



TABLE OF CONTENTS

06

MISSION & VISION

Supporting Doctors,
Strengthening Humanity

10

TRAINING AND DEVELOPMENT

PDP & Global Medical Progress

14

ARTIFICIAL INTELLIGENCE AND HEALTH

Establishing ai in our project

18

WELLBEING

Add a short teaser paragraph here

25

AMBASSADORS TRAINING AND TESTIMONIALS

Add a short teaser paragraph here

36

HEALTHY EATING AND EXERCISE

Add a short teaser paragraph here

48

AMBASSADOR'S NOTE

Add a short teaser paragraph here

55

NHS & BORDERS WITHOUT BORDERS

Add a short teaser paragraph here

BORDERS WITHOUT BORDERS IS NOT JUST A **NETWORK**

A **digital hub** for training and development

It is a living community built on trust, generosity, and purpose. A place where medical professionals are seen not only for their titles, but for their impact.

- **BECAUSE WHEN CARE HAS NO BORDERS,**
- **NEITHER DOES HOPE.**



OUR CONTRIBUTORS

Place a short biography of this magazine's contributor here.

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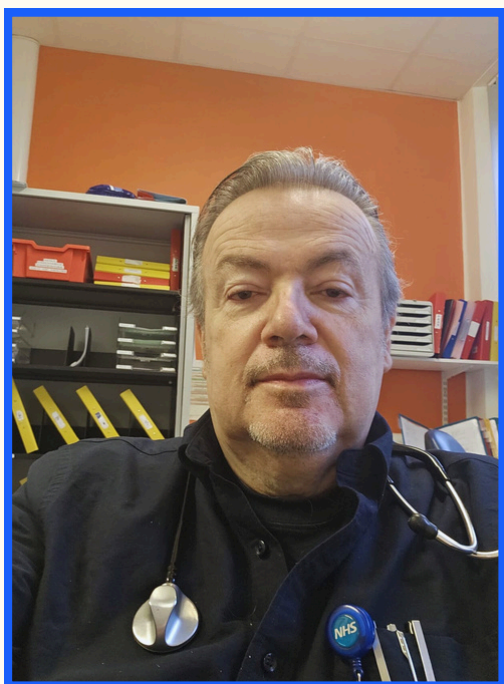
CONTRIBUTORS
SOO JIN AE
TAKEHIRO KANEGI

AMBASSDORS
DR. ROBERT URIMFUKE
DR. DANIELLE NANKEP
TCHOUDA TCHOUANGEUP



WELCOME NOTE

DR. SPYRIDON TROUS



INSPIRED BY NHS

Medicine, to me, has always been deeply human. It is shaped by the people we care for and the colleagues we stand beside. Over the years, I have learned that true excellence in healthcare cannot exist without collaboration, integrity, and wellbeing. **Borders Without Borders** was created from this belief – a space where doctors across the world can connect, support one another, and share knowledge without limits.

With the support of the NHS, this platform reflects my hope for future generations: a medical community where strong values guide our work, wellbeing is protected, and no clinician feels alone. This is the legacy **I am proud to help build.**

My work has taken me to diverse cultures and communities. Through these experiences, I've come to understand that well-being transcends borders. The common thread that unites us all is the desire for a better, more fulfilling life. It's this understanding that has fueled my dedication to guiding individuals on their personal journey towards self-realization and growth.

DR. SPYRIDON TROUS



MISSION

To create a trusted, **NHS-supported platform** that connects doctors and medical professionals across the world, enabling the **ethical exchange** of knowledge, experience, and expertise. **Borders Without Borders** exists to foster collaboration built on integrity, **mutual respect**, and a shared commitment to advancing patient care beyond geographical boundaries.



VISION

To build a globally connected medical community rooted in the values of the NHS ~ where doctors work together without borders to improve healthcare outcomes, inspire innovation, and shape a more equitable and collaborative future for medicine worldwide.

CORE VALUES

➤ INTEGRITY FIRST

➤ COLLABORATION

➤ RESPECT

➤ EXCELLENCE

➤ HUMANITY

➤ SUCCESS METRICS

➤ METHODOLOGY
AND DEVOTION

➤ FEEDBACK
AND PROGRESS

Borders Without Borders began in Aberdeen at ARI, inspired by doctors and the compassion that drives their work every day.

It was created to support doctors as people first- by offering connection, understanding, and shared strength.

Through open communication, inclusive leadership, and global collaboration, the platform brings doctors together in one trusted space to learn, grow, and support one another.



SUPPORTING DOCTORS, STRENGTHENING HUMANITY

By valuing diversity, transparency, and wellbeing, Borders Without Borders helps doctors feel less alone and more confident in their roles.

HOW **BORDERS WITHOUT BORDERS** ELEVATES MEDICAL PERFORMANCE AND LEADERSHIP



Great medicine begins with healthy, confident doctors. When doctors feel connected, valued, and supported, their performance and productivity naturally rise ~ not through pressure, but through purpose.



Borders Without Borders strengthens doctors by creating a global space for connection, diversity, and shared learning. By exchanging knowledge across cultures and healthcare systems, doctors expand their perspectives, sharpen clinical thinking, and grow as leaders.

RECRUITMENT

ACCREDITATION

COMPLIANCE

INTERNATIONAL STANDARDS

IT IS TIME TO REDEFINE LEADERSHIP SUCCESS IN HEALTHCARE AS BOTH EFFECTIVE AND WELL.



FROM ABERDEEN TO THE WORLD, BORDERS WITHOUT BORDERS STANDS FOR ONE SIMPLE TRUTH: **WHEN DOCTORS CONNECT, CARE TRAVELS EVERYWHERE.**

Rooted in Aberdeen's rich medical heritage and inspired by NHS principles of excellence and patient-centred care, Borders Without Borders brings together experienced clinicians, educators, researchers, and innovators to support the next generation of healthcare professionals.



ONLINE TRAINING AND DEVELOPMENT COURSES

PARTNERSHIP WITH RECOGNISED BODIES

ACCREDITATION AND EXPERT MENTORSHIP

COMMUNICATION & TEAMWORK

PDP & GLOBAL MEDICAL PROGRESS

LEADERSHIP DEVELOPMENT



Our leadership team provides strategic direction, ensuring that every initiative aligns with our vision of advancing global healthcare through connection, education, and wellbeing. Working across countries, specialties, and healthcare systems, the team is committed to creating opportunities that empower doctors to learn, lead, and thrive.

ONLINE TRAINING & GLOBAL DEVELOPMENT PLATFORM

Our online training platform provides accessible, flexible, and high-quality development opportunities for doctors and healthcare professionals around the world. Through expert-led education, mentorship, leadership programmes, and collaborative learning, participants can develop skills that enhance both professional performance and personal wellbeing.



Key focus areas include:

- Clinical Excellence & Best Practice
- Leadership Development
- Wellbeing & Resilience
- Artificial Intelligence in Healthcare
- Medical Ethics & Professional Standards
- Communication & Teamwork
- Research & Innovation
- Global Healthcare Collaboration

LEARNING MEDICINE AND LEARNING **THE NHS ARE** NOT THE **SAME THING.**



AS AN IMG,

I often get asked:
"What should I focus on?"
Honestly, even I did not know the
answer initially.

I thought knowledge alone would make
me ready to practise confidently. But
during my clinical attachments, the
junior doctors I shadowed gave me
advice I will never forget.

THEY TOLD ME:

"Once you learn the IT systems, there
will be fewer barriers when you start
working."

And I am so grateful I listened. Their
patience and guidance helped me
tremendously.

When I graduated outside the UK,

I thought my main focus would only be
clinical knowledge such as physiology
diagnosis, diagnosis, medical plans
and guidelines.

In fact, all those things matter but I
realised something important whilst
doing my clinical attachment in the UK.

*Medicine in the NHS is also deeply
practical and administrative.
The system itself is part of the job,
something that IMGs should keep in mind.*

Because the hidden side of the NHS
is not always medicine itself;
it's also learning

how to navigate the system.

- How to refer patients.
- How to request scans.
- How to order bloods.
- How to document properly.
- Who to contact.
- How to make referrals.
- Is it by phone or email?
- Which team to escalate to.
- How pathways function.

*Danielle Nankep
Tchouda Tchouangeup*





These small things bring medicine to life and you soon realise clinical knowledge alone is not enough: If you cannot request investigations, document safely, or prescribe appropriately, how can you practise effectively?

And I think many IMGs underestimate this initially. Not because they lack intelligence, but because every healthcare system functions differently.

You slowly learn the language of the NHS once you start practicing as a clinician.

- The abbreviations
- The culture
- The communication styles
- The bedside manners
- The referral patterns
- The unspoken systems behind patient care.

And over time, what once felt unfamiliar begins to feel like home.

That is what the ward is teaching me so far...

What has the ward taught you that medical school did not?

*Danielle Nankep
Tchouda Tchouangeup*



You do all that whilst trying to integrate into the system and still building confidence as a doctor.

It is a humbling journey to say the least.

But it has also taught me that medicine is teamwork. No doctor learns

- a healthcare system alone.
- Colleagues help you adjust.
- Nurses guide you.
- Seniors teach you.
- Other juniors reassure you.

PDP & GLOBAL MEDICAL PROGRESS

Within Borders Without Borders, **Personal Development Planning** (PDP) is central to achieving sustainable global medical progress and wellbeing by 2030. Individual growth drives collective impact.

THE PDP FRAMEWORK FOCUSES ON THREE KEY AREAS:



- Digital Development through online learning and global conferences.
- Clinical Excellence & Teaching by improving performance and mentoring doctors and ACPs.
- Leadership Growth to strengthen workplace culture, transparency, and wellbeing.

By investing in continuous development, doctors enhance their confidence, capability, and global collaboration ultimately improving patient care and strengthening healthcare systems worldwide.



CASE STUDY-01

72YEAR OLD FEMALE WITH L FLANK PAIN AND FEBRILE EPISODES

66

By **Sophie Cabrelli**
5th year medical student

Dr. Spyridon Trou (supervisor)
Consultant General Medicine



History of Presenting Complaint

Admitted with a 2 week history
of worsening L flank and back pain,
associated with febrile episodes,
nausea and diarrhea



No changes in waterworks,
no limb weakness or blood
in diarrhoea



Flank / back pain since getting
bilateral ureteric stent changes
at end of August

Past Medical History

Hydronephrosis-retroperitoneal
fibrosis resulting in extrinsic
compression of ureters. Has ureteric
stents (since 2021) and gets them
changed when indicated.
Last changed August this year.



Oesophageal dyskinesia

Diabetic insipidus

Seborrheic keratosis

Non smoker, Non drinker

Lives in care home

Plan on admission

DIFFERENTIALS TO CONSIDER

1. Pyelonephritis ?
2. Infective Uretic Stents ?
3. Infective Diarrhoeal Illness ?

Initially managed in ED then
transferred to Ward 105 (gen med)
for ongoing care

PLAN

- **IV ANTIBIOTICS:** Amoxicillin and gentamicin (escalated to Tazocin in light of inflammatory markers)
- IV fluids
- Antiemetics
- Pain control
- Stool culture
- Discuss with radiology re CT abdo pelvis
- Urology discussion after CT AP (change of ureteric stents. Urology thought this wasn't indicated and discussed pyelonephritis can take a long time to resolve- to continue with IV abx)?

RESULTS

**1ST CT ABDO
PELVIS ON
ADMISSION
(02/11)**

Fat stranding around kidneys and
ureters. Infective and inflammatory
changes seen. No collection seen.
Developing pyelonephritis cannot
be excluded

**2ND CT AP
A WEEK
LATER
(10/11)**

2nd CT AP a week later (10/11)
Unchanged urinary tract appearances.
No evidence of collection of abscess.
progressive pyelonephritis.
New bibasal consolidation and
progressive subcutaneous oedema?

Results from CTAP showed hospital acquired
pneumonia (HAP). Patient discussed with
microbiology and switched to IV co-trimoxazole

LAB RESULTS

ENTERIC INVESTIGATIONS
NEGATIVE culture, no pathogens

C.DIFF
NOT detected

BLOOD CULTURES
No growth anaerobic and aerobic

NEGATIVE

URINE CULTURE

LEGIONELLA

COVID

RSV

EXAMINATION (TODAY)

Patient lying upright in bed, stated feeling no better and still in considerable pain and feeling nauseous

- No pallor, tongue dry
- **A-** airway patent, patient conversing
- **B-** chest clear
- **C-** CRT 3s, HS I+II, bilateral peripheral oedema
- **D-** no focal neurology
- **E-** abdo soft, bowel sounds present, tenderness over L lumbar region and L hypochondrium

BLOODS

HB	: 106
MCV	: 95
Platelets	: 505
WBC	: 10.7 (had prev been 11.5, 16.8)
CRP	: 198 (had prev been 221, 260, 415)
K+	: 3.3 (2.5 on admission)
Na	: 142
LFT's	: Normal

NEWS= 4

- HR 95, SpO2 94% on 1L O2
- Last temp spike over a week ago

ECG on admission:
sinus rhythm, HR 63



LEARNING POINT



1. FRAILTY

In frail elderly patients we need to look at all the problems collectively, and formulate a plan that takes into account how all these factors interact with each other.

2. REVIEWING

Constant reviewing and re-thinking of the patients care is necessary, especially in a case like this when the answer is not black and white, and improvement is very slow. Need to keep an open mind on differentials

3. HOLISTIC CARE

Involving the whole MDT team, and asking for other specialties help in guiding the patients management plan

ONGOING STEPS



Continue IV co- amoxiclav- inflammatory markers slowly improving. Know from urology that pyelonephritis can take a while to resolve completely



Continue regular pain control and anti-emetics



Monitor Bloods

Now suspecting IgG vasculitis after finding aortitis on a scan from sept 2023. Patient received CT aortogram then ?CT PET after the results of this. This is ongoing at the moment.



A SILENT CASE OF SADDLE PE



Dr. Nankep Tchouangeup

When Breathlessness Hides a Life-Threatening Diagnosis

Patient: 78-year-old male

Admitted: 25/12/25 (Christmas Day)

Presenting Complaint: Decline in mobility and shortness of breath

History of PRESENTING COMPLAINT:

- Legs felt weak with decline in function
- Altered neurology in lower limbs (Left > Right) with reduced power
- CT Brain (29/12/25): old left parietal gliosis
- **PR:** normal perianal sensation and tone
- MRI requested



This case describes a **78-year-old gentleman** admitted with reduced mobility, lower limb weakness, and shortness of breath. His background included hypertension, type 2 diabetes, coronary artery disease, osteoarthritis, previous non-Hodgkin lymphoma, and hip replacement surgery.

Initially, the focus was on possible neurological causes due to worsening mobility and reduced lower limb power. Brain imaging showed only chronic changes, but further assessment revealed an important clue - persistent swelling of the left leg for several months.

Collateral history from family members highlighted episodes of sudden breathlessness following seizure-like events, during which the patient appeared grey but did not lose consciousness. These episodes, combined with unilateral leg swelling, raised suspicion of a possible thromboembolic cause.

DIAGNOSIS AND CLINICAL FINDINGS

The differential diagnosis for new breathlessness included heart failure, acute coronary syndrome, pneumonia, pneumothorax, COPD exacerbation, and pulmonary embolism. PE remained a key "must-not-miss" diagnosis.

Pulmonary embolism occurs when a blood clot, usually originating from deep veins of the legs or pelvis, travels to the pulmonary arteries and blocks blood flow. Symptoms vary depending on clot size and the degree of vascular obstruction.

Common features include:

- Sudden unexplained breathlessness
- Tachycardia and tachypnoea
- Chest pain
- Cough or haemoptysis
- Syncope or cardiovascular collapse



Investigations showed elevated troponin levels, new ECG changes with T-wave inversions, and echocardiography evidence of severe right ventricular dilatation and impaired function, suggesting significant right heart strain.

CT Pulmonary Angiography (CTPA) confirmed a massive saddle pulmonary embolism, a large thrombus crossing the bifurcation of the main pulmonary artery and extending into both pulmonary arteries.

WHAT IS A SADDLE PULMONARY EMBOLISM?

PE is defined as **sudden blockage** of the **pulmonary artery** or one of its branches by an **embolus**.

RISK STRATIFICATION ~ PESI SCORE

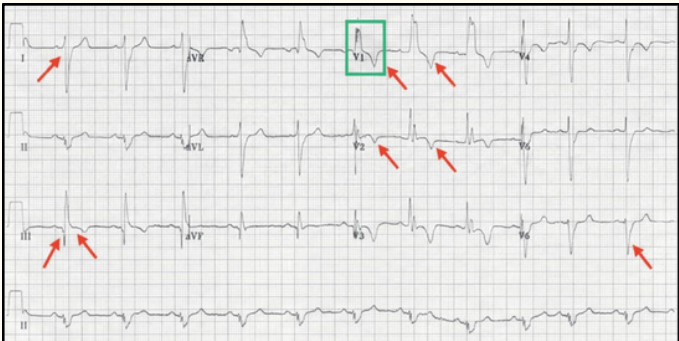


PESI SCORE EXPLANATION:

The Pulmonary Embolism Severity Index (PESI) is a validated clinical tool used to estimate 30-day mortality risk in PE patients, categorizing them into 5 risk classes (I-V) based on 11 clinical factors, including age, comorbidities, and vital signs.

Patient PESI Score:
178 (Class V = Very High Risk)
Estimated 30-day mortality: **10-24%**

CLASS	SCORE RANGE	RISK LEVEL	30-DAY MORTALITY
Class 1	< 65	Very Low Risk	0 - 1.6 %
Class 2	66 - 85	Low Risk	1.7 - 3.5 %
Class 3	86 - 105	Intermediate Risk	3.2 - 7.1 %
Class 4	106 - 125	High Risk	4.0 - 11.4 %
Class 5	> 125	Very High Risk	10.0 - 24.5 %



Clinical Message:

Not every pulmonary embolism announces itself dramatically. Sometimes, the most dangerous diagnoses are hidden behind simple symptoms.

Management and Key LEARNING POINTS

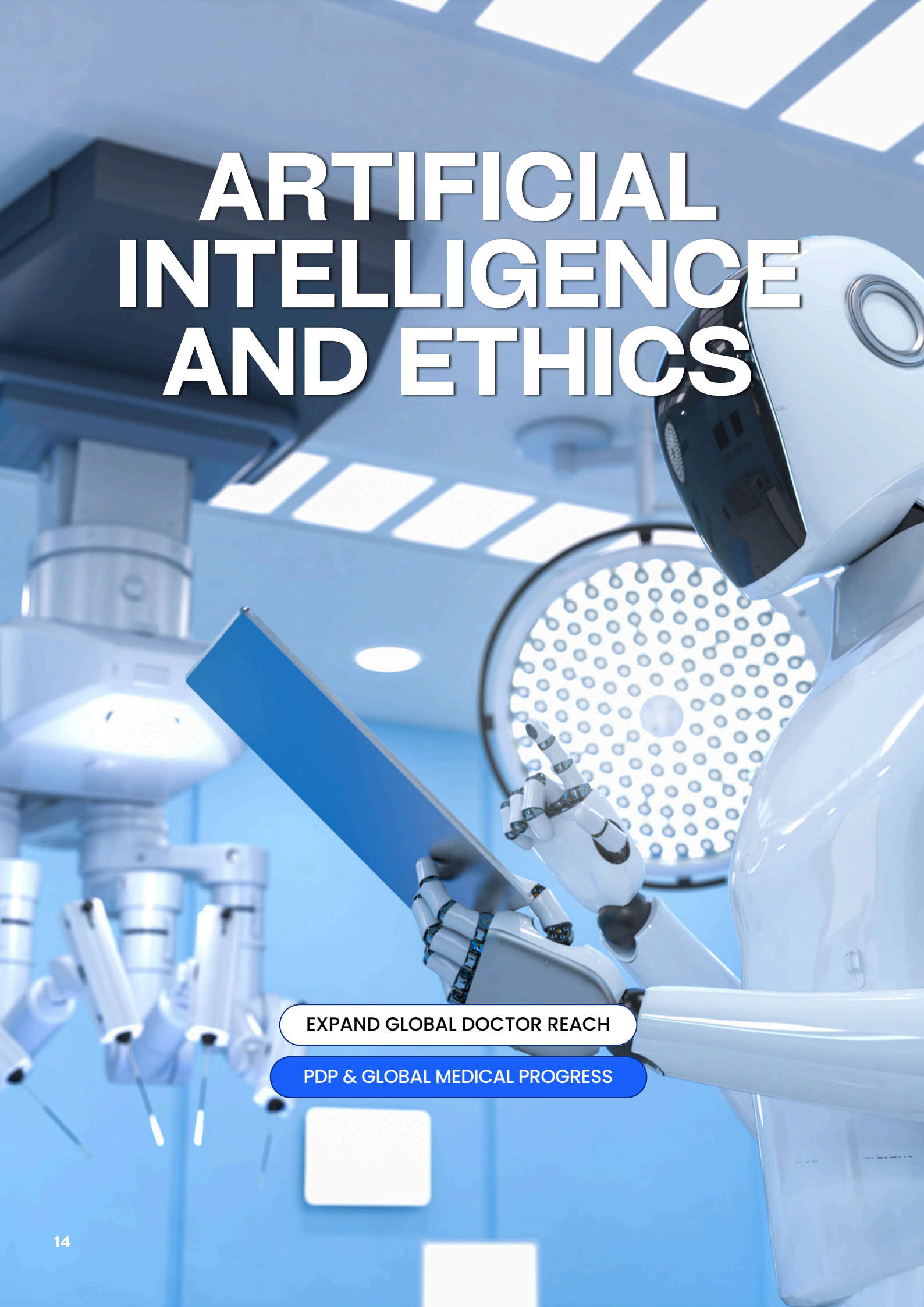
- Because the patient was stable and showed no signs of shock, thrombolysis was not required. Treatment was started with therapeutic-dose Dalteparin, followed by transition to Apixaban.
- Apixaban was commenced at 10 mg twice daily for 7 days, followed by 5 mg twice daily maintenance therapy. Direct Oral Anticoagulants (DOACs) are now preferred in many PE patients due to their effectiveness and reduced monitoring requirements compared with warfarin.

KEY LESSONS:

- PE can present with unusual symptoms, especially in older adults.
- Unexplained breathlessness with unilateral leg swelling should raise suspicion of venous thromboembolism.
- ECG changes can support diagnosis but cannot confirm or exclude PE alone.
- CTPA remains the definitive investigation for diagnosing PE.
- Treatment decisions depend on haemodynamic stability, not only clot size.
- This case highlights the importance of recognising subtle clinical signs. A patient may have a life-threatening saddle PE while appearing relatively stable making careful assessment, clinical reasoning, and early investigation essential.

Dr. Nankep Tchouangeup

ARTIFICIAL INTELLIGENCE AND ETHICS

A futuristic surgical room with a white robot holding a blue tablet. The robot is on the right, holding a large blue rectangular tablet. In the background, there are surgical lights and a large circular light fixture with a grid of small lights. The overall color scheme is blue and white.

EXPAND GLOBAL DOCTOR REACH

PDP & GLOBAL MEDICAL PROGRESS

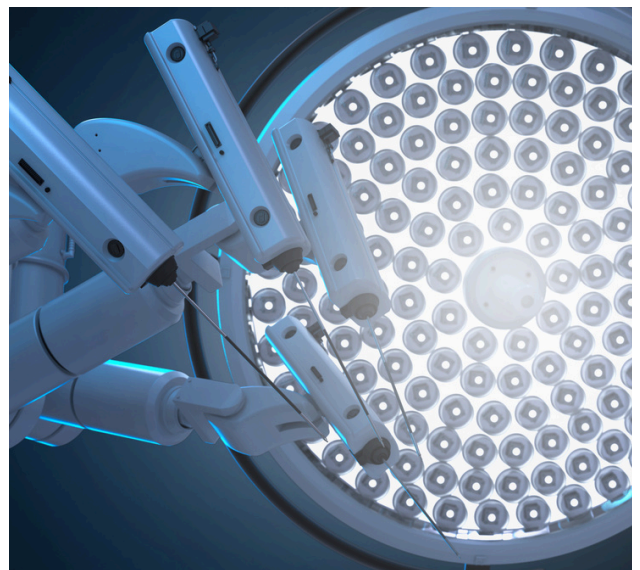


ESTABLISHING AI IN OUR PROJECT

**BY INTEGRATING AI RESPONSIBLY, BORDERS WITHOUT BORDERS
CAN ENHANCE COLLABORATION, EXPAND GLOBAL DOCTOR REACH
AND ENRICH NHS-ALIGNED COMMUNICATION INNOVATION.**

To grow **Borders Without Borders**, we can create an online innovation and training hub as a centre of excellence for global doctors to collaborate, learn and share AI skills. **The NHS supports AI** use with networks, guidance and training to help teams adopt tools safely and confidently.

We should build an **AI ethics framework** with clear principles and set up long-term monitoring and evaluation to ensure improvement. Because confidence and skills in AI vary widely, training and shared learning are essential so doctors worldwide can use **AI responsibly with NHS support**.



Holistic Wellbeing



EXPAND GLOBAL DOCTOR REACH

WELLBEING BEYOND BORDERS

WELLBEING & RESILIENCE

WELL-BEING FOR DOCTORS

Building world's most respected platform for doctors well-being.

Our mission

HEALING SYSTEMS. SUPPORTING DOCTORS.

We believe that better healthcare begins with supporting the people who deliver it. Our approach combines two powerful dimensions with one shared mission:
improving doctors' wellbeing while helping healthcare systems evolve.



PERSONAL WELL-BEING

We provide doctors with practical tools, global peer support, **leadership development**, and evidence-based wellbeing strategies that can be applied in everyday practice. By strengthening **confidence, resilience, and connection**, we help doctors thrive both professionally and personally.

SYSTEMIC CHANGE

We promote healthier workplace cultures through leadership, education, **collaboration, and innovation**. By sharing global best practices, we support healthcare organisations, **educators, and decision-makers** in embedding wellbeing into the future of medicine.



IT'S TIME TO REDEFINE LEADERSHIP SUCCESS AS HEALTHY AND HAPPY!

WHY WE ARE DOING THIS.

The Expert Committee extends a formal invitation to physicians, healthcare leaders, and medical professionals worldwide. Physician well-being in today's demanding clinical environment is not optional; it is a priority and a shared responsibility.

WE WELCOME:

- Doctors and Medical Educators
- Hospital and Healthcare Leaders
- Wellbeing Advocates and Frontline Professionals
- Researchers, Insurers and Strategic Partners



How Holistic Well-being **ELEVATES DOCTORS PERFORMANCE AND PRODUCTIVITY**

WELL-BEING AMBASSADORS

Strategies for Enhancing Employee Well-being through Leadership

1. Promoting Work-Life Balance
2. Recognizing and Addressing Burnout
3. Building a Culture of Wellbeing
4. Encouraging Professional Growth

BORDERS WITHOUT BORDERS has its own team of Ambassadors who work together to find ways to make a positive difference to the quality of life. Well-being Ambassadors play a vital role in supporting and promoting health and well-being in their departments.

Therefore, BWB provides high quality health and well-being standard care to all the Doctors & educators & Health Leaders. It provides and maintains healthy working environment by promoting and applying health and wellbeing standards.

Educating the mind without educating the heart is no education at all - Aristotle



HOLISTIC WELLBEING FOR ALL, BEYOND BORDERS



BEYOND CARE: WELLBEING FOR ALL



CARING FOR THE CAREGIVERS

At Borders Without Borders, we believe doctors deserve the same care they give so freely to others. Medicine is demanding, and without support, the weight of responsibility can affect not only performance, but the person behind the profession. Our commitment to holistic wellbeing recognises doctors as whole individuals supporting their physical, emotional, mental, and professional health.



Guided by a **Nine Pillars of Wellbeing** approach, we promote balance, resilience, connection, and purpose. Through global peer support, shared experiences, and compassionate leadership, we help doctors feel seen, supported, and valued. Because when doctors are well, care becomes stronger for everyone, everywhere.

AMBASSADORS TRAINING AND TESTIMONIALS

EXPAND GLOBAL DOCTOR REACH

WELLBEING BEYOND BORDERS

ESCALATION IS NOT WEAKNESS, IT IS CLINICAL JUDGEMENT IN ACTION.

As a junior doctor, I am learning that medicine does not reward silence. It rewards timely communication which involves escalation to seniors.

There is an unspoken fear early in training that calling a senior means failure, that asking for help means incompetence, or that escalating means you are not enough.



But I am learning that the opposite is true whilst practicing every day. Good clinical care often depends on early escalation, clear communication, and shared decision making within teams. In practice, this looks like speaking up sooner rather than later because deterioration is rarely sudden. It is often gradual, subtle, and easy to miss when you are holding the concern alone. If you see a red flag, escalate no matter how minor it may be.

I have learnt that seniors are not there to replace juniors. They are there to refine decisions, reduce risk, and see patterns that with their years of clinical experience is easily brought to light. So as juniors we must understand that in exceptional clinical teams, escalation is part of safety culture, not a last resort.

So as junior we must understand that in exceptional clinical teams, escalation is part of safety culture, not a last resort.

On the ward, this translates into something simple: if you are unsure, someone else should know.

If something does not feel right, it is worth a second opinion. If you pick up that a patient is changing and does not seem quite right, the decision to escalate has already been made for you.



ESCALATION IS NOT WEAKNESS,
IT IS CLINICAL JUDGEMENT IN
ACTION.



I have also realised that escalation is not only clinical but also emotional discipline. As a junior you have to refine your ability to act despite doubt, and to prioritise patient safety over self-consciousness. This is a sign of professionalism and growth.



The most experienced clinicians I have observed are often the most comfortable escalating early themselves, or encouraging juniors to do so without hesitation. I have seen my consultants escalate cases that was not within their discipline to specialities who acted promptly.

Medicine is safer when it is shared, not siloed. A single doctor holds information, but a team holds judgement and escalation is how that judgement is shared.

So perhaps we should reframe it entirely for junior doctors because escalation is not asking for permission, it is protecting patients. It is you applying the ethos of patient centred care. Therefore it is not a sign of weakness, but a marker of safe practice.

This is what the ward has taught me thus far...

What has the ward taught you that no textbook ever did?

TESTIMONIAL



DR. ROBERT URIMFUKE BASAKE



Working within the General Medicine Borders patients' team at Aberdeen Royal Infirmary, NHS Grampian has been a highly enriching and formative experience for me. The team fostered a supportive and collaborative environment where clinical excellence was matched by a genuine commitment to mentorship and professional development.

During my time there, I benefited greatly from structured and informal teaching, including departmental presentations, day-to-day clinical supervision, and hands-on mentorship in key areas such as ALS, ultrasound-guided vascular access and general medicine procedures. I was also supported in my academic progression, successfully passing MRCP Part 1 and Part 2, which reflects the strong educational culture within the team.

What stood out most was the ethos of shared learning and continuous improvement. The Borders team consistently demonstrated how high-quality patient care is achieved through teamwork, open communication, and mutual respect.

This philosophy is powerfully reflected in the Borders Without Borders initiative, a forward-thinking project that embodies the true spirit of the NHS – collaboration without limitations. It is more than a network; it is a platform that connects clinicians globally, promotes ethical knowledge exchange, and reinforces the idea that patient care transcends geographical boundaries.

Being part of this environment has not only strengthened my clinical competence but also shaped my values as a doctor. I strongly believe that initiatives like Borders Without Borders represent the future of medicine – where innovation, education, and compassion come together to improve patient outcomes on a global scale.

Dr. Robert Urimfuke Basake

TESTIMONIAL ★★★★★



**DANIELLE NANKEP TCHOUDA
TCHOUANGEUP**

Hello Dr Trous ,
I wrote this thanks to your interaction with John

The need for connection.

Sometimes, what stays with me most on the ward is not a diagnosis, a blood result, or a treatment plan.

It is the way we speak about people.

"He has dementia."
"She has dementia."
"She is confused."

And while those words may describe part of a clinical picture, they never describe the whole person

Because medicine is not just about clinical knowledge

It is not just about how well you diagnose
It is not just about memory, guidelines, or having the right answer at the right time

Medicine is, first and foremost, human!

It is connection.
It is relationship.
It is empathy, presence, listening, and care.

Danielle Nankep

Recently, I watched a consultant do something simple, but deeply meaningful

He brought a patient fruit. His favourite snacks
He took a few minutes out of his day just to say hello

He paused.

He recognised an individual, not just a patient
He recognised a need for connection
He understood the importance of presence, togetherness, and being seen

I admire that deeply.

Because medicine is beyond the books
It is real human connection

A conversation can be healing.
A listening ear can be soothing.
A hand to hold can be comforting.
A few extra minutes can mean more than we realise.

And yet, I often wish I had more time on ward rounds.

I wish I could stay a little longer.
I wish I could be there a little more.

But so often, the system is built for speed,
For movement
For efficiency
For quick outcomes.

And in that rush, the space for connection becomes smaller.

But the need for connection does not become smaller, if anything, it becomes even greater.

That is what the ward is teaching me:
That medicine is not only about treating illness.
It is also about recognising humanity.

That is what the ward is teaching.

I am posting what the ward is teaching me on my LinkedIn. This is post 4.

TESTIMONIAL ★★★★★



**DANIELLE NANKEP TCHOUDA
TCHOUANGEUP**

A bad team can break a good doctor,
but a good team can build one.

The difference between confidence and fear in
medicine is often one supportive colleague.

As a junior doctor, you soon realise that some
of the most important learning does not come
from textbooks but from people, the patients,
the nurses, the consultants, the registrars and
even the family.

The finest consultants I have met are not those
who remind you of hierarchy. They are those
who remember what it felt like to be new,
uncertain, full of questions, lacking confidence,
and sometimes overwhelmed.

They teach without humiliation, correct without
embarrassment, guide without ego, and lead
without fear.

There is something powerful about a senior
doctor who creates safety, not only the safety
of guidelines and protocols,
but the safety to say, "I am not sure."

I have worked with consultants that have created
space for me to ask for help and to escalate
concerns when I think something is not right
regarding a patient. With a great team, you also
have a say, you are collaborating to make the
right decision. That is something I love about the
general medical team I am working with at present.

That safety to learn without fear of judgement.
That safety that you will not be crucified should
you not know an answer to a question. It just open
rooms for us to see where we are lacking so that we
can study those areas more.

Research may call this psychological safety.
On the ward, it feels simpler than that. It feels like
belonging and not being afraid to express your
thoughts or working diagnosis or medical plan.

A supported junior learns faster, grows with more
confidence, and becomes independent through
guidance rather than fear.

I have also seen how the best teams share the load.
A colleague helping with jobs, a registrar staying
behind, a consultant taking time to teach and
having tough family discussions. All these small
acts that make heavy days feel lighter.

I think team work especially as a junior doctor is
this: helping carry a burden that was never meant
to be carried alone. Because medicine is already
demanding enough, and the team around you
can shape your entire experience of it.

It can be the difference between burnout and
growth, between fear and confidence, between
surviving and becoming.

That is what the ward is teaching me so far.....

What has the ward taught you that no
textbook ever did?

Danielle Nankep