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Medical Sciences

WHAT DOES IT MEAN TO BE A PEDIATRICIAN NOW IN ROMANIA?

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ABSTRACT
PEDIATRICS IS A BRANCH OF MEDICINE, SUBJECT TO THE DAILY SIEGE OF A MULTITUDE OF URGENT OR TRIVIAL CASES. IT IS A SPECIALTY WITH A GREAT EMOTIONAL LOAD, DUE TO ITS SPECIFICITY: IT IS CHILD-CENTERED, A FRAGILE AND PRECIOUS BEING. THE PHENOMENON, RECENTLY DESCRIBED AND OBJECTIFIED BY "BURNOUT" IS MUCH LARGER IN THE CASE OF THE PEDIATRIC DOCTOR COMPARED TO THAT OF OTHER SPECIALTIES.
AN ADEQUATE PROTECTION OF THE DOCTOR, A QUALITY ACHIEVEMENT OF THE MEDICAL DOCUMENT, AND LAST BUT NOT THE LEAST, A CORRECT RESOLUTION OF THE PEDIATRIC DISEASES, REQUIRE COHERENT AND RAPID LEGISLATIVE CHANGES.

KEYWORDS: PEDIATRICIAN, CHILD, EDUCATION.

In recent years we are witnessing an apparent process of evolution. It is, doubtless, a fantastic technological progress but at the same time it is a regression at the individual level. It is a certain educational involution of the not educated population in schools, a population that chooses the easy way of information from the source of value to the absolute oracle - Google.

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We are, personally, humans before we are doctors. We still believe, we know how long and we respect the oath of Hippocrates. We try to do good, to alleviate suffering, to show empathy, to maintain confidentiality, to put above all the welfare of the patient.

We try to fight patients' self-information and always keep our phones and minds open to advise (almost at any time) and give the best advice. We maintain our verticality, our honesty, but we become friendly and equidistant, we humanize the disease, we psychologically counsel the family, we reassure patients, we write prescriptions and we check results, we read analyzes and we translate the explanations into the meaning of patients. This is what any doctor does, almost, now in Romania.

But what makes pediatricians different? Maybe some playful sense that they never lose, due to the environment in which they spend most of their lives. But not only that. This is especially “burnout”. Pediatricians burn intensely, consume themselves daily, endure constant stress from several sources. It is, first of all, the specificity of the profession, the correct diagnosis and the speed of the therapeutic intervention, in a baby, for example, it makes the difference between life and death. And it is not easy, the little child cries, does not speak, does not say what hurts, has various manifestations covering a vast "spectrum" of diseases, is quickly exhausted and can make a multitude of complications, even in seemingly banal conditions. For example, a "harmless" virus can cause a high fever and a seizure in the young child. So is a dramatic episode[7].

The pediatrician must be a Sherlock Holmes, a Miss Marple and a Superman all at once. They have to gather information through meticulous medical history, to "squeeze" valuable information from the family, often an anxious, nervous and reluctant family. This is a second source of stress: the caregivers. They are parsimonious with crucial information about their own child's history but they vociferate, use invective, and ridicule the medical staff. They do not understand that we all, child, family, doctor, are on the same side of the barricade. They thought had superpowers, under the adverse influence of articles in the media, of the discussions on various "sites" of self-taught moms, of the misinformation of the search engines, to wait immediate healing of the small patient.

The pediatrician must always maintain his temper; have a calm attitude and a calm language, to cope with the general awkwardness (the crying of the sick child, the screams of the parents). To explain, to reason, to change already rooted concepts, to establish with the family's agreement why is needed the hospitalization, what treatment is required, what analyzes are needed, to draw a natural evolution of the disease, a reaction to the treatment, to estimate a hypothetical healing time and explaining to everyone that he is not God but, if allowed to do his job, can be a kind of Santa Claus who will be able to wipe away tears and chase away the disease.

A pediatrician who is also a parent can be considered a brilliant mutant. He has the ability to transpose himself in the situation of the agitated parent. He can understand the parent (up to a certain point), he will prescribe the safest and most appropriate treatment for the disease of the respective child, and he will treat the child like his own.

He will not prescribe antibiotics in a virosis and will not persist in a recommendation with linden tea or onion tea if the child has bacterial pneumonia.

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[7] Starmer AJ, Duby JC, Slaw KM, Edwards A, Leslie LK; Members of Vision of Pediatrics 2020 Task Force. Pediatrics in the year 2020 and beyond: preparing for plausible futures. Pediatrics. 2010;126(5):971–981pmid:20956424; Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012;172(18):1377–1385pmid:22911330; Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89(3):443–451

He will comfort, discuss, alleviate, will always be smiling and available, will hit the walls and tear them down, with the end goal to make happy a whole family. Because Pediatrics is a multi-structure, the pediatrician is not face to face with the small patient and is before at least one binomial (mother-child), and does this at least 30-40 times/day.

Without complaining, because it is the specialty he has chosen, with which he resonates and merges, which he would not change for no other. The pediatrician is often an exhausted doctor at the end of the day, a doctor who does not keep an eye during the shifts but, overall, is a Phoenix bird. It regenerates again and again with a childish smile, with each happy little hand waving at the end, with each "thank you"[8].

The pediatrician "grows up" with each of his patients, becomes the friend of the little ones, knows their preferences, behavior, knows their toys, knows what Santa has brought them, how old they are, notices a new dress or shiny shoes. He knows the cartoons; talk naturally about "Doc McStuffins", "Masha and the Bear" or "The Kingdom of Ice". He knows the Disney princesses and the scientific name of dinosaurs, discusses naturally about, cars, Lego games, kendama.

And yet, in Romania, at present, in the absence of legislation that defends the professional integrity of the doctors, the pediatrician is tired, besmirched, cramped by the wrongly perceived roller who belongs to the civilization.

The pediatrician does not see hospitals, only patients who have real problems. Most of the time, the cases you see are not emergencies. They sound like this: "coughing for a month", "some snoring", "apparently having a fever 3 days ago", adequate and standardized health insurance in terms of complexity of services, anyone has direct access to the hospital pediatrician. Family doctors are avoided (who, unfortunately, sometimes verbally, without attached documents send children to the hospital), outpatient medicine is short-circuited and all patients come to the emergency rooms.

There are, on average, 50-60 presentations, of which 8-10% represent real emergencies, the rest are trivial conditions that can be solved very easily in the outpatient setting. But the pediatrician must treat everyone equally, he takes the anamnesis and the complete objective examination of each one, in order to "sift" the real emergencies and intervene quickly[9]. He explains to nervous parents why, if they came at 9:00 with a 15-year-old child for a sore throat, they can wait 3-4 hours because they are not seen in the order of their arrival, because there is no "tail" at the candy store, but the real emergencies, established by the nurses which have priority. Respiratory failure, high fever, convulsions, severe dehydration will always be a priority for the older child. The pediatrician makes slalom during 24-hour shifts between the patients presented in the hospital, the hospital discharge of the respective day, which he also writes (on the medical papers, type into the computer, gives compensated prescriptions, establishes feeding schemes, follow-up, check-up), the cases admitted, he sees the hospitalized patients, modifies treatments, monitors[10].

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[8] Dyrbye LN, Varkey P, Boone SL, Satele DV, Sloan JA, Shanafelt TD. Physician satisfaction and burnout at different career stages. Mayo Clin Proc. 2013;88(12):1358–1367pmid:24290109; Fahrenkopf AM, Sectish TC, Barger LK, et al. Rates of medication errors among depressed and burnt out residents: prospective cohort study. BMJ. 2008;336:488–491

[9] Schwingshackl A. The fallacy of chasing after work-life balance. Front Pediatr. March 2014;2:26pmid:24745004; Medical Group Management Association. Physician Compensation and Production Report: Based on 2014 Survey Data. Englewood, CO: Glacier Publishing Services, Inc; 2015

[10] Linzer M, Konrad TR, Douglas J, et al. Managed care, time pressure, and physician job satisfaction: results from the physician worklife study. J Gen Intern Med. 2000;15(7):441–450pmid:10940129; Scheurer D, McKean S, Miller J, Wetterneck T. U.S. physician satisfaction: a systematic review. J Hosp Med. 2009;4(9):560–568pmid:20013859

It is a kind of advanced yogi who channels all his energy to think efficiently and find solutions to everything.

On leaving the shift, he goes home with the entire negative burden and faces the same problems as any ordinary man: he washes, cooks, goes shopping, participate at school meetings with the parents, reads medical literature and improves medical knowledge always because it is always a new day and a new beginning[11].

For example, a monitoring was attempted, for a period of 1 year of the patients present at the urgency room, in the so-called "emergency" regime.

If a few years ago there was a considerable difference between consultations, in certain seasons (summer, winter), with a clear predominance in the cold season, in recent years, there is no visible difference. The admission criterion was considered selective for the real emergencies.

Thus the presentations were, on calendar months: January - 1267, February -1165, March - 1004, April-998, May-1015, June-859, July-964, August-1003, September-992, October-1261, November - 1181, December-1359, and the hospitalizations showed as follows: January-151, February -162, March-93, April 98, May-91, June-102, July-115, August-131, September-99, October-203, November-261, December-188. (Fig 1,2)

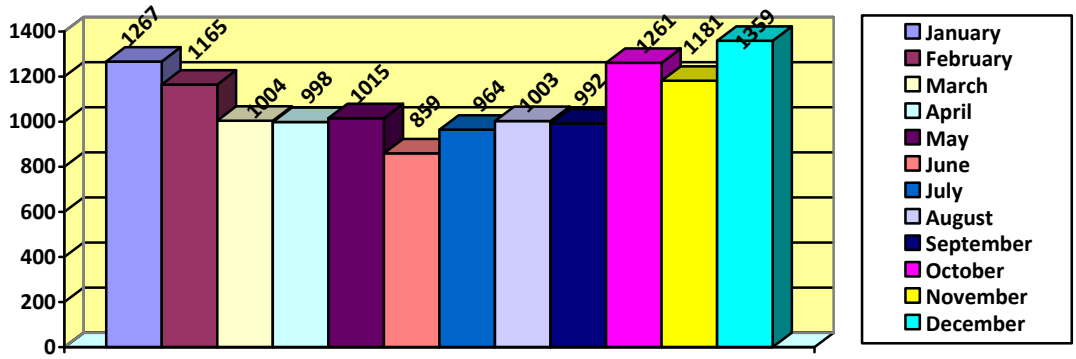

Fig 1 The annual presentation

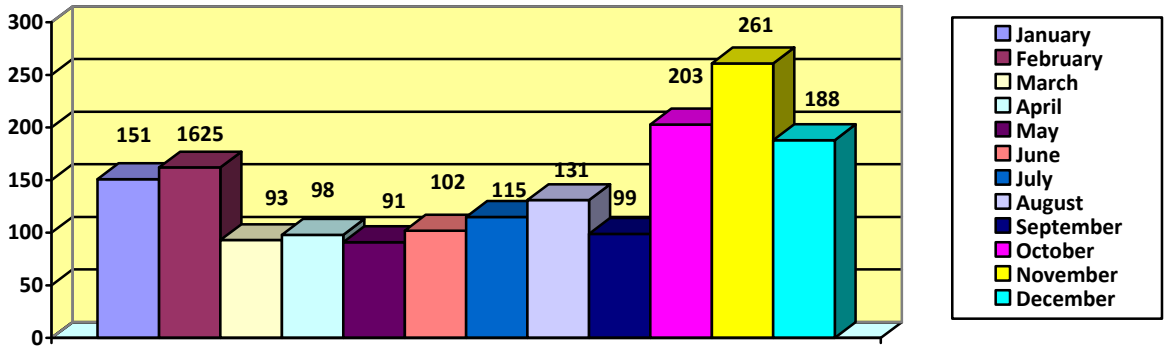

Fig 2 The annual hospitalizations

[11] Conners G; Committee on Pediatric Emergency Medicine. Pediatric care recommendations for freestanding urgent care facilities. Pediatrics. 2014;133(5):950–953

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The cumulative percentage for the veracity of emergencies was, on a calendar year 1.96%.

Excluding patients with chronic conditions who came for evaluation (ex bronchial asthma) who were 76 during that year remains a percentage of 12.58% emergencies in a whole year.

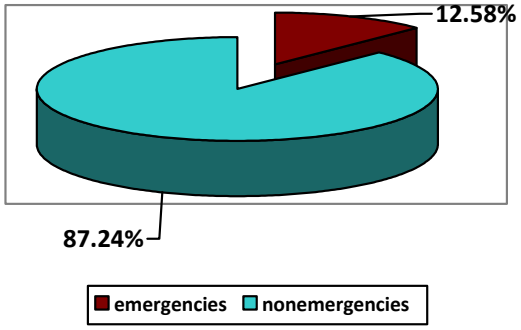

Fig 3 The percentage of emergencies

And then, burnout syndrome and emotional exhaustion in the workplace are realities of the pediatric profession.

So what is to be done in the context of the realities we face (population without minimal medical education, arrogance, exhausting shifts, continuous improvement, etc.)?

First and foremost, measures are needed to protect the doctor and the patient. A pediatrician, who sees in some shifts over 70 patients, cares for a whole section of hospitalized patients, writes medical records, epicrisis, prescriptions, medical letters, etc., can easily make errors, due to extreme fatigue. And yet it is not wrong because he was self-educated to be a robot, he does not eat, he does not sleep, he does not sit down for a whole day. He no longer belongs to himself but to others.

Legislative measures are just as imperative as health education that should be introduced early in school and learned with the alphabet.

Access to the pediatrician should be allowed after the patient has taken the primary medicine and direct presentation should be reserved for certain cases (severe with potential aggravation, chronic illness, performing complex analyzes - following a recommendation from the family doctor or other specialist).

Health insurance should target the entire population of a country. According to the model of the developed countries (Switzerland, Germany, etc.), insurance must be paid for any child differentiated according to the family's possibilities, from the minimal variant comprising a limited number of complementary investigations, to the complex variant, which includes access to the latest technology - CT , MRI, etc.

The offense of medical professionals, regardless of their specialty, must be punished.

The patient should go to the pediatrician informed and ready to pay for an outpatient consultation, if, following the consultation, it is not an emergency.

The doctors' hours during their shifts are included in retirement period, offering them additional protection and the reserve of assuming retirement earlier than the age limit.

In conclusion, there is much to be said and done. Currently, the burnout syndrome of the pediatric doctor in Romania is underdiagnosed and completely untreated or unforeseen.

In conclusion, what is it like to be a pediatrician now in Romania?

Beautiful. Exciting. Pioneering work. Resistance in the fight against bad manners. Satisfactorily.

Being a pediatrician in our country now is like a faint smile on a cheek flooded with tears. Only a rainbow.

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