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My night on call in Spain

The day starts at 8:00 h with a clinical session in the Respiratory Service of the Vall d'Hebron University Hospital, in Barcelona, Spain; from 8:00 to 9:00 h, a colleague discusses and explains to the rest of the department the most important articles published in the past month in his assigned respiratory journal. I run out at 8:55 h as I am about to start a respiratory outpatient clinic, where I will see 24 patients over the next few hours. Hopefully I'll have a break at 15:00 h so that I have the opportunity to have lunch and recover my energy to immerse myself in the evening–night shift.

The morning has passed without major incidents, except for the fact that I'm worried about a couple of patients I've seen: a 40-year-old man who is suffering from eosinophilic severe asthma that remains uncontrolled despite oral steroids and a 58-year-old woman with chronic hypersensitivity pneumonitis that I should submit to the lung transplantation programme. It is 15:50 h and in 10 minutes time I will receive the report on the 35 inpatients in the respiratory ward. The respiratory trainees are eager to see me appearing in the ward as it will give them the opportunity to try to finish their job and hopefully leave the hospital by 18:00–19:00 h. I've just arrived in the main corridor and the nurse supervisor asks: "Hi Iñigo, are you on call today? Get ready, you won't get bored!"

The residents report the medical history and the present situation of all the patients in the respiratory ward, which is divided into three teams. The general respiratory team reports on the patients under their care. They are particularly concerned about a 71-year-old man who is suffering from haemoptysis and who keeps bleeding despite regular measures. I should bear in mind that he might need an embolisation during my shift if things get worse. The residents also emphasise their concern about a patient who has been admitted from Mallorca due to a pulmonary proteinosis and who has undergone a total pulmonary lavage today and is feeling more breathlessness. I should keep an eye on him during the night. Afterwards, I receive the report on the patients in the ventilation unit, which includes 12 patients who suffer from chronic obstructive pulmonary disease (COPD) or neuromuscular diseases that are currently on non-invasive ventilation (NIV) or tracheostomy ventilation. The situation of a patient recently diagnosed with lateral amyotrophic sclerosis requires special attention since he suffered a respiratory arrest in the morning due to a mucus plug; the situation has been reversed successfully although he is very fragile. Last but not least, I receive the report from the third ward team in charge of the lung transplant patients. They all seem to be stable for the moment, although you can never trust this in these complex patients!

It is 16:40 h and I am already in charge of the respiratory unit of a hospital that covers a population of 450000 people. As soon as I have received the reports for the ward my pager rings! My colleagues in the emergency care unit require me to see a COPD patient who has been on home NIV and now requires acute NIV due to an exacerbation. They also want me to attend a patient who had left-lung transplantation in 2012 due to idiopathic pulmonary fibrosis and is now in the intensive care unit (ICU) due to breathlessness and hypoxaemia.

At 19:45 h pm I receive a phone call from a secondary hospital, which is located an hours journey away by car. They are attending a patient that is suffering from life-threatening haemoptysis and we are their referral centre for pulmonary embolisation when indicated. I listen to the past medical history and the present situation of the patient and I agree that embolisation should be the next step. I contact the on-call angioradiologist and the members of the ICU, since the on-call pulmonologist is in charge of managing the life-threatening haemoptysis.

Meanwhile I continue to resolve minor problems in the ward. The rest of the night shift goes by without other incidents. It is 01:50 h and I will try

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to sleep for a bit; if I'm lucky I'll be able to rest for several hours. My pager rings again, it is 04:40 h and I receive a call from the ICU. A 64-year-old man who was on invasive ventilation through a tracheostomy remains hypoxaemic despite high-dose oxygen and the thorax chest radiograph shows a left upper lobe atelectasis, probably due to thick secretions in the airway. They demand an urgent bronchoscopy to clean the airway and try to reverse the problem. For the next half an hour I do my best to aspire all the thick secretions that I find with the endoscopy. I return to bed. It is 7:30 h, the alarm clock wakes me up, I am about to hand over the respiratory ward. It is 8:00 h and the consultants and the trainees are back in the ward. They all kindly hear my explanations of the last news in the ward and wish me a good rest. I'm leaving the hospital after being on call in the Vall d'Hebron University Hospital Respiratory department.

Conflict of interest

None declared.