

By Dr Raj Kumar Menon

## Pre-call Blues and Other Stories – Why Junior Doctors are Losing their Passion for Work

A few months ago, I was flipping through some old case notes from the early 1990s for a research project and was surprised at how, a decade later, certain things have just not changed. We still have bad handwriting, we still do not fill up social histories on the clerking sheet and House Officers are still being routinely called up by dutiful nurses for hypocounts of 10.

Yet, I have been a doctor for a year and a half now, and even during this short period, one can sense the changes sweeping this profession. Our patients have changed, their diseases have changed and so too have their doctors. Not just in numbers, but in capability and outlook. The world sees medicine as the next frontier. These should be exciting times to be a doctor.

Yet somehow, whenever we are told to speak to Junior College students or pre-clinical students, our predictable advice would be “Get out while you can”, or “(Sigh) It is too late” or even just “(Sigh)”. And while most of these responses would be in jest, the reality is that many junior doctors especially HOs are still feeling burnt out and dissatisfied with their work. It becomes hard to stay at a job which demands long hours and social sacrifices while still maintaining a passion for it. It becomes untenable when that passion is lost. And this lost passion is something that we need to address.

### **“I WOULD LIKE TO SPEAK TO YOUR SENIOR DOCTOR.”**

One of the key sources of satisfaction for any doctor, and perhaps especially for a junior doctor, is the doctor-patient relationship. No matter how

long a day has been, it has always been nice to see a patient getting better and, as an added bonus, to actually have a grateful patient thank you for your help.

Unfortunately, we are increasingly seeing a new subset of patients – the unreasonable ones. Not so much those who are angry and upset as part of the grieving process, but those who hold doctors and nurses to unrealistic standards. They present with a variety of symptoms. They make mostly unreasonable demands on the nursing and junior staff. They seek immediate responses to their complaints, no matter how minor, despite being aware of how stretched resources are at most hospitals. Some demand investigations (like the magical “CT”) even after being counselled on other more appropriate ones. Still others threaten legal and public relations disaster inducing actions when they do not get their way.

It would seem that some view the hospital more as a hotel with the call bell acting as a surrogate for room service.

Such behaviour results in our junior staff spending a disproportionate amount of time with these patients, sometimes to the detriment of our other patients who require more immediate attention. This is especially so at night when time is a precious commodity. Ethical dilemmas notwithstanding, this is often a cause of distress to our junior doctors. Many of them are not sure how to respond to unreasonable requests and, in extreme situations, find themselves on the receiving end of verbal abuse which quickly culminates with them either apologising needlessly or sometimes even flaring up at these



Dr Raj is currently serving the nation in the jungles of Singapore and is painfully aware that he is not 18 anymore.

patients. Out of all the stressors a doctor faces, an angry patient is perhaps the one who hurts our young doctors the most. Medical school has made good inroads in teaching our students about conflict management and such instruction needs to be expanded on and continued once we start working. In the wards itself, it is up to the MOs, registrars, consultants, senior nurses and nursing officers to assume leadership when necessary to deal with such patients and most importantly to let the junior staff realise that they are not alone during such situations.

As for the patient's themselves, one can only hope that with time, they will begin to understand the limitations of the system we are in. Dealing with those limitations is well beyond the scope of this article and perhaps one day when conditions improve, our doctors will be able to rediscover the source of the satisfaction that this job provides.

#### **"AN EXTREMELY GIFTED CLERK"**

A consultant once told me: "It is very easy to be a HO. Just do what you are told." And indeed, to function as a HO, perhaps that is all that is needed. However, such a role does little to inspire the HO who, after emerging from medical school, usually intends to make a difference in the world.

Unfortunately in our current system, HOs run about filling charts and files, tracing results, performing all matter of duties which are designated as changes. Many a surgical HO lists his or her patients for designated operations, never truly understanding why they are being done. Medications with mysterious functions are dutifully written up in the IMR. Doses are changed in a seemingly arbitrary manner. Treating diseases become protocols based on habit rather than understanding.

Management plans are not being explained to them, and their opinions, even if they are indeed drenched in inexperience, are not sought. The teaching round is fast becoming extinct. In its place we have structured lectures now in most of the HO and MO postings which may be comprehensive, but may not be as effective as teaching during the actual ward round which leaves a much more distinct impression. And perhaps more importantly, a ward round which involves and recognises the contributions of every member of the team would let the junior staff realise that they too have a much larger role to play.

In the name of function and efficiency, in a quest to complete our ward rounds in an expedient manner, we may be ignoring the needs

of our junior staff to learn and to be involved in the care of their patients. With our manpower shortages being addressed with increasing output from our medical school and from overseas institutions, we just might be able to afford the time to teach and involve the junior staff in the life of their patients.

An inspired doctor would do much more for his patients than one who just scribes and runs errands. An inspired doctor would see his true worth and find real meaning in the work he does.

#### **"FIRST, DO NO HARM. AT LEAST TRY NOT TO."**

We have all had that nightmare. The one where you are clerking your 25<sup>th</sup> case for the night. Your clerking has been interrupted by four phone calls by the time you reach the systemic history. Your eyelids close for many moments as your pen trails a line of blue ink across the clerking sheet. You sense that the first and second heart sounds are present and record it as such. The 5<sup>th</sup> phone call is about the plug which fell out of the arm of the renal patient. The 6<sup>th</sup> phone call is about the collapse. THE COLLAPSE. And just as you feel that this is your worst nightmare, you realise that you are wide awake in your 7<sup>th</sup> general medicine call of the month.

This is not the 1950s, the 1970s or a rural country in a third world country. This is today.

Admirably, generations of junior doctors have risen to the occasion, pushing their limits, heroes in their own right. We comfort ourselves that it was worse before, that it can be done today. We rationalise that this is the best way to learn. Trial by fire, learn from your mistakes, the metaphorical construction of character.

Sometimes though, it does cross my mind, is this the best way? Do we have to learn the hard way, at the expense of our bodies, our minds, our dreams of what we want to do outside of medicine? Quietly we ask ourselves if our patients are suffering because we cannot spend enough time and thought on them, even though we want to.

If these questions do cause us some concern, then are we doing something to remedy the situation? Are we finding new ways to teach our juniors and students so that they are not learning crucial skills for the first time during a night call itself? Are we experimenting with new manpower deployments? Are we debating the merits of a shift system versus a traditional system?

And lastly, why do I have three of my juniors asking me in the space of one week, as their MOPEX approaches: "I do not think I want to do clinical work anymore, I love treating patients,

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but I just cannot do calls anymore. Is there anything else in medicine?”

### **“HELP!”**

The last point I have to make is perhaps one which affects a very small population of doctors – the depressed doctor. At some point of our careers, we tend to undergo some form of reactive stress or depression. Most of us will find ways to cope and perhaps this process might even help us in our self-development. Yet the clinically depressed doctor exists. In a study conducted between 1988 to 1998 at the National University Hospital (NUH), 32 house officers and medical officers with work overload and seven senior doctors with familial and work related problems were referred to NUH for clinical depression. In my cohort alone, there are a handful of doctors who have had or are undergoing treatment for depression. It would not be surprising if this was an underestimate with many suffering in silence. By the very nature of this profession, we are expected to deal with our problems and stressors in a stoic, unflinching manner with the patient’s welfare as our first priority. We deal with death, sickness, social maladies, medical errors – some of which may be our own. All of which, especially in confluence with other social stressors, can bring any person to his knees.

Yet a support structure for such a doctor who has difficulty coping is virtually non-existent. Those whose performance at work has begun to suffer as

a result of depressive or adjustment disorders would possibly have an added stressor from his or her peers and bosses to improve. In other systems around the world, schemes that require all doctors to attend regular interviews with a designated mentor figure or a psychiatrist are in place to help those in need. As doctors, it is all the more imperative that we do not leave our own peers, who are suffering, behind.

### **“I WANT TO BE A DOCTOR BECAUSE....”**

It would be just so easy to dismiss the problems that our junior doctors face as trivial; the whining of an already pampered generation. That if they were half as committed as they seemed at their medical school interview, these concerns would evaporate into thin, sterile air.

Yet perhaps we tend to forget that these are bright young men and women who joined medicine with what must have been mostly altruism. And it is our duty to safeguard that spirit which they brought with them.

At the end of the day for some, losing one’s passion for work is unavoidable. Our priorities in life may change and so may our motivations. But for those still trying to rediscover their lost passions, for those trying to remember what they said during that medical school interview, perhaps it is the very junior college students and pre-clinical students, brimming with idealism, to whom we often advise a quick escape from medicine, who might actually have the very answers to why we wanted to practise medicine in the first place. And why we still do. ■