Taking Care of Ourselves

By Dr John Chiam, Editorial Board Member

THE ALL TOO FAMILIAR 36-HOUR SHIFTS

Imagine this all too real, and all too often, medical scenario. You glance at your wristwatch, and realise that 5 o'clock is but a few minutes away. You look back at the 4 case folders in front of you, each of them with a little laminated white card which proclaims to one and all: "NOT CLERKED". You also realise that your last bite was the dinner you had a good 18 hours ago, the day before you turned up to work, to go on call tonight.

All too soon, the pager hanging by your belt starts to go off. Your colleagues, who were spared tonight's call duty, are handing their cases over to you. All this time, the 4 case folders are crying out for attention: "CLERK ME"! You look up at the whiteboard and note with despair that another 3 cases from the A&E are lined up to arrive in the ward.

And your call hasn't even started yet.

Amazingly, through sheer adrenaline and a will stronger than steel, you finish clerking the 4 patients, and in-between setting plugs and resetting them, you even manage to see to the 3 new cases from the A&E. Never mind the small issue of still not having had a bite to eat since dinner last night...

Then, all through the night, you rush from patient to patient, your emotions a raw mix of frustration (as yet another seemingly non-emergency admission is sent up by the A&E because the patient's relatives were nowhere to be seen), and worry (that last patient looked a little sicker than she should be), and utter hopelessness (oh, when, just when will this night end?!).

Sleep is scarce, and even when obtainable, often interrupted. If it's not the pager going off, it is you who wake up startled, wondering if the pager's gone off without you hearing it. And still, the flow of patients (you've seen over 20 by now) and the number of plugs that need resetting continue.

By now, midway through your call, you're looking sicker than half the patients admitted. You're hungry, tired, smelly and dead on your feet. That irritating sniffling nose that bothered you earlier in the morning has now turned into a leaky faucet that continually leaves large swathes of stains across your right sleeve (where you wiped it).

COLLAPSE: YOU OR THE PATIENT?

At 7.45 in the morning, just as you thought you had survived the night before, your pager rings with the dreaded –99 suffix. A collapse and a code blue! So, without so much as bothering with personal hygiene and your 5 o'clock shadow looking more like a Mahaguru's beard by now, you summon the last iota of will from your mind, and the final scrap of strength from your sinews, and take off to the rescue.

A good hour later, you trudge up to the call rooms for a quick shower and nick yourself half a dozen times while shaving with your eyes involuntarily closed. You then head downstairs to start your day, which will only end after your outpatient clinic at 5pm. By now, you are weakly aware of the ache in your joints, and the fever that has started to grip your body.

What's interesting is a comparison I often quote. I wouldn't get into the backseat of a cab if I knew the driver had gone without sleep for 12 hours. I wouldn't be brave enough to hop on that plane if I had foreknowledge of the pilot's sleep deprivation the night before the flight. Yet, doctors continually make life and death decisions even after 36 hours of wide-eyed duty.

Yes, we work 36 hours at a stretch simply because if we don't – like the House Officers going off at 8am the next day – the system collapses, bloods don't get done on time, discharges are left till 6pm, medications are not inked up and patients are not seen. It's become a fact of life that we are expected to tough it out, to suck it in and hold it there – any symptom of humanity (i.e. feeling tired, feeling sick) is immediately frowned upon as showing signs of weakness. Colleagues feel down, because the work now needs to be shouldered by the others, and you get a bad report from your consultants.

And, so, with a Piriton tablet washed down together with 2 Panadols taken from the ward stock while Sister wasn't looking, you soldier on, continuing to tend to patients (and their anxious and too often, demanding relatives) both in the wards and in the outpatient clinic.

All this would have been all right – an accepted part of the practice of institutional medicine in Singapore, an expected sacrifice and a call to duty from the junior ranks (House Officers, Medical Officers, Registrars) – a few months ago.

Of course, a few months ago, the world was a different place, and the word "SARS" hadn't entered the medical lexicon.

STAFFING SHORTAGE

Today, 2 colleagues have given their lives in the line of duty. Another lies in intensive care because a patient with SARS infected her and 40 others. And the newspapers have unkindly insinuated that she might have put others at risk, while continuing to work while she was sick.

Believe me when I say that given the opportunity and given the proper structural supports, none of us would like to put in 16-hour workdays. None of us would choose to work when we're sick, if we had enough staff to cover our duties. If we had the proper administrative backing, I'm sure all of us would relish regular hours and proper rest, sleep and time to recover if any of us fell ill.

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About the author:

Dr John Chiam (MBBS 1998, MRCP 2001), is concerned about the welfare and morale of his fellow colleagues and overworked (himself included) peers. He hopes his article will be a small voice of encouragement, for all the junior staff (from the House Officer right up to the Registrar/ Associate Consultant doing yet another stay-in night call) working consecutive nights and endless days. He hopes that all doctors keep safe and healthy, in these stressful and difficult times.

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Yet, these thoughts are often thought of as "dissident", and are frowned upon as a sign of failing. When – if – we bring this up at unit meetings and feedback committees, we are then regaled (and ridiculed) by tales from our seniors, of a time where they had to hook up the drips themselves, and where re-useable needles were carefully unplucked to be sterilised, and where glucose monitoring were still done by the doctors, and not the nurses.

Anecdotes of how they compared the colour of the glucometer strips (dark red = high hypocount, better give some insulin; light red = can ignore until the next check) because they were so swamped by patients, would then put us weaklings to shame.

Times are different now, unfortunately. Relatives with powerful connections and lawyer friends are ever ready to "further the interests" of their loved ones (which curiously often involves only the pecuniary sort). We are expected to spend an hour giving a detailed breakdown of everything we have done and are about to do to a relative, only to have another irate patient complain about his long waiting time. With the inverse pyramid and our rapidly ageing old on the horizon, this situation is only expected to worsen.

There simply aren't enough hands to go around – simply put, some brilliant genius' assessment of "oversupply" some years ago has effectively choked the life out of our healthcare system, as we know it. The mass exodus of trained, experienced professionals to the private sectors (greener fields, to be sure) has left us with a skeletal staff of relatively younger people.

SUGGESTIONS

What can be done then? Well, I have a few suggestions, gathered from the people on the ground. Whether or not these suggestions are seen as valid concerns worth addressing, or just the frivolous complaints of a whinger who couldn't cop it, I leave to the reader to decide.

1. We need proper staffing in order for well-meaning policies to take effect, and for those policies to work. It is hardly any use to put on paper that the House Officers go "post-call" at 8 in the morning, when the remaining House Officers, Medical Officers and even Registrars stepping down, are simply not adequate in numbers, to cover the outstanding duties.
2. The work environment must be conducive and supportive for those remaining in hospital service. Much has been done, and truth be told, much has improved since the days of old. Reports from the ground should not be sweetened, and glossed over – unhappiness needs to be voiced, and those concerns addressed. Too often, the prevailing message is for us not to "rock the boat". Bad luck, all it takes is the stress of something like SARS, and as you can see, the boat is sinking.
3. There needs to be a culture change – a revolution, in the way the medical profession sees itself. We must no longer feel bad, or be made to feel bad, if we fall sick. We need to be given permission to acknowledge that, being human, we too can feel under the weather, tired, fall ill or just feel sick of work from time to time.

CONCLUSION

Remember, we are ultimately responsible for our own well-being. SARS has rudely and powerfully forced us to re-evaluate our priorities, and our present day practices, in more ways than one.

And, taking the analogy of the oxygen masks dropping from the airplane's compartment – just as the mother is told to put on her oxygen mask first, before placing one on her child, we doctors should learn to take care of ourselves first, before learning to take care of others. Because we are certainly no good to our patients, if we ourselves are ill – or dead. ■

ANNOUNCEMENT

HSA RECALLS HEALTH PRODUCTS

For more information on Health Sciences Authority's recall of health products made by Pan Pharmaceuticals, please visit the HSA website at http://app.internet.gov.sg/scripts/hsa/communications/pressreleases.asp