

# YOU WILL SURVIVE

The guide for newly qualified doctors

doc<sup>2</sup>doc **BMJ** Careers

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9.00am: Heat 1 of the junior doctors' cardiac arrest hurdles.

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Starting life as a junior doctor is one of the biggest challenges you'll face. Five or six years of medical school can make even the keenest student feel institutionalised. Now, starting work, suddenly everything has changed. New people, new places, and new responsibilities.

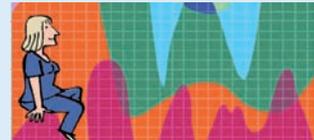
Self doubt can creep in: How will I cope on call? How will I keep up on ward rounds? What if I prescribe everything wrong? Don't worry. Be reassured by the fact that every doctor in the world has been through this and survived. Many of them contributed to this booklet.

"You will survive" started out as a discussion thread that received over a thousand tips and cautionary tales on BMJ Group's global online clinical community, doc2doc. For this second edition, we have also included invaluable words of wisdom written by junior doctors for *BMJ Careers*.

Good luck with the new job. I'm sure you, like most, will look back on your first year with fondness. Make sure you log on to doc2doc to tell everyone how you're getting on.

**Fiona Godlee**  
Editor, *BMJ*

- 1 INTRODUCTION
- 2 ON CALL & NIGHTS
- 5 WARD ROUNDS & NOTES
- 8 COMMUNICATION
- 10 DE-STRESSING
- 12 SKILLS STATION
- 14 FIRST DAY TALE
- 15 FIRST YEAR TALES
- 19 USEFUL EXTRAS
- 20 REFERENCE INTERVALS
- 21 PHONE NUMBERS



There are many things to remember when starting out as a hospital doctor, but securing medical legal assistance might not be high on your list. You will have NHS indemnity for the work you do within your NHS contract but for disciplinary issues, GMC referrals, coroners' inquests or fatal accident inquiries, the NHS won't help you.

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in any of these situations, ensuring complete peace of mind.

We are delighted to sponsor this book as it is full of valuable advice from your medical peers which we believe will help you survive some of the challenges of being a junior doctor.

**Jim Rodger**  
Head of professional services, *MDDUS*



### Prepare yourself for your first on call with these tips from those who have gone before you

Before that dreaded first on call you may well feel terrified and completely out of your depth. This is only natural. Remember, everyone has gone through exactly the same feelings before you—and survived.

*Adam Simmons, Rochdale*

Work steadily and efficiently, avoid rushing, and try to prioritise appropriately. Do not work with one eye on the clock. Accept that you will become trained, Pavlovian-style, to react to crash bleeps and alarms.

*Peter Martin, Essex*



However inane the requests on the other end of the phone, remember each call is potentially from a person with genuine worries about a patient. Show your gratitude to nurses who flag up important problems. But also be aware of unreasonable requests, and stand your ground!

*Adam Asghar, Yorkshire*

Be calm. It helps you deal with new problems in an organised, rational, logical, and safe manner. It also instils confidence in the people around you, from the nurses who will then listen to you and help you, to the patient who will not develop a fear induced tachycardia!

*Carla Hakim, Leicester*

Keep a list of tasks with the times you were given them. Mark off when they have been completed. This way you will not forget anything, and handover at the end of the shift becomes easier. Include patients' hospital numbers in the list so you can check results quickly.

*Adam Simmons, Rochdale*

Smile over the phone at the nurse who adds another task to your towering mountain of work. Smile at your patients, and smile at your seniors who often demand the impossible. Remember, it is possible to enjoy this job even in the middle of a night on call.

*Andy Shepherd, Milton Keynes*

It is normal to feel sick the first time you are on call.

*Claire Kaye*

Don't be afraid: help is only a bleep away!  
*Michael Haji-Coll, Chertsey*

When asked to see a patient during the night, ask the nurse to do a fresh set of obs and any other relevant tests (ECG, BM, bladder scan etc) while you make your way down to the ward.  
*Shamil Haroon, New Zealand*

You are your patient's advocate. Fight to get that x ray if it is needed, and listen when they tell you something they may not tell anyone else. *Claire Kaye*

Just remember: ask, ask, ask! The only stupid question is the one you don't ask.  
*Maryam Ahmed, Wolverhampton*

On my surgical nights I told each ward that I would do a mini jobs round at three points during the night. This meant that annoying jobs (writing up fluids, rewriting drug charts, etc) could get done in a single sitting. On some very nice wards, the staff would get me a hot drink and snack ready for when I was expected!!  
*Carmen Soto, Leicester*

## Eating

Busy or not, always have a break and eat when you're on call. You will make yourself far, far more efficient and, if you're anything like me, less grumpy.  
*Helen Macdonald, Oxford*

Take some food: it's surprising how hungry you can feel at 4 am when all the shops and canteens are closed. So go prepared.  
*Mahomed Saleh, Coventry*

## Things to take

Different wards have different layouts, so you won't know where all the equipment is, or if the wards are fully stocked. Save time by carrying some equipment (ABG syringes, cannulas etc) in an on call bag, along with a small reference book (*Oxford Handbook*) and a chocolate bar.  
*Michael Haji-Coll, Chertsey*

Some hospitals can be cold at night. If you have a quiet spell there is nothing worse than sitting in the mess feeling cold, so bring a jumper. If it looks pretty sensible then it's probably fine to wear down to the wards during the night.  
*Jo Godfrey, Swansea*

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## A night to remember with Mr M

It was 2 am when my bleep went off. It was one of the gastro wards. An elective patient had just been admitted from another hospital, and needed clerking in. I was perplexed by this: elective patients don't get admitted at 2 am, do they?

Mr M was a 70-something year old gentleman who had been admitted as a transfer from a nearby hospital for investigation of a suspicious "mass" on his liver. On examining him, there was nothing much to find – his BP was stable, and he was apyrexial. He had some mild abdominal tenderness and a few crackles at his left lung base, but nothing major. After clerking Mr M in, taking his bloods, and writing him up for some IV fluids, I trundled off the ward to continue my night's work.

At 4.30 am I got a call from the same gastro ward that scared the life out of me! Mr M had just passed about a litre of blood from his back passage. I went to see him straight away. To my horror, he was clammy, sweaty, and peripherally shut down. His BP had crashed to 80 systolic. Thankfully, he had two points of IV access. I grabbed one of the nurses and asked for some Gelofusine urgently. The nurse also offered to take the patient's full blood count, clotting screen, and a group and save. I noticed that he had been made "not for resuscitation" at

**"To my horror, he was clammy, sweaty, and peripherally shut down"**

the hospital he had been admitted from. Realising this patient was potentially peri-arrest, I contacted the on-call medical SpR. I begged him to come as quickly as possible

**"I begged him to come as quickly as possible to review the patient"**

to review the patient. To my relief, he was on the ward within 10 minutes. Fortunately, we managed to stabilise Mr M such that he could go for an urgent CT angiography, which revealed that he had suffered a tear in his cystic artery – hence the PR bleed.

So, what did I learn from this experience? It taught me the importance of the doctor on call and the nurses on the ward working together as a team to achieve the best possible clinical care. It makes such a difference when everyone works in tandem so bloods can be taken quickly and IV fluids put up promptly. I also learnt the importance of involving senior doctors when you need them. This patient required review and an urgent decision on his management including his resus status. Never be afraid to ask your seniors for help or advice, no matter how trivial the issue. The most dangerous junior doctor is the one who doesn't ask for senior help when it is clearly warranted!

But above all else, as a junior doctor on nights, pray you don't get asked to admit elective patients in the middle of the night, who are stable on admission but then deteriorate unexpectedly rapidly! Nights can be scary – but they do make us better doctors. Well, they have in my case!

*Declan Hyland, Liverpool*

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If you get chance to sort the following out before the ward round, you can make it run smoother:

1. Make sure all the notes are where they should be
2. Check all blood and scan results are in the notes
3. If you didn't manage the night before, prepare TTOs for the well, and phlebotomy forms for the sick
4. Familiarise yourself with the history of any new arrivals.

*Imran Qureshi, London*

Never, never, visit a patient at the bedside without some tactile exchange. Human touch can be healing (for both doctor and patient).

*William Hall, New York*

Sometimes patients decide to discharge themselves. You cannot stop patients with capacity from going home. Explain the benefits of staying and also what might happen if they leave. Document clearly either way. If in doubt, ask.

*Heather Henry, London*

## Using SOAP

The mnemonic BODEX is a good safety net for ward rounds: **B**loods, **O**bs, **D**rugs chart, **E**CG, and **X**-Rays/imaging.

And when writing in the notes, remember SOAP:

**Subjective** - How is the patient feeling? Retake any relevant parts of the history (e.g. do they have chest pain?)

**Objective** - How do they look? Write down the obs and your examination findings.

**Assessment** - Your impression of what's going on (e.g. pulmonary oedema improving, no new issues).

Lastly, document your **Plan**.

*Will Buxton, Sussex*



Try not to give instructions over the phone without later writing in the notes.

*Adam Asghar, Yorkshire*

Never make up an examination finding that you didn't actually examine.

*Rochelle Phipps, New Zealand*

Greet ward clerks, healthcare assistants, and nurses using their first names. They'll love you and make your life easier.

*Preetham Boddana, Gloucester*

Rather than pondering for hours over a dilemma, discuss it with your senior. Most consultants would prefer for you to call them rather than for a patient to suffer because you are unsure.

*Matiram Pun, Nepal*

## By the time you've found the notes and started writing, the ward round may have already moved on - these tips should help you get by

After the ward round, discuss and allocate urgent jobs.

Arrange another meeting for one or two hours before the end of the day, and chase up outstanding jobs. This should avoid the need to hand over routine jobs (chasing bloods etc) to the on-call team.

*Heather Henry, London*

Be polite, inhumanly polite, even when you want to scream your head off after being bled for the 100th time.

*Roberta Brum, Brighton*

Learn to think critically and organise your thoughts before speaking. Communicating with colleagues will then improve.

*Peter Martin, Essex*

Remember the power of a careful apology ("I'm sorry that happened"). This can avoid many complaints.

*Sarah Jones, Nottingham*

When communicating with patients, give them time to absorb everything you say.

*Adam Asghar, Yorkshire*

### A low note

One of my lowest moments as a house officer was being on a cardiology ward round as the lone junior surrounded by clever consultants and registrars. I was a few months into my FY1 year, and it felt like I was in the swing of things. However, just as I was starting to write in the notes of a patient, my registrar grabbed them from me and started writing himself. I felt so embarrassed - writing notes is one of the few things a house officer is expected to do without supervision, and yet I was obviously rubbish at it. And this registrar was really nice, so it wasn't like he was being cruel. He was just obviously frustrated at my incompetent note taking.

I have since learnt that writing notes is a more important job than it seems at first. When you're doing a busy on call, a good last entry from a diligent house officer can make all the difference and save you precious time that would otherwise be spent leafing through the entire set of notes. So what makes a good note entry?

- **A problem list** (see opposite)
- Documentation of how the patient is today. Note down vital signs, any history or examination that is performed on the ward round, and any discussions that have taken place between you and the patient (see **SOAP** p5). Recording what the patient has been told is useful for on-call staff.
- A clear management plan. Mark each task as "done" in the notes once completed.
- Different consultants and registrars like different styles of note keeping, so find out early on what they expect. If you are in any doubt over what has been said on the ward round, don't be afraid to ask for clarification—it's far better than writing something that makes no sense to anyone else. *Gayathri Rabindra, London*

Listen to the patient for they are telling you the diagnosis. Diagnosis is 80% history. Be empathic, learn to read body language, and learn to control your own body language.

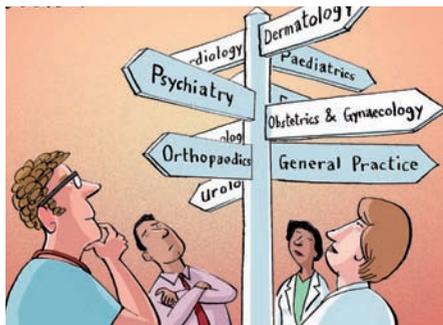
*Peter Martin, Essex*

Whenever I make an entry, I print my name, with my job description (shrink, Chief PooBah etc), date, and exact time. It is legible. I then sign. Many years later this may save my rear end. Some contemporaries are less anally retentive, but I like my rear end intact.

*Roger Allen, Australia*

Pre-empt questions: neurosurgeons will want to know a patient's GCS, serum sodium and INR; renal physicians will want to know the pH and serum potassium etc. It's like presenting the relevant findings from a physical examination in an OSCE.

*Adam Asghar, Yorkshire*



There is (or should be!) no such thing as a “routine” investigation. An investigation should answer a question, preferably one to which you already know the answer.

*Peter Martin, Essex.*

A three or four line **problem list** at the top of each entry gives me an idea of what I have pending for the patient and helps structure my plan—especially when alone on a ward round. It gets easier if you do it every day.

*Tim Baruah, London*

## SBAR - how to ask for help from a senior

**Situation:** “My name is Dr X, FY1, and I’m calling from Ward X; I need to tell/ask you about X problem”

**Background:** Patient age, reason for admission, relevant comorbidities, current issue, current obs, relevant investigations (ensure you have the notes, charts, and drug card handy when you call)

**Assessment:** “Based on my findings I think the current problem is. . .”

**Recommendation/request:** “I recommend we do X, Y, and Z; does that sound ok?” or “I request your advice” or “I request that you come to help”

Before you put the phone down make sure you either have a plan that you understand or a guarantee (even better: an approximate time) that the senior will come to help.

Ensure you document that you’ve contacted a senior; include his or her name, bleep number and the outcome of the discussion.

*Sarah Jones, Nottingham*

## Breaking bad news

My advice on breaking bad news is:

- Don't beat around the bush
- Don't use euphemisms
- Don't talk to fill the silence.

People hang on to hope until the last, so be kind and compassionate, but don't delay the message, and say clearly that the person "has died." Allow time for this to sink in, and then offer to answer questions or be of other assistance. It is useful to have a nurse with you to remain with the bereaved if you are busy.

*Rochelle Phipps, New Zealand*

Do not book urgent investigations on the system and just wait; find out the protocol for urgent investigations in your hospital and follow it.

*Heather Henry, London*

Nurses have long memories. Always treat them with respect, and they will help you out of all imaginable (and unimaginable) tight spots.

*Rochelle Phipps, New Zealand*

Never judge any senior or junior by the impressions and conclusions of other doctors.

*Bhavjit Kaur, Greenwich*

Be nice to everyone in the hospital, even the porters – it makes it so much easier to get things done. It is so true that people will do you favours because they remember you as the doctor who always smiles and says "hi".

*Maryam Ahmed, Wolverhampton*

When requesting an investigation you are communicating with another professional, tell them clearly why you are requesting the investigation.

*Peter Martin, GP, Essex*

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**Be polite:** remember the medical world is small, and people have long memories.

**Be concise:** most on-call registrars or consultants will be grateful for a brief but detailed summary of the patient you want them to see or review.

**Be precise:** know exactly what it is you want doing, when you want it done, and by whom.

*Mahomed Saleh, UHCW*

## Making a splash on nights

On my first night on call as a surgical FY1 I was called to see an agitated, tachycardic, and mildly hypotensive patient who was second day post-op after bowel surgery. The nurses informed me he had only passed 10 ml of urine in the last 4 hours. I ran from the opposite end of the hospital to find a clearly sick and possibly septic patient. ABC assessment was good (except for his tachycardia). He was experiencing abdominal pain but was too agitated to tell me more than that. On examination he was guarding around his lower abdomen; it was very tense, but he still had bowel sounds. His fluid balance chart (not fully complete) showed only 1 litre in (over the past 24 hours), and only about 500 ml out (all day) from his catheter. Culprit found: “He’s hypovolaemic,” I thought. So we gave him a 500 ml Gelofusine bolus followed by a 6 hr bag of Hartmann’s. Over the next hour his agitation worsened.

I called the surgical SHO who, after shouting at me for having woken him, promised to come, and asked if we had

**“I was promptly soaked by the 900mls of urine before I’d even withdrawn the catheter. The patient breathed a sigh of relief and thanked me, and the SHO walked in to find me covered in urine!”**

done a bladder scan. I had to sheepishly say we hadn’t thought of that. By the time the SHO got there we’d done a bladder scan, which showed over 900 ml. The catheter clearly needed changing as it was completely blocked. We set up the trolley ready for me to pass a new

catheter, disconnected the catheter bag, and deflated the balloon. I was promptly soaked by the 900 ml of urine before I’d even withdrawn the catheter. The patient breathed a sigh of relief and thanked me, and the SHO walked in to find me covered in urine!

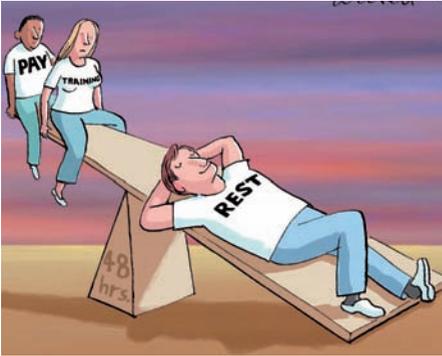


### My key tips for anyone approaching their first set of surgical nights:

- Perform catheter flushes and bladder scans before panicking about fluid balance
- Seniors may be asleep but they are being paid to work, so don't feel guilty about waking them up if you're unsure about something
- Always have a spare change of clothes or know the theatre changing room code so you can get changed if you get covered in blood, vomit, and/or urine.

*Sarah Jones, Nottingham*

## Being a doctor can be stressful; here's how to maintain a good work-life balance



doc2doc has several non clinical forums including book club, cycling, and travel forums [doc2doc.bmj.com](https://doc2doc.bmj.com)

Organise your annual leave early so you can plan when and where you're going to go on holiday for that all important stress relieving break. *Adam Simmons, Rochdale*

Remember, stress makes you make mistakes. The best way to relieve stress is to take your work easy but responsibly. Take feedback or comments positively. Don't let any irate comments or remarks bother you too much; they come and go. You should be more worried about your patients and the care you give. *Matiram Pun, Nepal*

Most importantly, try to have a life outside medicine, as medicine is a profession that easily takes over your life. *Tiago Villanueva, Portugal*

Know when to hand over something that takes you beyond your limits. Otherwise you will walk through the corridors with the hospital's problems on your shoulders, and that's the med reg's job! *Adam Asghar, Yorkshire*

Work hard, play hard. Exercise is probably the best destressor. Alcohol is probably the worst. Do NOT self medicate with hypnotics or antidepressants. Seek help if necessary; do not be embarrassed. *Peter Martin, Essex*

### Food

Don't drink so many caffeinated drinks, you will feel better with fewer. Don't be tempted by sugary foods when stressed. Instead eat some protein with some fruit or other healthy combination. Take a break for meals; don't skip them. Finally, when things are getting to you on a busy shift, take half a minute to take a few deep breaths and release some tension before diving back into the jobs.

*Susan Kersley*

Have food with you at all times to avoid protracted periods of hypoglycaemia. That liquid yoghurt or those all-bran biscuits in the pocket of your white coat are priceless. [Liquid yoghurt in a white coat? Sounds like an accident waiting to happen - Ed] *Tiago Villanueva, Portugal*

Always have breakfast as you just never know when lunch will be. *Maryam Ahmed, Wolverhampton*

Get to know your fellow house officers. Sitting in the mess or accommodation lounge moaning and laughing about the day, and commiserating about shared experiences, was one of the best ways I had of coping with stress in my FY1 year. Few people can empathise with your situation as well as those going through the same thing. It is also important to get the balance right; too much medicine in your life can drive you crazy.  
*Gayathri Rabindra, Sidcup*

Sleep is more important than partying, even when it seems like you have no life. You don't, but eventually you will, so don't ruin your mental health before you get there.  
*Rochelle Phipps, New Zealand*

Make sure you get a good night's sleep before any on calls. Planning a night out with your colleagues can motivate you.  
*Kiki Lam, Blackburn*

**Wear comfortable shoes and laugh a lot.**  
*Rochelle Phipps, New Zealand*

**Give yourself credit; you're better than you think.**  
*Mahomed Saleh, UHCW*

**Read fiction. Anything.**  
*William Hall, New York*

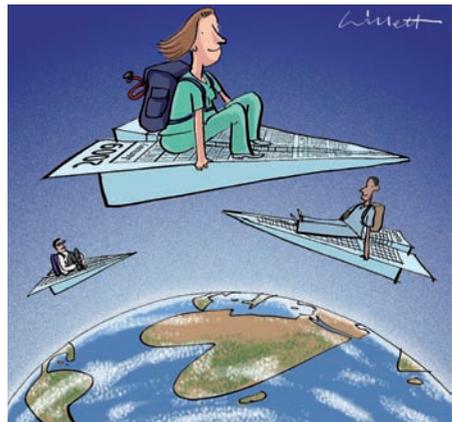
## Exercise

Join a gym or take some other form of regular exercise. When you get crash calls you don't want to be too tired by the time you get there to be of any use!

*Imran Qureshi, London*

Take a few minutes a couple of times a day to walk as briskly as possible from one end of the hospital to the other, preferably outside.

*Susan Kersley*



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## Tips for cannulating difficult patients

**Grossly oedematous patients** are difficult to cannulate because it is difficult to even see a vein to puncture. You can get around this by placing the tourniquet tightly, high up on the patient's arm, then pressing very firmly but gently on the dorsal surface of the patient's hand for, at the very least, 1 minute—the longer, the better, though. This pushes all the fluid away and should leave you with a clear view of a juicy, fat vein! You must have your needle ready, though, because the fluid can return very quickly and obscure the vein again.

**Warm water** can make veins visible and palpable. Get a small bowl or beaker (the ward should have plastic ones) and fill it with water that's hot, but bearable. Explain to the patient what you would like to do and why you are doing it. Then place the tourniquet high up on his or her arm, and ask them to submerge his or her hand in the warm water. Keep it there for 5 minutes. The heat should bring the veins up for you to puncture.

**Gloves** can have a great tourniquet effect—not by using them around the arm, but by getting the patient to wear one. Estimate the patient's glove size, then give him or her a glove one size smaller to put on, explaining that it will be quite tight and what you hope to achieve. Remove the glove after 5 minutes and cannulate away! You can also combine this with the warm water effect.

*Robin Som, Cambridge*



## ...and how not to do it

- Tell patients it's just a tiny scratch before you go digging into their flesh in every possible direction.
- Prepare your patients by telling them they've got difficult, narrow, and wiggly veins.
- Tell the patient you got into the vein but the tiny little valves on the veins are blocking your plastic cannula from moving in.
- Tell your patients they have fragile veins when you give them a great big haematoma.

**If all else fails**, call the friendly on-call anaesthetist (don't call the same anaesthetist twice in the same day; never call them within the same hour; get your fellow house officer to be the bad guy). You know you're in trouble when the on-call anaesthetist tells you that they are not a cannulation service . . . then you think subcutaneous morphine or fluids, supplemented with regular diclofenac intramuscular injections, might just be the easier, or, realistically speaking, the only option you have left.

*Yee Teoh, Kent*

Three questions to ask yourself and the ward staff at the beginning and end of the day: Anybody sick? Anybody new? Anybody going home?

*Mahomed Saleh, Coventry*

### Confirming death

If asked to confirm death, you need to write the following in the notes:

- Asked to verify death
- No response to painful stimulus
- Pupils fixed and dilated
- No heart sounds (for 60 seconds)
- No breath sounds (for 60 seconds)
- No carotid pulse (for 60 seconds)
- Time of death (HH:MM on DD/MM/YYYY).

Note whether there was a pacemaker palpable (for whoever does the cremation form), then sign, name, and date the notes, and provide a clear contact number (in case the bereavement office need you).

*Sarah Jones, Nottingham*

### Get rid of the bubble

Arterial blood gas analysis of a patient with severe pneumonia showed a normal pO<sub>2</sub>, which I was initially satisfied with. However, on reviewing the patient I found him clinically worse than the blood gas suggested. I repeated the ABG myself to find that patient was severely hypoxic. I later found out that the person who ran the first blood gas analysis had not removed the gas bubble from the syringe.

Lessons learned: always remove the bubble from blood gas syringe and treat the patient, not the test result.

*Farhat Mirza, Gillingham*

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### Look underneath those dressings

I was clerking a patient with sepsis who had subtle signs of a chest infection but not enough to explain the degree of his illness. The patient also had a dressing over his foot. In his letter the GP had written that he had examined a small ulcer on the patient's foot, which he thought to be healthy so had applied a fresh dressing. For this reason I did not examine the foot. Later, when the consultant asked for the dressing to be removed, we saw green discharge from the ulcer and cellulitis around it—quite embarrassing for me. The lesson I learned was always to look underneath dressings, even at the cost of annoying the nurses.

*Farhat Mirza, Gillingham*

## A first day to forget

I started in the Eastern General in Edinburgh on Sunday 1 August 1976, and experienced my first death from medical error on the Monday. Maybe this explains the rest of my career—as an editor and busybody, rather than practising doctor.

I wasn't totally terrified on that Sunday as I had done a couple of locums, but I was painfully aware of my many deficiencies. Interestingly in retrospect, I saw those deficiencies as entirely my fault. It never occurred to me that it was a failure of the system to leave somebody so inexperienced with so many responsibilities. Indeed, I knew about body systems but never had considered that the hospital might be a system.

That first day was quiet. My main job was to admit a woman in her early 40s who was coming in to have a specimen of bone marrow taken from her sternum. She was being investigated for pernicious anaemia. Such a patient would not now be admitted, and I don't think that anybody takes bone marrow from the sternum anymore. This story explains why.

I don't remember the woman clearly, but I think of her as ordinary and essentially well. She certainly wasn't sick. I think that she was a mother. She was under another consultant, so I didn't see her again until the following day.

The other doctor, Phil, who had also just started, was responsible for doing the sternal puncture, and because he had done several as a student he got a medical student from Ireland to do it. She was rather tentative and didn't manage to draw any marrow. So Phil took over and rapidly filled a syringe with marrow.

Seconds later the woman "fainted." It was rather a heavy faint—so they took her blood

pressure, which was initially normal, and did an ECG, also normal. I was doing a ward round with my consultant, and he went over to look at the woman. It seemed odd that she should be so deeply unconscious after a simple test, but he didn't think it necessary to do more than monitor her.

Slowly people began to realise that something terrible had happened. The senior consultant arrived and immediately grasped the seriousness of the woman's predicament. Now her blood pressure was beginning to drop. The most likely diagnosis was that the needle had gone right through the sternum and penetrated a major artery. So it turned out.

The woman was rushed to the intensive care unit, and cardiothoracic surgeons were called from the Royal Infirmary, about four miles away. The surgeons opened her chest, but it was too late. She exsanguinated.

I'm not sure what happened to the Irish medical student, but Phil, who seemed remarkably unfazed by the whole experience at the time, subsequently became an anaesthetist, an alcoholic, and a drug addict. He went to prison for driving while disqualified, was struck off, and died more than 10 years ago. All this may have been nothing to do with the death of the woman but more with his drinking as a student. We dissected the same body, a great bonding experience, and he spent most of his first term at medical school trying to drink 100 pints of beer in a week. The first time he got only as far as the high 80s but the second time he made it. He was a laugh, was Phil.

*Richard Smith, Clapham*

## “Doing the job of your dreams and learning something new every day”

The busy on calls, moments of intense pressure, and facing difficult situations with little experience to fall back on have all contributed to a steep learning curve, which every FY1 trainee encounters.

During my haematology rotation, seeing the effects of cytotoxic drugs on patients and being able to provide medical and emotional support was enlightening. Owing to a prolonged hospital stay with many patients experiencing severe illness, it was vital to develop an open, trusting, and supportive rapport.

Colorectal surgery was my last rotation; with a high turnover of patients, good organisation and prioritisation were essential. Being mostly ward based, I appreciated having done my medical and intensive care rotations beforehand,

allowing me to be thoroughly systematic while managing acute medical and surgical problems.

The most important aspect of this year has been reflecting on my attitudes and beliefs, and how these have played an important role in realising my career goals. On several occasions I have had to communicate very difficult information to patients and their families. This has been challenging but extremely rewarding. I can fully appreciate the importance of being an effective team player, developing good communication skills, and always having a patient centred approach.

The skills I have acquired as a junior doctor have been invaluable.

*Nida Gul Ahmed, Lincoln*



### “Will I ever get good at this?”

As a 12 month old baby doctor, I’ve had some developmental milestone delays, but I’m starting to walk after a long “bum shuffling” phase learning organisational skills.

At the start I was very apprehensive about my crash bleep going off. Well, I’m a bit sorry to say that I now love crash calls. I may still be nervous, but the adrenaline rush is invigorating. My first ever chest compression began with the sound of a cracked rib and the two minute cycle exhausted my arms, but the sweet sound of an output and a pulse brings a smile to my face. I was called to another patient who arrested in the ward toilet.

He didn’t make it, but I still thought that I could do this sort of stuff forever. Does that make me weird?

There is a lot wrong with the F1 year: portfolio stress, getting blamed for everything, fatigue, worry, arguments, constant pining for annual leave, and that old chestnut, death. But all that is forgotten when I’m dealing with an emergency and I remember for a few short minutes at least that I wouldn’t want to do anything else.  
*Clinton Vaughn, Surrey*



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### “My mind went blank—all those lectures on fluid balance and I still couldn’t think of what to give”

There is nothing like learning on the job.

Looking back I recall my first week as terrifying—I even feared fluid prescribing, which like many other things is now second nature. As the weeks passed I gained confidence and picked up the tricks of the trade, quickly realising that as long as the jobs got done everything remained sweet.

From putting out blood forms to ordering chest x rays, managing acutely unwell patients, and making nerve racking telephone calls to the on-call registrar, I fulfilled my role. Not a day passed without an exciting moment or a learning opportunity.  
*Omar Barbouti, Kent*

## “Having half expected to be a glorified medical student, I realised something had changed”

This has certainly been a year of learning to swim at the deep end.

My first night shift was spent covering a medical ward just after Christmas when there had only been skeleton staff for four days. It was emotionally and physically draining and made me want to walk away from my medical career and never look back, but I realise now I am better off for it.

Call me crazy, but I have gone from fearing night shifts to welcoming them as a pleasant change. Yes, I still feel that bleeps could be used as instruments of torture, but there is a surreal tranquility about walking down dimly lit corridors and talking in whispers. The satisfaction of accurately assessing and managing an acutely unwell patient, inserting a difficult cannula, or being offered a well buttered piece of toast are bonuses.

Having said that, it never ceases to frustrate me how the day you finish your set of nights is called “time off.” Surely giving me 23 hours to readjust my sleeping patterns does not equate to a mini holiday?

Foundation year has taught me how to be a doctor in more ways than one; clinical knowledge, although important in its own right, has almost been less relevant than mastering a calm and confident approach to the most stressful of situations.

*Yasmin Akram, Birmingham*

## “There’s something about the pressure of being expected to know that can make you crumble”

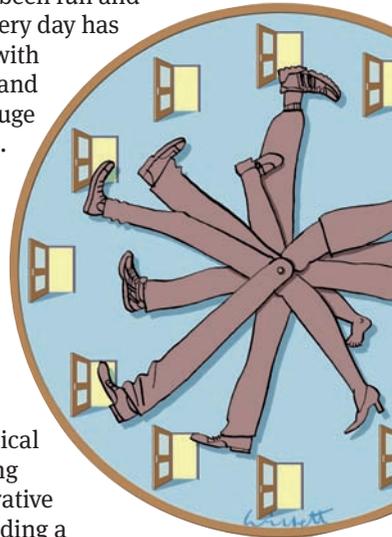
It can also ensure you learn something and learn it well.

The foundation year really lived up to its name, providing the foundations to build my career on. The gear shift from medical student to working doctor ensures there is plenty of responsibility, and with it pressure. Each specialty I have rotated through this year has given me different perspectives of hospital medicine.

It hasn’t all been fun and games, but every day has been packed with new learning and practising a huge range of skills.

The workload is immensely diverse and has included being the first on scene at crash calls; navigating the murky waters of medical ethics; auditing and administrative work; and holding a dying patient’s hand in his last moments. Week by week I have felt myself becoming a more competent and confident doctor.

*Ali S Hassan, Kent*



**“My confidence was destroyed when I was told that the previous FY1 doctors were the best the consultants had seen, and had worked to the level of senior house officers”**



Difficult, stressful, and sometimes negative experiences from the past year tend to stay with me, more so than the numerous exciting, fulfilling events. Memories include being unable to cannulate patients, making inadequate referrals, or watching patients improve medically, then suddenly deteriorate and die. Positive moments include talking to patients and relatives, and being thanked for clarity and empathy; patients recovering after being seriously unwell; and being complimented by consultants and registrars for doing a good job.

I have enjoyed and benefited greatly from the camaraderie between FY1s, and I have been fortunate to work within good teams, as well as with some great nursing staff. My most interesting conversations have been in the evenings or at night—making it almost worth being at work during antisocial hours.

With each new rotation I initially felt out of my depth, and yet by the end of four months I became more confident and was able to make more independent decisions.

*Tabassum A Khandker, Surrey*

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## From the hundreds of other tips we got ...

Gradually, you will become more familiar with “what happens next” in any situation, and you will grow more confident. Then you will get overconfident and cocky and make an error that shakes you (hopefully not a serious one). You’ll go back to being uncertain about when to be scared, but not quite as uncertain as before. Over time this will build up into a corpus of familiarity, humility, and confidence that you can depend on.

*David Berger, North Devon*

Everyone gets frightened and tired, and feels like an imposter at some stage. Work within your capabilities, never be afraid to admit you just don’t know, and you will be fine!

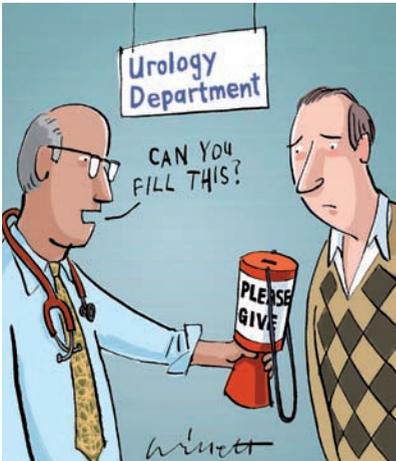
*Rochelle Phipps, New Zealand*

Drug companies lie occasionally and mislead often. Do not obtain your information from representatives. There is no such thing as a free lunch. Read the evidence for yourself (critically).

*Peter Martin, Essex*

The earlier your supervisors know about a problem, the sooner rectifying attempts can be made. If you are given a ridiculous rota, come up with an alternative and present it to those responsible for it. You may not achieve instant success, but you can strive to improve patient safety and working conditions, rather than grinning and bearing it.

*Adam Asghar, Yorkshire*



You are an FY1 - not superman - and people know this; mistakes are expected. This is how you learn. Ask for help, and you will usually get it. If after the first few weeks you still do not like your job, talk to someone about it. If you bottle things up you are in danger of becoming ill yourself.

*Catriona Bisset, Glasgow*

Organise an audit early as it may take time to gather information from notes. Re-auditing is important to complete the audit cycle (and impress at interviews).

*Kiki Lam, Blackburn*

Don’t be afraid to “blow the whistle” if you witness a dangerous incident.

*Adam Asghar, Yorkshire*

Most importantly... it gets easier! - *Claire Kaye*

# SCORING SYSTEMS REFERENCE INTERVALS

## Patients in AF: aspirin v warfarin (CHADS<sub>2</sub>)

Congestive heart failure	1
Hypertension (treated or not)	1
Age > 75 yrs	1
Diabetes	1
Stroke/TIA	2

Score 0 = Low risk

Score 1 = Moderate risk – daily aspirin

Score 2+ = Moderate to high risk – warfarin (if not contraindicated)

Seek senior advice before starting treatment

## Wells scores:

### for PE

Clinical signs of DVT	3
Alternative diagnosis less probable than PE	3
Heart rate > 100 bpm	1.5
Immobilisation or surgery < 4 weeks ago	1.5
Previous DVT/PE	1.5
Haemoptysis	1
Cancer	1

Score < 2 = Low probability of PE

Score 2–6 = Moderate probability of PE

Score 6 + = High probability of PE

### for DVT

Active cancer	1
Paralysis, paresis, or recent plaster immobilisation of the leg	1
Recently bedridden for > 3 days OR major surgery within 4 weeks	1
Localised tenderness in area of deep venous system	1
Entire leg swollen	1
Calf swelling by more than 3 cm compared with the asymptomatic leg	1
Pitting oedema – greater in the symptomatic leg	1
Collateral superficial veins – non-varicose	1
Alternative diagnosis as likely or more possible than that of DVT	-2

Score < 2 = Low probability of DVT

Score 2+ = Moderate to high probability of DVT

## Community acquired pneumonia (CURB65)

<b>Confusion</b>	New onset	1
<b>Urea</b>	> 7 mmol/l	1
<b>Respiratory rate</b>	> 30	1
<b>Blood pressure</b>	Sys < 90 or dia < 60	1
<b>65</b>	Age > 65 yrs	1

Score 0-2 = Mild to moderate CAP

Score 3+ = Severe CAP

## Abbreviated mental test (10 point AMT)

Age	1
Date of birth	1
Year	1
Time of day (without using clock)	1
Place (city or town is acceptable)	1
Monarch (or prime minister)	1
Year of World War I or II	1
Counting 20-1 (can prompt to 18, e.g. 20, 19, 18)	1
Recognition of 2 people (e.g. doctor, nurse)	1
Recall of 3 points (e.g. address or 3 objects)	1

NB: Variations exist; this is a guide.

## Pancreatitis scoring (Glasgow system)

<b>PaO<sub>2</sub></b>	< 8.0	1
<b>Age</b>	> 55	1
<b>Neutrophils</b>	(WCC > 15 x 10 <sup>9</sup> /l)	1
<b>Ca<sup>2+</sup></b>	< 2.0 mmol	1
<b>Renal</b>	Urea > 16 mmol/l	1
<b>Enzymes</b>	LDH > 600 IU/l or AST > 100 IU/l	1
<b>Albumin</b>	< 32 g/l	1
<b>Sugar</b>	BM > 10	1

Score 0-2 = Mild to moderate pancreatitis

Score 3+ = Severe pancreatitis (may require HDU/ITU)

## Chronic kidney disease (CKD) staging

Stage 1	GFR > 90 ml/min with structural/ biochemical abnormality
Stage 2	60-89 with an abnormality (as above)
Stage 3	30-59 ml/min
Stage 4	15-29 ml/min
Stage 5	< 15 ml/min

Labelling someone as having CKD requires two samples at least 90 days apart

Online GFR calculator: [www.renal.org/eGFRcalc/GFR.pl](http://www.renal.org/eGFRcalc/GFR.pl)

# ESSENTIAL TELEPHONE NUMBERS

Anaesthetics  
A&E x ray  
Anticoagulation clinic  
Anticoagulation nurse  
Bed managers  
Biochemistry on-call  
Biochemistry  
Bone scans  
Breast nurse  
Cardiology  
Cardiology clinic  
Care managers  
Chest clinic  
Chiropody  
Coroner  
CT  
Dermatology clinic  
Diabetes nurse  
Dietitians  
Doppler  
EEG  
EMG  
Endoscopy  
Eye clinic  
Facilities  
GUM clinic  
Haematology  
Hearing & balance  
Histology  
Histopathology  
Human resources  
IT  
ITU  
Liaison psych  
MDM coordinator

Medical manager  
Medical records  
Medical registrar  
Microbiology  
Mobility physio  
MRI  
OT  
Outpatients  
Pain team  
Palliative care  
Pathology  
Payroll  
PGMC  
Pharmacy  
Phlebotomy  
Physiotherapy  
Porters  
Pre-op  
Registry  
SALT  
Surgical manager  
Ultrasound  
Vascular USS  
X ray

## SURGICAL WARDS

## MEDICAL WARDS

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