

BECOMING A PHYSICIAN

Morning Report

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You pull into the hospital parking lot just before dawn — one of the first cars in, one of the last out. As a first-year resident, you make up in hours what you lack in experience. You speed-walk to the hospital's back entrance through the January fog.

You wonder if you left the iron on in your apartment. No matter how often you iron and bleach your white coat, it never looks or feels clean. You never look or feel clean. You wonder how many different strains of staph you're colonized with. Your best friend just had her first baby, but you've avoided visiting for fear of infecting him with some resistant bacteria. You already missed her wedding and baby shower. Trying to be a good doctor has made you a bad friend these days.

Your pager goes off at 7:00, indicating that it's activated for the day. For 14 lucky patients, you are now the first call for aches, pains, medications, codes, questions, and complaints.

Exiting the sterile hallway, you enter the frenzied cacophony of sign-out. It always begins quietly — a few residents and medical students starting their day arrive in crisp scrubs, venti coffees in hand. Colleagues who are bleary-eyed from working overnight rifle through their papers, piecing together the events of the past 12 hours. The room soon grows hot and loud with bodies and voices. The nurses come in to remind you that patients are still sleeping, but you know that no one ever sleeps in the hospital.

As you walk to your work-

room, you mentally map out the most efficient route for seeing your patients. It's 7:30. You have half an hour to review labs and vital signs on the computer, then 2 hours to see your patients before morning report — less than 10 minutes each to see how they're feeling, perform an exam, and check in with their bedside nurse. Three of your patients still think *you* are the bedside nurse, but that is the least of your worries.

You scribble down some numbers from the electronic medical record. The meticulous notes you took as a student have devolved into a few illegible scratches on a sheet of paper folded to business-card size. All you need is this grid of names, numbers, and abbreviations; the rest you've learned to keep in your head. You wonder how many of your precious memories have been replaced by medical data. But this thought makes you sad, and there's no time to be sad. It's time to walk into 14 patients' rooms and say "good morning" like you mean it, though it really isn't a good morning for either of you.

You breeze through the observation floor, the step-down unit, the oncology ward. You force yourself to take the stairs — the only exercise you get these days. You pass paintings and poems decorating the hallways and wonder whether someday you'll have the time and energy to stop and appreciate them. You can't afford to today — it's 9:30 and you're only halfway through your list.

You hadn't accounted for the

six relatives who each had questions about Ms. B.'s pneumonia, or the 20 minutes you waited to get a Tongan interpreter to explain to Mr. L. why he has to use his insulin. Meanwhile, the pager on your hip buzzes every few minutes — Mr. H. wants to leave against medical advice although he needs 6 more days of IV antibiotics; he'd been drinking 2 pints of vodka daily, and withdrawal is starting to kick in. Ms. S., on the other hand, doesn't feel ready for discharge. Wouldn't it be better to stay an extra day and make sure her oral medicines manage her pain? Can she just get one more push of Dilaudid before leaving?

It's 9:55, and you have one patient left — Ms. T. You might actually make it to morning report on time if you keep things brief. You've been taught how: walk in and set an agenda ("Good morning, Ms. T., I wanted to check in and see how you're feeling"), manage expectations ("I only have a few minutes to chat, but I'll be back later to talk more"), make the patient feel heard ("I'm sorry you're still feeling nauseated. Did the Zofran help?"), examine while you talk (the patient is alert and oriented, heart rhythm regular, lungs clear, belly soft and nontender, sclera icteric, unchanged from admission), answer questions ("Your bilirubin is 17 today"), exit courteously. You're on this last step when you make a critical error.

You see, Ms. T. is your favorite patient. She's a retired nurse, admitted 4 days ago with painless

jaundice and a pancreatic mass. She knows what that means. She greets you every morning with warm, motherly eyes — she's seen hundreds of frazzled interns pass through these halls in 35 years on the wards. "They get younger every year!" she jokes whenever a new doctor comes in. She humors you as you robotically run through your routine questions and exam. You try to wrap things up by summarizing the day's plan.

"We're hoping to have the preliminary biopsy results back this afternoon. Then we can figure out the next steps . . ." You trail off as her eyes start to glisten with tears. You instinctively reach for her hand. It's 9:59, and you sit down on the edge of her bed.

Over the past 3 hours, you've placed more than 50 orders, answered 17 pages, listened to 14 hearts and 28 lungs, talked to countless patients, nurses, residents, and social workers, but you realize that this is the only real doctoring you'll do today. These are the 60 seconds that will matter.

You both sit in silence for a moment. Ms. T.'s lips tremble while you search for the right words. You tell her you're not sure you have them. She understands and says "Thank you." You feel your eyes welling up. "Aren't you late for morning report?"

Ms. T. asks with a smile. "You better get going." You're in this together now.

As you scurry off, you scroll through the pages you'd been ignoring. Mr. H. is in the hallway yelling. Security had to be called. Ms. S. is still demanding pain meds. The Tongan interpreter is waiting for you outside Mr. L.'s room. He'll have to wait a little longer.

Morning report runs from 10:00 to 11:00. The chief resident presents a mystery case, and residents and interns are invited to ask and answer questions to hone their diagnostic and medical management skills. Some residents see it as an opportunity to show off their knowledge. You see it as daily potential for public humiliation.

When you arrive at 10:05, the case presentation is under way. A 29-year-old graduate student returns from India with fevers and diarrhea. You sit in the back of the room, trying to be inconspicuous. You know there are slides of blood smears coming, and you don't want to be tasked with interpreting them.

You choke down a few sips of lukewarm instant coffee, and it makes your thoughts even more manic than usual — the iron on at home, the Dilaudid you need to order, the baby you haven't seen, the interpreter waiting for

you, Ms. T.'s trembling lips. You're having trouble focusing on the case. Coffee and chronic stress have given you reflux, but you've learned to live with it, if this can be called living.

You feel your pager go off again.

"Re: Ms. T. Prelim path c/w pancreatic adenocarcinoma x54674"

You feel an ache in your chest — is it heartburn or sorrow? You stare helplessly at your pager until the backlight goes dim. You slowly become aware that the chief resident has been saying your name.

"Dr. Singh? Do you want to share your approach to fever in a returning traveler?"

Your mind goes blank as 20 sets of eyes settle on you. You know this won't be pretty, that it will only confirm what others suspect and what you sometimes believe about yourself: that you aren't a good doctor.

Taking a deep breath, you tell yourself what you learned today and what you wish you could tell every overworked, self-doubting, burned-out intern who comes after you: These are *not* the 60 seconds that matter.

Disclosure forms provided by the author are available at NEJM.org.

From Stanford Health Care, Los Gatos, CA.

DOI: 10.1056/NEJMp1701939

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