Internal Medicine Department – Ward B, Section 4200, as part of the medical team of Dr. Blanca Pinilla Llorente. Besides the specialist, the team was constituted by another fifth year resident (Dr. Lina Acevedo), a first year resident (Dr. Guillermo Soria) and a third year medical student (Sara Zaballos).

During morning periods (8-15h), we observed and discussed patients altogether and then divided medical registries.

I felt completely integrated in the team and could actively participate on clinical management of the patients, which allowed an important share of experiences and knowledge, namely between me and Lina, both at the 5th year of residency. Besides minor differences (in drugs used, analytic parameters valued, exams requiring informed consent, inter-work with other specialties...), our medical thinking and acting was very similar, which made me feel “at my home-hospital” immediately after the second day. I also accompanied Lina in an “on-call” shift at the hospital wards and attended clinical discussions regarding our patients with several other specialties.

I recognize that it was very important to fully understand patients’ and family’s language in order to profit the most from the Exchange.

During my stay, I followed 21 patients in Internal Medicine ward (summarized in table 1). The pathologies observed and the type of patients were very alike the ones I follow at my hospital. The admission diagnosis were mainly acute exacerbations of chronic illnesses (heart failure, pulmonary obstructive lung disease, and type 2 diabetes mellitus), as well as gastroenteritis, venous thromboembolism and urinary infections.

| Sex         | Female = 10  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male = 11</td>
</tr>
</tbody>
</table>

| Age (years-old) | Median = 79, range [30-93] |

| Functional status for basic daily life activities | Autonomous = 13  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partially dependent = 5</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Totally dependent</strong></td>
<td>= 3</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
</tr>
<tr>
<td>Domicile</td>
<td>= 19</td>
</tr>
<tr>
<td>Nursing home</td>
<td>= 2</td>
</tr>
<tr>
<td><strong>Deaths</strong></td>
<td>= 1</td>
</tr>
<tr>
<td><strong>Readmissions to the hospital in less than 48h</strong></td>
<td>= 1</td>
</tr>
</tbody>
</table>

Nevertheless, I may highlight some cases observed:

1. A 61 year-old female admitted for severe anaemia (haemoglobin = 4 g/dL), who was hiding a necrotic breast lesion of 5x6cm for three years (that we discovered in our physical exam at admission); breast cancer was diagnosed and the patient was oriented to Chemotherapy by Oncology team.

2. A 39 year-old female, previously healthy, who developed an important myositis after an upper airway/throat infection; all microbiological samples were negative and, besides positive ANA, immunological study was also unremarkable. She slightly recovered after three weeks of doxycycline. No diagnosis was evident, even after muscle biopsy results.

3. A 30 year-old male with myopericarditis, with an important increase in Troponin I, who voluntarily left the hospital without completing treatment and monitoring; Borrelia serology was positive, but it should have been repeated in order to permit diagnostic establishment.

4. An 84 year-old male with decompensated heart failure secondary to imatinib, prescribed for his gastrointestinal stromal tumour.

2.1.2 Outpatient clinic

I participated in the consultation of autoimmune diseases of Dr. Blanca Pinilla Llorente, in which I observed patients with Sjögren’s syndrome, erythematous systemic lupus, in study Raynaud’s phenomenon and ANCA-vasculitis.
2.2 Urgency Department

The Urgency Department of HGUGM follows the Manchester Triage system in what refers to priority of observation. The medical sector is divided in different areas (table 2).

<table>
<thead>
<tr>
<th>Designation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulantes</td>
<td>Observation of patients with any Manchester priority who are able to walk; the timings for observation obey to the Manchester colours</td>
</tr>
<tr>
<td>Box rápido</td>
<td>Part of the &quot;Ambulantes&quot;, where green and blue priority patients and patients with musculoskeletal complaints without history of trauma are observed</td>
</tr>
<tr>
<td>Observación</td>
<td>Observation of patients with any Manchester priority who cannot stand, as well as those with need monitoring or intoxicated patients; the timings for observation obey to the Manchester colours</td>
</tr>
<tr>
<td>Cuarto de shock</td>
<td>Emergency room; there is no permanent team there but doctors (specialists and residents older than the 2nd year of residency) are called by a siren when a patient enters the room</td>
</tr>
<tr>
<td>Área de alta dependencia (ADA)</td>
<td>Intermediate Care Unit, polyvalent, led by Internal Medicine specialists but in which there can be patients under the responsibility of other medical specialties; it has ten beds and admits unstable patients who need to be monitored or non-invasive mechanical ventilation; it does not admit patients needing central vein vasoactive support</td>
</tr>
</tbody>
</table>

I worked in Observación with Dr. Lina Acevedo and did two shifts in ADA, where I accompanied Dr. Ana Castuera and Dr. Andueza. From these shifts, I highpoint some cases:

1. A 44 year-old female with a lupus flare and severe haemolytic anaemia (under high-dose corticosteroids plus IV immunoglobulin).
2. An 81 year-old female with systemic sclerosis, decompensated cor pulmonale and oligoanuria.
3. A 30 year-old male with meningococcal meningitis.
2.3 Dynamic Area of Polyvalent Attention

The “Área Dinámica de Atención Polivalente” (ADAP) – Dynamic Area of Polyvalent Attention – is an independent department in HGUGM, headed by Dr. Pedro Conthe, and is organized as shown in figure 4 and described in table 3. It is a pilot-experience in Spain and was also a new organization for me.

Figure 4 – Organogram of Dynamic Area of Polyvalent Attention.

Table 3 – Description of the functional units that belong to Dynamic Area of Polyvalent Attention.

<table>
<thead>
<tr>
<th>Unidad de Corta Estancia</th>
<th>= short-stay unit (eleven beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits patients with acute conditions lacking clinical severity but benefiting from a short hospital observation/treatment, as intravenous antibiotics, fluid therapy, aerosol therapy</td>
<td></td>
</tr>
<tr>
<td>Hospitalización a Domicilio</td>
<td>= domicile hospitalization</td>
</tr>
<tr>
<td>Mainly for patients needing daily medical/nurse care but who are largely confined to bed and dependent on daily life activities and benefit to receive treatments at their own homes; a medical/nurse team observes patients at their places</td>
<td></td>
</tr>
<tr>
<td>Consulta de Diagnóstico Rápido</td>
<td>= fast diagnosis consultation</td>
</tr>
<tr>
<td>Observes patients derived by general practitioners, to expedite the study of constitutional syndromes, anaemia, lymphadenopathies</td>
<td></td>
</tr>
</tbody>
</table>

There is another valence – “Medicina de Enlace” or Connection Medicine that works as a link between general practitioners and hospital doctors, through which the first expose their
doubts on patient’s management or refer patients to be observed at Consulta de Diagnóstico Rápido.

Medical short-stay units were created under the hypothesis that the efficiency and quality of care for a patient who requires a reduced hospital stay can improve if he is observed in a separate unit, led by physicians who are familiar in the care of such patients’ characteristics and that should not simultaneously pay attention to more complex patients. Among the factors for the proper functioning of these units, it is highlighted the importance of proper patient selection, which should be done by the same team attending the unit; not using the unit for patients without the predetermined characteristics, which is essential for an adequate number of beds to the characteristics of the centre; and have organized an effective monitoring system in outpatient base (A. Muiño Miguez, An. Med. Interna (Madrid), v.19 n.5, Madrid, mayo 2002).

I worked in ADAP for four days, accompanying the patients that were admitted in the short-stay unit, under the supervision of Dr. Pedro Conthe and Dr. Maria Jesús Granda and with the second year Internal Medicine resident Dr. Paola Ditano. In this area, there were daily clinical discussion meetings to share decisions regarding the patients admitted and observed in domicile or outpatient regimen.

I followed patients with gastroenteritis, respiratory and urinary infections, lacking clinical severity but benefiting from a short hospital observation/treatment. A 70 year-old female patient had a urinary tract infection to an extended spectrum beta-lactamase producer Escherichia coli, and was discharged to complete intravenous ertapenem in day hospital regimen. I may also highlight the case of an 88 year-old patient with a serotonergic syndrome.

2.4 Other Departments

I spent a day working at the Stroke Unit, which is part of Neurology Department and has a total of six beds. It admits patients with acute cerebrovascular events, with modified Rankin scale ≤3. In that day, I accompanied a previously modified Rankin 0 77 year-old patient with an acute ischemic stroke, with 3 hours of evolution and total anterior circulation stroke syndrome
(National Institutes of Health Stroke Scale = 21), that entered the hospital through the emergency room. Thrombolysis was contraindicated for an abdominal surgery on the last three weeks. Computerised tomography scan showed total occlusion of left internal carotid artery and thrombectomy was performed by Interventional Neuroradiology.

### 2.5 Other Activities

I participated in several clinical sessions on various topics, organized by Internal Medicine Department and presented by residents or sponsored by pharmaceutical companies:

- **2/6** – Delirium and acute confusional syndrome
- **3/6** – Update in lipids
- **11/6** – Update on the treatment of Chronic Hepatitis C, based on the *European Association for the Study of the Liver Recommendations on Treatment of Hepatitis C 2015*
- **11/6** – New Oral Anticoagulants European Exchange (that counted with the presence of the Spanish cardiologists Dr. Antonio Fernández Ortiz and Dr. Marcelo Sanmartín, the English cardiologist Dr. Andrew Skyrme-Jones and the German cardiologist Prof. Henry Bonnemeier)
- **12/6** – Presentation of the drug Albiglutide
- **19/6** – Presentation of the drug vilanterol + umeclidinium bromide
- **23/6** – Update in endovascular therapy for ischemic acute stroke
- **24/6** – Update in arterial hypertension treatment

### 2.6 Main differences
One of the main goals of the Exchange Programme was to learn about the main differences between the two countries in terms of Health Care Systems and the main differences in the management of a particular topic or illness in both countries. Regarding the second item, I found minor differences already pointed. In what refers to organizational differences, I would like to mention the ones below:

- Family members are allowed to stay at the hospital (not only during “visit periods”) and this helps the patients to maintain their selves active, as well as increases support to those who are more dependent (the family helps with patient care and feeding); on the other hand, it might tire patients and be an additional stress factor sometimes.
- There is a great post-admission “background” support to avoid prolonged hospital stays, with units as “Corta Estancia” and “Instituto Provincial de Reabilitación” (that receives patients transferred from Internal Medicine ward who need to complete intravenous treatments or rehabilitation programs). Ambulances to transport discharged patients may be asked on the same day.
- There is a tremendous ambulatory network, helping to limit the number of patients needing hospital admission, with programs as “Teleasistencia” (a service created to be used by older people living alone or people with disabilities, allowing to call for help in an emergency, from their own homes; in addition to emergency care, it provides communication with the user to remind him or her of appointments or to alleviate situations of loneliness) and ADAP.
- The organization of Spanish Internal Medicine Residency is very different from the Portuguese one. There is no General Residency. First year residents work one year in Internal Medicine Department and during the second and the third years of Residency rotate through several departments: three months in Gastroenterology, three months in Infectious Diseases, two months in ADAP, two months in Cardiology, two months in Intensive Care, two months in Neurology, one month in Radiology, one month in Endocrinology and one month in Haematology. During the last two years, the residents spend one month and a half doing inter-consultation, one month in ADA, and four months doing a freely chosen external internship; in this period, they also rotate through Internal Medicine Outpatient Clinic, that has consultations of Arterial Hypertension, Osteoporosis, Thromboembolic Diseases and Hepatic Diseases.
- There is no referral to Internal Medicine Outpatient Clinic from General Practitioners (only to ADAP); Internal Medicine specialists do post-admission consultations or more specific ones (as above mentioned).
3. Madrid

Madrid is a city full of history and culture. Having the opportunity of experiencing its day by day “movida” during this month was another great achievement from my Exchange Programme.

*Picture 1* – View of Madrid from Lago, Casa de Campo.

*Picture 2* – Wall from metro station “Gregorio Marañón”.

4. **Conclusion and Acknowledgments**

The Exchange Programme of the EFIM gave me the opportunity to widen my medical views on an international way, experience another clinical reality working on the field for four weeks at a differently functioning hospital and share practical knowledge with high-quality healthcare professionals. At the end, I feel that Medicine is a universal language and way of being, a global family to which I am honored to belong.

I am also really glad and proud of being an Internal Medicine European member, and wish we can continue valuing medical exchange and having our minds opened to the immensity of the world.

I want to thank to Portuguese Society of Internal Medicine for its support and to EFIM Exchange Programme Working Group for making this life-experience possible.

Finally, I want to write my enormous GRACIAS to Dr. Blanca Pinilla, Dr. Pedro Conthe, Lina, Guillermo, Sara, Nadiya, José and Paola, for all the help, the precious fellowship and for making me feel at home from the very first day of my Exchange.

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*Pictures 3 and 4 – Part of the working team at Hospital General Universitario Gregorio Marañón.*

*Tienes más cualidades de lo que tú mismo crees; pero para saber si son de oro bueno las monedas, hay que hacerlas rodar, hacerlas circular. Gasta tu tesoro.*

Gregorio Marañon
5. Attachments

ATTACHMENT 1 – Invitation Letter

Dear Dr. Inês Chora:

The Exchange Programme of EFIM is pleased to extend an invitation to you to be a participant of the Exchange in the Internal Medicine Department of Hospital Gregorio Marañón, Spain.

You will be supervised by Dr. Blanca Pinilla, she will coordinate and facilitate your medical activities, and address your needs during your visit. Please contact her by email (blancapinilla@telefonica.net) to discuss any needs you may anticipate. Additionally, we expect that you will be involved in many activities that will allow cultural exchange among hospital and colleagues. According to the rules of the Exchange you should have a health insurance valid during all period of stay.

The invitation was approved by the European Federation of Internal Medicine and the Exchange Working Group and is valid for a period of one month beginning on June 1st and will conclude on June 26, 2015. You will receive a scholarship of € 600 after having successfully completed the Programme.

You will be issued a Certificate of Participation in this European Project.

We look forward to your time at Hospital Gregorio Marañón in Spain. We believe our Programme will be a very enriching experience to learn high professional skills in the practice of Internal Medicine in another European country. Your report will allow us to improve futures editions.

Sincerely,

Pedro Costhe
Chair Exchange Programme

Carla Arauíjo
Secretary Exchange Programme

Exchange Working Group: Pedro Costhe, M. Domenica Cappellini, Frank Bosch, Burçin Halaçi, Carla Arauíjo
Endorse: Daniel Sereni, President of The Foundation for the Development of Internal Medicine in Europe

For further details please visit: http://www.efim.org/en/european-exchange-programme-950
ATTACHMENT 2 – Certificate of presence

Madrid, 26th June 2015

We hereby certify that Inês Joao da Silva Chora, 5th year Internal Medicine Resident from Centro Hospitalar Sao Joao, Porto, Portugal, completed a one-month internship (June 2015) at Hospital General Universitario Gregorio Marañon, Madrid, Spain, on behalf of the Exchange Programme of European Federation of Internal Medicine.

Dra. B. Pinilla Llorente
Profesor asociado

Dr. K. Conthe
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