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A failing heart

EDITORIAL

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It is as though our health services are suffering from diastolic heart failure. Things are fine at the normal resting rate, but congestion builds up if there is too much adrenalin.

I can well recall the first time I saw a shift colleague cry. I was a junior doctor at the time, and we were well into the night shift. We were struggling to deal with the flood of patients that we had taken over from the outgoing shift team. The Emergency Dispatch Centre reported that another batch of stretchers were on the way. Breaking waves and illness have one feature in common: you can count on them coming, but you don't know exactly when.

Only later on did I understand what these tears were about. Towards the end of a strenuous shift, everything had simply reached breaking point. It was lactic acid oozing out after a long stretch above the anaerobic threshold. All my shift colleague needed was to take five minutes alone outside the reception area to dry the salty tears. Then, she continued the shift where she left off.

Nilsen and colleagues have interviewed health workers in somatic departments about their perception of the workload (1). The results show that health workers feel that the job is more hectic than previously and that the resources – in terms of time, space and pairs of hands – are insufficient to deal with all the tasks. Moreover, when things are hectic, more time is spent on logistics than on therapy.

This may be familiar to many of us who work in hospitals, but we nevertheless need to ask: Do the informants in this study paint the right picture? Is it perhaps just 'clinicians grumbling' from a generation of health workers who fail to understand that the profession is different from what it used to be? Perhaps they should adapt, rather than resist? Should we believe them? Have things

really become more hectic? It is easy for both managers and doctors to say that 'it's just the way things are now'. Behind it, however, lies an attitude of which we ought to be wary. David Hume (1711–76) stated that one cannot infer from an 'is' to a 'should be' (2), i.e. from the descriptive to the normative.

The informants in the study by Nilsen and colleagues feel that with an increase in pace comes a fall in efficiency. More time is spent on logistics and firefighting instead of on care and treatment. More profitable, planned activities get postponed. The study paints a picture reminiscent of the Frank Starling curve: a failing heart that can no longer keep beating. In a feature article, Dag Bratlid claims that in spite of the increasing number of doctors, less time is spent with each patient (3). More of the time is swallowed up by clerical tasks and reporting. Intuitively, this does not sound very efficient.

When heading out on a hike in the Sunnmøre region you often need to pass through a toll gate on the way up the mountain. You put the money in an envelope next to the barrier. To be sure, you can cheat, but a staffed barrier would cost more than the cheating of some sneaky hikers. This trust-based system works so well that you will hardly see a single electronic barrier in the Sunnmøre region. Mobile payment is the only modern system that local landowners have embraced. Many claim that trust is the very cornerstone of the Scandinavian model (4). Trust is efficient, because it eliminates the need to pay for reporting and control. Of course there must be quality control, but we should take care not to end up with a whole army of gatekeepers.

> ***«It is the feeling of going home without having done a proper job that eats away at one the most»***

Studies of so-called multitasking show that up to 40 per cent of the efficiency can be lost by constantly having to switch back and forth between work tasks (5). Multitasking may look efficient, but in reality it is neither safe, nor smart. When the workload is heavy, it is better to establish space for each individual to complete the task at hand. One thing at a time: how many wards pursue such a strategy?

Nilsen and colleagues claim that full resource utilisation may be seen as unconscionable. This tallies with a frequently cited article which found that mortality increased when the occupancy rate passed 92.5 per cent (6). High occupancy means that things go too quickly, in terms of care, observation and assessment. The study claimed that a buffer capacity should be built into both the personnel and the structure, to ensure access to flexible extra resources. This is similar to how generals call in reserves when the battle is at its height. I believe that we should be cautious in planning for a fast pace without having a plan for dealing with 'peaks'. An overloaded heart will easily become congested.

We are short of nurses and doctors today, as we will be in the future (7). Although this is most acutely felt in the primary healthcare service outside urban areas, we are well aware of the recruitment problems in our hospitals. Resource shortages are almost certainly linked to falling recruitment, but I do

not believe that heavy workloads, high staff turnover and the fast pace are the sole problem. It is the feeling of going home without having done a proper job that eats away at one the most.

After a while, the doctor who wept joined those who had found another job. The department not only lost an excellent and well-liked doctor, but also two years of investment. Later, I took over her position. And I frequently need to take five minutes in the fresh air and dry the tears from my cheeks – not because I am sad or something serious has happened; it's simply the lactic acid building up.

I love my job. But who knows how long it will last, because there is something unhealthy about these tears, something not very sustainable.

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