

YOU WILL SURVIVE

the guide for newly qualified doctors

Compiled by Tom Nolan, Imran Qureshi, Sarah Jones & Daniel Henderson



Starting life as a junior doctor is one of the biggest challenges of your career. The five or six years of medical school can make even the keenest student feel institutionalised. Now you're starting work, and 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 the ward round? What if I prescribe everything wrong? Don't worry. Be reassured by the fact that every single doctor in the world has been through this before and survived. Many of them have contributed to this booklet.

"You will survive" started out as a discussion on doc2doc, the social networking site for doctors that was launched earlier this year. As the discussion took off, one member suggested that we gather all the best tips into this book. A couple of months later here it is. We had over a thousand tips and tales from the doc2doc community, all of which are still available for you to read on the site (tinyurl.com/m5mbuf). The very best tips are available for you here, along with a few cautionary tales. At the back of the book are two pages intended for you to print off and take with you on the wards. They contain commonly used scoring systems and telephone numbers – two things that many doc2doc members wished that they'd had as house officers.

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

Dr Fiona Godlee, editor, BMJ



CONTENTS

1. INTRODUCTION
2. ON CALL & NIGHTS
4. WARD ROUNDS & NOTES
8. COMMUNICATION
10. DE-STRESSING
12. USEFUL EXTRAS
16. SCORING SYSTEMS REFERENCE GUIDE
17. ESSENTIAL TELEPHONE NUMBERS

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 that everyone has gone through exactly the same feelings before you—and survived.

Adam Simmons, F1, Rochdale

Work steadily, 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, GP, Essex



However inane the requests on the other of the phone, remember that each call is potentially from a person who is genuinely worried about a patient. Show your gratitude to nurses who flag up important problems. But also beware of unreasonable requests, and stand your ground!

Adam Asghar, F1, Yorkshire

Be calm. It helps you deal with problems you have never faced before 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, F1, 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, F1, 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, F1, Milton Keynes

It is normal to feel sick the first time you are on call - *Claire Kaye, GP*

Don't be afraid: help is only a bleep away!

Michael Haji-Coll, F1, 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 (e.g. ECG/BM/bladder scan) while you make your way down to the ward.

Shamil Haroon, SHO, Christchurch, 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, GP

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

Maryam Ahmed, CT1, 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, FY2, 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, ST1, Oxford

Take some food: it's surprising how hungry you can feel at 4 am in the morning when all the shops and canteens are closed. So get prepared.

Mahomed Saleh, F1, 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 (e.g. ABG syringes and cannulas) in an on-call bag, along with a small reference book (e.g. *Oxford Handbook*) and a chocolate bar.

Some hospitals can be cold at night. If you have a quiet spell then 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, F1, Swansea



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 to the ward from another hospital, and he needed clerking in. I was perplexed by this: elective patients don't get admitted at 2 am, do they? I went to the ward to clerk in the patient.

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 afebrile. 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 I.V. fluids, I trundled off the ward to continue my night's work.

At half four I got a call from the same gastro ward that scared the life out of me! Mr M had just had an episode of malaena and 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 I.V. access. I grabbed one of the nurses and asked for some Gelofusine urgently. The nurse even kindly offered to take his

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

full blood count, clotting screen, and a group and save. I noticed that he had been made "not for resuscitation" at the hospital he had been admitted

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

from. Realising that this patient was potentially peri-arrest, I contacted the medical SpR covering the wards. I begged him to come as quickly as possible 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 that bloods can be taken quickly and I.V. fluids put up promptly. But I also learnt the importance of involving senior doctors when you need them. This patient required review by a senior doctor, and an urgent decision on his management including his resus status. Never be afraid to ask your senior colleagues 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 that 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! Night scan can be scary – but they do make us better doctors. Well, I think they have in my case!
Declan Hyland, F1, Liverpool

Using SOAP

Remember the mnemonics BODEX and SOAP. Bloods, Obs, Drugs chart, ECG, and X-Rays/imaging - this provides you with a good safety net for ward rounds.

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, F1, Sussex

If you get a chance sorting the following out before the ward round 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, SPR, London

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

William Hall, internist-geriatrician, New York

Sometimes patients decide to discharge themselves. If the patient has capacity you cannot stop them 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, medical student, London



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

Adam Asghar, F1, Yorkshire

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

Rochelle Phipps, GP, New Zealand

Greet the ward clerk, HCAs, and nurses by their names—they will love you and make your life easier.

Dr Preeatham Boddana, renal physician, Gloucester

Rather than pondering for hours over a dilemma, discuss it with your consultant or senior (most consultants would prefer to be called than for a patient to suffer because you are unsure).

Matiram Pun

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 the jobs that need doing urgently. Arrange another meeting point about one or two hours before the end of the day, and chase up the jobs that still need doing. This should avoid routine jobs—like chasing bloods having to be handed to the on-call team.

Heather Henry, medical student, London

A three or four line problem list at the top of each entry helps give 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, ST2, London

Whenever I make an entry, I print my name, with my job description e.g. (shrink, Chief PooBah), date, and time (to the minute). It is legible, and 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.

Professor Roger K.A.Allen, thoracic and sleep physician, Brisbane, Australia

“A low note”

One of my lowest moments as a house officer was when I was on a cardiology ward round. I was the lone junior surrounded by clever consultants and registrars. It was a few months into my FY1 year, and I felt that I was in the swing of things. Just as I was starting to write the notes for a patient, my registrar grabbed the notes from me and started writing. I felt so embarrassed - writing notes is one of the few things that a house officer is expected to do without supervision, and yet it's something that I was obviously rubbish at. 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 which would otherwise be spent leafing through the entire set of notes. So what makes a good note entry?

- Write a problem list (see above).
- How is the patient today? Note down vital signs, any history and examination that is done on the ward round, as well as any discussions that you have with the patient (see SOAP, above).
- Detailing what the patient is told can be useful, especially for anyone asked to see the patient on call.
- Write a clear management plan. Mark each task as “done” in the notes once completed.
- Different consultants/registrar's 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, GP ST1, London

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

Roberta Brum, ST3, Brighton

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, GP, Essex

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

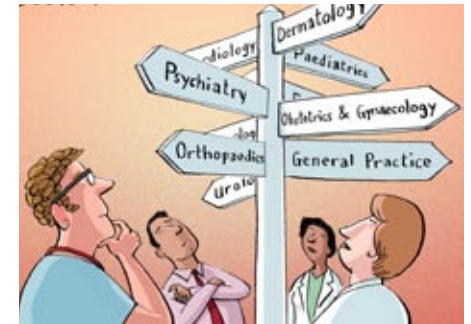
Peter Martin, GP, Essex

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

Sarah Jones, F1, Nottingham

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

Adam Asghar, F1, 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, GP, Essex.

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, F1, Yorkshire

SBAR - how to ask for help

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 that we do X, Y, and Z. Does that sound ok?”

Or: “I request your advice/that you come to help.”

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

Ensure you document that you've contacted them, including their name and bleep and what the outcome was.

Sarah Jones, F1, Nottingham

Breaking bad news

My advice on breaking bad news: don't beat around the bush, don't use euphemisms, and don't talk to fill the silence. People hang on to hope until the last, so be kind, be 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 any questions or be of other assistance. It can be useful to have a nurse with you to remain with the bereaved if you are busy and need to rush off again.

Rochelle Phipps, GP, 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, medical student, 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, GP, New Zealand

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

Bhavjit Kaur, SHO, Greenwich

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

Maryam Ahmed, CT1, Wolverhampton

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

Peter Martin, GP, Essex

Be polite: remember the medical world is a small world, 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, FY1 surgery, UHCW

Making a splash on nights

On my first night on call as a surgical F1 I was called to a patient who was second day post-op after major bowel surgery. He was agitated, tachycardic and mildly hypotensive and the nurses assured me he had only passed 10 ml of urine in the past 4 hours. I ran from the opposite corner of the hospital to find a clearly sick and possibly septic patient. His ABCs were good (except for his tachycardia), and 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 completed by the nurses) 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 and followed that up with a 6 hr bag of Hartmann's – over the next hour his agitation worsened.

I called the surgical SHO, who shouted at me for having woken him, promised to

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!

come anyway, and asked if we had given the patient a bladder scan. I had to sheepishly say we hadn't thought of that. By the time he 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 are:

- If a patient has poor urine output flush the catheter and bladder scan them before panicking about fluid challenges;
 - The SHO may be asleep, but the trust is paying them to work, so don't feel guilty about waking them up if you're unsure about something;
 - Lastly, always have a spare change of clothes or know the code to the theatre changing room so if you get covered in blood/vomit/urine you can get changed.
- Sarah Jones, F1, Nottingham*



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

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, F1, Rochdale

The best way is to take your work easy but responsibly. Take feedback or comments positively; any irate comments or side remarks should not bother you too much. They come and go, but you should be worried about your patients and the care you give.

Matiram Pun, MDSC graduate student, Nepal

Remember, stress makes you make mistakes. *Matiram Pun, MDSC graduate student, Nepal*

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

Tiago Villanueva, GP trainee, 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 (that's the med reg's job!).

Adam Asghar, F1, 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, GP, 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, life coach and retired GP

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, GP trainee, Portugal*

Always have breakfast as you just never know when lunch will be.

Maryam Ahmed, CT1, Wolverhampton

Get to know your fellow house officers. Sitting in the mess or our accommodation lounge and commiserating about our shared experiences, moaning, and laughing about the day 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 who are going through the same thing. However, it is important to get the balance right, as too much medicine in your life can drive you crazy.

Gayathri Rabindra, ST1, 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, GP, 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, F1, Blackburn

Give yourself credit: you are better than you think.

Mahomed Saleh, FY1 surgery, UHCW

Read fiction. Anything.

William Hall, internist-geriatrician, New York

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



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, SpR, 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, life coach and retired GP

We received hundreds of tips that didn't quite fit into the other chapters. Here are the best ones.

Be your own master – if you are being made to work a ridiculous rota, come up with an alternative and present it to those responsible for the rota. You may not achieve instant success, but with this attitude, you can constantly strive to improve patient safety and working conditions, rather than grinning and bearing it for 4-6 months.

Adam Asghar, F1, Yorkshire

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, F1, Coventry

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, F1, Blackburn

Don't be afraid to "blow the whistle" if you witness a dangerous incident.

Adam Asghar, F1, Yorkshire

Look underneath those dressings

When I was an FY1 I was clerking a patient with sepsis. The patient had subtle signs of a chest infection but not enough to explain the degree of his illness. He 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 was healthy and he had dressed it afresh. Therefore I did not examine it again. Later, when the consultant asked for the dressing to be removed on the post-take ward round, what we saw there was quite embarrassing for me, there was a green coloured discharge with cellulitis around the ulcer. So the lesson I learned was always to look underneath dressings, even at the cost of annoying the nurses. – *Farhat Mirza, F2, Gillingham*

Get rid of the bubble

Arterial blood gas analysis of a patient with severe pneumonia showed a normal pO₂, 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, F2, Gillingham

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.

Catriona Bisset, F1, Glasgow

"The good doctor will treat the disease. The great doctor will treat the patient with the disease." (Wish it was my quote but some bloke called Osler with his damn nodes got there first. . .)

Sam Thenabadu, SpR emergency medicine, London

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 well, 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, and 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, old fart (and former editor, BMJ), Clapham

Cannulating difficult patients . . .

1. Oedematous patients: Grossly oedematous patients are difficult to cannulate because it is difficult to even see a vein to puncture. You can get around this easily by placing the tourniquet tightly, high up on the patient's arm, and 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.
2. Warm water: Warm water can make veins visible and palpable. Get a small bowl or beaker (the ward will have plastic ones) and fill it with water that's hot, but bearable. Naturally explain to the patient what you would like to do and why you are doing it. Then place the tourniquet high up on their arm, and ask them to submerge their hand in the warm water. Keep it there for 5 minutes. The heat should bring the veins up for you to puncture.
3. Gloves: Gloves can have a great tourniquet effect – not by using them round the arm, but rather by getting the patient to wear one. Estimate what size glove the patient might wear – perhaps by comparing with yours – then get a glove one size smaller. Ask the patient to put the glove on, explaining that it will be quite tight. Naturally, explain what you are hoping to achieve. Keep the glove on for at least 5 minutes. Then remove it and cannulate away! You can combine this with the warm water effect as well.

Robin Som, CT1, Cambridge

...and how not to do it

- Tell the patient that it's just a tiny scratch before you go digging into their flesh in every possible direction.
 - Prepare your patients by telling them that they've got difficult, narrow, and wiggly veins.
 - Tell the patient that you got into the vein but the tiny little valves on the veins are blocking your plastic cannula from moving in.
 - Tell your patients that 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 that you're in trouble when the on-call anaesthetist tells you that they are not a cannulation service . . .
 - . . . and 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, F1, Kent*



Experience means knowing when to be scared and when not to. Gradually, your envelope of experience will expand; you will become more and 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 will shake you – hopefully not a serious one. You will 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. Only time and exposure can achieve this. Be patient! And enjoy the process.

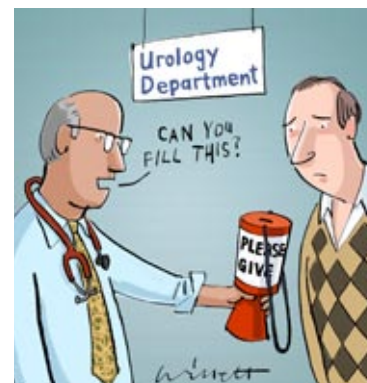
David Berger, GP, North Devon

Everyone gets frightened, everyone gets tired, everyone 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, GP, New Zealand

Drug companies lie occasionally and mislead often. They will always present positive results and may well suppress negative results. Do not obtain your information from representatives. There is no such thing as a free lunch. Read the evidence for yourself. Learn to read papers critically.

Peter Martin, GP, Essex



Keep in touch with your supervisors – the earlier they know about a problem you may have, the more quickly attempts can be made to rectify it.

Adam Asghar, F1, Yorkshire

Work should be busy and at times stressful, but it should also be enjoyable. If after the first few weeks you still do not like your job, talk to someone about it. Your educational supervisor, a friendly SHO or consultant, or a friend from outside work will all be able to offer advice and support. If you bottle things up you are in danger of becoming ill yourself.

Catriona Bisset, F1, Glasgow

Lastly and most importantly. . . it gets easier! - Claire Kaye, GP

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 ()
 - no breath sounds () > For 60 seconds
 - no carotid pulse ()
 - Time of death HH:MM on DD/MM/YYYY
- Note whether there was a pacemaker palpable (for whoever does the cremation form). Sign, name, date, clear contact number (in case the bereavement office need you).
- Sarah Jones, F1, Nottingham*

SCORING SYSTEMS REFERENCE GUIDE

Patients in AF – aspirin vs. warfarin (CHADS₂)

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 DVT and PE)

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

Score 2+ = Moderate to high probability

Community acquired pneumonia (CURB65)

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

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

Score 0-2 = Mild to moderate

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

Chronic kidney disease staging (CKD)

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

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

Dieticians

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