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“You will never know until you start FY1”

Throughout medical school you are repeatedly counselled that you will never know what it is like to be a doctor until you start FY1. It is reiterated for so many years, it becomes blasé and un-impactful by the time you graduate. The years spent learning and revising medicine and surgery give you confidence in theoretically managing unwell patients. You believe the sole goal is to treat and this belief is tested to its core during FY1, forcing us to consider what being a doctor truly means. You are often asked “how do you manage this patient?” rather than how you cure them, a distinction that is often lost on you in medical school but resonates louder than ever with us now. The following is a compilation of cases which have not only summarised what we learnt during FY1 but what will remain with us for the rest of our careers.

The statement “you will never know until you start FY1” is not descriptive. It does not depict any one situation or case but summarises the difference between the disease and acknowledging the patient. It explains the actual benefit of treating a condition against the need to manage and support a patient. Sometimes, it is not about what you can do for a patient but rather what you should do, and finding this equilibrium is not as simple as it seems. This was further enforced by the intensity and blurring of responsibility during the COVID-19 pandemic.

From the start of FY1, we were both exposed to DNACPR conversations. They are often profound experiences, that lose their memorability the more you witness and perform them. Initially, they are emotional and powerful conversations, that make you consider the benefit of treatment over focusing on comfort and dignity. These situations can leave you feeling as if you are on an island, surrounded by a family’s despair and sorrow. Often this can be overwhelming as DNACPR discussions can be the first-time death is openly discussed. Capacity and patient-centred decisions are preached at medical school, but only until you witness a patient decide against treatment, do

you truly begin to understand. Elderly patients tend to decide against resuscitation themselves, helping you realise it is better to guide someone to a peaceful end, rather than prolong their suffering needlessly.

A particularly memorable case involved a 45-year-old mother of three, who was diagnosed with MS in her late thirties. Insidiously, she had suffered with severe and frequent relapses resulting in multiple hospital admissions. Her general well-being had deteriorated, and in the last year the disease had taken her from full independence to being bed bound and requiring constant supervision and support from her husband. This rapid progression is associated with a poor prognosis and the medical team was confident she had a significant reduction in her life expectancy. Furthermore, due to her age and the previous independence her family had not appreciated the irreversibility and imminent progression of her condition. This triggered the need for a detailed and careful DNACPR discussion. It was clear that the words and manner used to this family would remain with them for years to come.

The family, especially her husband who was her full time carer, had the mindset that each admission was just a setback or obstacle to her recovery and were under the impression that the haste at which she had deteriorated would reflect the speed she could recover to full independence once again. Therefore, this DNACPR conversation was split into numerous emotionally demanding discussions, giving the family time to accept and comprehend the points that were being made.

We learn to have these emotionally draining DNACPR conversations with people, allowing them to be involved in the decision-making process, but never make them feel solely responsible for the outcome, understanding these decisions are a tough burden to bear. A burden we are happy to hold, especially in situations when the patient is unable to express their opinions or as in this case, when

the patient is young and previously fit and well.

As expected, some of the most prominent experiences of FY1 are dealing with death. In a healthcare setting this is a feature of all specialties and can be encountered at all times of day. Sometimes death is expected and sometimes it is not. The longer you work the more accustomed it becomes and overtime each event becomes less overwhelming and impactful. We both recall having to verify our first patient as dead in the middle of the night. Walking into the room and feeling so very alone. This is a stark contrast to failed arrest attempts which are adrenaline fuelling experiences, with a large team involved, giving you little time to reflect. It is easy to forget that a person has been lost, everyone becomes a patient, a bed number and a disease. You think you will be ready, and most of us have seen someone die before or lost a family member. But it is not until you are alone in that room, verifying a person, that you understand what death is. This evokes thoughts about more than that person but the people that have been left behind. Initially, this is overpowering, and it ruminates in your mind, but with time and experience the powerfulness of each event fades and you soon forget the names and faces of all those that you've seen.

As medical students we do not always give value to the role of a doctor. Your views are simple, you diagnose and you treat. But in reality, you encounter patients that cannot be cured. This can be for a number of reasons ranging from incurable conditions to lack of fitness for therapy. This can either make you focus on their comfort and care, or help them learn to live with their symptoms.

A case that reflects this, is that of an elderly lady who was admitted with poor oral intake, found to be suffering with oesophageal dysmotility. This is not a disease that commonly causes mortality. But she was struggling to consume food and had lost a significant amount of weight and was starting to show signs of malnutrition. It was clear at her age and with her frailty, if this continued, it would result in an overall physiological failure. Therefore, she was given long term nutritional support and a

PEG tube was inserted. In this case we did not cure her condition, but we helped her find a way to live with it. This distinction is something that is misunderstood by most until they participate in the management of these patients. In fact, these patients tend to be the ones that we help the most.

This is amplified when these situations arise at the end of life. When a patient deteriorates and death is imminent, a lot of small actions are performed by the junior members of the medical team. However, these actions are vital at this time. A sample of these include; prescribing end of life medications and rationalising the regular prescriptions, requesting a side room, calling the family and the chaplain if necessary. These jobs become a routine checklist as time goes on and sometimes their value is lost on us. These actions are fundamental to making those last minutes of that person's life as complete as possible. This can be frustrating, as doctors, we learn that action helps, we are used to seeing patients and formulating jobs that ultimately help treat them which brings satisfaction in performing these tasks. But we all learn to accept that it is in the patient's best interest to pivot your focus to comfort care and ultimately doing less.

In the geriatric setting you have more of an opportunity. There is the gift of time when it is known someone is dying and you are able to make their death as dignified as possible. These can be moving experiences, contributing to giving someone peace and significance at a time that can be surrounded by so much fear and uncertainty. It also gives doctors an insight into what patients value and want during this period. This situation is hard to empathise with - it is nearly impossible to imagine what the end of your life will be like is until you get there - highlighting the importance of really listening to patients at their final moments.

FY1s are depicted as the bottom of the food chain. You are often told you will be a "glorified secretary" and you will be guided by a senior plan. This is often true, but you are also a doctor. And so, at times you will be forced to make decisions and review unwell patients. Sometimes the

decisions you make will be the ones that decide the path the patient's care takes. You truly do have the responsibility of a doctor and this privilege is frightening but it is an honour few are bestowed.

This is demonstrated in a case featuring a 56-year-old alcoholic who presented with a head injury. His sole possession on admission was a bottle of whisky and it was soon found that he had a small intracranial bleed. He was discussed with neurosurgery who asked for his GCS to be monitored and for repeat imaging if it fell. This admission occurred during COVID and as a result he was kept under the admitting team due to bed and staffing shortages. This resulted in a parent team not specialising in the condition and the senior members of the team were reluctant to manage and see the patient. This patient lost all continuity of care and his drastic changes in GCS were not initially noticed. He was initially overlooked, until a junior member of the team became concerned and went through the noting, repeating the scan and contacting neurosurgery. The patient was swiftly transferred to the nearest neurosurgical centre and intubated for emergency surgery. This was an extreme situation, but it highlights that sometimes the actions of the FY1 are pivotal to managing the patient. It can be scary at the bottom of the hierarchy, especially when raising concerns to seniors, but ultimately your duty is to your patients and ensuring they get the best care possible.

A valuable lesson that you learn is that there is a limit to what you can do. The sick role is a well-documented concept. It refers to the patient and suggests that they should want to get better. As a medical student you never realise that there are patients that do not want your help and do not want to change activities or behaviours that are detrimental to their health. After all it is their choice. Generally, it is over social habits such as smoking of IV drug use. Sometimes they refuse procedures due to comfort or operations due to fear. One case was of a young mother who had a rare mycobacterium endocarditis. She refused valve replacement surgery as she was told by a religious member of her community it would resolve through her faith. She was counselled of the dangers of not proceeding with treatment and that this would be fatal in months if left untreated.

However, she had capacity and it was ultimately her choice. Watching someone walk away knowing the consequences, and being unable to help felt like a failure. However, it is a demonstration that you can only guide people, but you must always honour the first rule of medical ethics - autonomy.

The flipside to this is when the medical team refuses to perform a procedure a patient wants. This is a rare event and it is always a well thought through decision. A gentleman who suffered from obesity was found to have triple vessel coronary artery disease. In his age group the most common treatment choice is a CABG. However, he was deemed unsafe for anaesthesia and therefore surgery. He initially was accepting of this decision and was offered PCI. However, he soon became angered by the decision and became aggressive and untoward to staff. Eventually, this spiralled into a suicide attempt on the ward. He was stopped and provided the appropriate psychiatric support. But the experience showed me the lasting consequences of a decision to refuse treatment. It really brought home the gravity of such a decision. At first the idea of not trying seemed alien but it is our responsibility to act in the patient's best interests even if they do not always see it that way.

Finally, it is not possible to reflect on the lessons of our FY1 without mentioning COVID. We have already touched on the consequences of redeployment, limited resources on patients and doctors alike. Everyone was forced to work outside of their normal competencies and take responsibility for situations that were previously led by seniors. It was a steep learning curve. In a matter of weeks, we went from reading about the virus in the news to being labelled as "front line workers". We were redeployed, asked to work under new consultants and asked to cover different specialties. We were asked to watch people die from a disease we were not immune from.

While the rest of the world went into lockdown, we were geared up for battle, as soldiers in our own war fighting an invisible and undetermined enemy. The FY1 cohort was not alone in this, but we lacked the experience that our colleagues held. Unprepared for the shift in the patient demographic,

unprepared for the rota changes and unprepared for the dynamic administrative changes - whole departments transferred across site to neighbouring hospitals, further medical wards opening up with unclear management and staffing, specialty representation was being gained and lost from hospitals overnight.

Being a FY1 is known to have its highs and lows. As students we are encouraged to find outlets that can help us de-stress from the trials of being a doctor. Most people develop coping strategies in the form of socialising, sports, hobbies, and during COVID we lost all these escapes, when we needed them the most. Another by-product of COVID was the necessity for juniors to step up and work out of their competencies, we both felt these pressures on the wards and the need to demonstrate resilience while taking on more responsibility. In this new era, even at our level, we had to take factors like resourcing and capacity into consideration when making clinical decisions.

On reflection, as with most times of adversity, COVID brought us many lessons that we will hold with us throughout our careers. First and foremost, it taught us gratitude - for our own health and the privilege to continue to work in a service that holds patients at the centre of its infrastructure. It taught us the breadth of our own abilities and capability to adapt and demonstrate strength in dynamic and unfavourable times. Though the pandemic isolated us as individuals from our normal families and communities, we were able to create bonds with hospital colleagues, fuelled by a sense of camaraderie facing struggles together rather than alone. The pandemic is far from over and continues to be a burdensome source of unrest and anxiety, it has an uncertain future and at times it can feel like there is no end in sight. Instead we choose to focus on the lessons learnt driving us forward in this new stage as better doctors and better individuals.

In conclusion, this essay is an attempt to articulate the impactful lessons we learnt in FY1. They are fundamentally a series of challenges leading to exponential growth. Very few jobs will influence you

so tremendously as a person. We hope this summarises some of the key points we have taken away from the year. For those about to undertake the journey, we hope it softens the blow and prepares you for the beginning of a great career. For those who can seldom remember the beginning of the journey, we hope this triggers nostalgia and brings back some lessons long forgotten. The cases chosen are not medically brilliant or fascinating, but they show what we all see on a daily basis. They do not portray moments where we excelled but rather, they exemplify the lessons we were taught. They are the lessons we have learnt, emphasising “we”. While we believe they will be echoed by our peers, each journey will inevitably differ.

After all you will never know until you start FY1.