Lessons learned from internship

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Many medical students this year have asked me about what it is like to become an intern. The truth is, nothing you learn at medical school can fully prepare you for the transition to internship. In fact, 42% of newly qualified doctors feel their medical training does not adequately prepare them for starting work. [1] However, it's not all drama and chaos as shows like *House* would make you believe. Most internship work is spent on paperwork, requesting investigations and simple procedures like inserting cannulas and taking bloods.

From day one, interns are often rostered for after-hours work, something medical students often have very little exposure to. All of a sudden, new interns may find themselves looking after several wards overnight. Even though some, like me, are interested in critical care medicine, it can still be a challenging thought that over a hundred patients' lives are entrusted to your care. My first after-hours shift will always stick in my mind, having given me many valuable lessons that I have taken through internship. This is that night in my life:

It is 5pm and most of the doctors have already left. I turn on my pager, secretly hoping it will not beep. Two minutes into the shift, the pager sounds and anxiety kicks in. The nurse on the other side of the phone requests, "Doctor, can you please dose this patient's warfarin?" It feels strange to not have any other doctors nearby, and my first thought is to 'phone a friend'. However, I hold off, remembering that the answer lies in the hospital protocol for warfarin, found on all the computers. It reminds me that there is always an abundance of resources and guidance available to us as medical students and interns - if we are willing to ask and look for them.

For the next hour, the tasks are manageable. I re-chart medication charts and get a request to insert a cannula into an elderly lady for intravenous fluids. The team struggled to put the last one in, and her newest one has fallen out during a shower. The lady is thin with fragile veins, and after three painful attempts, the cannula still isn't in. She is tired of being poked and prodded, and I'm feeling frustrated. I decide to take a break and come back later.

The nurses then page urgently for a doctor. A patient has slipped and knocked his head, and now lies on the floor with a pool of blood beside him. When I arrive at the ward, I find a nurse beside the patient saying, "Everything's going to be OK, the doctor's here now," as if a miracle is about to happen. I do not feel like anyone's miracle worker, but as one of the first responders and because more senior help had not arrived yet, the nurses look to me for further instructions. My mind freezes, but kickstarts to life again when the basics of 'ABC' spring to mind. I feel incredibly grateful for the medical school hammering the ABC approach for such situations. I begin to assess and treat the patient. His airway is patent, cervical spine protected, breathing and circulation maintained. We apply pressure to the wound and perform an ECG and glucose. The few minutes waiting for help to arrive seem to last forever. When more help arrives, we give a huge sigh of relief. I notice that all this time, the patient's wife has been waiting outside and has been growing extremely worried. As the appropriate members are treating the patient, I take the opportunity to go to her, explain what is happening, and reassure her that her husband is being cared for. One of my consultants once told me that as a junior doctor, one of the best things to do in such situations is to communicate with the patient's family.

Just when I think that there has been all the excitement I'd need in one night, the pager beeps again. A patient is spiking a high fever, and the nurse is requesting antibiotics. I check through the patients notes first and note that she has been spiking fevers in the last few days, cultures are negative, and the treating team thinks it may be viral. A septic screen has been done, and it was previously decided paracetamol should be sufficient I reassess her and decide that she does not look too ill at this stage. She has been stable over the

last few days. I choose to leave her without antibiotics, as it does not seem likely that they will be beneficial. The next day, I will check on the patient and be relieved to see that the treating team did not decide to prescribe any antibiotics either.

Before the end of the shift, I go back to visit the elderly lady who still needs a cannula. If I fail, I'll need to call the duty anaesthetist, and I feel bad because it is getting pretty late in the night. I discuss with the patient, and she agrees for me to have one last opportunity to try. I aim for a small vein in her left hand, and by some stroke of luck, the cannula goes in and flushes smoothly. I breathe a sigh of relief and thankfulness. It reinforces to me that sometimes, just when we are feeling down and tired from trying, we can come back to the task and succeed.

Every day in the hospital, you learn something new. After completing my internship, I am able to reflect back on how much I have learnt in the past year. Completing medical school makes you a doctor, but that is far from the end of the journey. If I may offer some advice, it would be to stay calm in unfamiliar situations, stick with what you have been taught, and never be afraid to ask for help.

Conflict of interest

None declared.

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References

[1] Cave J, Woolf K, Jones A, Dacre J. Easing the transition from student to doctor: how can medical schools help prepare their graduates for starting work? Med Teach. 2009 May;31(5):403-8.