Weiss Memorial Internal Medicine Categorical and Preliminary Residents circa 1994
Our chief resident is in the middle with the tie and I am somewhere in the back!

Chicago Hopeful

By Assoc Prof Paul Ananth Tambyah

A/Prof Tambyah recalls fondly his training days as an Internal Medicine resident in cosmopolitan inner-city Chicago, and how being a trainee meant being given "ownership" of patient care, learning how to present and justify your own patient management plans, and being able to sit through teaching conferences without being paged away.

I will never forget what one Singaporean returning from overseas training said, which helped me decide to go to Chicago, "The only thing worse than being a MO in XYZ hospital is being a registrar. In the US, a trainee is a trainee. Your job is to learn. Here in XYZ hospital, your job is to take the subsidised workload off the consultants." Of course, that was more than 15 years ago, and I am sure things have changed a great deal in XYZ hospital.

On a bright summer's day in Chicago in July 1993, I started my Internal Medicine residency at Weiss Memorial Hospital by joining a group of newly-minted house officers or residents (the terms were used interchangeably then) for a one-week orientation. Dr KG Chua, the Malaysian Head of Interventional Cardiology Laboratory, and thanks to whom I got the interview for my residency, had become my "godfather". He introduced me to Dr Nishin Tambay from Pune, a Postgraduate Year (PGY) 2 Internal Medicine resident and the most savvy of the senior class. Between Nishin and Dr Chua, they helped me plan my route from the inner-city Chicago hospital populated by International Medical Graduates (IMGs) to the University of Wisconsin, an elite Academic Medical Centre.

Ours was indeed an "Ellis Island" hospital (as Abraham Verghese would describe it in his book *The Tennis Player*). The categorical Internal Medicine residents came from around the globe –Brazil, Pakistan, India and Sri Lanka; I was the lone Southeast Asian. In contrast, the Preliminary Medicine interns going on to Radiology, Anaesthesiology and Psychiatry were from the University of Illinois, Loyola University and University of Texas at Austin. We also had Transitional Year interns who did Internal Medicine with a flavour of their future subspecialty. These interns were headed for Radiology, Anaesthesiology, Emergency Medicine and Ophthalmology, and came from Northwestern University, University of Illinois and Duke University. The bottom line is that all the American-born doctors from "brand name" medical schools went into lucrative specialties while the Internal Medicine inner-city residency programme was filled with us hungry folks from overseas, politely known as IMGs. Still, we all did calls and attended morning report together, where we were systematically grilled by the Chief Resident or the attending *du jour,* and sat through the daily teaching sessions hoping we would not be called upon to expound on last week's *New England Journal of Medicine's* lead article!

My first posting was in neurology consults. The Programme Director anticipated that I might have trouble obtaining a full licence so I needed a rotation where I could function as a medical student, just in case I did not receive my Illinois temporary licence in time. My supervisor, a colourful

neurologist, ran a private practice in a wealthy suburb while covering consults in the inner city, so that he could keep up with teaching and maintain an academic title. I still remember my first day when he took me down to the CCU and asked the ward clerk to undo her first button. He explained that she was his patient and asked me for a spot diagnosis. Thanks to the coaching of our local neurologists including neuromuscular guru Ben Ong, I realised quickly that the midline sternotomy scar was a marker for myasthenia gravis post-thymectomy. He was suitably impressed and began to tell me great Chicago neurology stories (many of these have been published by one of his teachers, Dr Harold Klawans). The rest of the day consisted of rounding on two in-patient consults, discussing treatment with them, pharmacists and house officers on the team which took about an hour each (!), and then heading out to the suburbs for clinic. He had two new patients scheduled for the afternoon – both equally wealthy – but he let me conduct the history and physical exam. I then presented the cases to him while he caught up with insurance paperwork and fielded calls from other patients who had called in the morning while he was in hospital. I learned that I could not mention multiple sclerosis in my write-up for the lady with documented optic neuritis and "nice" eye signs, or she would never get insurance again. That was one of my first introductions to the notorious insurance companies who were to go on to kill healthcare reform proposed by the Clintons.

The following months were quite different. As an Internal Medicine categorical intern, I had to do seven months for IM inpatients, including one in the ICU. I also had four weeks of vacation which had to be preplanned a year in advance, and four months of electives in Neurology, Orthopaedic Surgery, Haematology as well as Infectious Diseases which I did at the main campus of the University of Chicago.

The ward routines were gruelling. We got in about 6.45am to take over from the on-call team. From 7am to 8am, we pre-rounded on our patients making sure that they were sorted out and the PGY-2 or 3 residents joined us at 7.45am to do the work rounds. Morning report occurred at 9am; the intern from the on-call team presented a case from the last night's admission while the resident presented the literature review to justify the clinical management decisions taken. These were the days before the internet so we had to visit the library in the middle of the night to look up relevant articles and conduct searches using the MESH headings on the library computers and Index Medicus. There would also be an attending physician at morning report. It was the Programme Director twice a week and the others took turns – they were all general internists so they had to be able to discuss cases ranging from a bad lupus exacerbation to COPD with pneumothorax, or the more common acute myocardial infarction with some complication or other.

From 10am to 12pm, pagers would go off non-stop as we performed "changes" ordered on the morning rounds. We would also meet with the ward attending to go over our management plans. The big difference was that the patients were OURS. This necessarily limited the number of patients we could take care of as we had to talk with families and plan home care arrangements, in addition to writing four-page notes with references to justify our management decisions! The consultants were there to back us up in case anything went wrong but the major decisions were made by us.

The Chief Resident used to prowl the wards for "interference"– especially by the private consultants who wanted to have a say in what happened to their patients without good evidence to back up their actions. If they insisted despite remonstrations from the Chief, the patients were simply transferred to the "non-teaching service". This meant that a resident or intern would not look after them, and the consultants interacted directly with the nurses like the private hospitals in Singapore. This was possible as we were a university-affiliated community hospital, and not an Academic Medical Centre where it would not have been tolerated. We did not mind the "non-teaching service" much as the PGY-2s were allowed to "moonlight" on this private service once they had received their full medical licenses (after a pre-registration year in Illinois). In the middle of the night, if a private consultant did not want to drag himself out of bed in -20°C weather, he could ask the on-call resident to review a patient and the resident would be paid.

In Academic Medical Centres, like the one at the University of Wisconsin where I did my Infectious Diseases subspecialty fellowship, there was no "non-teaching service". As such, all patients were the primary responsibility of the residents. The teaching attending (consultant) of the month had to sign off after cases were presented by residents but he was not allowed to interfere with the evidence-based patient management plans proposed. Chief Residents and Programme Directors stood ready to back the residents. I still remember calling up the consultant at night to present my management plan when I was a third-year

Winning the best intern award

I had to admit that this was my second time round with internship having done housemanship in Singapore (and NS!) before leaving for the USA

resident. I disagreed with her suggestion but she would not back down. We called on the Chief Resident to arbitrate and he reassigned the patient to another consultant! I was quite shocked as this would never have happened in hierarchical Singapore. But the Chief recognised that I had medical literature on my side (a quick trip to the library that night had verified my position). The following morning was a little awkward but in the American spirit of not taking things personally, the first consultant resumed regular interactions with me (and I think with a little more grudging respect!).

My wife Siok and I at the Hospital dinner and dance at the Ritz Carlton.

It was free for the residents as they knew we were trainees receiving a stipend, not workers on a salary!

In super-specialised services such as spine surgery or BMT, Academic Medical Centres had nurse practitioners who did all the clerking, routine laboratories and so on as these were deemed too specialised for interns, unless they had special interest in the subject. Every day at noon we had a didactic teaching conference. This would be a radiology round on Tuesday, a clinic-pathological conference on Friday, and specialty teaching sessions the rest of the week, taught by the different sub-specialists who covered the hospital. Thus every day, we had at least two formal teaching sessions, including the morning report. The nurses knew that they could not page us during these conferences and that made a huge difference – the only calls that were tolerated were for the on call or Code Blue team. Although we have very good teaching conferences in Singapore, very often we would get paged away.

There were two major dissimilarities between the calls in Chicago and in National University Hospital (NUH) circa 1992. First, we had a night float system similar to what we have in NUH right now for residents. If you were on call, you took admissions up till 9pm but you were only allowed to go home after you had "traced" the results of all the tests that you had ordered and signed them all out to the night float team. The following morning, you would come in at 6.45am to take over from the night float team. Fortunately, this was early in the era of health management organisations so it was difficult to order expensive investigations. We had to depend on our clinical skills as orders for procedures such as MRIs had to be justified to insurance company executives.

The second big difference was that the whole team – both interns and the resident, or in Singapore terms, both housemen and the medical officer, went on call together on a fixed four-day cycle. We would admit our patients on Day 1 and work them up on the post-call day. Day 3 was when we worked with social workers and discharge planners to make sure we could discharge everyone before Day 4, which was the pre-call day when we tucked in the few remaining patients and went home early to stock up on sleep before going on-call again. Some of the patients would end up in our clinics which we ran once we were medical officers. This continuity of care was something we used to have in the old medical units at Tan Tock Seng Hospital when each unit would go on-call in turn. I think this is better for patient care – it was certainly better for teaching as we could follow the patient from admission to discharge and even post-discharge.

The clinics were another demonstration of how the patients were OURS, and not our consultants'. There were two of us assigned to the Thursday morning clinics – Ana from Brazil and myself. We had a regular attending – Dr Brad Clifford who was also the Assistant Programme Director. We had to present every case to him and he would sign off on our notes – otherwise the hospital would not be paid by Medicare or whichever insurance company that was paying the hospital bills. When I went back to Singapore on vacation, I had to pass a sign-out sheet to Ana and make sure she knew what to do if any of the patients called her. Another thing I remember was the Chicago Police Department calling me at 4am to ask about the medical history of a patient who had been found dead at home. I had my sign-out sheet with me so I was able to rattle off the list of medical conditions ranging from Parkinsonism to prostate cancer, which convinced the police that the odds of a natural death were relatively high! I also recall another patient whom I had recommended surgery for renal artery stenosis after working her up for late-onset hypertension. Unfortunately, she developed a stroke peri-op. When I came back, Ana told me that the patient was aphasic, but this did not correlate with the territory of her stroke. Her daughter also called me as she was very concerned, not so much with the surgery complication but with the patient's general attitude. I will never forget the first thing the patient said to me as I walked into the room, "You lied!" "What?" I replied, surprised to hear an allegedly aphasic woman speak. "You said that the operation had a 90% chance of success – it has been a disaster." Her daughter was just as stunned, and told me that her mother had waited for "her doctor", whom she knew was a second-year resident, before speaking up about her disappointment with the surgery. This was an invaluable lesson

that I learned in helping my patients understand the risks of surgery quoted to them by our busy surgeons – an operation that has a 90% chance of success means that 9 in 10 people will have a 100% successful operation while it will be a disaster for the last one!

Perhaps more than the academic and clinical learning, what made the Chicago experience more complete was living and working within the multi-cultural, multi-ethnic mix that was part of a major urban teaching hospital. I still remember going for the "first month" celebration of my intern's baby. Dr B was a sweet Serbian lady from the then-disintegrating Yugoslavia. She had completed her PhD in Molecular Biology at the University of Chicago before starting on the residency programme. I went with Drs Kantor and Kramer from our very Jewish Weiss Memorial Hospital and was taken aback that the main dish was a suckling pig! Dr B somehow did not connect the predominantly Jewish consultant pool with her choice of traditional delicacies. As people stood around awkwardly, I remember commenting to my wife how this was unlikely to happen in Singapore as we would never hold a major scientific meeting on the day of a religious festival for example – but that was almost twenty years ago…

Work-wise, residents from different countries brought their own perspectives, in particular to the "workload". Many of us could not believe that one could be well-trained with a cap of seven patients per day per intern or 14 per resident. There were bragging competitions which I easily lost. The residents from India boasted of seeing 100 patients on a busy call night while the residents from Africa and Latin America easily saw 70 to 80 per call – they said they were so busy that they had no time for detailed notes and often just ordered investigations and wrote prescriptions. We soon discovered why US residents had these limits, as each patient had to be carefully worked up and ALL the opportunistic health screenings prescribed by the US Public Health Service such as Pap smear and cholesterol had to be documented and updated. Complex social issues had to be sorted out and thus there was no way the US could even reach Singapore's "standards" of only 20 to 30 patients per call, let alone those of Ghana and Brazil. Also, patients had to be presented to an attending (consultant), not with a oneliner like "This is a 60-year-old man with chest pain", waiting for instruction but rather, a detailed, yet succinct presentation with a well-argued management plan that needed the green light but no spoon-feeding from the attending. This sounds a bit idealistic but at both my residency and fellowship programmes, I had consultants and ward consultants who would take the time to challenge my management plans and make me justify what I was doing. Of course, there were others who were less enthusiastic about teaching, but they quickly learned that their academic days were numbered! If the Chief Resident gathered enough feedback from residents, they lost their privileges, unlike the lifelong appointments that many of us were used to dealing with back home.

All in all, my residency in Chicago and fellowship at the University of Wisconsin were tremendous learning experiences. After coming back home to a NUH Senior Registrar job, I had the opportunity to serve on the Singapore Medical Council's House Officer Accreditation Committee. I recall telling my colleagues on that committee about how in Wisconsin, we had two fellows (registrars) in my second year doing the work of three. In Singapore, each of us would have had to do 50% more work to cover the shortfall. In contrast, because all trainee salaries were paid by the Federal Government in the US, that would not have been allowed. The consultants agreed to do step-down calls which amazed me as these were some of the top people in academic Infectious Diseases worldwide – Prof Dennis Maki and William A. Craig, among others.

This proved once again that a trainee in the US graduate medical education system is a ***trainee***, not merely an extra pair of hands. I asked my colleague if this was possible in Singapore, given that we are constantly striving to improve our status as Academic Medical Centres and regional centres of excellence in medical education and training. His wise response was, "Yes, but it will take a long time and a mindset change." I would like to think that the upcoming residency programme is going to be the first step on that long road. SMA

…lonker	(708) 369 1649	MVP, s/p pericarditis, s/p TB exposure, HTN	[illegible] 30 QD	[illegible]
…wicki	none	Type I DM	Insulin [illegible]	[illegible]
…utler	769 0735	COPD, Sz disorder, Atyp cp	[illegible], Prednisone 10 QD, [illegible]	[illegible]
…alloway	338 3301	Restrictive lung disease	Oxygen, [illegible], Ventolin 2p QID, Beclovent 4p BID, Robitussin prn, Prednisone 30 QD	On lung transplant list
…urcy	224 6253	Sz disorder	Dilantin 100 TID, MVI, Thiamine	[illegible]
…vis	989 1930	Post-polio synd, macrocytosis,etoh use, s/p pacemaker, s/p parotid tumor, anorexia	Dig 0.125 QD, Zantac 150 QHS, Quinine 30 PRN, Colace 100 BID, MVI 1 QAM	[illegible]
…ck	588 9044	s/p UTI, substance abuse	Tylenol prn	[illegible]
…llis	566 3117	CVA, ↑Chol, HTN, Hypothyroid	ASA 1 TID, Vasotec 10 BID, Synthyroid 0.15 QD	[illegible]
…reen	271 8942	HTN, Microcalc. L breast	Maxzide 1 QD, K-Dur 1 QD, Xanax 25 QHS, [illegible] 20 QD	[illegible]
…ng	784 1582	COPD, ?PTB, Depression	Atrovent 4p BID, Ventolin 2p QID, Zoloft 50 QHS	[illegible]

Page one of seven for my clinic sign-out sheet
We had to leave details of our patients to the MOs covering our clinics when we were away

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