The Chan Siblings: Our EM Journey

It was pure coincidence that both of us chose to work in emergency medicine (EM).

Joanna (J1): During my rotation at Changi General Hospital's emergency department (ED) as a medical student, I was impressed by the formidable ED bosses and their calm and competent responses to a broad range of emergency situations ranging from cardiac arrest to a pouring nosebleed in a patient on warfarin. Subsequently, I chose to do a posting there as a baby medical officer (MO) in order to learn more. Although ED is considered a "hardship posting" by many, a willingness to work hard and learn, which was shared by my fellow Medical Officer Posting Exercise (MOPEX) MOs, made it such a positive experience that five of us from that batch applied for the SingHealth Residency Emergency Medicine Programme!

Jonathan (J2): I developed an interest in EM early on in secondary school as a member of St John Ambulance Brigade, reading about acute management of medical conditions, practising first-aid drills and teaching my juniors. At the end of Year 5 in medical school, I spent my two-week break on a voluntary EM Student Internship Programme. The programme allowed me to get more hands-on experience of working in the ED before starting residency (since in my time we could apply for residency as fresh graduates).

A MEANINGFUL SPECIALTY

J1: Patients come in their street clothes without having been "labelled" with a diagnosis. I like being part of the thought process which helps to form a problem list, and being able to give timely treatment that can stabilise the patient and sometimes solve their problem without an admission. It's a job which I find very meaningful. As someone in the front line, the doctor can make a big difference by going the extra mile for the patient's sake, whether it's taking a thorough history or a simple step like serving analgesia early instead of leaving a patient in pain.

J2: You can "cure pain" and relieve suffering. I like the sense of being part of a tag team with other providers, both pre-hospital and in the wards downstream, to provide the care that a patient needs. One memory I have is of a national serviceman who came in with a headache. In the ED, he had normal physical findings and no red flags, and he could easily have been dismissed as a low acuity case. However, his camp MO, who accompanied him, showed me a video clip he had taken of ophthalmoplegia which he exhibited earlier during the headache. We sent the video clip on to the ward doctors. Thanks to the proactive camp MO, this patient got the respect which his condition deserved and was admitted for MRI.

A DAY'S WORK

J2: There is no "daily routine" in ED. Every day is different and better experienced than described.

J1: We work in shifts and are rostered to see patients of different triage acuities during each shift. In Resuscitation, we see critically ill patients. In the Priority 2 area, we see trolley patients who need early assessment, and in the Priority 3 area, we see those with non-life- or non-limb-threatening conditions who may end up waiting much longer. Each group of patients carries its own set of pressures and challenges.

UNFORGETTABLE CASES

J2: There are some gory cases that I recall. There was a construction worker who fell from a height of two storeys. He came in with blood streaming from his nose and ears, and he had a low score on the Glasgow Coma Scale. It was my first trauma intubation. Unfortunately, although he survived the CT scan, he didn't make it to a good outcome. Later on, the neurosurgeon identified that the white substance we saw floating in the suction bottle along with all the blood we had suctioned

during the intubation was… his brains. Another patient whom I saw was a soldier who had his fingers blown off by a flash grenade that went off in his hand. Oh yes, my struggle with a plum-sized pile has to be up there on the list too!

J1: There are so many cases which I remember for various reasons. For example, I remember all the paediatric deaths, which included a previously healthy eight-month old who was found dead in infant care due to either sudden infant death syndrome or from choking on milk. I also recall the challenging cases I saw in Resuscitation, such as the difficult central lines in shocked patients who were so dry there was no flashback. I also remember many sad patient stories which were the result of social issues within vulnerable populations – loneliness and neglect among the elderly, poverty, and financial woes for migrant workers who can't pay for treatment.

Of course, there are also many humorous moments. My favourite was when a boy in children's emergency commented on the roll of paper used to line the bed: "Is that a giant toilet roll? It must be for a giant bum! [*turns to address his father*] Like your bum!"

CHALLENGES IN EM

J2: In junior residency, the frequent rotations, administrative work like procedure logs, patient follow-ups, and mini clinical evaluation exercises can sometimes pose a challenge to one's organisational skills. In addition, shift work, of course, means that sometimes one has to forego social engagements on weekends when one's friends are free. Fortunately, I have a very understanding fiancée and family members.

J1: Spousal support is very important for shift work, especially when children are in the picture – even more so for a child who is not yet sleeping through the night! My poor husband had to endure nights, when I was on duty, soothing a child back to sleep five times through the entire night and still returning for a full day's work the next day.

ADVICE FOR POTENTIAL EM DOCTORS

J2: One of the most important qualities an EM doctor must have is the ability to work with other people. In EM, we work closely with our valuable and powerful nurses. They have taught me how to dilute morphine, helped me to find plugs when I couldn't find them, pumped me up to receive standby cases as a young postgraduate Year 1 doctor and rushed to check when I needed help in seeing challenging patients…

J1: There is a steep learning curve in EM and one has to be prepared to ask seniors liberally when unsure, and to learn from one's mistakes. The shift work and the time pressure are not for everyone and I would suggest (as it worked well for me) that doctors who aspire to pursue EM should do an MO posting first, before deciding to make the commitment to residency. Putting patients first equates to a certain degree of obsessive checking. For example, you have to make sure the analgesia or nebuliser that you ordered gets delivered now (and not two hours later), and ensure adequate handover to the ward team. In the busy ED, when there are so many tasks vying for attention, you have to be your patient's champion for the important things that will make a difference to patient experience and outcome. ◆

PROFILE

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Dr Joanna Chan Shi-En and Dr Jonathan Chan Zhao Wang have known each other for 28 years. They share a love for EM, Star Wars (X-Wing pilots, not Jedi) and British comedy shows. They both stayed in King Edward VII Hall throughout all five years of medical school. Joanna is a senior resident under SingHealth EM Residency and Jonathan is in his third residency year under the National University Health System. They have a younger brother who wisely chose to do something not related to medicine.