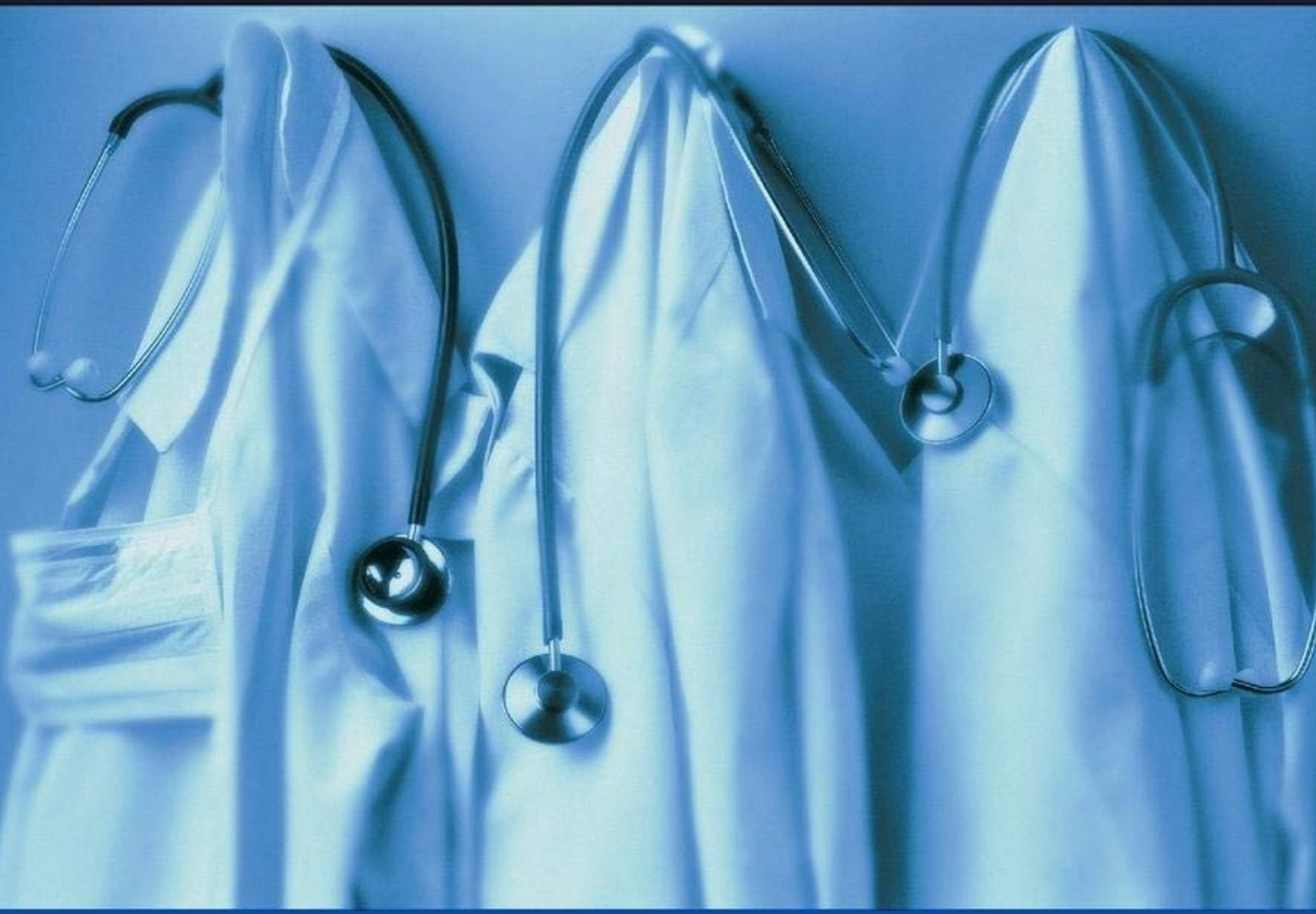
"A candid...gripping account." —*New York Times Book Review*

The Intern Blues

The Timeless Classic About the Making of a Doctor



UPDATED WITH A NEW PREFACE AND AFTERWORD

ROBERT MARION, M.D.

Author of *Learning to Play God*

The Intern Blues

The Timeless Classic About the Making of a Doctor

ROBERT MARION, M.D.

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Dedication

To my parents, Ann and Sam Marion, who sweated and slaved to put me through medical school so that I could sweat and slave as an intern

and to the pediatric house staff who compose our program, without whom this book would not have been possible

Epigraph

To live by medicine is to live horribly.

—*Linnaeus*

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Author's Note

Imagine walking into a room occupied by thirty-five tiny and very sick premature newborn babies. For the next twelve hours their well-being, their very survival is your responsibility. That was how my internship year began. It was definitely one of the most terrifying days of my life.

I somehow survived that year in spite of the fact that I and the other interns in my group received negligible guidance from the senior people in the program. I was overworked, overtired, lonely and insecure, often depressed, and conflicted by my own responsibilities, whether admitting an infant with a dangerously high fever or coping with the psychological and physical stresses of dealing with AIDS patients.

From July 1985 through June 1986, I worked with three interns: Amy, Andy, and Mark. Together, we've collected very personal notes—often recorded after a grueling night on call—about what it's really like, day by day, to spend a year as an intern, meeting too often with frustrations and not enough encouragement.

The Intern Blues is the product of those notes.

ROBERT MARION, M.D.

Preface to the Perennial Edition

Monday, January 6, 2001

"Tell me about your worst night on call." Without hesitation, Emily, a senior resident who was spending January doing an elective with me in Medical Genetics, responded to my request. "It's hard to single out an absolute worst night. I've had a few that would make the finals. They all happened during the winter of my internship. Winter is terrible for interns, you never see any sunlight; you get to the hospital when it's still dark, and you leave at night when it's dark again. You're never outside when it's sunny, and that's bad. But probably my single worst night was a Friday in February. I was working on the Infants' Unit at Mount Scopus, and that morning, a ten-month-old baby came in who we thought might have a septic hip **[an infection of the hip joint; a medical emergency because if left untreated, the infection can destroy the joint, leading to long-term disability]**. The intern who'd been on call Thursday night admitted her, and by the time we finished rounds in the morning, the orthopedic surgeons had whisked the child off to tap her hip before any of us had a chance to see her or meet the family. The child came back to the floor from the OR in the afternoon. About four o'clock, I got a call from the pediatric radiologist who said, 'I just reviewed the X-rays and I see multiple fractures of the hip. They make me suspicious of child abuse.' He told me to bring the kid down right away for a skeletal survey to see if there were any other signs of fractures. So I brought the kid down to the radiology department. The films were taken, and the radiologist saw what he thought were three old, healed fractures of other bones. They were subtle; he said he thought another radiologist might not have read them the same way, but he felt strongly enough about it that he thought a report needed to be made.

“So I took the baby back upstairs, and as the intern on call that night, it became my responsibility to make the phone call to Child Protective Services. I had to tell the family what was going on. That was horrible. They were Spanish-speaking, and my Spanish is not so good. Plus, since only one parent is allowed to stay in the hospital with the child, the parents were split: the father was home, and the mother was in the baby’s room. As best I could, I told the mother that we’d found evidence of new and old fractures on the X rays and that we suspected child abuse . . . she was devastated, horribly devastated. She started crying, and I didn’t know what to say to her to calm her down.

“Then the investigators from Child Protective Services came to speak with the mother. By this point, it was about midnight. They talked to the mother, and then they interviewed me; they wanted me to be the expert witness. They asked me questions about the radiologic findings. What did these fractures mean? How could they have happened? Is there any way they could have occurred other than through abuse? I had no idea how to answer them. And this poor mother was asking me questions, too, questions she deserved answers to. But I didn’t have any answers for her, and it being the middle of the night by this point, there was nobody around who could give her those answers. It was horrible.

“Then the detectives came. First they interviewed the mother. She was horrified; she denied that she or the baby’s father had done anything wrong, and I believed her. . . . I believed that she didn’t have anything to do with it. The detectives asked me the same questions the Child Protective Services investigator had asked. I don’t know. . . . This was the first time I’d ever dealt with anything like this, the first time I’d ever had to handle any of the legal aspects of my job. My approach to the same situation is very different today, after two years of experience dealing with these kinds of problems. But back then, I didn’t know. . . . I thought, ‘Here I am, the pediatrician in charge of the case. I’m supposed to know the answers to all these questions the detectives are asking me.’ They were hounding me, writing down every word I said. I figured that since I’d called them and they’d come in at three o’clock in the morning, that I should have at least been able to tell them for sure whether this child had been abused or not. It was horrible, horrible for me, horrible for the mother, horrible for the family, horrible for the kid, horrible for everyone involved.

“Meanwhile, while all this was going on, it was a typical busy winter night on Infants’. By the time the detectives came, we had three or four more admissions to work up, and a few IVs had fallen out and needed to be replaced. There comes a point in the night when you’re working and working and you finally realize that you’re not even going to get fifteen minutes to lie down. You’re not going to have time to eat, you’re not going to have time to go to the bathroom. I had all this work to do, all these thoughts about the baby with the fractures going through my mind, I was exhausted, and I was having trouble concentrating. At about five thirty, I was talking to the mother of one of the new admissions, trying my hardest to stay awake and take the history. I was definitely half asleep while I was talking to her, droopy eyed, and after asking a question, this mother turned to me and said, ‘Doctor, I think you already asked me that.’ The fact that I had lost track of what I was doing kind of jolted me out of my sleepiness. I got really worried that I was going to screw up and make a major mistake, and so I willed myself to pay attention. Then, I walked out of the room and saw the intern from one of the other floors. She had come down to see how I was. Just seeing her face and realizing she was also awake at that hour brightened the night enough to help me get through it.”

“So you got through it,” I said.

“Yeah, I got through it. I got through all those horrible nights on call as an intern. It was bad.”

“What happened to the baby with the fractured hip?” I asked. “Did they ever figure out how she had broken those bones?”

“Not that I know of,” Emily replied. “The mother continued to deny that she’d done anything wrong. The father also denied hurting her. The investigators blamed one, then the other, then the first one again. They finally sent the baby to a foster home pending completion of the legal case. I had to appear in court. That was another horrible experience, one I haven’t thought about in a while. But I don’t know what ultimately happened. I never got follow-up.”

As I write this, it’s been over fifteen years since Andy Baron, Mark Greenberg, and Amy Horowitz, the three frightened, inexperienced medical-school graduates whose audiodiaries serve as the basis of *The Intern Blues,* and I first talked about this project. Since that morning in

late June 1985, when we sat sprawled on the lawn outside the home of Peter Anderson, chairman of the Department of Pediatrics at the Albert Schweitzer School of Medicine, a lot has changed in our residency program. When Andy, Mark, and Amy began their residency, our training program was huge. Our more than 100 house officers staffed seven general pediatric inpatient wards, three neonatal intensive care units and well-baby nurseries, two pediatric intensive care units, three emergency rooms, and about six outpatient clinics. These many activities were distributed among four major teaching hospitals arrayed on two separate campuses in the Bronx. In trying to provide care for the sick infants and children who were admitted to these inpatient units, as well as for the more healthy ones who visited the ambulatory care clinics, our interns were unbelievably stressed. They were on call every third night, usually spending those nights awake in the hospital, often caring for critically ill, sometimes dying patients; having to deal with frightened and angry parents, lab technicians who didn't give a damn, intimidating and demanding nurses, and abusive attending physicians; rarely even having a glimmer of a chance of getting some sleep. They spent their days traveling from one campus to the other, providing care to their inpatient charges, then signing out and heading off to one of the other sites where a full panel of clinic patients awaited them. Since they spent most of their hours outside the hospital trying to catch up on sleep, they had little or no time for a social life, often going weeks without speaking with friends, family, or, in fact, anyone who worked outside the hospital.

Between 1985 and the late 1990s, a series of events began to pare away at our program, both internally and externally. Government subsidies for the training of young doctors shrank. Because of a presumed "doctor glut," hospitals were offered incentives to train fewer residents. A major internecine struggle between Mt. Scopus Medical Center, the major teaching hospital of the Albert Schweitzer School of Medicine, and New York City's Health and Hospitals Corporation caused our program to withdraw its trainees from our two municipal hospital affiliates (Jonas Bronck and West Bronx Medical Centers). As a result, by the time Emily began her internship in July 1998, the program had shrunk dramatically. Emily became part of a residency force of only sixty-five, less than two-thirds the number with whom Andy, Mark, and Amy had worked. She and her colleagues spent most of their training time at Mt. Scopus Medical Center, venturing out to University Hospital

only for rotations in the Neonatal Intensive Care Unit. They cared for children on only three general pediatric wards, in one NICU, one well-baby nursery, one pediatric intensive care unit, one emergency room, and two outpatient general pediatric clinics.

Although the paring of the size of our program had an effect on our trainees, no single event in the lives of interns and residents had as much of an impact as the adoption of the Bell Commission Regulations. In July 1989, New York became the first state to institute laws regulating the working conditions under which young doctors could be trained. Back in the days Andy, Mark, and Amy were interns, there were no regulations governing the conditions under which house officers worked. Interns and residents typically worked 110 hours per week, spending 36 or more hours in the hospital during a single on-call shift, working 18 to 24 hours in the emergency room without relief. The new regulations changed this outrageous situation: They limited the number of hours a house officer could work to 80 per week, with no more than 24 consecutive hours as part of a single shift, and no more than 12 consecutive hours working in an emergency-room setting.

As a result, by the time Emily began her training, life had become much different for interns. Emily was on-call every fourth night instead of every third. Instead of having to hang around until five or six (or seven) p.m. after spending another sleepless night in the hospital, as had been the custom back in the days prior to the introduction of the regulations, she was encouraged to leave no later than noon on her post-call days. No longer needing to spend precious minutes commuting from one campus to the other to fulfill her patient-care responsibilities, she was able to get out of the hospital earlier on non-call days, too, contributing to her ability to have some semblance of a social life. Yes, thanks to the Bell Commission Regulations, life for house officers should have improved dramatically.

The key phrase there is "should have." "The fact is," Emily said later in our conversation, "residency was actually pretty good. But internship was horrible. Even though I was on every fourth night instead of every third, it was still brutal. By the time February rolled around, I was chronically overtired. During the first few months of the year, I was so nervous and scared I was going to accidentally screw up and kill someone, I had trouble sleeping even during the nights I wasn't on-call. And seeing kids so sick, and watching some of them die, and dealing

with their parents and families—nothing in life prepared me for that. By the time I became a resident, it wasn't as bad. I felt more sure of myself; I knew what to do for my patients, how to handle most situations. But internship? I'm glad I never have to go through that year again."

So, although the events documented in *The Intern Blues* occurred more than fifteen years ago, the message delivered by the three young doctors-in-training is still relevant. Yes, it's true that some of the events that occurred may be dated, and some of the methods used to train house officers are no longer in use. But there are things about internship that will never change. As long as medical school graduates are plunged into a setting in which they have to care for sick and dying patients over long hours with very little support from those around them, the experiences of Andy, Mark, and Amy will continue to ring true.

Since the original publication of *The Intern Blues* in 1989, I've had the opportunity to speak with a lot of people who've read the book. In addition to noting similarities between the experiences of one of or more of the interns whose lives were chronicled and their own experiences, many former residents have noted that the book was most valuable to them as a way of educating their loved ones. "My parents never understood what I was going through," many have commented. This was the case with me, as well. When I was a resident, my father used to ask me, "When you're on-call at night, what does that mean? You go home and wait for them to call if they need you?" After reading the book, he finally understood.

I think this function, *The Intern Blues* as an educational tool for non-doctors, is also still valid today. In fact, I think reading the book before beginning one's internship may be harmful to the future intern's health; rather, the book should be read by the parents, other family members, and loved ones of interns prior to the start of their training years. That's the only way they'll truly understand what hell their loved ones' life is likely to become.

Preface

All of the events described within this book actually occurred. Not all of them, however, involved the intern to whom they have been assigned here. In order to provide the doctors, patients, and staff with anonymity, some of the occurrences, patient contacts, and reactions have been altered or switched. As a result, some of the characterizations that emerge represent composites rather than actual portraits.

Additionally, the names of the hospitals, physicians, staff members, and patients have been changed. To render the interns even less identifiable, their physical characteristics have been appreciably altered. In spite of these changes, however, this is a work of nonfiction; the events and experiences described are all true.

This book would not have been possible without the cooperation of a large number of people. I'd like to take this opportunity to thank the faculty and administration of our pediatric program, the administrations of both the hospitals through which our interns and residents rotate and the medical school affiliated with those hospitals, the house staff who make up our program, and especially the interns who allowed me to just about live inside their heads during that very difficult year.

Finally, I'd especially like to thank the following people: my wife, Beth, and my children, Isadora, Davida, and Jonah, for putting up with the long hours I spent playing with my computer rather than playing with them; Pamela Altschul, editorial assistant at William Morrow, for her help and sharp insights; Diana Finch, my literary agent, for her encouragement; and Adrian Zackheim, senior editor at William Morrow and self-proclaimed "medical junkie," who has been there to guide me through every step in the writing of this book.

Introduction

The stretchers arrived at the emergency room about fifteen minutes after I started my shift. I had barely had enough time to say hello to the residents and nurses on call when suddenly, out of the clear blue, three critically ill brothers were being wheeled into the trauma area.

We all immediately went running to the back to meet them. One of the Emergency Medical Service workers yelled out an abbreviated version of their story: "It's an apartment fire. The FD **[Fire Department]** pulled them out of the bedroom. We loaded them onto the stretchers and transported." He further explained that the boys' mother was at that moment being wheeled into the adult emergency room. She was near death.

Apartment fires were unusual in May; they're usually winter events, when everyone's using space heaters to try to keep warm. But unusual or not, we swung into action. With very little discussion, we triaged them: The senior resident took the eight-year-old, who was semiconscious. The junior resident began to work on the six-year-old, who was the best off of the three: His vital signs were stable and he was awake enough to answer questions. And the two interns and I moved straight toward the ten-year-old, who was comatose; he wasn't breathing on his own, and his fingers and lips were beginning to turn purple. We knew we had to act fast.

By reflex, Amy, one of the interns, grabbed the black rubber ambubag and began to force oxygen into the boy's lungs while I went about gathering the supplies needed for intubation. I got a pediatric laryngoscope **[a light source with a metal blade at its end, designed to push away the tongue and illuminate the back of the throat]** and an endotracheal tube from the code cart. Meanwhile, Andy, the other intern, after listening with his stethoscope, had determined that the boy's heart wasn't beating. Without a word, he immediately began pumping the

chest about a hundred times a minute. At that point I heard the announcement over the loudspeaker: “Attention, attention: CAC in the pediatric emergency room. Attention attention: CAC in the pediatric emergency room.” I was relieved to hear it: It meant that help was on the way.

After Amy had bagged the kid for maybe a minute, I nudged her away and got ready to do the intubation. I concentrated all my efforts on the back of that boy’s throat. Holding the laryngoscope in my left hand, I placed the instrument into the patient’s mouth and shifted it around until I could clearly see the vocal cords. Then I began to push the endotracheal tube through those cords. At first the tube slipped backward, falling down into the esophagus. I repositioned it and tried again. This time the tube slipped right through the cords and slid down into the trachea.

I was sure it was in, so I began to call for a piece of tape, but before I could get the words out, a healthy piece of the stuff was being dangled before my eyes. Anticipating my need, Amy had torn a supply and now all that needed to be done was to apply one end to the skin of the boy’s upper lip and wrap the other end around the tube so it would remain steadily in place. It took me about a minute to secure the tube, and when I finished, I hooked up the ambubag and began to force oxygen directly into the boy’s lungs.

As I compressed the ambubag, I began to take stock of the situation. The trauma area was now packed with medical personnel who, thanks to the loudspeaker announcement, had come running from all corners of the hospital. It was then that I realized that for the first time all year, Amy Horowitz, Andy Baron, and Mark Greenberg, who had answered the call for help, were all working together on a single patient.

Amy grabbed the ambubag and relieved me. Andy was continuing the chest compressions, while Mark was working on getting an IV into the boy’s arm. He succeeded on the first try and was simultaneously hooking up the IV drip and asking one of the nurses for a shot of epinephrine, a drug that hopefully would help start the boy’s heart beating again. Meanwhile, I began to attach the leads from an electrocardiograph machine to the boy’s wrists and ankles, in an attempt to monitor the activity of his heart better. All this was being carried out without a word of direction from me. Each of us knew what had to be done and were doing it without any prompting.

It took nearly fifteen minutes to get that kid's heart started again, but after Mark had pushed in the second round of medications, electrical activity began to appear on the cardiograph paper. "We've got complexes," I said when I saw them. "It looks like a normal rhythm." The interns breathed a sigh of relief when they heard my words. Now comes Miller Time!

In another minute, the boy began breathing on his own. He was reasonably stable now, so we pulled back and took stock of what needed to be done. Amy volunteered to take charge of the boy until the intern from the ICU **[intensive-care unit]** upstairs came down to get him. His brothers, now also stable, and our patient went up to Jonas Bronck's pediatric ICU about a half hour later. After prolonged hospital stays, they each recovered and were discharged home. Their mother, however, wasn't as fortunate. She never regained consciousness and died later that night in the adult ICU.

Watching those three interns working together on that boy in such perfect harmony, with such confidence in their judgment and their technical ability, it was hard for me to believe that only eleven months earlier they had begun this internship. It seemed incredible that they were the same people who, when I had talked with them out on the lawn of Peter Anderson's house in Westchester County at orientation, had seemed so tense and uncertain and downright scared to death.

I had met Amy, Mark, and Andy at that orientation retreat at the house of the chairman of the Department of Pediatrics on June 26, 1985. All around us on the lawn, the exact same scene was being played out: Stretched out on the grass were groups of three or four new interns, each looking well rested and tanned from their month of vacation and each as tense as a turkey around Thanksgiving because of the year of torture that loomed ahead. Sitting with each group of interns was an attending physician, one of the senior doctors affiliated with the pediatric program, who would serve as teacher, mentor, and at times taskmaster to the new interns. We attendings were trying our best to convince these guys that the next twelve months weren't going to be as bad as they had been led to believe. In other words, we were lying through our teeth.

Over the past seven years, it had become traditional in the Albert Schweitzer School of Medicine's pediatric residency training program that the internship year begin with this orientation retreat. Regardless of what the day accomplishes, it's a nice idea, an opportunity for the thirty-

five new interns to get to know each other in a relaxed atmosphere, to make friends with the people with whom they'll be spending every day and every third night over the next twelve months. The retreat also gives the interns a chance to meet the chief residents, the four physicians who are directly in charge of them, the people they'd have to turn to in times of crisis.

My first meeting with Amy, Mark, and Andy started out pretty disappointingly. I'd led small groups at these retreats for the past three years, and this one was definitely the hardest to get off the ground. The idea was to get the interns talking about their concerns so that they'd discover these concerns weren't unique, that the same fears were shared by each of their classmates. But for that to happen the interns had to talk, and so far they were keeping their mouths tightly shut.

I decided to cut through the small talk and take a more direct approach. "Look," I began, "I know you guys must be scared to death. You're so nervous, I'm getting jumpy just sitting here. What are you so worried about?"

There was silence again for what seemed like hours, but it was probably no more than a minute. I was thinking I'd have to come up with some other tactic when Andy Baron suddenly spoke up. "I'll tell you what I'm worried about," he said just loud enough to be heard. "I'm worried I don't know enough."

"Don't know enough about what?" I immediately asked, overjoyed that somebody had actually said something.

Andy thought for a few seconds. "I'm worried that I'm going to get out there on the wards and be expected to know certain things that I just don't know. I don't know the kinds of things doctors are supposed to know."

"What are doctors supposed to know?" I asked.

"They're supposed to know everything," Andy replied without hesitation. "They're supposed to know what to do in an emergency; they're supposed to know what's going wrong when it goes wrong and what to do to make it better. I don't know any of those things. I never had to know anything that important when I was a medical student."

"Doctors are also supposed to be able to do things like start IVs and do spinal taps," Mark Greenberg said next. "I don't know about you guys, but if I were to go into a hospital today and do a spinal tap on a baby, I could be charged with assault with a deadly weapon. I'm not

sure, but I don't think a criminal record is exactly what we're trying to accomplish here."

"So you're worried that you don't know enough and that even if you did know enough, you couldn't do anything to help the patients because you don't have the technical skills," I said. "Is that about right?" The three of them nodded yes. I wrote this down on a piece of paper. As group leader, I was supposed to act as a kind of anxiety scorekeeper.

"Look," I began to explain, "if you think we'd expect you to come into this knowing how to start IV's and do spinal taps, and knowing what to do in a cardiac arrest, you're out of your minds." Meeting blank stares, I went on: "All of us were interns once and we know how completely hopeless you are at this point. We know that all four years of medical school gives you is a basic foundation on which to build. Every medical school graduate knows a bunch of facts but very little practical information. You know all the complex physiologic mechanisms that are necessary for the digestion of food by the intestine, but you've never actually taken care of a patient with a malabsorption syndrome; you know how the glomeruli of the kidneys filter impurities out of the blood, but you've never had to manage fluids and electrolytes in a patient whose kidneys have failed. That's what you're going to do in this internship: learn how to put all these principles into practice. And while you're learning this stuff, we're not going to let you do anything that might even come close to hurting the patients. The only thing we'll ask of you over the next few days is that you somehow figure out how to get yourselves onto the wards without getting too lost. Anything more than that is extra credit. Now I'm sure that made you all feel a lot better, right?"

It obviously didn't, and they all fell silent again. "So what else are you worried about?" I finally asked. "Or is that it?"

"Well, okay, so maybe you don't expect us to be able to make decisions on our own, but there are a lot of other things we're going to be responsible for," Andy responded after a bit more silence. I liked Andy right away. "I mean, starting Saturday, parents are going to be trusting us with their sick kids. They're going to expect us to take care of them and make them well. I'm worried I'm going to wind up betraying that trust."

The other two considered this. "That's certainly a frightening thought for society," Mark added. "People trusting me with anything."

I added "Anxiety about responsibility" to my list.

“I don’t know about you guys, but I’m worried about my home life,” Amy Horowitz said next. “I can understand worrying about doing a good job, but I’ve got a two-month-old baby at home. If I’m on call every third night and I’m exhausted the next night, that means I’m only going to have one night out of every three to spend with her and just about no days.”

I knew Amy from her days as a medical student, and of all the interns in the incoming group, she was the one about whom I was most concerned. “Who’s going to be taking care of the baby while you’re at work?” I asked.

“We have a baby-sitter during the day and my husband will be home every night,” she replied. “I’ve been on vacation since I delivered, and I’ve spent a lot of time with her. It’s really going to be hard.”

The others considered this and were silent for a few moments. “Yeah, outside life, that’s a problem for me, too,” Andy finally added. “I’ve seen what happens to interns. They don’t have time for anything. They turn into boring, out-of-shape slobs, and I don’t want that to happen to me.”

And I added “Anxieties about home life: No time for families, hobbies, or exercise” to my list.

We spent about an hour talking. Even though it started out slowly, our discussion rapidly picked up steam. The interns had some kind of chemistry that made them work well together. By the time Mike Miller, the department’s director of education, finally called us to lunch, our list of anxieties covered nearly two pages.

Things had gone so well during the second half of that hour that at the end of our session I told Amy, Andy, and Mark about a project I’d been thinking about for some time. “I’ve thought about trying to write a book about internship,” I told them, “and I’d like you guys to help me with it. All you’d have to do is keep a diary and meet with me for dinner every once in a while. After some discussion, the interns agreed that they’d like to give it a try. Since one of their anxieties was that they’d lose touch with their nonphysician friends who had no understanding of what it was like to work a hundred hours a week and who therefore could not possibly sympathize with this lifestyle, they thought that a book about what an intern’s life was like might be helpful to future interns. They decided that tape-recording their experiences would be the best method of keeping a diary.