



## Week One, Revisited

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**D**r Stone, your patient is ready.” I had heard those words a thousand times throughout residency. But this was different. I’m no longer a novice physician with someone looking over my shoulder. I’m a novice physician without someone looking over my shoulder. I’m an attending now. Before walking into my first patient’s room 3 years ago, I looked down to make sure that I had cut the tags off my white coat. Now I looked down to make sure that I got all the stains out.

I participated in the annual June 30th ritual earlier that summer. I packed up my belongings and prepared for a transition. I left my large university hospital job to work at a rural hospital on the Apache reservation in Northeast Arizona. I anticipated plenty of differences between the two environments, but the new experiences that I could anticipate were also the most trivial. I prepared for a different electronic health record and atypical diagnoses. But I wasn’t ready for what happened when I needed to use that EHR to admit someone with one of those atypical diagnoses. As I logged in to the computer, a sudden, striking realization sunk in. If I clicked the admission order, that’s it. That’s final. There is no attending double to check my thought process, no dark room full of case managers to compare my H&P to admission criteria. There is no longer review *before*

action, just consequence *after* action. So I’d better get this right. Suddenly, my clicking finger felt a lot heavier.

I have a rare luxury in today’s medical system. I work for an organization that culturally and financially values preventive care and patient convenience. So I wasn’t all that surprised when my patient that came in for abdominal pain follow-up also wanted to get her knees injected. That’s why I signed up to work here. But I was surprised about the postresidency stress disorder that flared up when I thought about adding on a procedure in clinic. Old thoughts raced through my mind. I’ll need to find an attending, we’ll need to get prior authorization, another resident is probably using the procedure room, and who can do anything in 15 minutes?

But as my palpitations slowed, the clouds of residency parted. I’m no longer running on 4 hours of sleep, my old pager is now assigned to some unsuspecting new intern, I’m the attending that we’re looking for, and I have a say in my own schedule. “Why yes, actually I can inject your knees today.” What a delightful surprise.

My first shift on our inpatient service brought several more lessons. I agonized over the decision to transfer a very sick infant to a bigger hospital with an intensive care unit. Is this something that we could manage here? Will she get worse quickly?

Again, the lessons that I was prepared for were the easy part. I knew how to look up ICU criteria. I knew how to write a hospital summary. The transfer process is easy to navigate, but sending an 8-week-old child and her terrified family on an hour-long helicopter ride through a pitch-black sky is by no means a benign process. I was not prepared for that. The whoop, whoop, whoop of her helicopter flying over my house that night is not a memory that will fade quickly.

The lessons learned that first week were not only medical. There were plenty of cultural lessons, too. Just not the ones that I was expecting. The morning after transferring out the infant, I rounded on a patient who was recovering from a COPD exacerbation. We had set up home oxygen, and he was making excellent progress. The patient was someone who looked like he could easily rope horses for another 70 years, despite his 68% oxygen saturation at admission. He improved quickly, but I was worried that he would decompensate when he returned to his mountain home about 2,000 feet above our already high-elevation hospital. His admission chest x-ray showed a total blackout on the left side, and the patient told us that he had his lung taken out as a child,

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From the Whiteriver Indian Hospital, Whiteriver, AZ.

the way someone might reference an appendectomy. I couldn't disregard a missing lung as easily as the patient could, and I needed a few more answers before discharge.

I requested his paper chart from the locked halls of medical records, and made a fascinating dive into the health care system of 1957. First, just touching an exam note that was written during the Cold War, before desegregation, and when Vietnam was just a country, was magical. I was captivated by the experimental use of penicillin and streptomycin, the entire HPI that read "Coughing for 3-4 days," and the one-line discharge summary, "Ready to go home." I read about the 3-year-old boy who was sent to the tuberculosis sanitarium where his mother was already admitted, and I saw the reference to an upcoming pneumonectomy.

I followed along with our patient's annual checkups by the TB officer until the patient was deemed free of disease a decade and a half later. I grimaced and chuckled at the closing lines of his TB chart that recommended "the boy live a sheltered life," because he wasn't expected to live much longer. And then I relayed this information to the leathery septuagenarian who was currently refusing home oxygen because he wasn't quite ready to be "the old man who pulls a tank behind him." I was impressed by his determination, and I pictured myself being just

as stubborn in forty years. I realized that the cultural differences between me and the 70-year-old Apache man weren't as stark as they might seem. They were certainly no greater than the differences between me and my predecessors that cared for him as a child.

In fact, the cultural transition was one of the rare instances in which I actually *overestimated* the change. I spent the summer reading about the degree of historical tragedy caused by generations of slow-motion genocide, and I wondered if I could ever truly relate to my patients. Then I saw the warmth of new parents holding their baby, or the worry of neighbors who followed behind the ambulance to check up on an elder who lives down the street. There are plenty of similarities and differences between all of us, and I suppose we just find what we're looking for.

My last patient that week thanked me for being a kind doctor. I treasured her telling me that, but I was equally haunted by her words. As a physician, it isn't enough to just be kind. I owed it to her to also be knowledgeable, prepared, and effective. Was I? She was an elderly woman with advanced kidney disease. Nothing about her care is straightforward. Residency provided me with the tools to provide her medical care, but it's clear that the next stage of my career is when the real learning happens.

Plenty of lessons from residency carry forward into attendinghood: be humble, show kindness, eat frequently. But the lessons that I expected to learn this year were almost comical in their simplicity. The lessons that I expected to learn were the ones that I had already learned. There is an incredible depth to our profession that I am just now scratching the surface of. I won't get a certificate in 3 years to show that I've marked all of my educational checkboxes, but that's kind of the point. At its rawest, our profession is about connecting with other human beings at the deepest level. Those interactions are by their very nature entirely unpredictable. The lessons I learn as an attending won't be clean, predictable, or finite. Maybe that's the first lesson.

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