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HANDOFFS

A Grumpy Old Man

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Ms Chen acutely worse, altered, please assist, room 522—Beth, chirped my pager. Ever increasing time pressures meant that hospitalists were supervising rounds almost daily. I had sent my resident, Beth, and the rest of the team to round separately that day, to foster their independence. It looked like we would be meeting ahead of schedule.

I'd received a similar page 2 years earlier when I was a junior resident myself. From the beginning of internship, our faculty never hesitated to challenge us. I will never forget when one of the hospitalists who had just come across an unresponsive patient tapped me on the shoulder and casually asked, "Hey, you wanna run a code?" and will never forget my inadequacy or the specific assistance I required in those tense few minutes. He, and the ICU team that arrived, gave me every chance to lead, and supported me each time I hesitated.

In similar fashion, I had sent my intern, David, to admit a patient with suspected CHF. I received his urgent update shortly after our patient arrived on the cardiology floor: *Mr Johnson dropping sats, please help, room 207*. I jogged to the patient's room, where I found David, 3 nurses, 2 medical students, and in the center, Mr Johnson: lethargic, gray, cachectic, and making no effort to rise from the 40 degree incline of his hospital bed. Weak respirations fogged his non-rebreather mask about 28 times a minute.

David offered a quick report: "74-year-old male, CAD, hypertension, dementia … CHF exacerbation … hypertensive to 190. I think he needs IV nitroglycerin and another 80 of lasix."

I was pleased to hear him commit to a diagnosis and plan, but after sitting Mr Johnson up for a quick exam, I couldn't agree. "Are you sure? He sounds more junky than crackly. Neck veins are flat."

"His EF is 25% and he's been here 3 times with CHF."

"Well, that won't protect him from anything else." Mr Johnson slumped forward, accessory muscles firing weakly, and only half-opened his eyes to a loud command and vigorous shake. "Well, let's get the diagnosis later, what does he need, now?"

"Well, the lasix and the nitro …"

"Assuming this *is* CHF, looking at him now, will that work fast enough to prevent intubation?" David shook his head no. "He's full code, right? Let's just call a code before he gets any worse. Anyone disagree?" A nurse made the call, then guarded the door to turn away everyone but anesthesia and the MICU as they arrived.

"So what do you think it is?" David asked.

"This doesn't smell like failure. He's not anxious, he's more obtunded than dyspneic. He looks hypercarbic. He doesn't have COPD?"

"Nah, just vomiting, then weaker, more confused, restless."

"Maybe he aspirated. We'll see. So what do you want to have ready for anesthesia?"

"Um, meds. An IV. Chest X-ray ready."

"Good … they bring the meds … he's got an IV … how about we pull the bed from the wall and raise it up, get some suction ready, take the headboard off?" Nurses sprang into action.

"If he's hypercarbic, shouldn't we bag him?" David asked.

"Good point," I said. David took the mask from the bag of emergency gear from the wall and started to fit it on Mr Johnson. "It's a 2-person job, if you want to hold the mask—2 hands, good." A nurse began ventilations, and I added some cricoid pressure. "Keeps us from inflating his stomach."

Seconds later, anesthesia arrived, and David provided a concise, organized summary. Mr Johnson was intubated and whisked without incident to the MICU, where bronchoscopy extracted several mucus plugs. He was soon extubated, and later recovered from a delirium which began with promethazine for nausea. It was the last year before the 80-hour workweek regulations, and not once in the entire process—from admission, to emergency on the ward, to initial MICU management—did I or my fellow residents think to call an attending, although I'm sure we would have learned something, as I hadn't suspected a mucous plug. We weren't hiding anything. We were just taking care of our patient.

Two years later, it didn't seem odd that my junior resident called me for assistance with Ms Chen—initially. In room 522, much as I found Mr Johnson, I found Ms Chen: elderly, lethargic, gray, frail, laboring to breathe, rhythmically fogging a non-rebreather mask 30 times a minute, only half-opening her eyes to

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a vigorous shake. It was day 4 of her fifth hospitalization for bronchiectasis-related respiratory failure within 2 months.

"She just got a treatment but she still sounds awful," offered Beth. Indeed, Ms Chen's chest was gurgly and wheezy throughout. "We put her on a non-rebreather, but that hasn't helped."

I glanced at her monitor. "Sat's 99%. What was she before?"

"96%."

"So hypoxia isn't the problem—who's this?" I asked, as transportation staff arrived.

"Stat head CT for Chen," he replied.

"I'm sorry, she can't go off the floor right now. Thanks for coming," I apologized, and sent him away. "Beth, can you lay her flat or send her off the unit right now?"

"She's altered and I need to rule out stroke."

"Let's talk about that later." I did a quick neuro exam as I spoke: "Besides, she resists weak but equal; pupils and face symmetric—she's not focal. What's a more likely cause?"

"... Metabolic? We can repeat her morning labs ..."

"Will they be different? Why is she here? What's her exam telling you?"

Beth took in the scene before her, as Ms Chen struggled weakly to ventilate her lungs, and after a brief pause she had it worked out. "She's hypercarbic. She needs an ABG. You think she plugged?" She shook her head, and grasped Ms Chen's hand in her own. "But she really hates suctioning."

"Well, she's DNI, and without it, she could die." Beth agreed; we also called for noninvasive ventilation. But the team missed much of the action. The medical student missed the entire event—aside from attempting to summarize it from second-hand reports for rounds the following day. I realized only later that her intern had been pushed to the back of the room for the critical decisions (much like the students during Mr Johnson's emergency), and headed out midway to attend a mandatory teaching session—the chief residents had begun taking attendance. The resident soon left for noon conference and afternoon clinic, enlisting me to write transfer orders and call the family. Finished with her other work, and under pressure to "bank time" against work hour limitations, which she was at risk of violating, the intern signed her pager over to me and left in the early afternoon, after sheepishly asking me if I wouldn't mind keeping an eye on our patient.

Later, a translator and I met with the Chens to comfort them and plan care for the family matriarch, having found a quiet solarium we could use, with summery views of the city and ocean in the distance to belie the grim topic of discussion.

"What is your understanding of her lung problem right now?"

"*Nay yeega jee um'jee huigor fai ho jing yeung?*"

"What were her hopes and fears about her health?"

"*Nay jee um'jee huigor see seung hai mai ho tai hoi?*"

My mind drifted during the Cantonese as I thought about how I use the unique teaching opportunities offered by wholly translated meetings. *Never check the time. This body language says I am listening. I am speaking to them, not the translator. I make notes because families don't remember much after the C-word*, I would whisper to trainees while families conversed with translators. Now, as I began to discuss hospice philosophy, I felt acutely alone.

My team had missed most of a great hospital medicine experience: applying knowledge to manage a physiologic crisis; using communication skills to ease the resulting human crisis. Recently, to manage the latest set of work hour restrictions, our residency program withdrew from medicine consultation at 2 of 3 sites, and from the medicine wards at the hospital that serves most of our insured, geriatric, and oncology patients. The cost of this experiment to the overall residency experience is unknown. But cases like Ms Chen's remind me how much I missed being the primary doctor. I do not mind the new tasks I perform for my trainees. But I worry about what they are missing: sufficient responsibility for making key clinical decisions while protected by supervision on demand. I am glad my internship challenged me—it prepared me for residency, moonlighting, and attending positions. Without a doubt, residency remains challenging, but it seems that the greatest—or first—challenge imposed on residents is now to beat the clock, not to become a well-rounded, capable, independent physician.

That night, I complained to my spouse, then a psychiatry intern: We weren't giving our trainees the best preparation for a career in medicine ... the lengthy shift I spent managing a hypotensive crisis would be forbidden now ... my pre-"work hours" interns were much happier than their "work hours" successors ... a 4-year residency must be around the corner. The response I got was more bemused smile than grave concern. "You don't think that's important?" I asked.

"Of course I do. It's just that with all this talk about the days of the giants," he said gently, "you're starting to sound like a grumpy old man." We chuckled. He was right. I expect a lot from myself, my trainees, and every clinician. I'd figured I'd be worthy of the title at some point.

But ... at 30?

Disclosure: Nothing to report.