

## A look at the psychodynamics of 'being on-call'

MARK G. A. MORRIS, Psychiatric Registrar, Woodilee Hospital, Lenzie, Glasgow G66

Experience of being resident on-call is common to all practitioners who have worked through the training grades. Other professions have their lean years while in training, for example the apprentice years in the law profession or the junior financial executive's commitment to his company, but being resident on-call in a place of work, ready to deal with any emergency for a significant fraction of one's waking and sleeping life, is peculiar to the junior grades in the medical profession. Judging by the opinions expressed by my colleagues, all registered practitioners are united in having experience of being on-call and finding it to some extent irksome. Part of the problem lies in having to do long periods of overtime for reduced rates of pay, often in dilapidated surroundings when one could be more enjoyably occupied elsewhere. Most people decide that the benefits of serving the prescribed training period in the junior grades to become vocationally trained general practitioners or members of one of the Royal Colleges outweighs the short-term discomfort. In this paper I examine the experience of 'being on-call', working through the different aspects. I argue that the irksomeness of the experience may derive in part from the echoing of unconscious conflicts.

It seems that the on-call experience arouses more anxiety than one might care to admit. This anxiety is presumably repressed, but it resurfaces in various guises and games played in the planning and preparation for a period of duty. For example, my colleagues are easy-going and it is unusual for voices to be raised at even the most controversial clinical meeting but where the on-call rota is discussed there is a certain tension. There is no crime so great as trying to shirk one's fair share and yet it seems as if secretly everybody wishes to do just that. Trainees can 'forget' that it is their duty night, and come to work without an overnight bag, perhaps dealing with the anxiety by denying the forthcoming duty till the last moment. Demands for improvements in the on-call accommodation are common, as if living in the most palatial surroundings would make 'being on-call' pleasant and relaxing.

The start of an on-call period resident in the hospital means leaving one's family and home. The 'good things' of family life – partner, children, comfortable home and belongings – if lost, even temporarily, may echo conflicts of the oral stage of ego development (Freud, 1977; Rycroft, 1972). There was recently intense interest among trainees in a new vending machine in the hospital dispensing chocolate and

confectionary; one trainee described on-call as 'transformed' following its installation. At the beginning of a weekend, the sight of a junior doctor struggling in with enough groceries to last a month is a familiar sight. Take-away food is popular; on-call kitchens commonly have a pile of foil containers waiting to be disposed of. It could be argued that the loss of sublimated sources of oral satisfaction (the 'good things' of family life) to take up residence on-call may cause regression to the earlier stage of eating for comfort, explaining the fascination with food. The glossy magazines and paper-backs of vacuous content in on-call rooms may be partially sublimated oral substitutes, being bought 'as a treat' rather than for the doctors' edification.

While on-call, the doctor is under the control of the hospital. When his page goes he will have to answer it and deal with the problem, day or night, in the bath or having a meal; nothing he does is immune from possible interruption. This considerable limitation of one's freedom is irritating, and rage may unconsciously be developed. One avenue for dissipation is at the source of the interruption; often members of the nursing staff, and the doctor's non-verbals (and in some cases, verbals) will leave them in no doubt if he feels that a call is unjustified. Nursing staff seem well aware of the possibility of the on-call doctor being less than civil when disturbed, and some may be surprised to know that there is a debate in the ward before the doctor is called when the severity of the problem is weighed against his likely reaction. Rage also finds vent in the doctors' common room the next day, when the duty is assessed in terms of the amount of 'rubbish' one has had to deal with. This restriction of the doctor's freedom may echo the experience of the omnipotent infant when his parents began to impose their control over his actions. Freud's anal stage, "... seen when a baby obstinately refuses to empty his bowels when he is put on the pot ..." (Freud, 1977), is seen by Erikson as a conflict between the child's "autonomy versus shame and doubt" (Erikson, 1965). When called, the doctor is faced with the choice of either answering against his wishes; or exercising his autonomy and withholding his attention, when he may doubt the advisability of his action and worry about its possible consequences.

Having been called, the doctor is required to make clinical decisions. Management decisions made in the heat of the moment by the trainee using his fledgling clinical skills are considered in the cold light of the

next day by his senior colleagues. The nursing staff are well versed in the clinical practices and foibles of the latter, and part of the patient's emergency assessment seems to be to find out which consultant will be responsible for his care in order to avoid any form of management that he might consider inappropriate. If the developing clinical skill and competence of a junior doctor is seen as similar to the emerging sexual potency of a child, then 'cutting remarks' about inappropriate emergency treatment may represent a symbolic castration, echoing oedipal conflicts and castration anxiety (Freud, 1977). A second oedipal anxiety is that the infant's tiny organ will be insufficient to meet the fantasised sexual needs of his mother; perhaps this is reflected in the anxiety that an emergency will arise while 'on-call' that will be too difficult to manage, and to the doctor's chagrin, will overwhelm his clinical skills.

Being on-call can, of course, be stressful and exhausting, when one is 'busy' or when continuous hard work extends for days without respite. It is then that the on-call doctor decides that all his problems are the fault of GPs for inappropriate referrals or for leaving real pathology unattended too long. Or that the 'real problem' lies in the hospital management, the nursing staff or indeed any other group that does not include him. When practising GPs work in the acute hospital setting, they are much more understanding of the problems that face those working in primary care when deciding whether or not a patient requires an emergency hospital referral. "But as for deputising doctors . . .". The spectacle of a student nurse dashing about during an emergency resuscitation having been severely chided for forgetting some trivial instrument is a good example of projection in a situation of stress. The experience of being 'stretched' or 'at the end of one's tether' may echo the anxiety of the primitive ego of disintegration, which is dealt with by projection into a 'bad object' – the so-

called Paranoid-Schizoid position (Segal, 1981). The doctor unconsciously divides the hospital into two groups, say, doctors and nurses, then projects all the 'badness', onto the latter. If he is really lucky, the nurses will identify with the projection, and start apologising! While staff groups are able to protect themselves from these 'bad' projections, patients are not. A common group to be scapegoated is the acute medical situation are people who have overdosed or have alcohol-related problems; they demand much time and effort of busy staff, and yet their pathology is to some extent 'self inflicted'. Sadly, it may be that these are the most likely groups to identify with the doctor's projections, acting them out with further self-destructive behaviour.

I have argued that some of the anxiety aroused by the experience of being resident on-call may be caused by the echoing of unconscious conflicts encountered by the developing ego; leaving home, being called and making management decisions reflecting Freud's oral, anal and phallic stages respectively. I have suggested ways that these and primitive splitting and projection may affect the doctor's relationships with his colleagues and even his patients. Perhaps one way of guarding against these problems is to reduce the junior doctor's hours, but another is to remember the adage "physician, heal thyself" with the addition "and give due attention to thine unconscious conflicts while on-call".

### References

- ERIKSON, E. A. (1965) *Childhood and Society* (second edition). Harmondsworth: Penguin. pp. 239–266.  
 FREUD, S. (1977) *On Sexuality*. Harmondsworth: Penguin. pp. 33–169, and pp. 315–322.  
 RYECROFT, C. (1972) *A Critical Dictionary of Psychoanalysis*. Harmondsworth: Penguin. p. 109.  
 SEGAL, H. (1981) *Melanie Klein*. Harmondsworth: Penguin. pp. 113–124.

---

## Dr Inayat Khan

Dr Inayat Khan, Chief Medical Officer at the Psychotropic and Narcotic Drugs Unit at WHO, and Fellow of the College, retired early this year. He worked for nearly 20 years at WHO serving the international community by providing an unbiased opinion on the public health and social problems associated with the use of dependence-producing psychoactive drugs, on the one hand, and their therapeutic usefulness on the other. He also worked to

promote the rational use of these drugs, once they were registered and available for use. Over the years he visited many countries round the world to stimulate interest in the field, and will be greatly missed by the scientists, clinicians, and administrators with whom he worked. He will continue to live in Switzerland and we wish him happiness in his retirement.