



2007 Ship Doc 2: Inside Passage to Alaska



By John Loofbourow, MD

In the previous issue, the author described a trip as ship's doctor on an icebreaker in the Antarctic. This time he heads north, on a much plusher cruise liner.

I USUALLY PREFER TO TRAVEL WITH some sort of connection to people and place; something that makes me, for a time, a participant. And I had never been to Alaska. So, after surviving the application process required by a large Alaska cruise ship line, I agreed to serve as ship physician to about 1,300 passengers on a two week round trip from Vancouver, British Columbia to Seward. A full-time Filipino physician would care for 650 crew members. We would be assisted, (or directed!), by two experienced full time nurses.

Vancouver is a collage of water, mountain, industry, and ordered British style residential areas. It's like a Seattle or Portland on the metric system, and with many more mosques. Arriving there the night before, at 6:30 the next morning I was picked up at my airport hotel and transported to the cruise ship passenger terminal at Granville Square, where big cruise ships tie up surrounded on three sides by Money: modern multistoried business, financial, and commercial buildings lining manicured central city streets.

As in the Vancouver airport, luggage carts in the huge ship passenger terminal are free. Hundreds of debarking passengers filed by in the opposite direction, but only crew on my side of the operation, so I gratefully passed with a few other crew members through the security screening, emigration and immigration barriers, up the gangway, and checked in with the ship's security officer.

After reviewing my tired documents for the third time that morning, he gave me a pass key, and I found my way to my 6th deck cabin. Leaving my gear there, I asked my way to the 2nd deck infirmary.

The ship interior was such a maze that I was lost much of the time, unsure which was port or starboard, forward or aft. But at last I found the infirmary, and met the outgoing physician, the nurses, and the crew doctor. The clinic was surprisingly spacious, consisting of four private patient rooms, a one-bed intensive care unit, X-Ray, a lab, substantial pharmacy medical supplies, associated offices, storage, bathrooms, a kitchen, and three cabins for full time medical staff.

Most of the on-board automated lab testing - cardiac enzymes, tox screens, chemistries, ETOH measurement, etc. - would be illegal in the U.S. because of oversight regulations or legislation. We tend to ban the good in favor of the perfect, greatly increasing the cost of medical care. On the other hand, a ship captain, and indirectly the medical staff, is free to exercise common sense and reason. My office had a small medical library, a computer with online access for browsing and email, printer, and an electronic desktop covered with a daunting array of memos and procedural documents. There was online access to E.pocrates, and several other medical electronic resources not familiar to me.

The debarking physician led me on a tour of the ship, and iterated the dress requirements: dark blue blazer and pants with white shirt and tie; a lab coat could be used in the clinic, a tuxedo or dark blue suit and tie for formal dinners. The ship physician is provided a voucher to buy drinks for passengers, and is requested, but not required, to socialize. Gambling and socializing in cabins is verboten.

The crew's weekly fire and lifeboat drill followed, and I completed several hours of environmental and emergency training programs required of crew, and returned to the infirmary to review emergency medical procedures with them.

The Crew

The entry level crew consists largely of young men and women from Indonesia and the Filipinas. They work very hard, especially in Vancouver and Seward, because the cruise begins and ends there. They must disembark 1,300 passengers, and take on a like number the same day. That implies at least 5,200 pieces of luggage on eight decks, to be taken to and from the dock.

They must clean and make up all the cabins, offload huge quantities of waste, and bring aboard even larger amounts of new supplies. At the same time, new passengers unfamiliar with the ship and its routines require patient responses to about 100,000 questions.

These youngsters were the life of the cruise. They were always animated, polite, and attentive. They put on nightly shows at dinner, with elaborate costumed ethnic dances, and shows in the ship theater. I naively assumed them to be people lost between two worlds, having left remote rustic villages, now forever changed by exposure to the wider world, so that they were essentially noble but homeless cruise ship migrants.

I was wrong. The average steward has studied English and tourism for several years in a non-village like Jakarta; has survived a competitive employment screening, and had 6-month training with the cruise line before starting a one year contract. Most return home to find other work in the tourist trade. Some become long time employees or rated maritime officers: Not the average unskilled migrant worker.

As the last passenger boards, we leave Vancouver in the late summer light for a night at sea, to awake in Ketchikan. On the second evening, again at sea, the officers, including the physician, are introduced to the new passengers officially, and the first formal dinner takes place. Each night there are two dinner seatings, and several show productions. An impressive array of optional activities is offered throughout the day and evening. There are two pools, a gymnasium, fitness classes, art classes, art auctions, a spa with amenities, a casino, shops, restaurants, bars, dance venues - so many things to do that I can't remember them all.

Physician duties include:

- Carrying a beeper for 24/7 on call. An exception is that while in port half the medical staff can be ashore by turns.
- Attending office (clinic) twice daily at 8-9 a.m. and 5-6 p.m.
- Completing the considerable paperwork required.



Passenger makeup was roughly 30 percent families with children; 45 percent couples of various age, often healthy retirees; 10 percent singles of all ages; and 15 percent people in delicate states of health, usually elderly. Of most concern to the physician are people with serious or complex illness who hope to make a last voyage on an elegant cruise ship before they leave this life.

This is not an exaggeration. The physician I replaced attended one death. The nurse who came aboard left a Hawaiian Islands cruise ship where three people died. I was fortunate, though I preventively debarked anyone who gave off a

whiff of sudden death, or was likely to have an event beyond our capabilities - like the suspect deep vein thrombosis who, once ashore, was MRI-morphed into an embarrassingly minor ruptured baker's cyst. I was only called out at night twice in 14 days, for people with chest pain; and even then, was back asleep in a few hours while the full time staff ran the unit.

By current U.S. standards, most typical myocardial infarcts would receive on board clot dissolution therapy, because timely transfer to an appropriate facility is not possible. Exceptions include cases where the event occurred in port or in certain further evolved infarcts. I often made cabin phone calls or visits to check on ongoing problems like a nasty brown recluse spider bite of the foot and an infected leg laceration. There was no norovirus epidemic though I obediently quarantined a couple of suspects, according to protocol, knowing that had it been the real thing it wouldn't have mattered because the virus is so highly infectious. Neither was there a respiratory infection run. The ship was rife with hand sterilizing gel. Perhaps it was effective.



The Paperwork

Medical records were hand written, extent and overall detail at the discretion of the physician. The cruise company provides \$1 million malpractice insurance; even though that seems marginal, maritime law is a different tort environment than that in the U. S.

So is the billing procedure. The cruise company itself charges for all medical care, excepting injury sustained aboard, which is free of cost. A passenger's credit card is billed, and a detailed receipt is provided on the spot so passengers can later collect from their own insurance, or trip insurance. It seemed to me that charges for office visits, medications, and treatment for minor illness or injury were reasonable compared to California, while charges for intensive or step-down type care were comparably miniscule. Physician pay is nominal, but a spouse and or child in the same cabin are without cost, except for optional extras like body repair in the spa, shopping, side trips, etc.

I would not hesitate to recommend that experienced emergency department colleagues try working the Inland Passage cruise to Alaska. It is stunningly beautiful, particularly in the spring, when the mountains are still dressed for winter. The springtime sea is quickening with life, and is usually well-behaved, sheltered by the off shore islands. Cruise ships often dock directly along the main streets of picturesque Alaskan towns like the capital, Juneau.

While side trips are many and varied, I met an elderly European expatriate from Vancouver who does a tour about three times yearly just because he likes the cruise life. He doesn't go ashore at all. The industry - that is certainly what it is! - has been very successful in part because of our continent's north coast physical features, but also because the large ship trips are relatively reasonable. It costs from \$100 to \$200 per day to be pampered and paraded in luxury among scenery that otherwise would extract a considerable physical and economic toll on the traveler. In my advancing old age, I might go as a passenger, free to lose sleep at the poker table instead of the infirmary.

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