A day in the life of a respiratory registrar

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Nicole is currently a Respiratory Registrar at Liverpool Hospital in Sydney, and will be completing an Interventional Pulmonology Fellowship in 2018. Nicole has a keen interest in Tuberculosis and spent most of 2016 working in a community health centre in Dili, Timor-Leste, managing patients with TB, HIV, malnutrition and a variety of general medical conditions. Beyond the hospital walls, Nicole enjoys reading, live music and good food, wine and sport - not necessarily in that order.

Editor: Elizabeth Campbell

The incessant beeping of my alarm clock can no longer be ignored. The new week begins with a wintry Monday morning breeze sneaking in through the folds of my coat which battles to warm my body and brain in preparation for the week ahead. The influx of influenza is upon us, and so, Respiratory registrars are exchanging the anxious greeting of 'Winter is here' in the corridors. It will be a busy day ahead but if I can manage the drive to work without spilling coffee on myself, I'm sure I have the aptitude for anything.

The lung cancer multi-disciplinary meeting may seem like a bleak start to the week, but it is a critical meeting which helps to facilitate and expedite best patient care. Witnessing the chorus of oncologists, physicians, surgeons, pathologists and radiologists coming to a consensus is really quite beautiful. The interstitial lung disease case conference is a similar multidisciplinary meeting necessitated by the complexity of these conditions and the increasing diagnostic and therapeutic options available. It's an exciting, ever-changing landscape.

At 9am, the ward allied health and discharge planning meeting kicks off, coordinated by our diligent NUM. The winter ward round is a whirlwind of blue aprons, gloves and masks. It feels like a never-ending game of pass-the-parcel, unwrapping but always re-wrapping, and with the prize at the centre the trophy of avoiding the flu and getting to come back to work healthy to do it again the next day!

By 11am we're doing the dash for coffee and splitting up the rest of the round and jobs that are accumulating along the way. I go to speak to Mrs Dobson's two children who have come in to talk about her deterioration over the weekend. She has severe COPD and has been on home oxygen for 2 years, but has now been derailed by pneumonia and an exacerbation of her cor pulmonale. Over the weekend, her respiratory failure worsened and she looks breathless this morning and is fatiguing. We propose a trial of non-invasive ventilation. I stand by the bedside adjusting the pressures with her nurse and one of our physiotherapists, reassuring her and explaining to her children that this

is a temporary supportive measure that is designed to help her feel more comfortable. It may not be enough to save her this time. I see Mrs Dobson's children's eyes moisten as one goes to take her hand, but I am relieved to see her respiratory rate settle, and that she is able to get some rest.

By then consults are kicking off and the reviews for pre-operative optimisation of COPD and possible new diagnoses of sleep disordered breathing are just the beginning. These are such good opportunities to speak to patients about smoking cessation, inhaler technique, weight loss strategies and ways to improve sleep hygiene. The conversations are often interrupted by pages and phone calls, but it's taking the time to talk to people, listen to their stories and acknowledge their concerns that helps them more than a prescription most of the time. Hearing about their cat, Ginger, or about how their local footy team is going is part of the therapeutic relationship, for both patient and doctor. It gives me a chance to guiltily confess to Mr Nguyen that the housewarming pot plant I was given four weeks ago is already dying, but I reassure him that my life-giving skills are top-notch within the hospital walls.

I rejoin my team on the ward and check in on Mrs Dobson again. She's pulling off the NIV mask and we set it aside for now. Some oral morphine helps her breathing and, with her family standing vigil, she looks comfortable once more. We then wheel a young man with a parapneumonic effusion into the treatment room to do an ultrasound and then insert a chest drain. A satisfying gush of straw-coloured fluid signifies a job well done, and we reassure the patient that he'll be ok and back to work in no time.

I catch the second half of journal club but, in an attempt to scoff down some sandwiches while I listen to my colleague talk about sleep apnoea in stroke patients, I manage to drop something akin to chutney on my pants. It's no big deal since the bronchoscopy list is starting and I'll be changing into scrubs in a minute. I print off a list of the cases and collect their imaging to review in-between putting in cannulas and reminding patients of how hungry they are by being the fourth person to ask how long they've fasted for. I reassure them that they fortunately escaped the chutney. The list includes a simple inspection for a patient who had a tracheal stent inserted last week, and an endobronchial ultrasound-guided biopsy of lymphadenopathy for a patient discussed in the lung cancer meeting. This is followed by a cryobiopsy to try to help with treatment decisions for a patient with unclassifiable interstitial lung disease, and finally, a radial probe biopsy of a peripheral lung lesion. I never played much Nintendo growing up, and even though purulent airway secretions are still gross after all these years, the twisting and turning whilst sucking and slurping that stuff up with the bronchoscope is just so satisfying!

After the list, we go check on all the patients, who are doing well, then I get changed back into my chutneyed pants. I grab my bottle of water and head back to the ward to catch up with my team. Mrs Dobson has taken a turn for the worse. Her breathing is slower now and she is looking more peaceful with her IV cannula removed and the blinds letting a bit of sunlight into the room. I try to smile reassuringly at her daughter, and she smiles knowingly back. I tear up a bit too, thinking of when my grandfather was in hospital. I leave them to enjoy this precious time together, reminded of the privileged position held by those of us who deliver health care to people in a time of need. I don't think it is possible to feel that way all of the time, but in the many moments when you

do, it is a powerful imperative to take a breath and then keep going, to strive to be a better doctor and a better person in general.

And so another day ends with sore feet, a chocolate bar and the knowledge that the pulmonary hypertension clinic, lung function reporting and something unexpected a… a…. aaaccchoooooo! await tomorrow. Oh oh.

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