Chapter 1: **Starting up**

Day one of your first job is rarely the nightmare you think it will be. Half of it is taken up by firm meetings and introductions to the hospital. During the other half you will be introduced to the wards. It's all over before you know what's happening. You are finally a real doctor. And then it's day two and you have to get on with the job . . .

Panic?

Never panic. The thing that strikes terror into the hearts of day-one junior doctors is the thought that they, alone, are expected to battle with disease and death when they have never given an IV drug in their life and don't know how to plug in the paddles of the cardiac arrest trolley. That's if they know where to find it. The ward and hospital are often unfamiliar. The whole thing is enough to give you a nasty rash, which many junior doctors do get.

The one thing to remember is: YOU ARE NOT ALONE. You are a modest, essential cog in a vast machine which churns away quite happily whether you know exactly what you're doing or not. You soon will. Nobody expects you to know much on the first day—or even in the first month. And everyone will show you what to do.

People to help you

You are surrounded by people who can help you. All you need to do is to ask them. They include:

1 Nurses who usually know more about what you are doing than you do, as they have watched and done it for years.
2 Patients who want kindly, properly and with as little pain as possible.
3 Other doctors who love to demonstrate their skill at just about everything and are always open to requests for help.

- Problems arise when junior doctors do NOT ask for help. If you feel panic rising in your throat, just ask for help. This is counter-intuitive for self-reliant medics, but it saves lives (yours and the patient's).
- Attend orientation day for junior doctors if the hospital has one. It is useful for finding out what the hospital can do for you.
- If possible contact your predecessors before their last day on the job. They can give you invaluable information about what to expect from your new job (the idea for this book came from a request for help from a new junior doctor). In particular, ask them about what your new consultants do and do not like.
- Most people find that they are physically exhausted during their first week of work. Such fatigue passes as you get used to the hospital and new routines.

Three basic tips

1 Always take the initiative in hospitals. If things are not working, do something about it. Big institutions can become stupid places to work in just because no-

one bothers to address things that are clearly going wrong. Figure out a solution and contact whoever is in charge of the problem, whether it be a doctor, nurse, manager or the porter.

2 Similarly, take initiative in managing patients. Present seniors with a plan for your patients rather than just asking them what to do. Thinking strategically actually makes work more fun and prepares you for more responsibility.

3 Order your work. When tasks are being fired at you from all directions, priority-setting is really important. Try to learn early on which things are super-urgent and which can wait for more peaceful moments. Despite the hype, there is quite a lot of down time in your junior doctor year.

Other useful start-up information

Dress

It is worth bearing in mind that patients often dress up to the nines to 'visit the doctor'. I once watched an elderly woman with deteriorating eyesight, high-heeled shoes and lopsided make-up hobble over the hospital lawn to visit the diabetes clinic. Having always dressed casually, I dressed my best from then on.

• Changing from student to doctor mode can put grave dents into your early pay cheques. If nothing else, buy good-quality shoes which will look good and will stay comfortable on your 36th hour.

• You may get stained with all sorts of unmentionable substances as a junior doctor. *Stain Devils* from supermarkets and household stores can remove most things. Soaking garments in cold water and lots of soap, followed by a normal machine wash removes blood stains.

• Some hospitals will reimburse you for dry cleaning bills associated with work-related accidents, such as major blood stains on suits. Phone hospital personnel through the switchboard.

• While wearing theatre pyjamas ('blues') on the wards can be all the rage, doing so is an infection risk and frowned on by most hospitals. If you have to wear them outside theatre, remember to change regularly and return them to the hospital laundry to be washed!

Equipment

Always carry:

1 Pen (more than one).
2 Notebook/PDA/piece of paper.
3 Stethoscope.
4 Tourniquet.
5 Torch.
6 Bleep.
7 Loose change for food/drink/newspaper.
8 Ophthalmoscope (if not readily accessible on wards).

For ward rounds and working in casualty, as above plus:

1 White coat.
2 Tendon hammer (preferably collapsible).
3 Wooden spatula.
4 Orange sticks.

• Consider carrying everything in a traveller's pouch or a small shoulder bag.

• All equipment should be labelled with your name, either by engraving or hospital wrist bands.

• Junior doctors definitely need

access to ophthalmoscopes. Ward ophthalmoscopes have an amazing tendency to walk and to run out of batteries. Therefore, buy your own portable ophthalmoscope, and examine people's eyes at every opportunity. Pocket veterinary ophthalmoscopes are sometimes the most portable, cheap and reliable, and little known to medics—as they are advertised for vets.

• Ask your ward pharmacist for a couple of aliquots of tropicamide to carry in your top pocket. One to two drops greatly facilitates ophthalmic examination. It takes a few minutes to work. Record the procedure in the notes and tell the nurse. Having failed to do the latter, I was once fast bleeped by a frantic student who thought the patient was coning. Never use tropicamide in patients with a history of glaucoma or eye surgery.

• Consider carrying a ring binder (see Chapter 2) containing important team info, a handful of blood forms; radiology requests; blank drug charts; history, discharge summary and TTO sheets. Such a binder allows you to do a lot of the paperwork on ward rounds, before it gets forgotten. It also saves having to dash off to the stationery drawers in the middle, which tends to go down badly with seniors.

First-day paperwork

The first day is mainly paperwork. Here is a checklist of documents to bring:

• GMC registration certificate
• Medical indemnity certificate
• Bank details
• Induction pack and contract from the Trust
• Occupational health report (and data card if you have one)

Geography

• Get a map of the hospital from reception to help you learn where everything is.

• Specifically, find out the location of: blood gas machines, canteen, casualty, wards, radiology department, doctors' mess, drink machines, endoscopy, labs for crucial bloods, nuclear medicine, on-call rooms.

Ward rounds

Think of yourself as the ward round producer (much of it *is* performance). Give yourself 15 minutes' preparation time to have everything ready. For each patient, be prepared to supply at the drop of a hat:

1 Patient ID (name, age, date of admission, occupation, presenting complaint).
2 Changes in condition and management since last round (with dates of change).
3 Results (any investigations carried out recently).
4 Assessment (physical, social, psychological).
5 Plan for in-patient management (future investigations, ops, drugs).
6 Plan for discharge (see p. 5).
7 X-rays (ask your seniors which ones to have available).

It is helpful to print off a list of patients to give to consultants and the senior registrar, which includes 1, 2, 3 and 5 of the above.

• Unless the patient asks for relatives to remain present, it is a generally a good idea to ask them to leave the room while the team examines the patient. Curtains

are not sound proof. People will often give more information if their relatives are absent.

• Ask your registrar which X-rays to have available. Get these from the X-ray department well ahead of time (occasionally the ward clerk arranges this for you).

• Each consultant has up to five pet details that he or she wants to know about each patient. Find out what these are from your predecessor and supply them tirelessly at ward rounds (these could range from occupation to ESR to whether or not the patient has ever travelled to the tropics).

• Never say that you have done something you haven't, and never make up a result to please seniors. It is bound to backfire.

• Do not argue with colleagues in front of patients.

• Get a clear idea of the management plan for each patient. Sometimes instructions may be dealt out in a half-hearted way, only for you to learn later (to your cost) that they were meant in earnest. Do not allow seniors to get away with this. Make definite 'action points' and if your consultant cannot be pressed into being clear, then ask your registrar.

• If you work with a partner, such as a fellow junior doctor, make sure that jobs arising from the round are clearly allocated. Meet up later for a 'paper round' to make sure that everyone is clear about which jobs remain outstanding.

Social rounds

You need to let the social team know how your patient is going to cope (or not) on discharge.

1 Ask yourself: how is this patient going to manage physically, socially and mentally? Specifically, draw up a list of 'disabilities'. These are things that the patient *cannot do*, for whatever reason. From the Barthel Activities Index (p. 246), consider bathing, bladder, bowels, dressing, feeding, grooming, mobility, stairs, toilet, transfer.

2 Have relevant patient details ready (see below). Most are available from the medical notes and the front-page admissions sheet. Otherwise try the nurses, nursing notes, the patient, relatives and the GP.

3 If you are required to give a history, try to include the following points:

- Patient ID.
- Prognosis: short and long term.
- GP and admitting rights to local hospitals (usually in the admission sheet at the front of the notes and dependent on home address).
- Type of residence and limitations (e.g. stairs).
- Home support and previous reliance on social services.
- Financial status.
- Special problems which need to be addressed (physical, social, mental, legal).
- Questions you want to ask members of the multidisciplinary team to help you plan for discharge of the patient.

4 Go to the meeting with specific questions you want answered. Make sure you come away with 'action points'—not just vague gestures from various team members about your patient's care (this goes for all ward rounds).

5 Translate medical jargon into normal English for social rounds, as some members of the social team may not be fully fluent in medical acronyms.

6 Familiarize yourself with key people from local rehabilitation services, residential homes, nursing homes and alcohol support services. Effective liaison can prevent or at least curtail hospital admission.

Night rounds

Always do a night round. This can mean the difference between a relatively happy house job and a sleepless nightmare. If you do nothing else, make sure you have checked off the following before going to bed:

1 Analgesia.
2 Fluids.
3 Infusions (on the few occasions where you are required to make them up, leave them in the fridge and tell the nurses where they are).
4 Sedation.
5 Sign for drugs you have verballed during the evening (p. 119).
6 Ask each team nurse on the night shift if he or she has problems that need sorting out before the morning.

- Start your night round *after* the night nurses' start of shift and drug rounds have been completed. This is when they identify problems that you need to deal with before going to bed.
- Tell night staff to bleep you if they are concerned about a patient. Paradoxically, this combined with reassurance and information about worrisome patients cuts down bleeps.
- Inform every team nurse of what to do if a sick patient's condition changes. Sometimes you can set limits for relevant signs (e.g. pulse, CVP, T, BP) beyond which you want to be called. Write these in the notes.
- If bleeped for an apparently trivial matter, try your best not to sound irritated. Be ready to go to the ward, even if only to provide reassurance. Again, paradoxically, this reduces bleeps. If nurses are confident that you will turn up if requested, they will not bleep you ahead of time.
- If your room is a long way from the wards, you can sleep in a side room on the ward. Ask the sister or charge nurse, who will usually oblige, especially if you offer to strip the sheets in the morning. Point out that you are more readily available if you are sleeping on the ward. You might get brought cups of tea and breakfast in bed!

Discharging patients

Clearing hospital beds is an invaluable skill which will earn you lots of brownie points from virtually everyone. To clear beds effectively:

1 Make plans for people's discharge on the day they arrive. Ask yourself:

- When will they be likely to leave?
- What will get in the way of this person going home or being transferred?
- What can be followed up in clinic?

2 If possible, write discharge summaries (see p. 13), sending the TTO (drug prescriptions) to the pharmacists early in the day to avoid delays.

Work environment

Evidence suggests that upgrading your environment upgrades your work—and you. Old, decrepit NHS hospitals can be depressing. There are ways you can make your particular corner of it a great place to work, even if the rest of the hospital has miles of yellow peeling

paint, dripping pipes and corridors of empty wards.
• There is no crime in asking hospital supplies for better furniture and accessories, like shelving, desk, chairs or bulletin boards. They can always say no.
• Take a plant to work.
• If you have a tiny desk (or no desk), order a better one. Ring hospital supplies and ask if there is a spare one somewhere. Or request a new one. There's nothing like drawers that slide open easily for making paperwork easy. As a doctor with tons of notes to write, you are entitled to a desk of some kind.
• Consider buying a personal audio (e.g. cassette deck, CD player, MP3 player). Label it clearly with 'Dr X'. It can do wonders for long winter weekends and nights on call. Lock it away.
• Put postcards/pictures/photos up in your work area. If you don't have a bulletin board, order one from hospital supplies.
• Most hospitals provide a computer in the doctor's room. Make sure you get as much internet access as local policy allows. Carry a disk or portable USB hard drive. It will allow you to carry your work with you.
• Bring decent coffee or cocoa supplies to work. A single-cup cafetiere, some packs of coffee at the back of the ward fridge and a jar of your favourite spread can upgrade your existence no end.

Bibliography

Most junior doctors read little other than fiction during their job. You probably don't need to buy anything you don't already have. A few recommended texts are:

• *Acute Medicin*e: Sprigings D. and Chambers J. (2001) Blackwell Science, Oxford. A comprehensive guide to emergencies.
• *Clinical Examination*: Talley N. and O'Connor S. (1996) Blackwell Science, Oxford. This book is great for revising detailed clinical examination.
• *Oxford Handbook of Clinical Medicine*: Hope R.A. (Editor), Longmore J.M., Wood-Allum C.A., Hope T. and McManus S. (2001) Oxford University Press, Oxford. A great pocket reference text for medical and surgical conditions.
• *Dunn's Surgical Diagnosis and Management: A Guide to General Surgical Care*: Dunn D. and Rawlinson N. (1999) Blackwell Science, Oxford. A great book for HO and SHO level surgical trainees.
• *The ECG Made Easy* (and sequel, *The ECG in Practice*): Hampton J. (1997) Churchill Livingstone, Edinburgh. An approachable guide to the mysteries of the ECG.
• *Junior Doctors' Handbook*: Published annually by the BMA, free to members. An excellent summary of your rights and useful information for your early years as a doctor.
Recommended texts for the medical specialties (SHO level texts) include:
• *Pocket Consultant: Gastroenterology*: Travis S., Taylor R. and Misiewicz J. (1998) Blackwell Science, Oxford. This book clearly explains gastroenterological problems and procedures which are invaluable for medicine or surgery.
• *Pocket Consultant: Cardiology*: Swanton R. (2003) Blackwell Publishing, Oxford. As for Gastroenterology above.
• *Lecture Notes on Respiratory Medicine*: Bourke S. (2003) Blackwell Pub-

lishing, Oxford. Beautiful explanations of the pathophysiology and principles of management of respiratory disease. A very good primer for the Chest Unit job.

• *Essential Neurology*: Wilkinson I. (2005) Blackwell Publishing, Oxford. A concise and clearly illustrated guide to clinical neurology.

• *Rapid Medicine*, Sam A.H. et al. (2003) and *Rapid Surgery*, Obi E. et al. (2004) Blackwell Science, Oxford. Both are memory joggers for core facts.

• *Patten's Neurological Differential Diagnosis* (Springer-Verlag) provides a more comprehensive guide to differential diagnosis.

• *Essential Haematology*: Hoffbrand A., Pettit J. and Moss P. (updated every reprint; the most recent edition, 2001) Blackwell Science, Oxford. A superb book!

• *Essential Endocrinology*: Brook C. and Marshall N. (2001) Blackwell Science, Oxford. Another very useful primer for an Endocrine Unit job.

There are no particularly good small books for rheumatology or nephrology. We recommend using the appropriate chapter in any medical textbook such as *Medicine*: Axford J. and O'Callaghan, C. (2004) Blackwell Publishing, Oxford; or *Clinical Medicine*: Kumar and Clark (1998) Harcourt Brace, London.

For fun and rapid insight into the world you are entering, try: *House of God*, Sham S. (1978).