

Master of AAEM Series — MAAEM

Welcome to the Tribe: Thoughts on Starting Out in EM

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Yesterday I received this (redacted) email:

Hello Dr Lex,

Over the past two to three years I have come across your various teachings and pearls in emergency medicine. I have had a strong passion for emergency medicine since my undergrad years at Temple and as a scribe in a Philadelphia ED. I was recently accepted into ED residency at Virginia Commonwealth University and was hoping for any advice you may offer in this new chapter.

Thank you so very much for your time.



I thought about it and came up with this. Feel free to copy, adjust, edit, add your own thoughts, and share with those whom you feel it might help.

First and foremost, welcome to EM. I am biased, but I truly feel we are the most interesting 15 minutes of every other specialty.

Second, thank you for being a member of the military. I was drafted in 1966, so I had no choice, but my medical training and experience in Vietnam made me into a totally different person than I would have been otherwise ... and I hope it was for the better.

Third, I am about 30 years removed from my residency in EM. When I trained, 90% of the attendings had trained in another specialty and they were not a 24-hour presence. On night shift, they headed off to bed about 11:00pm and reappeared to cosign charts at 6:30am. We were on our own and it was a sign of weakness to wake them up for help.

You are about to enter into one of the scariest — and most difficult — times of your life. You will start with an unconscious incompetence that you will recognize very quickly: “I know so little that I had no idea how little I know.” After a few weeks, you will reach conscious incompetence, and this is probably even scarier: “I now know how much I don’t know. Oh crap.” By the time you graduate, you will be consciously competent. But you may not reach the peak of unconscious competence until you’ve been in practice a few years.

You now feel very smart and full of evidence-based medicine, although you’ve probably been a little rattled by working with some physicians who seemingly ignore the evidence. Get used to it. For instance, every textbook will tell you the starting dose of morphine for someone in acute pain is 0.1-0.15mg/kg; in reality, it will be 4mg, for many reasons. Every textbook will tell you that the loading dose of phenytoin for acute seizure management is 15 to 20mg/kg; in reality, it will be 1 gram. At least 15 articles over the past 30 years have shown the superiority of metered-dose inhaler albuterol over nebulized albuterol for acute asthma, but I assure you that 90% of patients who are wheezing will get the nebulizer. You will memorize the Ottawa Ankle Guidelines, and then probably ignore them. Don’t question this — you are not in a position to challenge the “common

wisdom” while you are inside the loop of residency. Just remember when you start practicing on your own what the right answer is. Albert Schweitzer understood this when he said, “Imitation is not the main thing in learning; it is the ONLY thing.” (Although I cannot locate the source for this quote, it sounds like something Schweitzer would have said).

What do I mean by “inside the loop?” It’s where a vast majority of people live their entire lives. But creativity and innovation are outside the loop. You can get there eventually, but residency is not the appropriate time or place. You will silently question decisions of your seniors more than you care to think about. You will silently question yourself when you have followed all the rules and used all your knowledge and come to a different conclusion.

Whether your mother is alive or not, you will talk to her in your mind a lot. “Mom, I decided to do X to a patient. Are you proud of me?” It’s also something that will come in handy when you talk to a consultant. “Call your Mom and tell her what I told you. Then ask her if you’re making the right decision and if she’s proud of you.”

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“You will need good mentors all your life. Most mentors will pat you on the back and say, “Good job.” The best mentors push you past where they are and help you succeed far more than they can and not be jealous of you. Remember, “everything worth having is on the other side of fear,” and a mentor is sometimes needed to push you through fear.”

You will feel like an impostor for the rest of your life. “There’s been a dreadful mistake ... I should NEVER have become a doctor. I’ll never get it right.” This is a good thing. If you recognize the limits of your knowledge, it will stimulate you to learn more. If you don’t doubt what you are doing at least once a week, you are probably doing the wrong thing. And get used to reading articles and blogs and listening to podcasts. The evidence is pretty clear that to stay current and maintain competency, you will have to actively learn for an average of five hours weekly for the rest of your life. You are not and will never be infallible — the greatest learning moment in your career will be when you no longer have to pretend that you know everything.

Do NOT speak ill of patients. They are not the enemy. We are the one place that many people know they can come and be treated like a human being. We take care of some of the most unloved people in the world, and we do it because we want to. Never forget that we get to touch sick people, who has been allowed this privilege through history? Gods, prophets, kings ... and physicians.

I recommend that as an intern, you occasionally ask your faculty member to come to the bedside with you when you present the history and physical results — maybe once every shift. It cuts down on bullshit, and a good attending can supplement what you have learned by asking an additional question or two without making you look bad. You then discuss the differential at bedside, using difficult words like “cancer” and “stroke” if appropriate, because the worst-case scenario is what the patient is worried about also. When you walk away from bedside, the attending, patient, and any family present know what you are thinking and what plan has been laid out.

The most difficult thing you will do is tell a parent that a child has died unexpectedly, but fortunately it’s something you only have to do every few years. The most difficult thing you will do on a day-to-day basis is convince other doctors to take care of sick people. Get used to it. Sometimes doing the right thing will piss people off; if it is the right thing, you’ll sleep fine at night.

Also get used to being second guessed. “Guess what those clowns in the ER did THIS time?” We want to be protective of our tribe, of course, but never lose sight of the patient coming first.

Remember that other specialties are trained to find out “What does this patient have?” Our goal is to determine “What does this patient need?” When a patient arrives with tachypnea in a tripod position with blue lips, do we know the diagnosis (other than the all-inclusive “respiratory failure”)? Probably not, but we know exactly what to do.

You will need good mentors all your life. Most mentors will pat you on the back and say, “Good job.” The best mentors push you past where they are and help you succeed far more than they can and not be jealous of

you. Remember, “everything worth having is on the other side of fear,” and a mentor is sometimes needed to push you through fear.

Find a copy of the ACEP Code of Ethics and read it. Then read it again. And remember that ethics is a daily destination, a daily challenge. Every shift should start by looking in a mirror and saying, “It’s not about me.”

Mahatma Gandhi once said, “Whatever you do will be insignificant, but it is very important that you do it.” Don’t lose sight of that.

Savor your successes but then move on: dwelling on them causes overconfidence (and there is nothing more dangerous than a cocky ER doc). Learn from your failures but then move on: dwelling on them causes indecision.

Half of what you are learning is wrong or will be out of date in a few years.

Don’t feel guilty — it’s because half of what your instructors are teaching you is wrong, because half of what THEY know is wrong. It’s not their fault. If they knew it was wrong, it would be unethical for them to teach it.

Emergency medicine is becoming the proceduralist by default. Currently, American Board of Internal Medicine requires five procedures for someone to become board certified: ACLS, peripheral venous access, arterial blood draw, venous blood draw, and pelvic exam, pap smear and cervical culture. If you look at the Core Content for EM, there are literally dozens of procedures in which we must show competence, both ultrasound-guided and blind. No other specialty comes close.

And never forget that “A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it.” (Max Planck, *Scientific Autobiography and Other Papers*). In other words, science and medicine change one funeral or retirement at a time.

I don’t know if you’re into music, but I worship at the altar of John Coltrane. Miles Davis you probably know. What you may not know is that he literally changed the music three or four times. Bop --> cool --> hard bop --> fusion. Coltrane was a student of Miles, but also of Thelonious Monk and Coleman Hawkins, Lester Young and Eric Dolphy, Indian music and African music, Buddhism, Shintoism, Taoism, Christianity, and Judaism, always seeking, always questing. Miles may have changed music, but Coltrane changed people’s expectations of what music should be. In the same way, emergency medicine borrowed from medicine and surgery, pediatrics and psychiatry, anesthesiology and obstetrics, pulmonology and cardiology, and not only changed medicine, but changed people’s expectations of what medicine should be.

Welcome to the tribe.

Joe ●

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