A day in the life of a paediatric registrar

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After the 8.00am handover from the night team, we join the consultants gathering in the radiology conference room for a review of the month’s interesting imaging with the radiologist. A brain tumour, a bladder refluxing back into the kidneys and an unusual case of pneumonia make up the majority of discussion time.

On the ward round of the special care nursery, a premature newborn has developed feed intolerance so we have to decrease the volume of milk given each feed, but this baby has had difficulties with poor growth. Hopefully the vomiting will improve in the next few days so the volume can increase or otherwise the milk will require fortification with extra calories and micronutrients.

In the paediatric ward, numerous patients have been admitted overnight with wheezing after a change in the weather and the usual winter outbreak of respiratory infections. We aim to see the sickest patients first, followed by those ready to be discharged. Part of the assessment always includes establishing rapport - an important facet of any medical specialty, but uniquely to paediatrics, can be much more fun as you get to be silly; playing games to engage the young children but taking a different approach for the older child and adolescent. A sense of humour is a must for any aspiring paediatrician!

The sickest patient today is a young girl just 3 months old diagnosed with bronchiolitis, a viral chest infection. Although last night on admission her illness was moderate in severity, this morning her condition has deteriorated and the nurses flag her as a priority patient or us to see first. Her mother is distressed seeing her so unwell and the consultant decides to start her on high flow oxygen to help her breathe more easily. I plan to review her within an hour to make sure she is improving. Although children can deteriorate quickly, they usually recover just as quickly which can still amaze me - seeing a child bedbound and lethargic with illness one day, and running around playing the next.

After the ward round, routine jobs are interrupted when the resident and I attend the birth of a newborn due to foetal distress- the baby is suspected to be unwell at delivery. After checking the resuscitation cot carefully, I have the resident run through the steps of neonatal resuscitation to refresh his memory. Happily, the infant is born in good condition so no resuscitation is required. It always brings a smile to my face seeing a healthy baby received by mum and dad. We make sure to congratulate the proud new parents before heading back to the ward. It is such a privilege to be a small part of the family’s experience bringing a new life into the world.

Later in the afternoon, I’m called to assist with a young girl in Emergency Department with prolonged seizures. The emergency department doctors and nurses are already maintaining the airway, placing oxygen and a intravenous line so my role involves charting medications, taking additional history from the father and informing him about what is going on. I also telephone the patient’s usual neurologist to discuss increasing
the usual medications. Once the patient has stabilised, documentation complete and a plan is in place for admitting her to the ward after a period of observation in ED, I catch up with the medical students for a tutorial about febrile convulsions.

Teaching is an important part of my job as the most common training pathway for medical graduates is general practice, so my medical students and junior doctor colleagues could be dealing with significant numbers of children in their career. I always remind myself that these doctors could be looking after my own children in the future, so I try to focus the teaching on the most relevant, practical and safety-focused aspects.

Reviewing my bronchiolitis patient in the paediatric ward, the breathing now looks much more comfortable. I can sense that the level of tension in the parents has dropped. Being aware of the emotional state of those around you can be a big help in paediatrics as sometimes there is a deterioration that you can't quite pinpoint, that the parents or nurses have noticed subconsciously. This can assist you in knowing when to increase monitoring and detect serious illness in order to escalate treatment earlier.

Heading back to the birth suite, a newborn is being delivered with the assistance of a vacuum cup: despite the best efforts of mother pushing, baby's head isn’t coming down far enough. On being born, the cord is wrapped around the neck, quickly released by the obstetric registrar. At first, the newborn doesn't cry so he is brought over to the resuscitation cot. I supervise the resident giving stimulation and resuscitation breaths to the baby using a special mask while the midwife checks the heart rate - it is on target at over 100 beats per minute. The baby boy starts breathing on his own after a minute but is working hard to breathe so I update the parents before bringing him around to the special care nursery. I check in with the resident to debrief about the resuscitation, make sure he's coping ok and reflecting on what we could do in future to help things run more smoothly.

The early evening sees me examining newborns in the postnatal ward for concerns found on the baby checks: a suspected heart murmur, undescended testis and unstable hip joint formation. Interpreting the significance of minor anomalies can be challenging at times as they could be isolated normal variants, or a sign suggesting an underlying syndrome with multi-system problems. Making sure the family is aware of the follow-up plan and corresponding with the GP or specialist helps ensure the patient receives comprehensive care.

Checking in on my nursery patient from earlier, the breathing is much improved, so I send him back to his mother for those important first cuddles and a breastfeed. She is happy to have him back and grateful that he is breathing easier. Separating mother and baby is avoided whenever possible to allow for bonding, but is sometimes necessary when the infant is unwell.

The nurses call me to talk to a family on the paediatric ward: they have been researching their child's diagnosis on the internet and have a few questions about the implications for the future and screening for complications. Due to their high degree of anxiety, explaining the disease course and assuring them we are doing everything that is needed takes quite some time. However, I leave the room with the feeling that they now have a greater comprehension of the condition and know which reliable resources they can use for future concerns. This is one of my favourite parts of the job: difficult
discussions that lead to patients and their parents having a deeper understanding, to help manage their illness.

If I’m finding an encounter with a family member uncomfortable, I remind myself that this is probably the most worried and stressed they have been in their lives as there are few things more frightening than your child being unwell and feeling powerless to do anything about it. Usually the discomfort I am feeling is their transferred distress and if I can show compassion whilst giving them the advice and support they need to help their child get through the illness, that makes my years of training and study worthwhile.

To finish my 12.5 hour shift, I admit the last few patients to the ward before updating the handover list and calling the boss to inform her of important results before giving handover to the night team at 8.00pm. Head home for dinner and a rest, I reflect on the day’s activities: diverse, working with lots of age groups in many departments of the hospital, requiring multiple facets of my role. The variety of never knowing exactly what you will see or do each day is part of what drew me to train in paediatrics. It is a fantastic feeling knowing your day’s work to prevent and treat disease could help improve your patient’s life for not just years, but decades to come.

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