The Night Shift

by

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"Night shift doesn't start till 5 pm."

The RMO assigned to mother us looks at us with a look that is both annoyed and amused. We're lying of course, she knows we're lying, and we know that she knows we're lying. But in the pyramid of healthcare workers, we are in the lowest most tier. The most useless of the useless, medical students, so our presence here is a mere performance.

"You were supposed to report at 3."

"Ma'am Pakistan's 3 is at 5."

A smile manages to breakthrough her stern face, "Stop loitering and get to work".

Work.

Standing in the dimly lit corridors of Gynae and Obstetrics Surgical Unit, with our backpacks full of emergency snacks, water bottles, bug sprays, and power banks with scarcely a pair of Steth & B.P apparatus between us, we know and play well the role assigned to us. The doctors with their obscenely long list of responsibilities won't have time to explain or show anything useful to us, so we will be expected to do 'scut' work. Work that can be demonstrated via the age-old monkey see monkey do method.

We approach the doctor's room to unload our luggage and quickly layout our steps for the shift. Jim Rohn, commonly known as a famous American motivational speaker, and less commonly known as the patron saint of medical students on night shifts once said, "If you don't design your own life plan, chances are you'll fall into someone else's plan. And guess what they have planned for you? Not much."

And so, it is in the light of his wise words, my friends and I vow to not step in the labor room come what may to avoid any screaming, violent, angry doctors. But the guardian angel that looks after brainless medical students must have taken the night off, for just in that moment, a resident doctor spots us hovering near the cockroach infested closet and immediately in a terrifying, yet remarkable, voice screams at us to take vitals.

Vitals.
Yes.
Body temperature.
Blood Pressure.
Pulse Rate.
Respiratory Rate.
And Oxygen saturation.

Seems simple enough, when you only have to go through the ordeal once.

But we know when she screams at us to take "vitals," she means not of one patient or two or three. She means of the entire ward, a sum of probably fifty and increasing women, most of who are actively in labor so have unstable numbers that will have to be taken three to five times for a reliable evaluation.

Now, admittedly, we are all too broke and miserly to invest in an automatic B.P apparatus, or even in a stethoscope that would give us a clear listen to the mild pulsations in a patient's Brachial artery. That paired with the general volume of the ward what with its screaming babies, mothers and doctors, makes it near impossible to tell exactly when you stop and restart hearing the pulsations without a fair bit of delusion.

A fair bit of delusion, I've realized, is required a lot in medicine. For example, when a senior doctor palpates a patient's abdomen and tells you that they have splenomegaly (enlarged spleen) and then you too palpate the same region and convince yourself that

1. I can feel the spleen
2. I have never palpated a normal one, but this is definitely bigger

To be very just, we should have no problem in doing something as painstakingly time consuming as taking over a hundred vitals. But we have a couple of reasons to be as defiant as we are. The number one being that we do not get paid.

Every other person in this ward at this godforsaken hour is being paid to be here. This is their job. They have a purpose, a reason and a significant role to play. We on the other hand are unpaid laborers doing parts of their jobs that they don't want to do themselves.

Secondly, they have studied and passed all the exams they need to and don't have any incredible academic stress weighing down on them.

All this time that we waste haunting the walls of this traumatized institution can be better spent reading a book or watching a video lecture. Not to mention, staying up all night inadvertently leads to us missing our morning lectures and clinical rotation the next day.

And three, no one should be asked to teach us on top of their already ridiculously long list of responsibilities. So as much as we hate the cranky, unfeeling doctor who is assigned as our supervisor, we know we are an added burden being thrust upon them unfairly.

Speaking of whom, as soon as the resident doctor is done yelling, my friends and I leave the ward and head to the O.T area where our mother is, no vitals taken.

If you've ever undergone a surgical procedure and accidently woken up because anesthesia didn't do such a great job at knocking you out, you might have seen a lineup of vivid, multi-colored children loitering at the side of the operation room like power rangers or more accurately, the Teletubbies. In case you have, that's us! Sorry for our attire and our general existence. We do not know what to do or how to behave or what we are even seeing most of the time.

I recall a couple of weeks ago in a different ward, we witnessed a nephrectomy (removal of kidney), and after a senior surgeon had carefully walked us through the indications, steps, and post-op complications, we asked him, very stupidly, where said kidney was on the laparoscopic monitor screen. He was taken aback, and then silently pointed to the mushy mess the operating surgeon had been poking at for the past half hour.

Let me tell you, it looked NOTHING like a kidney (which is generally true for all the organs except the liver which is as glossy and spectacular in real life as it is in pictures). Anyway, after that humbling experience, the beauty of delusion in medicine was made even more clear. Pretending you know what you are looking at is key to pushing along.

I've assisted on a C-section before, the operating surgeon was a young woman, and she was nice enough to talk me through everything she was doing and even let me perform subcuticular stitches. But this day was not unfolding in the nicest of ways, so when the smell of the theatre (think burning flesh, blood, disinfectant and human insides), started to nauseate all of us, we headed back to the ward.

There, in the post-op room we hunted down a relatively stable conscious patient and asked her consent to take history.

History taking is generally fun. You get to find out the story behind a patient, all the arcs and plot twists that led them to being admitted in an underfunded, understaffed public hospital where the population of cats and rats far outnumbers the population of humans and where they are disturbed at 9 pm by a bunch of 20 something year olds to be asked unwanted questions.

Either way, they never refuse us. Probably because we are the only healthcare workers they meet who aren't on a time crunch, so we are more receptive to their tangents, side stories, complaints of evil doctors and nurses and general chatter. The patient I interviewed had a particularly interesting story.

Her first husband had died, after gifting her a lifelong STD and two children who died of it in their infancy. And now she was married to and had just given birth to the child of his brother, who was unemployed and generally frisky considering they had four children in under six years. This baby was born despite the woman being on contraceptives.

We could not determine whether the woman was tired or unhappy. And if she was unhappy, was it due to the unwanted child, her previous dead children, her dead husband, or the new alive one? Whatever it was, she did not talk to us after the first few questions and instead let her chirpy sister-in-law tell us the tale.

The histories my friends took were equally depressing and after what seemed like an hour, we crashed into an empty room to discuss them.

Usually, you can take 2 or even 3 histories in a row without feeling exhausted, but in gynae and obstetrics, the histories are so long and so detailed, that jotting down all the important information for even one tires you out.

We also have to account for all the time and energy it takes to communicate with the patients, since both parties speak poor Urdu. They, because most of the time they are from interior Sindh or Baluchistan, and us because of the post-colonial effects on our education system and society leading to us having a debilitating inferiority complex to the white man. So, it always takes us a while to communicate what exactly we want to ask, and for them to answer.

On top of that, in this ward we also have to inquire about the patient's sexual health and history. A generally taboo topic, it is even more awkward when broached by unmarried 'adult children' to a complete stranger.

If there is a word for coitus in Urdu, then I do not know it, but the extensively long, grammatically incorrect and incoherent sentences we use to ask about it could be repeated in a hit comedy sketch. At one point after inquiring about her pregnancy, my friend makes the grave mistake of asking the patient if she is married. The attendant and the patient don't stop laughing for a good 5 minutes.

"How can she have a kid without being wed," they laugh. We contemplate telling them how but decide otherwise.

In the empty room as we discuss our patients, the same resident doctor who yelled at us earlier, barges in with a very pregnant woman at her heel, and asks us if we know how to perform a CTG.

A CTG or cardiotocography is used during pregnancy to monitor fetal heart rate and uterine contractions. We all shake our heads, and she quickly ushers the patient to an empty stretcher in the corner and asks her to lie down with her belly exposed. Squirting a blob of ultrasound gel, she picks up the mouse and rubs it around in circles on her abdomen. The CTG monitor, that is probably the model that came out the year dinosaurs were walking the Earth, displays the heartbeat of the fetus inside. Once the size of the graph is formidable enough, she snaps a photo on her phone and asks the patient to get up.

"Thats how it's done," she says, and then asks me to note down her phone number and send the rest of the CTGs to her on WhatsApp.

We decide ourselves that this is probably a 2-person job, and so a friend and I stay back while the rest leave. We awkwardly ask the next patient to lie down and expose her belly, and then mimicking the doctor, squirt the gel and use the mouse to find her baby's heart.

But after a couple minutes of trying, we realize the monitor isn't really displaying anything new and the CTG of the previous patient is still on.

Thinking to refresh or insert a new page, I press random, unlabeled buttons on the machine to no avail. They just beep, show options I do not understand and change the volume of its blown speakers. After some more twiddling, we figure its best to call the doctor and ask but just in that moment, my friend finds the fetal heart and the monitor starts displaying a new set of squiggly lines.

I look over and sheepishly smile at the clearly suspicious and worried mother, "Sorry we are just students, this is our first time."

A timeless excuse really.

She is kind enough to smile back and then asks us if everything looks okay. Crazy thing to ask someone who couldn't even operate the machine 2 minutes ago.

In any other country or maybe even a better set-up, I could be sued for malpractice for what I say next, but in Pakistan, in a public hospital that is severely overburdened, I know that if I speak to her kindly, I will most likely be the only one to do so during her entire visit. So, I reply, "We are not sure since we are only students, the senior doctor will explain you the details, but from what we can guess, your baby has a good heartbeat."

That's all she needs to hear, she is happy.

I'm also happy. An easy enough guess since we do know normal fetal heart rates. At least she didn't ask us why a CTG is being done, what the yellow lights mean, what is going to happen to her next or literally anything else.

We perform a good 8 to 12 CTGs this way, just a mimicry of what the doctor had done with no thought to anything else about the procedure and once we are through with all the patients, we head out to catch some air.

None of the rooms in this wing of the hospital have air conditioning, which is brutal considering the physical strain the women here are in. It is stuffy and hot and reaches groundbreaking hell like conditions in the peak hours of June. Besides, everyone knows Karachi summers are just especially bad - the air traps heat and quickly becomes fatal for a normal, healthy individual. How these women are surviving in it is beyond my comprehension.

After a few moments of pause and relief, we decide to head out to Burns Road for dinner and inform mother that we will be back within two hours.

Karachi, being the middle child of cities, stays true to all stereotypes and is wide awake on our arrival. We enjoy chicken chatni rolls and makhni handi and pray to Saint Flagyl to save us in case of food poisoning.

The beauty of night shifts is how it gives us desi kids, who wouldn't be allowed on our rooftops past 11, a free pass to have a sleep over with our friends. As we chat away, our laughter numbs out all recollection of the gruesome images we were just exposed to. Heading back to the hospital is painful, like stepping out of dream sequence into the screeching reality of your alarm clock.

As soon as we step foot in the corridor, the dread washes over us so intensely that we immediately know that none of us are capable of enduring anything more. We attend one more C-section and do a couple more CTGs before we are once again begging our mother to let us go home.

She strictly says no. Our safety is her responsibility, but she lets us off for the night and so we head to the room that has been assigned for us.

The room, which in a different century must have been a seminar room, is now a dumping spot for broken equipment and old files no one bothered to sort and shred. The chairs are lined with dust and the table creaks every 2 minutes. We accept our fate and take our much-needed rest.

None of us will be able to sleep, that's for sure, so we pull out any card games we have and kill time. I take the coffee packet I brought from home and dump it into the chai from the hospital canteen. All my non-junkie friends look at

me with concern, but I know that without sufficient caffeine in my bloodstream, I will be the insufferable cousin at a sleepover.

At 1 a.m., the delirium starts to set in. My friend tells us a story of two tragic lovers brutally killed by a manic serial killer that slightly resembles the plot of a movie I once watched long ago. She ends the story by suggesting that the spirit of the dead lovers haunts the very room we occupy. Spooked by the weird air in the room, we convince ourselves that the rats that keep descending via the vents are in fact their ghosts and we take turns making scary noises and screaming in fear for the next few hours. In retrospect, nothing about the story or what followed was scary, but the shiver I felt in my spine and the clear descent of my heart into my stomach every time my friend looked at me weird was extremely real.

By 3 a.m., we hit full psychosis and are convinced there is a jinn pacing the halls outside given that the small window on the door has a shadow passing by on it every few minutes. Scared to death, we leap to open it each time only to find the hall completely empty.

What we do not realize is that right across our door, is the door of a washroom, its only demarcation being a faint outline with no handle or hinges. Dedicated on catching the jinn, a friend of mine squats by and waits to pop out the instant we see a shadow, and on doing so launches a screaming contest between us and the poor sleepy man coming out the washroom.

That is the end of jinn stories for us and the rest of the night passes in sharing non-spooky gossip and party games.

At 5 a.m., we go to the doctor's room to wake up mother and ask her to sign our attendance sheet so that we may be relieved. She does so in a blink and just like that we are free.

Heading home in a rickshaw, I realize how A24 film coded an empty Shahra-e-Faisal is, with its sleepily blinking orange streetlights, and lazy blue air, I already know what I will say once my real mother inquires how my night shift went.

Like anything.