OOH: why can't we put own well-being first?

Dear editor,

Having followed the out-of-hours (OOH) debate with interest over the past few months, I feel it is time for me to comment.

I wholeheartedly agree with Nick Thomas (letters; July 6 issue). We can no longer be allowed to ignore the unpalatable fact that we, as vets, kill ourselves four times more often than the rest of the general population. I am rather fed up of the smokescreens that are often cited as reasons for the statistics, such as personality type, access to drugs and the performance of euthanasia leading to an acceptance of this form of death. Personality types who are perhaps more prone to suicidal thoughts exist across the whole population, not just among vets. It is the added pressure that vets are placed under that ultimately leads to the act of suicide. Regardless of whether we want to admit it, there is absolutely no doubt in my mind – from personal experience and through talking to colleagues – that long working hours (often without any breaks), coupled with high stress and responsibilities that lead to emotional exhaustion, are the root causes of suicide in our profession.

In response to G A Maxwell's comments (letters; June 8 issue), I certainly do not regard my farm and equine colleagues as second or third-class citizens; I have nothing but respect and admiration for the job they do. Opting out of their OOH is never likely to be an option, but for OOH cover to be sustainable, a humanistic rota is needed.

To say we are not giving younger vets enough experience of certain types of surgery by using OOH providers is not necessarily the case. In the past few months, my practice has had three splenectomies, one caesarean and one gastric dilatation, followed up by an elective gastropexy, and all presented within normal daytime hours. If vets gain enough surgical experience of any type, then they should be prepared for most emergency situations.

I take issue with Paul Atkinson's comments (letters; July 6 issue) that vets who work at dedicated OOH clinics have poor communication or clinical skills. I was responsible for running an OOH clinic for 18 months, and have now been a small animal partner in a respected veterinary practice for more than a year. I certainly do not regard myself as having poor clinical or communication skills. Indeed, while I was running the OOH clinic I believe we gave clients an excellent service that they were very grateful for. Many used us on regular occasions, because they knew we were awake and ready for them. The often stated argument that OOH clinics do not offer as good a service to clients because they have to travel to an unfamiliar building in the dark is, frankly, nonsense, and it panders to clients' unrealistic expectations at the expense of ourselves. Experience from the emergency clinic tells me that patience, reassurance, empathy and clear directions overcome clients' initial fears. They soon realise it is no different than going to the A and E department at their hospital or using the OOH GP service at a different building to their usual doctors' surgery. Some clients will still complain when their practice's favourite vet is not on call, and some will put considerable pressure on phone staff to contact that particular vet. Again, this is due to a totally unrealistic expectation that one vet should be available to them 24/7.

In 2009, the vast majority of small animal cases seen outside daytime hours in general practice were, unfortunately, not genuine emergencies. Instead, they were cases that we ended up seeing and dealing with for client convenience – often after several stressful phone conversations between the client and the practice. Practices also have the background fear of an RCVS complaint being made if they do not see a (non-emergency) case outside normal hours. All this achieves is to make vets work longer, more stressful hours than during the daytime.

We are not absolving our responsibilities after 5pm. In my practice, we all conscientiously look after our patients well beyond hours to provide clients with the best continuity of care; partners are always there to provide back up to the assistants. I would take issue with Mr Atkinson's suggestion that subscribing to an OOH provider should mean we drop our RCVS tier level, and that we somehow have less ethics and commitment. What we are actually doing is taking responsibility for our own health and well-being, and in doing so we are ensuring we are able to provide a better service to our clients, have happier vets and improve practice profitability.

Lastly, I would like us all to consider the following: we are forever talking about our responsibilities to our patients and clients, but what about our responsibilities to our loved ones? What do they think about the increased stress and pressure that being on call inevitably causes? I know for a fact that my supportive, but long-suffering partner – who works in the human health field – is looking forward to the day in a few months' time when we subscribe to an OOH provider.

Yours faithfully,

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