

By Dr Tan Wu Meng, Editorial Board Member



## Reflections of a 30-year-old Houseman

### INTRODUCTION

An Editorial Board colleague, having watched the movie *The 40-Year-Old Virgin*, suggested I write an article in a similar vein, given my past experience of being a House Officer (HO) of *un certain age* (as the French might put it). I am unsure if the comment referred to my bedside manner or my age, or something else entirely.

My journey to qualification as a doctor was a somewhat prolonged one. I am one of those specimens that might be called a clinician-scientist, in that I have training in both clinical medicine and bench research.

### RETURNING HOME

It was a difficult decision choosing whether to return to Singapore for the HO year. Junior doctors in the United Kingdom have

plenty of "welfare". For example, there are regulations limiting the number of hours one can spend on-call. Financially, one is not disadvantaged, for an ongoing supplement of 20% to 80% of the base salary is paid to those with long hours, unsociable shifts, or more "siong" (heavy) postings.

So why did I choose to come home? Well, eight years is a long time to spend overseas. Parents and grandparents grow older. School friends grow more distant, no matter how hard one tries to keep in touch. Furthermore, my long-term wish is to settle down in Singapore, the land of my birth. The weather here is never cold, family is somewhat nearer than a 14-hour journey by air, and local food is readily available at decent prices.

And if I eventually wish to practise in



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Singapore, why not do it from day one, starting as a HO?

### **AGE: 30 AND STILL KICKING**

As a returning foreign graduate, I started in the month of March, “out of sync” with the local graduands who start in May. My colleagues already had 10 months of experience as HOs, which made the learning process far less painful – these veteran HOs showed me the ropes and provided invaluable advice and guidance. I tried to repay the favour to my new colleagues when the Great Handover came round, and I suddenly found myself the (relative) senior of two months. Hopefully I did not make too much of a mess of things.

One unusual aspect of being an older HO was that some of my Registrars were more youthful than myself. However, it did not bother any of us. I guess such things become issues only if people let them be so.

While the controlled experiment would have been difficult to do, I certainly felt that I had less energy doing HO calls at the age of 30 and going on 31. Post-call outings were few and far between – I preferred to go home and seek solace in deep, dreamless sleep.

### **MEMORABLE PATIENTS**

Although life as a HO was very busy, there were still many memorable experiences. Some were of scientific or clinical interest. Some of them were happy, and a few were heartbreaking. However, such is the nature of Medicine, which deals with issues from bench to bedside, and – more importantly – matters of life and death.

**Mr A.** I remember well a gentleman with advanced metastatic cancer. His wife was expecting their baby, but it was not clear if the father would survive long enough to see his child. The complications of his disease would have shattered a lesser man’s spirit, yet his stoicism and cheer hardly wavered. I felt great sorrow when I discharged him home for terminal care – I had gotten to know him during his month-long stay in hospital, and both of us knew it would likely be our last meeting on this earth.

As it turned out, he held on long enough to witness the birth and to hold his newborn, but passed away shortly after. I think the hardest part of caring for patients with terminal illness is when you get to know

them – because the loss hits that much harder upon their demise. I only hope that when my time comes, I will face it with the same courage and spirit which he did.

**Mr R.** I remember a young man who had lost his leg in a hit-and-run accident. His otherwise well-toned physique hinted at a previously active lifestyle, which compounded the tragedy. Understandably depressed and having lost his will to live, he refused rehabilitation and was not keen on further treatment despite the sepsis, which edged closer every day. Thankfully, we were able to make contact with a high-profile amputee, who very generously agreed to visit the patient. Seeing a fellow amputee who had beaten the odds to lead a productive, active and affluent life made a huge difference, Mr R’s morale rapidly improved and a few days later, he was actually flirting with the nurses! I hope he is doing well.

### **BEST CALL / WORST CALL / LAST CALL**

My best on-call was a bittersweet experience. It was a public holiday, so there was disappointment at missing out on the celebrations. On the other hand, we only had about eight admissions that night, of which one went directly to Intensive Care. All the remaining seven patients were interesting, and the on-call Registrar bought food for everybody as the night was otherwise fairly quiet.

Even my worst on-call had its bright moments. I had the privilege of working with a generous Medical Officer (MO), an experienced veteran from the Philippines. Surviving that call would have been impossible without his kind assistance, for over 20 new admissions reached the ward between 5 pm and midnight, with at least another 10 in the wee hours of the morning. I stopped counting after we reached 30 cases. We also had the misfortune of having two collapses in quick succession, in adjacent beds. I do not know if the second patient’s demise was hastened by his witnessing the collapse of his neighbour.

My last HO call was also bittersweet. My MO and I had to attend to the terminally ill parent of a personal acquaintance of mine. He was in great discomfort and we tried to make him more comfortable, but he passed away the following day. I wish there was more we could have done for him.

**SURVIVAL SUGGESTIONS**

**Pre-rounding.** If your team is agreeable to the idea, it can be helpful to come in a bit earlier to pre-round the patients. I remember an outstanding senior who told me this was one of the best ways to learn. Seniors can sometimes be squeamish about letting HOs make decisions, and this is one way for them to assess your acumen. Do not be discouraged if you get corrected or put down – after all, one is there to learn. To avoid confusion, write “KIV” (keep in view) in front of your management plan – if all goes well, there is the satisfaction of only having to cross off the KIV during the ward round proper!

**Follow-up on interesting on-call patients.** This is particularly applicable to busy calls where the HO may not get the opportunity to return to the patient after the initial clerking. Was that really a mixed mitral valve disease murmur you heard? Or was the low-pitched diastolic rumble actually coming from your unfilled stomach? The only way to know is to have a look at the case notes a day or two later.

**Do as many procedures as possible.** MOs are generally willing to teach you, especially if you offer to take on some of the procedure workload thereafter. Medical Oncology, in particular, has a large number of patients requiring pleural or abdominal taps. Neurology provides an endless supply of lumbar punctures, and there will be the occasional arterial line in the High Dependency Unit. Each posting has its opportunities – just keep an eye open for them.

**Online Resources.** Some hospitals subscribe to UpToDate.com, which has a good supply of articles. Another useful website is run by the Royal College of Pathologists of Australia ([www.rcpamanual.edu.au](http://www.rcpamanual.edu.au)), which lists and explains a large number of lab investigations, from the mundane to the esoteric. It even explains how one might test for carcinoid syndrome in a dialysis-dependent patient with end stage renal failure, and thus no urine output for the conventional 24-hour 5-HIAA collection. (This dilemma actually occurred in real life.)

**During night calls, the two biggest enemies are hypoglycemia and fatigue.** So make sure you grab a meal and pack some snacks. Chocolate has excellent sugar content, but tends to go soft while sitting in the pocket. I preferred to carry muesli

bars as well as a copious supply of sweets. Clorets are useful as they freshen the breath while also supporting the blood glucose. My dentist will recoil in horror but I am sure he does not read *SMA News*.

**Be nice to your nurses.** They have a difficult job too. Be polite to them and try to win their respect, because they will look after you and can be your friends and allies. If you can, get them chocolates from time to time, if only so that you have an excuse to indulge in chocolate as well. A bolus dose of chocolate is a guaranteed cure for any form of depression.

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Hold on to your compassion and intellectual curiosity. I think this is the hardest part of the job, especially as the months wear on and the dual spectres of fatigue and cynicism continue their war of attrition. Never forget that your patients are vulnerable, often afraid and invariably in need. Similarly, never forget that medicine is full of curiosities and atypical presentations – this realisation can help keep you going when the chips are down, and it can reduce the risk of missing a diagnosis when you are riding high and the chips are up.

Last but not least, try to enjoy the HO rotation. It is only a year long. It will entail a lot of hard work, but it will be worth it. And it will also be the last time you can say to yourself, “if all else fails, call the MO” – because in a year’s time, you will be the MO. ■