Through the Eyes of a Medical Student:

LIFE AT KING'S COLLEGE HOSPITAL

Text by Han Shu Xin

Week 1

Team – together, everyone achieves more

It was my first day at the Emergency Department (ED). I was pretty lost. I recall trying to get from the card collection office back to the ED, which had me take a few detours down different corridors, only to find myself time and time again back at the same spot. I marvelled at the wide array of patients I walked past as I was doing so – the dark-skinned, blonde and blue-eyed – along with the occasional chatter in British English. This was all a whole new world to me. Eventually, I managed to stumble back to trauma nurse Iona Polson's office, with the help of the staff at the information desk. I also made it a point to geographically map the locations of the different departments in my head so that I will never be lost again.

I was assigned to Max, the Emergency Nurse Practitioner (ENP) on duty at the Urgent Care Centre (UCC) that day. The UCC was completely packed, and yet the ENPs remained calm, treating each patient with utmost care. The occasional grumble by patients who had been waiting in line for a long time were met by helpful nurses who kindly assured them that they were next in line, or suggested that they have a light tea break if a long wait was expected. The

phlebotomist was busy trying to calm an anxious patient to take some blood for tests.

Despite the flurry of activity going on, communication between staff and fellow staff or patients remained friendly at all times with "thank you very much", "I appreciate that" and "no problem at all", and were met by exchanges of smiles from both parties. It was only after a week that I noticed that this was but commonplace. Everyone was willing to help each other out; junior doctors could easily approach senior doctors for help regarding any patient, regardless of apparent complexity or complaint. Doctors and nurses alike looked out for patients who were upset or in pain, making sure that their pain was addressed with paracetamol, appeasing squabbles between patients waiting in line, and giving directions to those who looked lost. This made the busy ED a happier place to work and be in, with patients leaving satisfied with their care and filled with gratitude.

Week 2

The vulnerable individuals – of toxins and poisons

When I entered the cubicle, there laid a middle-aged gentleman – brows furrowed, with hints of despair behind his frightful, tired eyes, clearly anxious. Just the night before, he had been ingesting G (gamma-Hydroxybutyrate) – a colourless, odourless liquid commonly known as a "date rape drug" – as a sexual stimulant and was now experiencing the withdrawal effects of it. He was honest and frank about its abuse and that he had been using it for a long time now, together with methamphetamine, which helps to complement its effects.

While this was a first for me, Dr T explained to me that she had seen tons of cases similar to this during her public health rotation, where there were plenty of drug abuse cases. Vulnerable individuals – the homeless, poor and shunned, and the physically and emotionally abused – were particularly prone to drug abuse.

This gentleman shared with us his worries – he was tired of being at the mercy of drugs. He understood that it was a huge financial burden, costing him his relationship with his family and essentially his life; he wanted to get his life back on track. Prior attempts at doing so were futile – he had relapsed after a year of being off drugs. But this time, he wanted to change for good. Dr T expressed her genuine willingness to help and did so promptly by engaging the drug team on-call that day. Soon, one of the staff came to enrol him in their rehabilitation programme. He expressed his gratitude.

However, basic blood tests needed to be taken. We knew that this was going to be a tricky task – he was acutely dehydrated and most of his veins had collapsed or fibrosed from the overuse of intravenous drugs. Dr T tried her best to find a suitable vein but alas, trials at pricking him with the needle failed again and again. He winced at every trial. The pain was so unbearable that he yelled for a stop after multiple trials. Eventually, the registrar was called in and a plug was successfully set with the help of some handy lignocaine, a smaller needle and a keen eye for a suitable vein.

Coming from a place where drug laws are extremely strict, I have had little experience with patient admissions for illicit drug use in Singapore. I am fortunate to have the privilege of meeting some of these individuals here. Be it the haggard looking intravenous drug abuse lady, hair dishevelled and teeth discoloured with brown stains, who beamed at me when I passed her a new gown upon noticing the blood stains from her prior venipuncture, or the aggressive alcoholic who was subsequently escorted out by the big, burly security personnel upon name-calling and upsetting a fine dark-skinned gentleman passing by, these individuals helped me to gain an insight into a world beyond what I had previously known.

Week 3

Life on the brink of death

King's College Hospital is one of the major trauma centres in the region. It receives patients by walk-ins, ambulance and air (the helicopter). On a busy day, one can hear the ongoing ambulance sirens in the neighbourhood whizzing past the traffic, and see the ED parking lot decked in yellow and green, patients being pushed in stretchers by ambulance personnel eager to send in the sick for further treatment. Paramedics are well equipped and trained to carry out emergent procedures ranging from simple face masks to complex intubations en route before being received by the ED.

An elderly gentleman, in his 60s, was wheeled through the doors of the Resuscitation Department. He was unconscious, with a Glasgow Coma Scale of 6. Fortunately, he was breathing spontaneously. From his body emanated an unpleasant and distinct smell akin to rotting flesh. He looked very ill indeed. His arm was stiff and rigid, and his bum sustained a huge, 7 cm by 10 cm open wound that was black and foul smelling. He was living alone and had been found unconscious, for what seemed like three days based on when he was last seen, by neighbours who felt something was amiss when they noticed the foul-smelling odour coming from his home.

A quick head-to-toe assessment was done – Airway, Breathing, Circulation, Disability and Exposure. He was then whizzed over to the CT head scanner. The doctor kept close by during the wait outside the room, watching out for signs of desaturation. We called out to the patient every time he had closed his eyes for a long time, and heaved a sigh of relief when we realised he was just snoozing. We propped him up onto the CT machine using the Patslide. CT images revealed a grim prognosis – a

large left-sided basal ganglia bleed. The doctor told me he was unlikely to last very long. Neurosurgeons were called in.

Throughout the process, however, despite being in an unconscious drowsy state, he was constantly being addressed by name and informed of the various steps along the way – of being changed out of his clothes, transferred and moved from place to place. The effort towards upholding patient respect and dignity even in their most vulnerable states was, what I felt, commendable. What may be bread and butter in the department – major trauma, bleeds and strokes – is actually of utmost significance and has lifelong impact on the individuals and their loved ones.

As for the patient, I didn't have the opportunity to follow up with him. All I know was that he was eventually admitted to the wards and was in a state of recuperation.

Week 4

Mental health is wealth

> " …. I am nobody; I have nothing to do with explosions.
> I have given my name and my day-clothes up to the nurses
> And my history to the anesthetist and my body to surgeons.
>
> They have propped my head between the pillow and the sheet-cuff
> Like an eye between two white lids that will not shut.
> Stupid pupil, it has to take everything in.
> The nurses pass and pass, they are no trouble,
> They pass the way gulls pass inland in their white caps,
> Doing things with their hands, one just the same as another,
> So it is impossible to tell how many there are.
>
> My body is a pebble to them, they tend it as water
> Tends to the pebbles it must run over, smoothing them gently.
>
> They bring me numbness in their bright needles, they bring me sleep…"
>
> – Sylvia Plath

American poet and Pulitzer Prize winner, Sylvia Plath, described in her famous poem "Tulips", about her lifelong struggle with depression, between the oblivion of death and the responsibility of life, to help us gain an insight into the world she lived in. Her struggle eventually led to her unfortunate suicide by putting her head in the oven and turning up the gas.

The hospital, as much as it is associated with life and living, is very much the place of frailty and death. Suffering from mental health disorders is a plight that many of our patients face, some unfortunately stigmatised by the very community they reside in, and it is up to us clinicians, through our interactions with these patients who entrust us with their painful secrets, to offer a listening ear and, as much as possible, a helping hand.

I was tasked to take a medical history from a patient who had been referred for suicidal ideations by her GP. I met Ms A, a small-framed and thin-built elderly lady who had been suffering from a kidney infection for months – it was truly unpleasant, as she described the foul-smelling urine and painful sensation upon voiding. She had tried antibiotics for months but to no avail. She was fed up of being in pain – physically, emotionally and mentally.

As she spoke, her fierce tearful eyes meeting mine, she recounted stories of her partner's passing, of being cast out by her family, of being a victim of identity fraud and of being stripped of her finances. All these were compounding her own physical pain. She broke down, face cupped gently in her palms, and I briskly handed her some napkins for her tears.

She had also been experiencing significant weight loss down from a dress size of 14 to 4, but she couldn't care less if cancer struck, for "I would rather be dead than living", a phrase she brought up multiple times throughout the conversation. Her sheer helplessness at her own situation was heart-breaking.

She was eventually seen by the psychiatric team and sent home with medications for her urinary tract infection. As part of the ED team, we did what we could and wished her well. It reminded me that behind every patient lies a story, that it is up to us as physicians to cure sometimes, to relieve often, and to comfort always.

This care towards our patients extends to our fellow colleagues and peers. More recently, the World Health Organization meeting in Geneva included "burnout" as an official occupational phenomenon in its latest revision of the International Classification of Diseases. The nature of our work, caring for the health of others, can be a demanding and exhausting feat. It is then up to every individual – whether medical student, junior doctor, allied health member or senior doctor– to treat one another with the love and respect we all deserve.

Thank you

I would like to thank all the doctors, ENPs, phlebotomists and patients that I've come across and interacted with. Each has taught me lessons in more ways than one. ◆

Shu Xin is a Year 5 medical student from National University of Singapore Yong Loo Lin School of Medicine. She enjoys having hearty conversations with *ah mas* she meets at the hawker centre and laughing with her friends and family. Her idea of a perfect day would be having a dip in the pool, eating freshly baked bread and indulging in 99% cocoa dark chocolate.