THE JUNIOR DOCTOR SURVIVAL GUIDE

Paul Watson MBBS, DipSurgAnat
General Surgery Registrar, Austin Hospital, Melbourne, VIC, Australia

Joseph M O’Brien MBBS, BMedSc(Hons)
General Medical Registrar, Austin Health, Melbourne, VIC, Australia
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PREFACE

We all live in the ocean of medicine. On our best days the water is still and clear. Sometimes the waves build, crashing over us. We need only put up our hands and someone will lift us from the storm. Remember to keep your head above the water and offer a hand to those who are being battered by the waves.

With great pleasure we present the *Junior Doctor Survival Guide*, a companion to the new students, interns and residents beginning their incredible journeys as medical practitioners. We wrote this text from the perspective of giving handover to you, our colleagues, regarding the daily life of the fledgling junior doctor.

There is a strong focus on the practical nature of working within the hospital system, learning the day-to-day job requirements often overlooked by formal medical education. Most interns spend more time worrying about how to order investigations, put on a backslab and properly document patient plans than they do about the minutiae of specialist practice. This is where we come in.

The prevocational years of medicine are greatly influenced by the hand of experience. It takes time to adjust to the inner workings of a hospital and becoming a busy, young professional. This text is the sum of our collective experiences, a series of tips and tricks for surviving that initial foray into the great unknown.

With a large number of concise chapters (and hopefully a bit of levity) we hope this book can provide a framework for you to build your own skills and knowledge with the wisdom to pass what you learn to others.

*Paul Watson*

*Joseph O’Brien*

*thewelljuniordoc@gmail.com*
CONTRIBUTORS

Kelsey Broom MD, BBiomedSc
Resident Medical Officer, Queensland Health
QLD, Australia

Kerry Jewell MBBS, BMedSc(Hons)
Medical Registrar, Austin Health
Melbourne, VIC, Australia

Todd Galvin Manning MBBS, DipSurgAnat, DipLapSurg
Research Fellow, MS (Urol) Candidate,
Department of Surgery (Urology), University of Melbourne, Austin Health;
Department of Anatomy and Developmental Biology, Monash University;
Young Urology Researchers Organisation (YURO),
Melbourne, VIC, Australia;
British Urology Researchers in Surgical Training (BURST),
United Kingdom

Joseph M O’Brien MBBS, BMedSc(Hons)
General Medical Registrar, Austin Health,
Melbourne, VIC, Australia

Rami Shenouda MBBS, DipSurgAnat
Emergency Registrar, Alfred Health
Melbourne, VIC, Australia

Paul Watson MBBS, DipSurgAnat
General Surgery Registrar, Austin Hospital,
Melbourne, VIC, Australia

Lachlan Wight MBBS, DipSurgAnat
Orthopaedic Registrar, Barwon Health
Geelong, VIC, Australia
REVIEWERS

Anna Bondorovsky  MD, BSc (Anatomy & Histology and Physiology)  
Hospital Medical Officer, The Royal Women’s Hospital  
Parkville, VIC;  
University of Sydney,  
Sydney, NSW

David A Kandiah  MBChB(Hons), MClInEd, MPH, MHL, MBA, PhD, MRCP(UK)  
FRACP  
Clinical Professor, University of Western Australia  
Perth, WA

Benjamin Kwan  MBBS, BSc(Med), FRACP  
Staff Specialist, Sutherland Hospital  
Caringbah, NSW

Kate Lord  MBBS, BSc(Hons)  
Physician Trainee, Austin Health and Northern Health  
Melbourne, VIC

Hareeshan Nandakoban  MBBS, FRACP  
Network Director of Physician Education and Renal Staff Specialist, Liverpool Hospital  
Liverpool, NSW

Yogendra Narayan  MPH, MHA, Grad Cert PSM, DSM, FRACMA  
Specialist Medical Administrator, Medical and Dental Workforce Services, Western Sydney  
Local Health District  
NSW

Louisa Ng  MBChB, MD, FAFRM (RACP)  
Rehabilitation Physician, Supervisor of Intern Training and Deputy Director of RMH  
Clinical School, Royal Melbourne Hospital  
Parkville, VIC

Belinda Weich  MBChB, FRCAP  
Senior Staff Physician, Mackay Base Hospital  
Mackay, QLD

Kristen Pearson  MBBS, FRACP  
Consultant Geriatrician, Northern Health, VIC
Thanks to my friends and family who have supported me through this grand adventure. A special mention goes to my co-authors, Joe, Kelsey, Lachlan, Kerry, Rami and Todd. To the powerhouse team at Elsevier, Larissa, Lauren, Neli, Anitha and Linda, I thank you for your enthusiasm and superhuman patience! This is dedicated to all the junior doctors who work tirelessly, compassionately and admirably.

Paul Watson

I dedicate my work on this book to my family and friends, for their kindness and devotion. Together they have tolerated complaining and foot-dragging for nearly three years. Thanks go to the Elsevier team who took a gamble on two cocky interns from the country, to my co-authors who generously donated their time and, lastly, to the caffeine and sugar that enabled me to (almost) meet deadlines.

Joseph M O’Brien
A thorough admission is a good start to a patient’s inpatient stay. It is well documented in the evidence that patients presenting with common illnesses who have rushed admissions (e.g. on weekends or public holidays) tend to have longer inpatient stays and a moderately higher mortality.

The admission usually begins with a referral to your team – either from your colleagues in the Emergency Department (ED) or from an external doctor. ED staff are under time constraints and will place a lot of pressure on you to review their patient as soon as possible. Not all of your referrals will require admission – sometimes there are alternate outcomes that would better suit the patient’s needs, for example sending them home with Hospital in the Home (HITH), back to their nursing home with a residential outreach service or asking them to return to Outpatients Clinic with further investigations completed.

From a junior doctor’s perspective, the ‘heart’ of the admission lies in an organised history-taking and appropriate length examination. A good admission is very similar to a long case, something you may be well versed in – however, in reality there is often a compromise between thoroughness and efficiency as an admitting resident or registrar role is quite busy. It is quite common for senior students and interns to accompany a registrar during an admission, and in many rotations the residents are required to admit without the immediate supervision of a senior clinician. As such, it is a good idea to get a lot of experience with admitting patients as early in your career as possible. As a junior this usually means documenting for the admitting registrar and completing their paperwork for them to speed up the admission (see Fig. 16.1 for an example of a paper admission). While the senior doctor leads the admission, the intern can request imaging, serology and miscellaneous pathology (both for in the emergency department and for the next few days – don’t forget to put bloods in for the following morning!), completing the drug chart, writing up fluids and taking note of the GP and other specialists’ details to request more information.

**HISTORY-TAKING**

Being well prepared and having a system for taking a history is covered elsewhere, but remains integral to the task. It is good form to document at the top of the
Example Admission

Patient Details
Mr Joe Blogs
UR 123456
DOB 1/1/1935

Presumed Diagnosis
?Cholecystitis ?Choledocholithiasis

Issues
Mr Blogs is a 79 yo gentleman who was admitted to St Elsewhere on the 29th July with severe RUQ pain, jaundice and intermittent fevers.

# ?Cholecystitis
- Increasing RUQ pain for two weeks. Associated with intermittent fevers over about a month. Wife did not notice jaundice – was pointed out to patient by his daughter who had not seen him for two weeks.
- Some weight loss – around 5 kg. Patient reports some anorexia.
- Denies chills, rigors, PR bleeding, melaena or reflux.
- Last meal breakfast, cup of tea and toast at 7 am.
- Discussed with surgical registrar on call – to be fasted and prepped for theatre tomorrow. Would like CT-abdo as already booked.

# Hypokalaemia
- K^+ = 3.3. Patient has a cardiac history, aim >4.0
- Supplemented IV in ED

# Acute kidney injury
- Baseline creatinine 120 on bloods from ED one month ago
- Gentle IV hydration, ?dehydration
- Nephrotoxins withheld

Medical Conditions
- NKDA
- Treated hypertension
- Treated hyperlipidaemia
- Osteoarthritis – on NSAIDs, awaiting bilateral TKR by Mr Orthopaedic Surgeon
- Ischaemic heart disease (AMI 1997). No recent TTEs or angiograms as lost to Cardio follow-up.

Past History
- MVA: Several long bone fractures, managed at Big City Hospital. No metalwork in place, underwent extensive rehab 1982.

Social History
- Lives with supportive wife, Carol.
- Retired engineer.
- Ex-smoker with 35 pack years (quit 1997). Minimal alcohol consumption.
- Baseline effort tolerance 500 m. Walks without gait aids.
- Drives, cooks, cleans and manages finances independently.

Family History
- Father died of AMI at 54 yo.
- Mother died of stroke at 82 yo.
- Paternal uncle had multiple myeloma.

Medications
- Aspirin 100 mg PO mane
- Perindopril 5 mg PO mane
- Atorvastatin 40 mg PO nocte
- Ibuprofen 400 mg PO TDS

FIGURE 16.1 Example of a paper admission.
Examination
- General: Overweight, severely jaundiced, elderly gentleman in considerable pain despite analgesia. HR 105, BP 140/90, RR 15. SaO₂ 97% ORA. Currently afebrile – last recorded fever 38.9°C on presentation to ED at 0900.
- Upper limbs: Pulse regular but tachy. No palmar pallor, asterixis, clubbing or stigmata of chronic liver disease.
- Head and neck: Icteric sclera. No conjunctival pallor. JVP +2 cm. Dry mucous membranes.
- Abdomen: Liver edge palpable 3 cm below costal margin. No palpable splenomegaly. Bowel sounds present. Explicitly tender in RUQ. No venous hum. No masses.

Investigations
- LFTs deranged – BR 56/ALP 127/GGT 392/ALT 95
- FBE 99/11.4/146
- UEC T34/3.3/Cr 230/Ur 12. Previously documented creatinine 120 one month ago
- CXR NAD
- Abdominal USS: Hypoechoic lines in gallbladder, common bile duct 6 mm thick, gallbladder wall 4 mm
- Awaiting CT-abdo/pelvis on admission

Plan
1 Admit under Gen Surg A (Thompson)
2 Regular medications + VTE prophylaxis while platelets >50
3 FFMN
4 Plan for laparoscopic cholecystectomy
5 Analgesia and anti-emetics as required
6 Morning bloods
7 Gentle IV fluids while fasting – note AKI, consider med review if does not respond to fluids
8 IV potassium
9 Await CT-abdo/pelvis on ward
10 IV triple antibiotics
11 Withhold nephrotoxins – ACE and ibuprofen ceased

FIGURE 16.1, cont’d

admission a brief summary of the presentation (abbreviations are acceptable for the sake of speed) – for example, ‘91yo F p/w 3/52 increasing SOBOE on a b/g known CCF and IHD. Anyone who glances at your admission note will immediately get a sense of why this patient is coming into hospital. This is also important for coding purposes.

From here the logical progression is through the history of the presenting complaint (HOPC), medical history (MHx), past medical and surgical history (PHx), family history (FHx) and social history (SHx). Key facts about the admission may come to light in these latter categories, which are all too often skipped in an effort to save time. They may be brief, but are always worth touching upon.

EXAMINATION

Again, having a system for examination will smooth out this process. A targeted examination may be performed in a busy ED but, for those who are considering the RACP pathway, admissions are an excellent opportunity to practice your long cases. Document well – there’s little point in performing a thorough examination and not passing on that information to the other people in the treating team. It
is not uncommon to admit patients for other medical teams (e.g. on cover) and you want to convey that you have assessed this patient properly. For patients with a concurrent psychiatric condition (or delirium) it would be prudent to include a brief mental state examination in this section of the admission.

**INVESTIGATIONS**

Include investigations that have already been completed by the ED or previous treating team. Consider only including those investigations you can personally verify – for example, do not write ‘Raised troponins’ if you have not seen them on the pathology system yourself. It is good form to write the exact figures if available, but abbreviations are encouraged – for example, ‘FBE 135/19.5/563’. Do not forget to include imaging.

**IMPRESSION**

Alternatively referred to as ‘Assessment’, here you should consider including a one or two sentence summary of what you think the situation is. For example, ‘APO, likely 2° new onset AF. Must exclude infective precipitant’. If the patient’s presentation is unclear, this is a good opportunity to document your differential and reasoning.

**PLAN**

Ultimately, this is the most important part of the admission. What will this patient be doing in hospital? Why is it necessary to admit them? Usually numbered, begin with, ‘1) Admit under Gen Med Team’ and work through your plan stepwise. Do not forget to include medication changes, fluid rates, electrolyte supplementation, non-pharmaceutical components of the plan (such as whether or not venous thromboembolism [VTE] prophylaxis is required), what kind of diet the patient should go on (e.g. nil by mouth for those fasting, diabetic for people with diabetes or low sodium for those with congestive heart failure), the regularity of observations and any altered parameters and future investigations and referrals (including allied health). If any special type of hospital bed is required (e.g. a bariatric bed or an isolation room) specify it here, so that the bed manager can coordinate it.

After the admission is complete, you will often have to liaise with your senior clinician. Remember, they are very busy people who want a rapid overview of the patient you are technically placing under their care. Start with a summary, speed through the relevant history and examination findings, report the investigations that have a role in the admission and explain your plan. As always when discussing patient details – never lie!