THE NEW NORMAL

I'm in the critical care area of my emergency department. It's 10.30 pm on a Tuesday; the post-dinner surge of patients which started after 7 pm is showing no signs of abating and everyone's struggling to keep up with the load.

It's been a busy shift – there were 24 patients on trolleys waiting to be seen when I started at 4 pm, and the last I checked, there were about 40 patients outside in the consultation area where the ambulatory patients are waiting. It's been a blur of patients since then, as my fellow emergency medicine colleague and I vet and clear cases with the medical officers, in order to come up with early plans and dispositions for the patients on the "shop floor", in an attempt to thin the waiting crowd. The observation ward is full; however, the wards upstairs haven't been able to take in the admitted patients yet, so all the patients that have already been seen and admitted are still stuck with us.

In order to maximise the use of the limited space in the department, the nurses have lined trolleys side by side, with each trolley almost touching the other (an infection control nightmare). I see two department radiographers shuffling sideways through the narrow pathways between the trolleys, trying to reach their target patient – an elderly lady from a nursing home. They then proceed on to the game of rearranging beds (much like a sliding puzzle game, where you attempt to rearrange tiles to assemble a picture), in order to create a pathway to move that trolley out of the morass of beds that the patient in question is trapped in, just so that they can bring the patient to do her X-rays.

The access gridlock in the emergency department is beginning to cause the gears of the emergency department to grind slowly down, and has rendered the department a three-walled enclosure. Patients and ambulance casualties are flowing into the department continuously, with almost no patients leaving for the wards upstairs in the near foreseeable future. The nurses struggle to keep up with their tasks as the number of patients grows, while the doctors struggle to find their patients in the crowd and not let the pressure of the queue get to them. It is hard though – four out of the six medical officers doing the evening shift have missed their dinner.

It is noisy. There's the conversation between nurses as they hand over tasks and instructions to one another; the constant chatter of medical officers with their patients as they take history; the casual conversations of patients commiserating with one another as they lie waiting; the moans of patients in pain; the vulgarities yelled by an alcohol-intoxicated man; and the constant ringing of the telephones. I can hear the security personnel just beyond the doors of the critical care area explaining to impatient family members that they will have to wait until one of the physicians or nurses comes out to update them. I hear the annoyingly high-pitched beeps of the trolley call bells. I hear the reporting of an 87-year-old cancer patient's medical history to my colleague as he goes through another case with a medical officer nearby.

From the resuscitation area, located just a few metres and an open doorway away, I hear the rhythmic compressions of a mechanical cardiopulmonary resuscitation (CPR) device and instructions delivered by

an urgent voice. It's the cardiac arrest case that was brought in earlier as a standby case by the Singapore Civil Defence Force ambulance.

I enter the resuscitation area to see if there's anything I can do to help. Oh, the smell. The patient in cardiac arrest had loosened his or her bowels at some point. I can't see the casualty as there are too many people around – nurses, paramedics and doctors. I see medical students standing at the side watching the cardiac arrest resuscitation unfold, eyes wide open as a scenario that they've only till now been reading about finally play itself out in real life.

I squeeze myself next to the resuscitation leader who is a senior resident. The casualty is female. She is frail, thin, elderly and tiny-looking on the trolley, wrapped by the compression band of the CPR device, head lolling from side to side from the force of the compressions delivered, with an endotracheal tube emerging from her mouth. My colleague looks exhausted; it's been a long resuscitation. Too long. Asystole. She is not coming back. He looked at me and sighed morosely. He's going to let her go, he says. He steps out to break the news.

The ambulance standby alarm sounds – piercing and shrilling, silencing all the doctors and nurses outside. A soft collective moan goes up from the exhausted nurses in the resuscitation area. "Standby for a 54-year-old male, case of chest pains, ETA seven minutes."

Another wave of frantic activities break over the nurses as they hasten to prepare another cubicle for the impending arrival of another patient, exchanging rapid-fire instructions with one another as they divide the tasks among themselves.

The senior resident returns; his expression sombre at the news he had to break to the deceased's family. I can hear their wails coming from outside the department.
He hears of the incoming case and I see him visibly shrugging off the weight of the previous case and preparing himself to move on to receive the next casualty.

A young man grimacing in pain from a dislocated shoulder is pushed in, past the shrouded deceased patient, into the next cubicle, opposite an intubated patient with septic shock that has been waiting for an intensive care unit bed for the past two hours now. I tell my resident that I will deal with the shoulder dislocation and invited the students to help me. They happily oblige, full of energy still. I'm tired; it's nearing seven hours into my shift. My thoughts feel dull and my footsteps are sluggish. I think of all my emergency physician colleagues around Singapore, who are all struggling in their own ways, in their own embattled departments, fighting their own fatigue and hunger to treat the sick and the dying. I don't feel so tired now. At least I know I'm not alone in my experience.

It's almost midnight now and I've finished handing over the shift to my night shift colleagues. I say my goodbyes and tell them I will see them in several hours as I'm scheduled for work in the morning shift. They make sympathetic faces.

They ask me how my shift was and I dully tell them, "It was okay."

I drive home, turning north on the expressway. I turn off the radio, preferring to drive in silence for a while. Too much… noise today. I'm starving, as I've not had dinner. On a whim, I exit the expressway and drive to a Japanese restaurant that I know opens till late.

The sukiyaki is delicious; the meat tender and the beer, icy cold.

I think it's been a good day after all. ◆

PROFILE

TEXT BY

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Dr Lim Jia Hao is a full-time emergency physician working in the Singapore General Hospital's Department of Emergency Medicine. He has a special interest in critical care and medical education, and is extremely grateful for the fraternity of emergency physicians in Singapore who have taught him so many values and lessons.