Transitions in Care

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I arrive at the hospital in the early morning and soon afterward my colleague hands me two sheets of crisp white paper listing her patients. After her long night on-call, she is ready to relinquish her patients to my care. I spend a few minutes with her, scanning this index of unfamiliar names while she emphasizes details relating to her sickest patients. Alongside the rows of names are tidy “to do” and “to know” columns where personal details, critical test results and response plans for worst case scenarios have been reduced to acronyms and abbreviations. I’m convinced that these two impersonal pages contain all I will need to know to care for these patients over the grueling shift ahead—responses for every contingency.

Often the only contact I have with my colleague’s patients are their names and diagnoses on these sign-out sheets, when a nurse passes along a routine request or gives me a quick update. On occasion, I remain at a patient’s bedside, agonizing over a critical decision. Some encounters expose the lingering uncertainty inherent in caring for little known patients, yet other interactions reveal confidence, born out of budding experience.

I cautiously interpret the hemorrhagic stroke patient’s head CT for the family that just arrived in town after driving hundreds of miles.

Did they have any idea what I was explaining to them?

I absently okay the bisacodyl suppository for the constipated patient in the midst of a hectic emergency room admission.

I no longer reach for my pocket guide when prescribing such common medications.

I hesitantly pronounce the young woman’s death while her husband tearfully accepts that her 10-year battle with breast cancer has ended.

Was I sensitive to the new widower in the midst of a chaotic night?

I urgently assess the man with severe thrombocytopenia who just fell out of bed and hit his head.

Could we have done more to prevent his fall?

I quickly check the hyponatremic patient’s sodium level, then make a slight adjustment to her intravenous fluids.

I continue to become more comfortable with such routines of patient care.

I reflexively order blood cultures and a chest radiograph for the febrile patient, distracted by the piles of paperwork on my desk.

Should I have taken more time to evaluate him?

I smoothly place a central line, the thick sterile gown and mask concealing beads of sweat, as the septic patient becomes progressively hypotensive.

With each procedure I enhance my poise to act under stress.

Many hours pass before I finally see the shadow of distant mountains outlined by the approaching dawn. The chatter of nurses at shift change and the aroma of breakfast wafting from heavy food carts rolling down the hall mean that my relief is finally arriving. I glance over the now well-worn sign-out document, marked with hurried notations and smudged with tea stains. The night’s interactions—some challenging, some easily forgettable and a few leaving a lasting impression, have transformed sterile data into living, breathing individuals.

Reflecting on the night, I consider how I, too, was transformed. Forced to rely on my growing clinical acumen, I perceive that I am settling into my role as a physician. Decisions that once seemed pedantic appear increasingly straightforward, and conversations that previously felt halted become progressively more natural.

As my shift ends, I prepare my sign-out document, creating new rows and columns while deleting others. With the exchange of a few words and this fresh sheet of paper, I relay updated patient information to the next team member. Exhausted, I snap on my helmet and bicycle toward home. Wheels spin beneath me, the spokes casting a hypnotic shadow on the pavement. I envision my colleague proceeding from patient to patient, sign-out in hand. For him, as with me, each encounter will animate the lifeless sign-out sheet as the cycle begins again.

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