Time for action not for sympathy

Trisha Greenhalgh

For two weeks my patients and I have been the victims of "efficiency savings." The authority has refused to pay for locum cover, so I have been doing two people's work while another houseman is on holiday. There have been twice as many "take" days, twice as many emergencies, and twice as many odd jobs that make up the bulk of a houseman's work. But there are not twice as many hours in the day and I have cut corners.

When "on take" I admitted a woman with probable cholecystitis. Her pain and temperature settled overnight. Normally I would have gone and talked personally with the radiologist so that the patient could be squeezed on to the next day's ultrasound list. But this week I had no time. I scribbled a card and put it in the out tray. It took two days to reach the *x* ray department; the appointment came back for next Tuesday and the patient spent five unnecessary days in hospital.

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A month ago a woman came in to have a benign breast lump removed. She asked in passing about being sterilised and I arranged for a laparoscopic sterilisation to be done under the same anaesthetic. Talking to the gynaecologists, altering the theatre lists, and finding the consent forms took half an hour. I did not have half an hour, and when a patient with a hernia pointed out his varicose veins and early varicose ulcer I said that he would have to see his general practitioner and go on the bottom of another waiting list.

My routine business rounds became weekly instead of daily. "N A D" in the notes came to mean "not actually done" instead of the traditional "no abnormal diagnosis." Discharge summaries and referral slips piled up in the tray that I used to pride myself on keeping empty. Postoperative blood tests were overlooked. Results that I ought to have filed were left lying around and got lost. I worked till nine or ten each evening and every other night. I lived on chocolate bars and black coffee. I was harassed, short tempered, and unsafe.

After 11 days of not leaving the hospital grounds I was constantly dizzy, I had palpitations, I heard imaginary telephones ring, and I jumped when anyone else's bleep went off. I sometimes felt that I was outside my own body, watching myself filling out endless forms or asking the same questions to the twelfth admitted patient of the day. Patients whom I used to greet with a cheerful "How are you, Mrs B?" now stopped as they passed my desk and asked, "Are you all right, doctor?"

Perhaps I did not cause any direct harm to my patients over the past two weeks. There is certainly no objective way of measuring the inefficiency and avoidable suffering which arose indirectly from my excessive workload. But looking back at the quality of care I was able to give I can assure the authority that an overworked doctor is necessarily a bad doctor, and a bad doctor is, on top of everything else, a false economy.

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I wrote that article five years ago. Since then I have seen reports confirming the danger to both doctor and patient of excessive hours of duty. I have seen capable and conscientious colleagues driven to mental illness, marital breakdown, and alcoholism. I have read the suicide note of a dear friend whose on call rota was hell on earth. I have read recommendations for the urgent and drastic reduction of working hours in the major specialties, and I have seen them all but ignored. I spent three years as a registrar and have now returned to work as a senior house officer in a specialty with which I am unfamiliar. I am expected to make life and death decisions after 36 hours or more on my feet. Once again, I am exhausted, confused, and frightened.

The problem of overworked junior hospital doctors has not gone away—most of us simply get promoted and forget about it. It is time to stop nodding sympathy to articles such as these. It is time to organise, to fight, and perhaps even to strike.

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African Medical Research and Educational Foundation

It was a novel idea at the time, and I suspect probably still is, that in those parts of the world where distances are great, communications poor, and specialists thin on the ground it may be more efficient to take medicine to the people rather than concentrate care in a large urban hospital. Michael Wood realised this, and thus was born the Flying Doctor Service of Africa, the original seed of the African Medical Research and Educational Foundation (AMREF).

From this seed has developed a tree whose many branches spread far over east Africa, bringing comfort and care and laying the foundation for a scientifically based service. As its name implies, AMREF has three functions. The Flying Doctor Service, based in Nairobi, has expanded and now serves an area from Mozambique to the southern Sudan, bringing fast and efficient aid to the remotest villages. It deals with the bread and butter of African primary health care: trauma, emergencies, and the evacuation of those needing more specialist care. It also delivers skill of a very special kind—notably, Sir Michael's special interest, plastic surgery, with its power to restore function to burnt, mangled, or leprous limbs. The other branch of primary health care—immunisation, the early diagnosis and treatment of common disorders, and the control of infectious disease—is accomplished through a network of rural health centres and clinics staffed by trained nurses and medical assistants. Here AMREF plays an important part in continuing education, sponsoring where possible the training of health workers and distributing well planned, low cost, simply written, and profusely illustrated manuals. In addition a constant stream of journals, magazines, and newsletters has appeared over the years. Subjects have included simple medical skills, epidemiology, community medicine, a guide to drug use, which could usefully be adapted to British use, and always the encouragement of basic research.

Research is, indeed, AMREF's third main branch. Work has been pioneered in measuring the prevalence of specific diseases, on diet and health, and on the uses of local, usually herbal, medicines. Modern technology has been profitably used, especially in a programme for screening the Turkana people for hydatid disease by means of ultrasound.

AMREF now has international recognition and respect, its importance as a bridge between north and south being recognised by the impressive number of countries that support it. It is one of the few east African organisations that has maintained a steady progress through all the problems of drought, famine, civil disturbance, and grave material shortages.

What does AMREF need? Primarily money. The financial success of initiatives such as the various "aid" appeals has drained money away from organisations like AMREF, yet support which is reliable is doubly useful, because it ensures continuity and frees the administrative staff from the laborious task of fund raising. Covenants, of course, but also sponsorship of projects and trainees are always welcome. Contact AMREF at Suite 2, 68 Upper Richmond Road, London SW15 (01 874 0098).

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