ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

KK CE Reflection

I am fortunate to be attached to KK Children's Emergency (CE) for my elective for 3 weeks. I remember being rejected at first when I emailed the administrator because there were too many students. However, thank God for His grace that I managed to be accepted. It was an enjoyable and enriching elective. The reason why I chose KK CE for my elective is because I am interested in Emergency Medicine and love children. In emergency medicine, we have to treat patients of all ages, and it is important to learn how to manage them well. Hence, coming to KK CE, I hope to see the cases commonly seen in Singapore and learn a great deal from the doctors working in KK CE. KK is the only women's and children hospital in Singapore, so they have all the specialist in this hospital. Their KK CE is amazing as well! I also hoped that through this posting, I know how to deal with critically ill children, but I got more than expected. This is also my first time entering a women's and children's hospital in Singapore which is an eye opener for me. The tutors I met are all passionate about their job and great mentors, especially my mentor, who is really patient with me. Many of whom which I wish to emulate in the future.

KK CE is pretty organised when it comes to elective, they gave us an individualised timetable which we will follow different mentors on different shifts who gives us a variety of teaching. There was also a structured teaching timetable which includes tutorials, case presentations, journal club, x ray meetings, trauma conference and simulations. I have learnt a lot from these teachings which supplement the clinical teaching while on shifts. Journal club focus on the pain control for paediatrics. In adults, we follow the WHO analgesic ladder which only has 3 steps but for the article, there are 7 levels for paediatric pain control. From non-pharmacological to topical to oral to intranasal to intravenous to the use of adjuncts. This brings a whole new level of managing pain for children, which I think can be applied to adults too. The trauma conference features a teaching on chemical incidents. The lecturer gave an insightful lecture on the Japanese sarin attack which overwhelms the hospital and reminds me that we have to be prepared. It is not if, but when. Given the rise of terror attacks nowadays.

Clinical teaching by my supervisor and mentors throughout these 3 weeks have been very useful. One important takeaway from the teaching is that no matter which discipline you will be working in the future. It is very important for a doctor to know one's approach and differentials. I used to think we derive

differentials from the symptoms and story the patients tell us but a great physician should have a list of important differentials so that we do not miss out any critical, life threatening illness. This is especially important when doing emergency medicine because though many may not come in with serious conditions and be safely discharge, one may be the serious one and we should not miss out. If not dire consequences ensue. Therefore, this leads to finding a good approach to every patient. In the CE, different places will require different approaches. In the P2 and P3 area, you approach with a good history, with differentials based on the main presenting complaint, either acute or chronic presentation. Whereas for a patient seen in resus, patient has to be stabilised first before approaching for history. This brings in nicely to my next important teaching during my night shift in KK CE. There was a child who was seen in the resus standby for smoke inhalation. Our top priorities are airway obstruction, inflammation, compromise and carbon monoxide poisoning. I have learnt that asking about the size of the room and the source of smoke is important in determining the severity. It turns out that our patient did not suffer from smoke inhalation based not he history but got severe asthma which became status asthmaticus. Patient initially was found cyanosed at home and could not speak full sentences. However, only when treatment was stepped up to magnesium sulphate that the patient is able to scream and cry. Theophylline was even prepared. The patient was sent to the intensive care unit. The tutor gave us essential teaching especially when dealing with a child in the CE. Usually, we start the resuscitation using ABC (airway, breathing, circulation) but in paediatrics, there is another ABC before the usual ABC. Its the PAT (paediatric assessment triage) is a quick assessment of the child using A (appearance), B (effort of breathing) and C (circulation to skin). These are measured using observations. In appearance, we use the mnemonic called TICLES (tone, interactability consolabiilty, speech). In B, we look at abnormal breathe sounds, abnormal breathing movements,

retraction and flaring. In C, we look at the skin to see if its pallor, mottled or cyanosed. This helps us to quickly triage patients especially when they cannot communicate to us sometimes.

Besides the amazing teaching, I was attached to different doctors who have many ways in dealing with patients and parents. I have learnt a great deal from them. One excellent example was how I see the doctor remained calm throughout. He used paper and pen to write down key words as he explained to the parent clearly. The parent was really annoyed with the process of getting urine sample to screen for UTI because she claimed to be inefficient. I know that it takes lots of patience to calm and convince the parent to carry on with the test if not more invasive methods would need to be used. Another example I observed was by talking to the children. When the child came to CE for laceration and T&S was required, the doctor explained to the child which

makes it easier for him to understand. He said while showing the boy that suturing is like tying shoe laces and there will be no pain when he listens to instructions but if he moves when suturing there will be pain. He uses a an approach which is both firm and rewarding when dealing with children so that they will listen to you. I also helped out in procedures such as manipulation and reduction, backslap and suturing. Another practice which which see in the CE that the adult emergency rarely do is to give leaflets to the patients or parents. This helps to educate them and improve health literacy which helps to calm parents down.

One of my objectives to come to KK CE is to observe their emergency department system. I think they are using an efficient system to see patients. Patients are being cleared through triage before categorising to P1, P2+, P2 and P3. P1 will be seen immediately while P2+ will be seen almost immediately. This is their new system, they used to have '9 cases' which I later found out that, if your queue number has a 9 in front, it means you need to be seen almost immediately. The consultants are also very helpful. They help to clear cases besides being there for advisors for the medical officers. The people in CE are also very kind and helping to medical students. It would be a great place to work in. One service which I find it admirable is the referral service provided by CE. Usually, the emergency department refers patients to other specialties in the hospital, but for KK CE, they have their own referral clinic so common conditions can be seen by the CE consultants as follow up. Hence, it does not stress the other specialities and also help the patients to be seen faster as the patient load is high. Being the only dedicated women and children's hospital in Singapore, the whole Singapore children comes to the CE. This follow up clinic can help to prevent repeated CE attendances. Many of the cases seen in CE are fever, cough, runny nose, gastroenteritis, reflux, asthma, febrile fits and bronchiolitis and hence it is important to be well versed in these conditions and explain it to the parents clearly.

Compared to the UK, the cases seen are about the same and the need to explain and reassure parents are essential. The case load in UK is much lesser than in Singapore, possibly because there is one CE in almost every hospital. In Singapore, there are only 2 CE. I think it was great to see the difference and similarities between 2 countries CE and both can learn from each other.

That concludes the end of my posting in KK CE. It was an enjoyable and fulfilling elective being able to learn from really good mentors and from the patients. I thank God for His grace for this opportunity to be here for my elective. KK CE is an excellent centre for children emergency care and I hope to be able to work here in the future.