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Welcome to My World . . . or Some Loose Approximation Thereof

Is hospital medicine a bona fide specialty? Do something long enough, and as Justice Potter Stewart said when defining a certain taboo carnal subject many years ago, ''I know it when I see it.'' Although working groups may struggle to conceive a master set of core competencies for hospitalists, I will tell you this: no texts are needed, and you know that you are on to something when 2 hospitalists practicing 3000 miles apart shoot each other a knowing glance and, without words, ''just understand'' what the other is thinking. After 10 years of practice in several hospitals, I have had enough mind melds to last a lifetime. Who needs science after all? I mean, how many of us can keep a straight face when asked if we have ever heard this line: ''Ah, yes, Dr. Flansbaum, umm, I am Dr. Smith from the surgical ICU, and we have a patient hospital day 34 status post Whipple that is no longer surgically active. . . .'' See, you are smiling already. Do I have to finish the sentence for you?

What follows is a collective experience of things that I call the grind: things so small, so inconsequential, that no one will ever cite them individually as the deal breakers of the day. Collectively, they are the fabric of who we are and that little sore on the inside of our cheek that we just have to touch every few minutes in order to remind ourselves of why dermatologists always look so happy. Any accompanying sage lessons are also free of charge.

1. Why at the end of the day, always on a weekend after you have found a comfortable seat as far away from the nurse's station as possible, do you open up the chart and see 1 line of open space left on the last page of the progress notepaper? Even better, why is the note above it a follow-up from vascular surgery, written in font size 24, in a form of Sanskrit that not even Steven Hawkings would recognize?
2. Okay, how about this: For patients with loooong lengths of stay, how many creative ways can you write ''Awaiting placement, afebrile, no complaints (in compliance with billing rules of course)?'' The correct answer is between 16 and 23. A thesaurus helps for word number 1—try ''stable'' to start—and change your pen from fine point to medium point on odd days. Then add ''tolerated breakfast'' on Monday, ''lunch'' on Tuesday, and ''dinner'' on Wednesday. Voila! Who said this was tough?
3. Okay, this one boggles my mind. You wish to auscultate a set of lungs. The patient is sitting on his gown. You attempt to lift the gown, and instead of raising his tush, the patient continues to sit

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while you tug away. Is this just me? It happens every week.

4. The medical students are great. They are ambitious and make teaching fun. Why though, at 9:59 AM, with an upcoming meeting with your chief at 10, are there no PC terminals at the station available ... except for the MSIII on MySpace.com with the chart you could not find (for 5 minutes) underneath his clipboard? Yes, Virginia, make me remember those days.
5. Clearly, this is one of the more helpful lines you can get from a consult: "Patient needs to be medically optimized, and consider head MRI." Consider? Is not that why I called the consult in the first place? Let us consider not to use the word "consider" any more. Consider that. I feel better.
6. While we are on the topic of consultants, a dollar goes to you if this has never happened during your time on the wards: (1) the consultant visits, (2) the consultant evaluates, (3) you speak with the consultant, (4) all of you agree that the patient can go home, and (5) you then read the consult after the patient is dressed and his IV is out. Umm, a head CT before discharge and please have the neurosurgery clear the patient before discharge? Am I working in a parallel universe? Too much caffeine? Lord, give me strength.
7. Your beeper goes off at 2:57 PM. At 2:57 PM plus 5 seconds, you call the number you were paged from ... and no one answers. Does the word "ponderous" come to mind? This invariably happens every day, of course, typically when I am in the midst of multitasking 4 conversations. However, I extract some form of perverse cosmic revenge when I need to make a call and pick up an "open" extension from a ringing multiline phone. Invariably, I click the button to engage a line and, oops, good bye caller. I am only kidding; that never happens (is my nose really growing?). Just think, I could have been the one screaming, "Is Laverne here?"
8. You get an admission, a patient whom you have never met, and his room is listed as 428. You walk in, and the patient nearest to you is a well-groomed middle-age individual with a welcoming smile. The patient next to him is breathing fire, screaming at an imaginary executioner, and claiming that you are the guilty party and need to die. Which patient do you think is yours?
9. Those of you who work with housestaff will appreciate this one (file it under "systems issue: fix next week"): You have a discussion with a patient regarding his PM discharge at 11 AM. You arrange the follow-up, you review the new medications, you discuss who will pick him up after dinner, and so forth. You get that warm and fuzzy feeling that you have done your job and all is right in the universe. Naturally, you also tell the resident that the patient can go home. Lo and behold, you look at your census the following morning, and the name of the aforementioned patient radiates like a beacon from the screen. You then poke your head into the room, feeling assured that it is merely an error, and the aforementioned patient is lying in bed, smiling and happy to see you. You ask, "What happened?" The reply, "I don't know." "Didn't your son come last night to pick you up?" The response is "yes." After the penetrating ulcer in your stomach bores a little deeper, you discover the "official" discharge order did not occur, and the patient was content eating chipped beef and sleeping on said "contoured" mattress 1 more night. Serenity now, serenity now.
10. The fifth vital sign? Is that the new black? Heck, number 5, I think we are up to 11 or 12 these days. Need a new metric installed? You guessed it: add it to the list!
11. Do you ever get LOS fatigue with a particular patient that is so severe you go to bed the previous night and have problems falling asleep? Really, what do you say to a person when his hospital stay exceeds, say, 5 months? Yes, I actually think of topics and issues that I can incorporate into the conversation which will spice up the relationship. New bed sheets, a fresh coat of paint? It would make a good Seinfeld episode, no?
12. Is it me, or is having 2 patients in the same room like being a flight attendant wheeling around the beverage cart? Get one the peanuts, and then the other wants the pretzels. For sure, add 10 minutes to your time in room 728 tomorrow.
13. If a patient is unable to leave the hospital for reasons unrelated to discharge planning (locked out of his house, the child is out of town until the next morning, etc.), why do I feel so naughty when I get off the phone with the MCO medical director after offering explanations? I do not get it. You think that the hospital employs a battery of runners to padlock homes and steal patient's clothing. Who wrote this playbook?
14. I love my consultants. Really, I do. I am not picking on them today. The high points of my day are the exchanges that I have with my subspecialty colleagues. However, the myopia that per-

vades some "sign off" notes give me pause. For example, a patient admitted for gastrointestinal bleed, s/p EGD, and stable at 72 hours post arrival receives a consultant note as follows: "if patient eating and ambulating, can be discharged home as per PMD." Surely, when the level of transferred oversight shifts to the level of caloric ingestion and sneaker use, well, let us just say that I am all for some new E&M codes. They did not tell me about this in hospitalist school.

15. Don't you love the feeling of your beeper going off, and 30 seconds after the first page, boom, it goes off again—both to the same extension? I mean really, I am a nice guy, but do you really want to rile me up this early in the morning?
16. The nurse pages you from 1 floor away—10 seconds from where you are standing. You recognize that number, you knew that it was coming, and for sure, waiting on the other end is that family member who hails from a foreboding place. How quickly does your brain do the computation—do I use the phone and let my fingers do the talking, or make that stroll and have that face-to-face summit? No sarcastic comment is needed. I see us now, hands joined, joyfully singing Kumbaya in a loving embrace.
17. "Gee, it is not busy today." Say that on the wards and you get a leering glance. However, say that in the emergency room and you will meet your death. There is something about that phrase and the emergency department. The nurses there do not forget, although a Starbucks cappuccino does put a nice salve on the wound.
18. On your day off, do you ever notice that your beeper vibrates on your belt . . . and you are not wearing it? I am not kidding.
19. An irony of life: I have developed an immunity to cigarette smoke in hospital bathrooms. Why is that? It is like peanut butter and jelly. They just seem so happy together.
20. Do you want to transfer that patient to psychiatry? No, no, no, you silly hospitalist—did you not notice that abnormal BUN and atypical lymphocyte on the peripheral smear? Hey, Dr. Freud, can you write me for some of that Prozac too!
21. We need to consult a rulebook on chair ownership. Did you ever notice (a tinge of Andy Rooney here) that case managers "own" their seats? I know that the world is not quite right when a case manager shoots me that dastardly glare, as if to say, "Flee, you silly physician, I live at this station, you are merely my guest!" As far as that chair is concerned, perhaps if a small plaque is added to the backrest with a suitable donation, my legs will finally get their deserved daily rest.
22. Finally, do you want to become invisible? Go to the reading board and stand behind a radiologist at 10:30 AM. Do it long enough, and after a few days, you will be saying "*I'm Good Enough, I'm Smart Enough, and Doggone It, People Like Me!*" Do you want to disappear completely? Try it on a Friday.

Okay, okay, I will stop there. It is funny, though; this stuff really happens. Despite the aggravation, I see these commonalities as the glue that binds us, assists in building the esprit de corps in our profession, and adds a little levity to the work place. Outside the hospital (not inside, of course), I can confidently state that these routines are part of who I am. After all, it is all about the "knowing glance" that I mentioned previously. The humorous part is that we are certainly on someone else's list. Probably a nurse, an emergency room doctor, or maybe a physician's assistant is scribing away at this minute, and we are number 7: "Those hospitalists really tick me off . . .."

EPILOGUE

Note to self—look in the mirror occasionally; you might learn something.

I apologize to all my nonhospitalist colleagues if you sneered. I love all of you. Today.

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