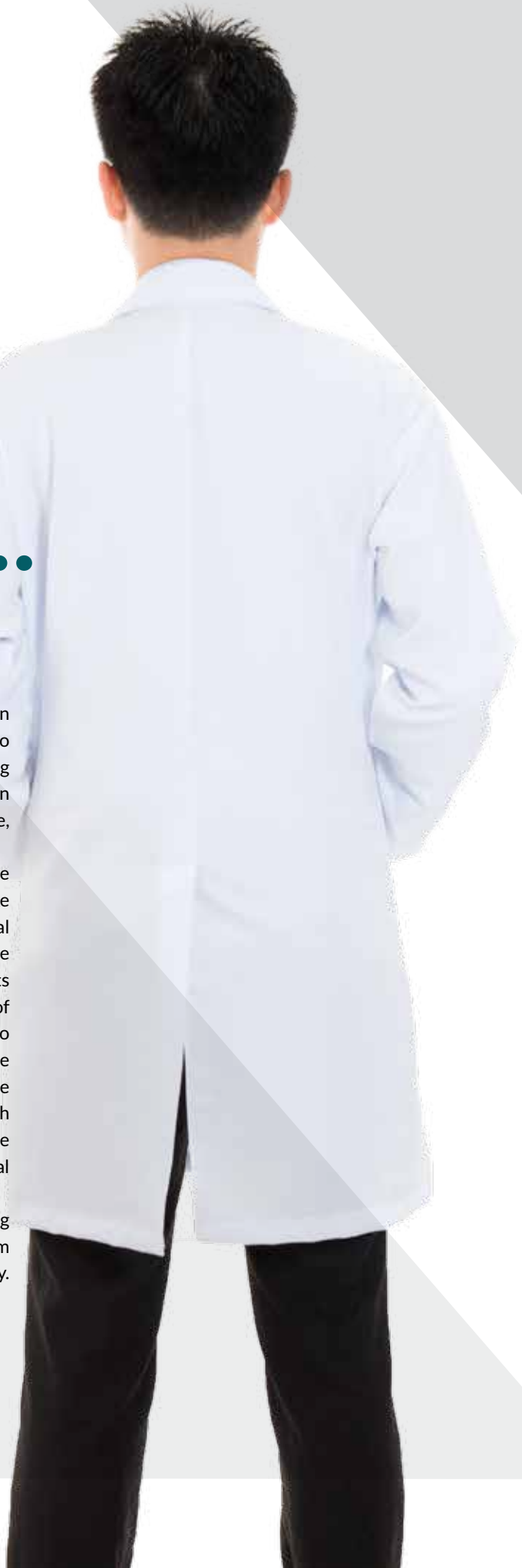
A Day in the Life of a Resident In...



What is a typical day in your life like? We posed this question to seven residents in different specialties, and asked them to pen their thoughts. What we received were heartwarming and passionate accounts of life as a doctor in training (DIT) in Anaesthesiology, Emergency Medicine, Internal Medicine, Pathology, Psychiatry, Radiology and Surgery respectively.

Truth be told, there is no typical day at work for these trainee doctors, due to the dynamic nature of their duties. However, like in any formidable team, each DIT plays a different but crucial role in patient care – some will battle diseases head on while others will provide, as Radiology DIT Dr Peh Wee Ming puts it, intelligence to their comrades who are at the front line of healthcare. While all seven DITs recognise the need for them to carry their weight at the workplace, they also acknowledge the importance of working well with all members of their healthcare teams. The septet share stories about building rapport with allied healthcare colleagues and absorbing as much knowledge as they can from senior clinicians while providing medical support, exemplifying a climate of teamwork in the wards.

As young doctors embark on the long and arduous training path, Surgery DIT Dr Lim Tian Zhi emphasises the need for them to keep the spirit and passion burning throughout this journey. Now read on and take a walk in their shoes... ■

By Dr Lim Jia Yan

ANAESTHESIOLOGY

Dr Lim Jia Yan is a first year resident in training. She hopes to go to sleep happy and wake up raring to go every day.

It is 7.30 am.

A collapsed patient with a ruptured abdominal aortic aneurysm comes crashing into the operating theatre (OT).

"Start CPR, get the adrenaline, activate the massive transfusion protocol!" my registrar orders.

My colleagues and I scramble into action, fighting to resuscitate the patient while the surgeon prepares to operate.

Despite our best efforts, we lose some patients.

Some days we are defeated.

As an Anaesthesiology trainee, my days are a colourful blend of clinical work and hands-on procedures.

We start every elective day by preparing the OT. We will check that the anaesthetic machine is working and draw the drugs required for the first case of the day. As the first patient is wheeled into the OT, we will do a quick preoperative assessment and explain the anaesthetic plan to the patient after consultation with the Anaesthesiology senior. Once the surgeon has arrived, we can then proceed as planned.

There is no typical day in Anaesthesiology. We are exposed to a multitude of surgical cases under different disciplines. A frail elderly patient could come in for a major liver resection that requires the insertion of invasive lines and an epidural. Or we may have to perform an awake fibreoptic intubation for a patient with symptomatic cervical spine spondylosis before surgery.

At times we would receive orthopaedic lists that offer opportunities to perform anaesthesia for spinal or nerve blocks under the guidance of a senior. As the consultant stares down at you, your hands tremble and heart palpitates. The crushing anxiety soon gives way to a flood of euphoria as soon as the procedure is completed successfully. Every patient and every surgery adds to our repertoire of skills, and our seniors are like our private tutors, patiently teaching and guiding us each day.

The belief that we anaesthetists retreat to a corner and play Candy Crush once the patient is under anaesthesia is untrue. We are always looking out for the patient's vital stats, ensuring that he is haemodynamically stable, anticipating what might happen at each step of the surgery, and observing what mischief the surgeon may be up to. You never know when a patient with a laryngeal mask airway may go into laryngospasm, or when the surgeon may decide to rest his arm on your airway circuit and cause a disconnection.

Apart from our work in the OT, we rotate through the intensive care unit as well, where we learn the comprehensive approach of managing a critically ill patient by utilising our arsenal of pharmaceutics and practical interventions. The joy of seeing a patient progress from dependence on a ventilator to achieving extubation is immeasurable.

A jittery lady has just been pushed into the OT for her first cataract operation.

I hold her hand and she grasps mine with fear and anxiety, only releasing her grip after the operation ends.

She leaves smiling, feeling relieved that the ordeal is over and thankful for the silent encouragement.

Sometimes a small touch makes all the difference.

Some days we are triumphant. ■

EMERGENCY MEDICINE

Dr Jonathan Chan is a second year resident in the Emergency Medicine department, National University Health System, who is temporarily on a break to serve in the Singapore Armed Forces Medical Corps. He likes Star Wars, cats, setting 14G IV cannulas, and he already knew he wanted to do Emergency Medicine since he was in secondary school.

By Dr Jonathan Chan

IS THERE a typical day for the Emergency Medicine resident?

Daily ward rounds, where we can decide on each patient's plan for the day, are not for us. We live for the unexpected and thrive on the unpredictable. The challenge lies in having to adapt to each case at hand, diagnosing and starting treatment early, before moving on to the rest of the never-ending crowd.

One day, my first patient was a foreign woman, handed over from the previous shift, who had been admitted by her employers for a psychotic episode. She seemed stable in the observation bay, quietly observing the nurses and doctors going about their business, and was even cleared for general ward admission by the psychiatrists. *That* was before I walked past her after taking blood from another patient. As I was emptying my tray into the bin, a nurse screamed "NO!" I spun around just as someone grabbed me from behind. The lady was at my elbow, a manic glint in her eye and her teeth about to close in on my upper arm. A split second later, the nurses successfully wrestled her off me and back into her bed. I trotted off to see my next patient, while dialing PSY to tell them: "Hey, guess what just happened?"

Every now and then, the raucous shriek of the VHF radio would suddenly cut through the din at the Emergency Medicine department (EMD), heralding the arrival of the sickest patients. This time, it was a middle-aged man with an ST segment elevation myocardial infarction, and his electrocardiogram had been transmitted electronically. The invasive cardiac lab had already been prepared and the cardiac registrar was also on the way. But at the crucial moment when the patient was transferred from the Singapore Civil Defence Force trolley to the hospital bed, he went into ventricular fibrillation, limbs quaking and eyes rolling up. The senior doctor was the quickest to react, roaring, "STAND CLEAR!" As the resuscitation team dived away, he snatched the defibrillator paddles from the cart and delivered a charge that fired the man's heart back into sinus rhythm. Total time in fibrillation: four seconds tops. Without missing a beat, the team swung back into action, electrodes hung up, cannula inserted in, and soon the cardiologist had whisked him off for his angioplasty.

No day is ever mundane. Most cases we encounter in the EMD usually involve fevers, chest pains and giddiness. However, once in a while, one meets a drunk who overturns our ECG machine in a moment of agitation, or a drowsy man found on the street with an intravenous plug already inserted in the antecubital fossa (we later discover that he escaped from another hospital!).

We see all kinds of patients who come our way. Our work may sound simple, like merely suturing a laceration, relieving someone's ureteric colic, or popping a dislocated shoulder back into place. However, we find satisfaction in making a difference to patients who arrive in the EMD scared and in pain, but later leave with their symptoms relieved and anxieties allayed.

Indeed, there is no typical day, and I would not want it any other way. ■

INTERNAL MEDICINE

Dr Er Chaozer is a National Healthcare Group third year Internal Medicine resident who has turned advanced Internal Medicine senior resident. He graduated from the University of Glasgow in 2009, and was elected to the Membership of the Royal College of Physicians in the UK in 2013.

By Dr Er Chaozer

MY DAY starts at 7 am with "pre-rounding", which means identifying new admissions, sick patients, planned discharges, and scheduled procedures or surgeries. This ensures that work during the actual round is prioritised according to the degree of urgency. Once I have completed my pre-round, I will then see the patients assigned specifically to me.

I start off by analysing patients' vital signs, capillary sugar levels, intake and output charts, and behavioural charts before conducting physical assessment for them. Then I will gather collateral input from my allied healthcare colleagues, such as nurses, therapists, dieticians, speech therapists, social workers and pharmacists. It is also vital to check the patients' blood test results, imaging results, past medical records and medication. Finally, I will categorise their active and background issues into medical, functional and social aspects to ensure holistic care, before formulating management plans for them.

At 9 am, the consultant arrives and starts reviewing the patients and our pre-round entries to devise the eventual care plans that will be carried out after the round, such as making referrals, discharging patients, updating patients' families, and performing bedside procedures. My day ends at 4 pm with a brief "exit round", where I review the patients' progress.

I love the diversity and complexity of General Medicine. Our patients often present with undifferentiated complaints, like weight loss and giddiness, but they may not give a standard medical history like those in the textbooks. An internist has to work up the differentials by interpreting the history accordingly, and incorporating the examination findings to decide the relevant investigations required. *An internist performs relevant, cost-effective and evidence-based investigations only!*

An internist may have to manage more issues that arise while he is working out the main diagnosis with his expertise, and refer patients to the respective specialists only if indicated. *An internist makes necessary referrals only!*

An internist looks after a patient's bio-psycho-social well-being. A patient with poorly controlled type 2 diabetes will eventually require exogenous insulin. His diabetes, along with its related complications, can easily lead to depression and increased stress on his family members. Without dedicated caregivers, diabetic patients with poor eyesight may not be able to perform insulin injections safely. This example illustrates the close relations between medical, psychological, functional and social issues. An internist has to coordinate with other allied healthcare personnel to ensure all aspects of patient care are well managed. *An internist is a generalist!*

I advocate patient-centred, junior-directed and senior-guided ward rounds. Junior doctors spend the most time in the ward. They are the bridges that connect consultants with patients, allied healthcare personnel and family members. Junior doctors are the ones who collate and reflect the input from various parties. By allowing them to formulate care management plans, they will then learn to be managers rather than reporters or scribes. Meanwhile, patient safety will not be compromised in the hands of these young doctors in training, as they are supervised by their consultants. Through this process of supervised hands-on learning, the juniors can constantly sharpen their clinical judgement and identify new learning goals.

Patient care is about teamwork. It is important for us to remember that everyone is indispensable, and no one should be regarded as redundant! ■

PATHOLOGY

By Dr Derrick Lian

Dr Derrick Lian works in the remote basement laboratory of KK Women's and Children's Hospital. He spends his free time with his family and working towards being a certified sommelier.

(Note to the surgeon: you may wish to just read the final diagnosis at the end of this article.)

PATHOLOGY IS a poorly understood medical specialty in the world today, even among our medical colleagues. We are often thought to be dishevelled and poorly dressed people hiding away in basement labs behind microscopes looking at glass slides. We are also mistaken as people who do autopsies, solve great murder mysteries, and amaze others with our stories during cocktail parties, thanks to the "CSI effect".

An interesting fact not many know is that the Pathology family in Singapore comprises four clinical subspecialties – histopathology, forensic pathology, medical microbiology and chemical pathology. Each subspecialty is different, with relatively few overlaps in training. Currently, residency is only offered for histopathology, while the other three are still under the basic specialty training/advanced specialty training system.

For the rest of this article, *Pathology* will refer to histopathology, the largest branch of Pathology in Singapore. (The number of clinicians from the other three subspecialties is so small that you can probably squeeze all the forensic pathologists, medical microbiologists and chemical pathologists into a minibus. They have vastly distinct trainings, and I would probably be doing them a disservice by simplifying their work into a short paragraph. So anyone interested in these subspecialties should attempt to locate one of these specialists and attempt a posting before signing up for the traineeship interview.)

Pathology is a consultant-driven discipline, which means that all reports need to be checked and co-signed by a consultant before they are dispatched to the wards or requesting clinicians. This is very different from most disciplines, where a medical officer or resident can treat and dispatch patients with simple, straightforward ailments without any active supervision from a senior.

The life of a Pathology resident is fairly routine and unvaried. It begins with a morning tutorial session at a multi-head microscope, which consultants use to show all kinds of weird and wonderful tumours and feel extreme satisfaction when the resident is unable to come up with a diagnosis.

This is followed by a whole day's worth of looking down microscopes at glass slides (doing tedious tasks like microscopically measuring resection margin clearances, counting mitoses or looking for that one tiny acid-fast bacilli) and formulating pathology reports. The resident would then bring the slides to the consultant in charge for reviewing and more quizzing.

The Pathology resident's day ends at unpredictable timings, depending on the amount of work. It could end as early as 5 pm or as late as after 10 pm! After work, the resident still has to read voluminous textbooks. Studying is a very large part of a Pathology resident's life – I have heard that pathologists are second only to anaesthetists in their love for studying and exam taking!

While my description of a day in the life of a Pathology resident sounds awfully boring, there are some reasons why one would be attracted to a career in this specialty! In my opinion, the major draw would be the relatively stable working hours one would eventually enjoy, the absence of night calls and weekend duties, and the hassle of swapping your call with someone else's. You also won't be getting random adrenaline rushes of having your work phone going off. Pathology is a very academic specialty, heavily featuring both education and research. It will certainly appeal to you if you are also interested in collaborating with clinical scientists and oncologists in cancer research. Finally, if you enjoy having the final say, or being the "gold standard", Pathology will definitely resonate with the narcissist within you. ■

Pathology resident, gross examination of daily activities: benign; no evidence of malignancy.

Dr Gillian Lim is currently embarking on her fourth year of the National Healthcare Group Psychiatry Residency Programme. In her spare time, she enjoys singing, marvelling at nature, and being pleased with little things in life.

PSYCHIATRY

By Dr Gillian Lim

Arrive at work and discuss
The inpatients on our list.
Should venlafaxine be titrated?
Should lithium be increased?

Call J's family to ask
For mood symptoms before last week.
And Madam L will need ECT
What was her last energy level? Have a peek.

Then off to clinics.
Quite a list, 12 patients I need to see.
The new case a young man
With agoraphobia and panic in his history.

Now on to the review cases,
Each given 15 minutes per slot.
Usually partially compliant and stable,
But then again you never can expect what they've got.

"Doctor, you're so young."
"Doctor, my heart is dead."
"Doctor, my mother threw away my three months of valium."
"Doctor, my day you've made."

In between you'd have to expect your phone
To go off at least once or twice.
From a frazzled house officer in the wards,
Updating or seeking advice.

The clock strikes two, it's time to blue
Off to the wards to see your luck today.
8's good, 16 the usual,
26 and you barely know what to say.

It's a whirlwind and you move along,
Schizophrenia, delirium, anxiety, depression.
Eyes tired, mouth dry, hand aching,
You write down your nth suggestion.

But days end, things wind down
It's time to sit and ponder.
All the sadness and betrayal,
But yet all the hope and wonder.

The father keeping vigil
For his daughter who overdosed.
The son who holds his mother's hand,
Lost in delirious throes.

The patient working two jobs
To keep his son in school.
The nurse who after all her hours
Manages to keep her cool.

It's these aspects that keep me going,
That bring me back for more each day.
As a psychiatric doctor in training,
I know this life is one I'd want to stay. ■

RADIOLOGY

By Dr Peh Wee Ming

Dr Peh Wee Ming is a third year resident in Diagnostic Radiology. When out in the light, he spends time with loved ones and reads storybooks about real life.

DAY 467 OF RESIDENCY, 1800 HOURS

This is war, waged in the bodies of every registered patient in the hospital, on a galactic scale. I collect my thoughts. Tonight, I am the intelligence officer on duty, and I need to be ready.

My agency functions as the IMINT of Medicine, and our work spans the gamut from collection of imaging intelligence, to analysis and synthesis, and finally distribution to frontline commanders.

I barely warm my seat before the first call comes in. An elite agent from MRI Radiography is on the line; she sees something odd on a scan and would like tactical input. I review the images and decide on additional sequences to perform before terminating the operation.

Meanwhile, my worklist loads. 70 X-ray reports pending! My heart sinks.

2000 HOURS

I am on my 45th X-ray that shows perihilar consolidation with a slightly big heart. Most probably cardiogenic oedema, but I feel the cognitive bias creeping in from an earlier case. Unlike the one before, there is no good history to rely on and the bloods are yet to be out. And my list is groaning from the weight of another 70 X-rays. I sneeze, and wonder if someone is cursing me for skiving and leaving so many X-rays unreported.

"Clinical correlation suggested," I type. *Urgh*. What a cop out. But I move on.

DAY 468 OF RESIDENCY, 0200 HOURS

Dozens of critical battles are being fought simultaneously – liver transplants, acute abdomens and the like – all in need of imaging and attention. The intensity of the war is getting to me, and the pictures are starting to blur together.

Next up, a brain CT scan for a patient presenting with first seizure. My tired eyes widen at the sight of something bright in the left centrum semiovale. A glioblastoma multiforme? An oligo? I briefly feel like Jack Ryan from *The Sum of All Fears*, attempting to identify the intentions of this potential threat. Is this a bogeyman plotting the demise of its host? Or perhaps a stable everyman who would occasionally erupt into madness? I scour the images for more clues, and note the serpentine-draining vessel. An arteriovenous malformation! I ring up the frontline with this piece of information, and make a mental note to seek the advice of a senior the next day, someone who has studied this entity for longer than I have.

0500 HOURS

The night is still, and I manage to clear my list for the first time. Just as I am about to get some shut-eye, the phone goes off with a request for immediate CT reconnaissance in a patient with probable haemoperitoneum. I find, with much effort, the single vulnerability of this enemy, a subtle arterial blush, and with that, we can bring in the strategic forces – the interventional radiologists – to embolise the daylights out of it.

0800 HOURS

My consultant greets me cheerily, "How was last night?" The answer is written all over my face. "Haha you guys are weak! In my time, we had to do 300 X-rays!" she says. I muster a feeble smile. We go through the cases. "Did you see this rib fracture? This nodule?" *Erm*, no. And then it hits me, a reminder that I am still a neophyte in these arts of perception and cognition. *Ars longa, vita brevis* indeed.

I stick around a while to reflect on my victories and failures from last night. All things considered, it was a fairly good night. I think about my comrades at the front line, neck deep in the trenches, and hope that I have provided useful intelligence. I cast aside any self-doubt from the missed nodule and miscalls for now, and rest for another battle another day. ■

SURGERY

By Dr Lim Tian Zhi

Dr Lim Tian Zhi is a freshly minted Postgraduate Year 2 (PGY2) who just completed his housemanship and had the "P" struck off his MCR number.

THERE HAS been much discussion about the idea of having PGY1s enter surgical residency. Some may say surgical rotations are filled with hardship and a torture both physically and mentally. Many feel that the commitments of being a trainee and a house officer (HO) are different so one may be too stretched to do both well. My experience as a first year resident (R1) in Surgery has been positive, and I would like to share my two cents' worth on my past year as an HO/PGY1/R1.

Professionalism and collegiality

I entered residency knowing that my priority lies with HO commitments. Work should not be passed on to a non-surgical trainee just so that you can hop over to assist in a laparoscopic appendicectomy. You respect the role of your colleagues and divide the changes well in order to complete it in the most efficient manner. Everyone should be given an opportunity to assist in the operating theatres (OTs) for the exposure and enjoyment of a surgical posting. A collegial working environment is what wakes me up in the morning feeling refreshed and energised.

Determination and hard work

We read up about our patients, rush to the OTs and perform administrative duties required of surgical trainees on a daily basis. Through sheer determination and tough mental willpower, we are able to push through and maintain this diligence consistently.

Self-satisfaction

Be thankful of what we have and not compare, as the grass always seems greener on the other side. Trainees should see the positive aspects of the residency programme and provide constructive criticism to pitfalls that are present, rather than lament and complain about them. Only through such measures will the programme then mature and progress.

Closing thoughts

"Choose a job you love and you will never have to work a day in your life". – Confucius

The unpredictability and fast-paced nature of any surgical residency always keeps one on their toes. We see trauma activation, perforated bowels and ischaemic limbs daily. Acute measures can be brought upon surgical patients with rapid response bringing about much delight to many. We get to hone our surgical skills not just in the OTs, but also by managing patients with their interests in mind.

Being a junior member of the department, I am very grateful for the teaching and guidance that my seniors and mentors have provided me. I also laugh, cry and joke over stuff with these colleagues and friends.

The General Surgery residency is an arduous and long process. It is important to keep the spirit and passion burning throughout this journey and be guided till the end. No one can predict the future. Learn from the past, enjoy the present and change the future. After all, "The best is yet to be"! ■