

I was redeployed in early April from my role as an ST1 in Histopathology to a general medical ward. The possibility of being drafted to a clinical area had been broached around a month prior to this; in the interim while awaiting confirmation regarding whether or not it would become necessary, I had the opportunity to attend a number of refresher lectures aimed at doctors facing redeployment. As I had last worked clinically within the previous year, redeployment was perhaps less daunting a prospect than had my experience on the wards been more remote. Nonetheless, I had not worked in general medicine for two years and was not familiar with the wards in my current hospital. There was both medicine and logistics to be learned and relearned, from the management of diabetic ketoacidosis to how to get a surgical consult.

I worked at senior house officer level on a team staffing the 'non-COVID' medical wards, looking after most of the general medical patients outside of the AMAU. I dealt with patients with a wide variety of diagnoses, including acute coronary syndrome, stroke, COPD exacerbations, pyelonephritis and hyperosmolar hyperglycaemic state. The old familiar challenges of fielding bleeps, frequent on-call shifts and lengthy ward rounds were counterbalanced by a supportive team and the appreciation that was apparent on a daily basis from the public and from local businesses and charities, whose generous daily donations of meals gave us one less thing to think about.

It was interesting to observe the differences in life on the wards amidst the pandemic compared to during normality. One of the more challenging aspects was the termination of visiting hours. This was of course an essential tenet in reducing COVID-19 transmission, but opened my eyes to how helpful a family member's first-hand impression of the progress of their relative can be. Another striking change was the relatively low number of presentations, and therefore admissions, of patients with non-COVID related symptoms. And of course there was the ever-lurking threat of the virus itself, casting every cough, low-grade fever or complaint of nausea in a new light.

My experience to date in Histopathology proved useful on a few occasions, for example in being familiar with the surgical management of cancers, discussing the completion of death certificates and highlighting the need to include a patient's history of malignancy on the cytology request for a pleural aspirate.

As the number of COVID-positive admissions dwindled, several of the COVID-designated wards were reassigned to general medicine and surgery and I was released back to my Histopathology post. I have gained a lot from my experience of redeployment; it renews the purpose of my work as a Histopathologist to be reminded of the patients and stories behind the specimens we receive. In addition to this, the leadership and innovation I witnessed in restructuring the hospital and mobilising its resources in such a short period of time and in such unprecedented circumstances was inspirational. And last but not least, redeployment has resurrected my appreciation for the relative peace of a bleep-free role!

ST1 in Histopathology, London deanery