Sawbones 224: The Secret Life of Doctors

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Intro (Clint McElroy): Sawbones is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello everybody, and welcome to Sawbones, a marital tour of misguided medicine. I am your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: It's a little too much sort of like, bravado for my name, I think. I regret it instantly.

Sydnee: It sounded a little more like… like a radio DJ.

Justin: Yeah, that's not me, folks. I'm just regular Justin. In fact, I'm less than regular Justin, because I come to you today hat in hand. Uh, like, on behalf of my wife and the Maximum Fun network… it's Max Fu—

Sydnee: Our lovely children. [laughs]

Justin: Yeah. [laughs] Our lovely children. Who just… just want a square meal. Three hots and a cot. No, um… this is the MaxFunDrive. It's an exciting time. I don't feel humble. I'm thrilled, because it is a time where we all get to come together as a network, and with one voice, hold hands and say, "Hey, you! Give us money for this." [laughs]

Sydnee: [laughs]

Justin: The uh—we've been on the Max Fun network since we launched our show in 2000 and…

Sydnee: 13?

Justin: 13? We're at 220-some episodes. That's rough—

Sydnee: Has it been five years?

Justin: Almost five years. I think in the summer, right? It'll be five years?

Sydnee: Wow. I can't believe that.

Justin: Believe it or not. Um, but uh, the MaxFunDrive is when you—if you're not familiar, it's when we ask our listeners, if they are able, to really join the Maximum Fun network. Not just like, listen, but really become a member. And by that, we mean pledging a certain amount of money that you can—are able to comfortably donate each month.

We're gonna talk about what you will get in exchange for, uh, these donations. These thank you gifts. You're not really buying them. What you're paying for is the content that you've enjoyed, and it's a way to say, "Hey, I like this being in the world." And um…

Sydnee: And we really appreciate you showing that support, and so… And if you're already a member, maybe you want to think about upgrading your membership.

Justin: That would be wonderful, too. MaximumFun.org/Donate is the address. If you like our show, if you can spare a few bucks to support it, and the other shows on the network, um, the sho—you choose when you donate or upgrade, what shows you listen to. And the majority of your donation goes right to those shows. A smaller percentage goes to Max Fun to pay for its employees, and uh, the great team over there. And then, the rest goes straight to the shows.

So, that is a way to show your support, and to help make it possible for us to do this. Um, just to give a personal story, Sydnee works fewer hours than she used to, um, because she wanted to make more time to research and make Sawbones great, and record Sawbones, and do more live Sawbones, and stuff like that. So, um…

Sydnee: Yep.

Justin: And that's thanks to y'all. So…

Sydnee: Yeah, thank you.

Justin: Uh, that—we'll talk more about that at the break, but that actually, Sydnee, dovetails… not ducktails. Dovetails… whoa. Was that intentional?

Sydnee: Ducktails and dovetails?

Justin: Ducktails and dovetails? Is that a thing?

Sydnee: I don't know of anything else ducktails would've been a play off of.

Justin: Yeah, 'cause it's not—it's really—it sounds like—it's inter-capped in such a way that it like, it should be something, but… anyway.

Sydnee: Y'know, ducktails instead of…

Justin: Uhh…

Sydnee: There's nothing I can say there that is…

Justin: Nothing makes sense. There's no end to that sentence.

Sydnee: No. And some of them are inappropriate or expletives, so… we'll just stop there.

Justin: There you go.

Sydnee: [laughs]

Justin: Uh, today we are going to do an episode that is kind of different, but I think it'll be kind of fun and interesting. You're giving Cooper some weird looks. Is she okay?

Sydnee: No, she's just squirming all over the place. She's gonna need to be picked up. Also, ducks—is it just because of ducktails, like, tails?

Justin: Yeah, like, they have tails, and also…

Sydnee: Well, they don't have tails, but they've got that pointy part.

Justin: They do have tails! There's an end to a duck. Ducks do have an end.

Sydnee: Okay, anyway. In the hairdo—

Justin: That you could refer to as a tail.

Sydnee: —there's the hair—the hairstyle.

Justin: Of the ducktails hairstyle?

Sydnee: Isn't that what that's called?

Justin: You understand it would be pretty wild to call a hair style a ducktail if ducks did not have tails. You realize that would've been the first thing at the hairdressers' association…

Sydnee: [laughing] I meant the way that it's like, smooth like a greaser, right?

Justin: Yeah, no, I'm not debating the size and style of the ducktail sort of, uh, look. I'm saying that it would've been wild if ducks did not have tails, to call that style a ducktail.

Sydnee: It's like a butt.

Justin: So, uh, what we are going to do today… I'm going to ca—I'm calling it, because it sounds dramatic. The—the secret life of doctors. Um, but really, what we are gonna do… and because, I think it's interesting. Y'know, the doctor comes in, when you have your appointment, from a patient perspective. The doctor comes in, they see you for, y'know, however many minutes your appointment is. We'll get to that here in a sec.

Sydnee: Mm-hmm.

Justin: And um, then they disappear. So what are they doing the rest of the time? We're gonna break this into two chunks.

Sydnee: I mean, golfing.

Justin: Golfing, pretty much. Uh, I'm gonna break this into two chunks. Um, the first will be sort of Sydnee's regular day-to-day. And although she is a family practice doctor, I'm sure it's somewhat different for other specialties, but maybe you can address that sort of as we go.

Sydnee: Sure.

Justin: And then, second half of the show, we're gonna talk about hospital service, which is like, working at the hospital itself. Um, so, Syd, let's actually start… and now, this would've been, obviously—we talked about residency a couple of times. I don't think we want to focus on that so much. I'm kind of thinking where you're at now, as an attending physician.

Sydnee: Sure.

Justin: First off, why don't you talk a little bit about what that means? Uh, being an attending physician. And then let's get into your like, day-to-day.

Sydnee: An attending physician just means that I finished all of the training portion of being a doctor. Y'know, there's the years you're a medical student. There are the years that are kind of like apprenticeship years, where you're a resident, where you are a doctor, and you do get paid, but you're also still in training. And then, following that, you become an attending physician, meaning you're done with training. You're out there on your own. If you mess up, it's your fault, now.

Justin: Flip or fly.

Sydnee: Yeah. So, uh, I am an attending physician. I have been since 2012. Yes.

Justin: Okay, so let's start with a typical… let's—'cause your days are a little bit different. Let's start with Tuesdays.

Sydnee: Okay. And I—so, first of all, let me preface with, I do family medicine. So I see all ages of patients. And I largely do outpatient medicine. And when we say outpatient, we mean, in the office. Not in the hospital. That's inpatient. So I largely do outpatient medicine, and I do not do a lot of like, procedures. So, that just kind of is a broad view, like, that's where I fit in the medical spectrum.

So, I see you for like, checkups. Y'know, I see well child visits, or immunizations, or just to make sure they're doing okay. And then I also see people for chronic disease management. Diabetes, hypertension, that kind of stuff. And then, if you're like, sick. You got a cold or something. So, that's kind of the gamut of where I fit into the world.

Um, I work in an academic practice. So, we have medical students in residence that I teach, and then, I also see patients in that setting. Which is a little unique, because doing what I do, you could work in an academic practice, but most docs don't. They either work in a private practice, which is kind of what you think of as like, the doctor's office, where you go, and there's one or two doctors, and the nurses that work with them, and that's kind of it. Y'know, freestanding.

Justin: They're in a strip mall between a gun store and a, um, a fortune teller. That kind of thing.

Sydnee: Is that usually where doctors' offices…

Justin: There's like, different places they could be, I guess.

Sydnee: I mean, I guess it could be.

Justin: Could be.

Sydnee: Sure. Uh, and then there's also, y'know, large group practices, with many, many doctors, still outside of academics. Still outside of a hospital. But they would all do this similar kind of thing.

I start my day, uh, seeing patients at eight AM, generally, on Tuesdays specifically. But I mean, at our office, everybody starts at eight, pretty much. And the way that primary care visits are generally broken up… and it varies from place to place, but this is usually—this is the most common schedule.

I am scheduled a patient every 15 minutes. So, if I've already seen you before, that means you're an established patient with me. You get 15 minutes scheduled for your visit. If I've never seen you before, and you're a new patient to me, you get 30 minutes scheduled for that visit. Subsequent visits, of course, will be 15 minutes.

This would be different in different specialties. I know for instance that, if you're in psychiatry, your visit may be scheduled for an hour. Y'know. If you are in some—some other subspecialties, you might get 30 minutes for every visit. But in primary care, this is pretty standard. There are some that do 20 minute visits, but for the most part, 15 minutes is all we are given per patient.

Justin: Um, okay, so, when you are gonna go into a patient's room, how do you—do you like, review them before you go in? Or how does that work?

Sydnee: Mm-hmm. I uh—so I have access to their medical record through… we now have an electronic medical record. And again, this is the rule, rather than the exception. There are still places that have paper charts, in which case, you would have literally a folder of old notes. Y'know, old lab results. Old… whatever testing they've done, that you could flip through first.

Um, but I just open up their chart in their computer, and I sit, and I usually—if it's a patient I've seen before, I usually just review the last note that when I saw them previously, to remind myself, what specific issues did we cover? What did we want to make sure and follow up on this time? Um, I look at any other labs they've had done since then. Any other visits. Maybe they've seen another specialty. I can look at all those notes.

Justin: Where are you doing this?

Sydnee: So, I have an office that I share with one other physician, where I could actually go and sit and have a little more privacy to review charts. But I generally work out of my nurse's station. So when you go into a doctor's office, especially one with like, a multi-physician practice like mine, there are… ours has eight different nurse's stations, I believe?

And at each one, the nurse is stationary. So it's tied to whatever nurse works there.

Justin: So they tie the nurses to the station?

Sydnee: Yeah. Yeah, he or she does not move. They—no, they don't—

Justin: Oh, god.

Sydnee: No, not tie. Not literally. Ha ha. But the doctors might move about. Now—

Justin: It feels that way, doesn't it sometimes, my fellow nurses? I'm just imagining that's an issue that nurses complain about. I don't know. Solidarity.

Sydnee: The main thing they complain about is that since the hospital bought our practice, we can't have coffee at the nurses' desks anymore.

Justin: [sighs]

Sydnee: Pods, we actually call them. They're actually called pods.

Justin: Oh, like the Keurig? Those are fine. But I don't, uh…

Sydnee: [laughs] Not—no. We call the nurses' stations pods.

Justin: Oh, not the—okay. Uh, do you—

Sydnee: I work out of pod six.

Justin: Pod six. [laughs] Okay.

Sydnee: Generally. But I mean, doctors might move around.

Justin: Doesn't that get on their nerves? Like, get out of our pod. This is the—this is our pod. You have your own office. Does that bother them?

Sydnee: No, because there's a—

Justin: I know you bring a lot of your mom's fudge in, so maybe you've bought…

Sydnee: That helps. No, I think it's—I think it's better. For me, and this is—again, this is personal. For me, I like that I have—so, at our pod is a little desk with two computers. The one that is the nurse's computer, you don't mess with it, because that's their computer. And they use it all day long, 'cause they're doing a million things on it. And then, there's the other one that whatever doctor is working out of that pod can use. And we're right next to each other.

And I love that, because my nurse will go out to the waiting room, get the patient that I'm gonna see, while I'm reviewing their chart, bring them in, take their vitals, find out what they're here for, open up a note in the chart, and then come to see me.

And that time, that face to face time I have with my nurse is great for… if there's any issues right off the bat, she can warn me quickly. Like, "You should see that patient right away, there's something going on," or just, "Heads up, this bad thing happened. This sad thing that they were telling me about. Y'know, just so you're aware." Or, "They mentioned to me that they saw a doctor outside of our practice, and so, I'm gonna go try to track down that record while you're seeing the patient, so maybe we can get that record before they leave today."

And for me to ask questions like, "Hey, did you get a call back from so and so?" Or, "Have you read this task that I sent you yet?" That kind of thing. It's really important to take care of patients.

Justin: For you and the nurse to have that proximity.

Sydnee: Yeah. Yeah. For us to—I mean, my nurse and I have—we've worked together, essentially, since I started there. And we have a great rhythm now. Like, we're a good team.

Justin: Uh, the idea of using different computers throughout my day, and having a—using a computer that other people also use makes me want to scream and throw my head through the plate glass window that is in my office.

Sydnee: I—I have to use—

Justin: You are painting the grimmest hell for me. I cannot imagine using multiple computers and having to share them with other people. I want to cry. That's the saddest thing I've ever heard.

Sydnee: I use a different computer, essentially, every 15 minutes.

Justin: Ugh! [pained groans]

Sydnee: Because each room has its own computer.

Justin: Oh, you wound me. Oh, Smirl.

Sydnee: Which a lot of people complain about. Like—

Justin: Yeah!

Sydnee: Well, then, the doctor is looking at the computer instead of the patient. I try really hard to make sure that the majority of the time, I'm focused on the patient talking and interacting and examining. But it would be impossible to practice medicine without a computer in the room.

Justin: Um, okay, so once you go into the patient's room, I think we pretty much… I mean, I think people are pretty familiar with that part. Y'know, you're asking them what's going on. You're doing the checkup.

Sydnee: And while I'm doing that, I'm also responsible for generating a note based on the encounter. Which is just a record of what you said, what we talked about, what I recommended, and um, any exam findings. That kind of thing.

Justin: Now, do you do that note while you're in the room?

Sydnee: I do part of it while I'm in the room. Some doctors are fast enough to finish it while they're in the room. I like to talk too much, and I like to talk about stuff that isn't important to the visit too much. I spend time chatting with my patients, probably more than I should.

So, as a result, my visits take too long, probably, and I don't finish the note in the room.

Justin: So they—but they always go 15 minutes, 'cause you said, every 15 minutes, you have a patient. So…

Sydnee: Oh… no, they go at *least* 15 minutes. I—I would say that I—probably in an average day, I don't have a single appointment that only lasts 15 minutes, unless somebody just happened to come in for, "My nose is runny, can you just make sure I don't need an antibiotic" kind of visit. Those can last 15 minutes.

But anything with chronic disease management, anything if we're dealing with like, mental health issues… you can't cram that stuff into 15 minutes.

Justin: Um, yeah.

Sydnee: If I'm only running an hour behind at the end of the day, I feel pretty good.

Justin: Well, at least you get your lunch break, right?

Sydnee: I haven't gotten a lunch break since I… since I started medicine. I mean, I think as a medical student, I may have gotten lunch breaks. But since residency started, I have never, never had a lunch break.

Justin: It's scheduled in your day theoretically, but…

Sydnee: Yes. There is an hour between 12 and one when I am supposed to be eating lunch. I am never eating lunch at that time.

Justin: Um… that's lovely, Syd. What a good doctor you are.

Sydnee: [laughs] And I think—I think—

Justin: That also is why, by the way, I'm gonna take my sidebar here. Hi, it's Justin. Please show up on time for your medical appointment, *please.* Can you do that for me so my wife is not even further behind, and later in getting home, and… it messes up our whole day, so please be on time for your medical appointments. Hi. I know you have a lot going on. I'm sorry. We all do. Go—be on time, please.

Sydnee: It is hard. Especially if you're the first appointment of the morning, because if my first patient is late, the rest of my day… there's no way I can make up that time, 'cause I'm gonna lose time throughout the day anyway.

And that's something a lot of people say, "Well, you expect me to be on time, but yet, you're running behind. How do you justify that?" I don't want to run behind. I hate making my patients mad. I hate… 'cause I inevitably get yelled at. Maybe not every day, but every week, by somebody who had to wait, and is very angry with me. And I feel very bad about it.

But the reason you had to wait is that someone else had an issue that took longer. Sometimes it's an emergency. Sometimes it's… I mean, you'd be shocked how many times someone comes in to discuss, y'know, their blood pressure. And five minutes into the visit, they're sobbing, and they're talking about something that has nothing to do with that, but that they really need to talk about that day.

And y'know… I believe a good doctor goes where the visit leads them, and doesn't try to… force a visit on a patient that they don't feel they need at that moment. Y'know, sometimes I just have to look at people and say, "Listen, let's focus on this today, and I'm just gonna have to bring you back to talk about your… y'know, your glucose readings have been too high. We'll talk about that next time, 'cause clearly, this is more important to you today."

Justin: Um, is that a pretty good summation of like, your standard, like… when you're in the office?

Sydnee: Like, what I do every day?

Justin: That's a pretty good summation of that?

Sydnee: Yeah. I see—and then, at the end, once I'm done seeing all my patients, that's when I have to finish all the notes, and submit all the billing for all of the patients that I've seen. So—which is just me sitting at a computer, typing typing typing, and submitting all the bills electronically.

And uh—and that is just the patient part of it. That's actually just a small part of what I—my duties at the office.

Justin: Alright, well let's listen. That's what we're here for. What else you do?

Sydnee: Uh, the other thing that fills… every minute that I'm not seeing a patient, any second that like, let's say I have a cancellation and I have a free second. I'm waiting while my nurse puts a patient in a room, or over my lunch break. So called lunch break. Um, I—through the electronic medical record, I am sent tasks. I have an inbox with tasks in it.

And the tasks are questions from patients who have called, who electronically sent me tasks, who dropped off paper at the front desk. There are questions about refills. They're lab results or x-ray results. They're messages from other physicians, approving refills. Um, and I have to do all of those every day.

So, most days, I get probably… anywhere from 30 to 50. 30 on a light day, 50 on a really heavy day. Varies throughout the week. Um, and all those have to be done, which can either be sending electronic tasks back to my nurse, calling a patient, ordering more tests. Y'know. I mean, it varies.

And then there's my actual mailbox of paper mail. Which is filled every day with faxes from pharmacies for medication refills, for equipment refills, approving home health, nursing orders, physical therapy orders… all that stuff has to be reviewed by me and signed. So, I have a mailbox every day that's full of, probably, again, like… 10 to 20 pieces of paper that I have to read, and either scan into the medical record, or sign and mail back or fax back to somebody.

Justin: Um, can you talk about River Park?

Sydnee: Uh, I also work at a psychiatric hospital in our community. And there, um, I'm not a psychiatrist, obviously. I'm in charge of medical management. So, in order to get admitted to a psychiatric hospital, you

have to be medically stable. Y'know, not need some sort of acute medical care first.

And so, when you are first admitted, you're examined by me or one of my colleagues. I do a full head to toe physical exam, take a history, and… a lot of it is make sure that patients who are on chronic medications are continuing to receive those. If they need special labs ordered because of other medical conditions they have, I make sure those get ordered at admissions.

And then, people get sick while they're there. Y'know. Some people are there for a long time, and so, I see the usual coughs and colds. I manage like, um… medications that get out of whack. People who are on a blood thinner called Warfarin, it always goes all out of whack once they start different medications there. That kind of thing.

Justin: And lectures, right? You do lectures sometimes.

Sydnee: Yes. I do lectures to medical students. I do lectures to the residents.

Justin: You do lectures to them. [laughs] That is a way of…

Sydnee: To them. [laughs]

Justin: A way of describing it.

Sydnee: Um, and uh, I also precept. That's another thing I do. So, because I'm in an academic facility, um, any residents who are seeing patients have to have an attending who is overseeing them while they're doing that. So, that's always good to know. If you're seeing a resident physician, you might—it might give you pause, 'cause you think, "Well, they're still in training. That's not safe, is it?"

Justin: And you're right!

Sydnee: No!

Justin: Oh.

Sydnee: [laughs] Because there's someone like me sitting in an office that they are talking to about every single patient they're seeing. The earlier in their training, the more likely you might actually see me. I may actually come in the room before your visit is over to like, shake your hand and reassure you, "Don't worry, we just talked about everything. You're fine."

Um, but as residents progress, they usually don't have to bring us in the room. But um, I'm discussing every single aspect of your care, or someone is, who's already done with training, and y'know, making recommendations and suggestions, or just saying, "Yeah, you're on the right track. Good job."

Justin: Anything else outside of hospital service that you want to touch on?

Sydnee: Meetings?

Justin: Meetings? Everybody's got meetings.

Sydnee: I was gonna say, I don't think that's particularly…

Justin: No.

Sydnee: I meet a lot with medical students. One on one meetings, like, advising. Mentoring. Um, that kind of thing.

Justin: Next generation, right?

Sydnee: Yeah.

Justin: It's beautiful. Anyway, uh, we're gonna talk after the break about hospital service. But first, we're gonna take a trip to the… not really the billing department.

Sydnee: No. This isn't the billing department.

Justin: This is the giving department.

Sydnee: Aww.

Justin: Aww.

Sydnee: That's nice.

Justin: Uh, this is the MaxFunDrive, folks. We only do this once a year. Once a year, we come to you and say, "Hey, if you've enjoyed this show or the other shows on the Max Fun network, can you spare a few bucks to help support that?" And that money does go directly to the shows that you listen to. There's a percentage that goes to Max Fun for their staff, who help us make the shows and handle stuff like advertising, and producing for some of our shows, and pledge management, and all that great stuff.

So there's the staff there at Max Fun is supported by your donation, and also, the rest of it goes directly to the shows you listen to. That's why it's so important when they ask you to choose the shows you like, uh, make sure you choose all the ones you like, because that is who is getting your hard-earned cash.

We have, uh, several different donation levels. And they range from five dollars, all the way up to, I think, 200 is the highest possible, uh, level. We have gifts at each of those levels. We're not gonna dwell too much on some of the higher tier ones, because we know that that's asking a lot for most people, so uh… go to MaximumFun.org/Donate if you want to see those higher tiers.

If you can give five dollars per month, you are going to get over a hundred hours of bonus content. And I mean *well* over 100 hours.

Sydnee: I was gonna say, it's probably way higher than that.

Justin: I think we've veered into like, five days of bonus content. All the shows put out a new episode, a bonus episode. It's always pretty cool and

special, and you get access—every year. You get access to every year's bonus content. I mean, hours upon hours of stuff.

Sydnee: For example, we just did an episode, uh, live from a local pharmacy. [laughs] Where I basically talked about how bad a lot of over the counter medications are, and how many don't actually do anything for you.

Justin: Um, and we did one about like, medicine in the future, I think? Wasn't that one of them?

Sydnee: Mm-hmm. And we've done an ASMR episode.

Justin: We did an ASMR episode. We did a, uh… Two and a Half Men finale commentary track.

Sydnee: That's right, we did.

Justin: Do you remember that?

Sydnee: That's right, we did.

Justin: We absolutely did do that. Uh, that's a thing that we did. So, we have done a lot of those, and they are all there waiting for you.

Sydnee: Along with every other show.

Justin: Uh, yeah. Every other show, um… what did Still Buffering do this year?

Sydnee: Uh, we did a teen quiz.

Justin: Oh.

Sydnee: It was a teen quiz challenge. How much have we learned from each other?

Justin: Excellent. Well, you—and those are, uh, there and available for you to download. You're also, uh—with The Adventure Zone, we played Dungeons & Dragons with Lin Manuel Miranda for the first time he'd ever played. That's in there. Um, we also—

Sydnee: It's worth it just for that, really.

Justin: It's fun. There's a—and you get a demo of a song called Ghost Horse that he wrote. It's a parody of, uh, Fugue for Tinhorns. Is that right? Yes. Um… I think that's the name of the song. It's from Guys and Dolls. Uh—

Sydnee: And this is just at the five dollar.

Justin: That's just the five dollar level! If you can do ten dollars, you are going to get a *very* cool pin, designed by Megan Lynn Kott. Every show. You get to pick what show's pin you want. Um, and uh, every show has a very cool one. Ours is a sort of patent medicine looking bottle that says "Cure-Alls Cure Nothing" on the pin, and it's really cool.

Sydnee: You can come to the website and check out all of the different pins, uh, to entice you. They're excellent.

Justin: Uh, not to keep bringing up Still Buffering. I really like the Still Buffering pin this year. I think it's the best one. It's a little like, "For Dummies" guide, and it says "How to Adult." It's very cute.

Sydnee: It is very cute.

Justin: But all the pins are great. You can't go wrong with the pins, and that's at ten dollars a month, plus you get the bonus content. Now, if you give $20 a month, you are going to get… I think this is so exciting. The Max Fun 2018 Max Fun Family Cook Book.

Sydnee: Now, Justin, you submitted a recipe.

Justin: I did! All the Max Fun hosts, uh, a ton of them submitted recipes for everything from cocktails to desserts, everything in between. Um, great

recipes from their hearts. I donate—I gave my mom's recipe for chess bars, and they are—Sydnee has eaten them multiple times. They are…

Sydnee: They're delicious.

Justin: Quick review there. Amazing.

Sydnee: It's—yes.

Justin: They're real Baptist desserts. It's gonna take you on a journey.

Sydnee: Very decadent.

Justin: It's got, uh, a box of confectioner's sugar. I mean, they're out of control.

Sydnee: And it will make you the hit of every event you ever—people will be asking you to bring chess bars to their events forever, once you make these.

Justin: If you make 'em by the way, send me a picture. I'd love to see that. Um, you're also gonna get, uh, some cool space-themed cookie cutters. Um, and—oh! The recipe for—my dad submitted one for—we did an episode of My Brother, My Brother, and Me a long, long time ago called Spaghettigeddon, uh, that was an episode we recorded after our stepmother Carol made us some spaghetti. She submitted her spaghetti recipe into the Max Fun Family Cook Book. That's all waiting for you.

Plus, you get the enamel pin, plus you get the exclusive bonus content. And the donation levels go up from there. There's 35, 50, 100, 200, and there's great gifts if you go to MaximumFun.org/Donate. You can see those. But honestly, like… by the way, those continue to accrue. So whatever you get at your top tier, you get all the stuff before it.

But honestly, I personally think it's less important how much, and more important that you try to support… again, if you comfortably can. I don't want to put anybody in dire straits.

Sydnee: No, we just appreciate you for listening. But if you're in a position that you can listen and support our network by becoming a donating member, that would be awesome. Um, if you already are doing this, thank you.

Justin: Thank you.

Sydnee: We super appreciate it. And if you're already doing it, and you're thinking, "Y'know, I really like those gifts, and I'm in a position where I might want to upgrade my membership."

Justin: Maybe you picked up some other shows. Or maybe you're just listening more.

Sydnee: This would be a great time to do it, 'cause you get a gift, and then you feel really awesome, 'cause you helped us out.

Justin: Yeah, and you know, every time you listen to one of our shows, that you helped make it. And that is not hyperbole. That is the truth. Um, it means so much to us. You're supporting our family in such an incredibly humbling way, and we so appreciate you doing this. We only do it once a year. We come to you with these episodes, and we try to make it fun.

And it is fun. For me, it's cool that like, even though it's a time where we're like, asking people to dip into their wallets and give us some money, um… the outpouring of positivity from people on the MaxFunDrive hash tag is really lovely and beautiful, and um…

Sydnee: Yeah, it's just nice to hear how many people listen and appreciate the shows, whether or not you support 'em. So…

Justin: So, thank you for your kindness. Again, one last time, that address is MaximumFun.org/Donate. Please, if you can… and don't wait, 'cause you might forget, and you think, "Oh, I'm gonna do it." Just open up another tab, or just pop open your phone. Do it real quick. It's fun. I mean, it's not

fun. You're putting in your credit card information and stuff. It’s fine. But it’s not like—it’s onerous, I'll say that.

Sydnee: And make sure you check all the shows that you listen to and enjoy. That’s a really important part.

Justin: Yep. So, MaximumFun.org/Donate. Sydnee, you are on hospital service now.

Sydnee: Yes. Well, not now.

Justin: I am miserable. It’s—it’s so hard. This week is so hard for me. And I did say week. And that’s what we’re talking about. Tuesday to Monday, usually, for you, right?

Sydnee: Yes. So, I also take care of patients who are *in* the hospital. And everybody does this a little differently. Y'know, back in the olden days, I should—

Justin: There we go.

Sydnee: To draw—I mean, it’s Sawbones. That’s the show. Back in the olden days, this day would break down very differently. An old-timey family doctor would do what I do, see patients in the office just like I described. They also probably would have some home visits, some house calls to make that same day. And then, that same day, they would also be going to the hospital to round on any of their personal patients who were admitted to the hospital.

And that was the model for a long time. Wherever your patients were, you saw them. At home, in the office, or in the hospital. As you can imagine, that’s hard to have much of a life.

Justin: Yep.

Sydnee: And the bigger your practice grows, the more impossible that becomes. I mean, if you've got several people in the hospital, and you've

got, y'know, 40 patients to see that day in the office… when are you gonna get all that done?

Justin: Right.

Sydnee: So, uh, what a lot of practices do is what our practice does. We—all of our patients who are admitted to the hospital are seen by one out of our attendings each week. And we alternate. So—

Justin: Well, no, they're seen by your attendings each day.

Sydnee: Well, yes. Yes, sorry. Our attendings—

Justin: A different attending each week.

Sydnee: A different attending each week, and yes. Obviously, we see the patients every single day. And that is the way we are structured to do it. A lot of practices do that. Uh, more and more are going to a model where they will work with a hospitalist. So when you are admitted to the hospital, there's a certain group of doctors who just work inside the hospital. That's all they do all day. And they will take care of your patients while they're in the hospital, and then, hand over care back to you when they're released.

Justin: Hospitals, I bet, are the ones like, that have all the secret… like, the best shortcuts. They know the best stuff in the cafeteria. They're the ones, like, that you should ask for directions.

Sydnee: Yes.

Justin: I know that plays inside—

Sydnee: They know—yes.

Justin: They know where the bodies are buried.

Sydnee: Because that's the only place they work. That's all they do. They don't do any outpatient care. They just do the hospital. They are employed by the hospital, usually.

Justin: Mm.

Sydnee: Since I'm in an academic practice, not only do I see these patients in the hospital of all my… of all my colleagues. I also guide a team of residents in doing so. So, while all of the patients are technically admitted to me, and I see them every day, and I am ultimately the one responsible for making the decisions, y'know, involved in their care… uh, I am doing this sometimes through… senior, junior, and intern residents that I work with. I have a team of six.

Justin: Let's do this chronologically. 'Cause you go in just bafflingly early on—

Sydnee: It's really not that early. It's seven AM!

Justin: On her hospital service. I know, but it means I have to wake up at six. I mean, can you imagine it, folks?

Sydnee: So I wake up at six, and I sneak out of bed to try to not wake up Justin.

Justin: Never works.

Sydnee: Or Charlie, when she's in bed with us. Which is often.

Justin: [laughs] At that point in the day, yes.

Sydnee: And I try to sneak out of bed and get ready and quickly drive into the hospital to be there at seven AM. At seven AM—and every academic practice probably does this a little different, but this is the way we do it.

At seven AM, we have a check out, meaning that the resident who was there all night, actually slept in the hospital and took care of people all night long,

uh, sits down. We have a list of all of our patients, and we each get a copy. Physical list. Paper list. And they run through the list, and basically tell us what happened overnight. Y'know, here are any changes. Here were any things that went good or bad, and here are the new people that I admitted last night.

Our service is very busy. We have a very heavy service. So that number of new patients could range anywhere from five or six on a lighter day of work, to… uh, I think the most I ever personally admitted was 17 in one night.

Justin: Wow.

Sydnee: So it can get pretty busy on inpatient service. Um, that usually takes about an hour, of us just briefly—this is a very brief checkout at this point. Just quick updates.

At that point, everybody breaks up to go see their patients. And that's when, if you were in the hospital… this is when the doctor shows up to actually examine you, talk to you, and let you know what's going on. This is a good piece of advice.

If you, uh, have a loved one in the hospital, and you're wanting to talk to the doctors more, get more face time with them and actually be there when they come and check out your loved one and make the plan? The morning is when we do that, usually. For the most part.

Our patients are spread all over the hospital, since we do family practice. We do all ages and all problems. So I start at the top, just… I don't know. We just do. We start at the top and work our way down. We go to the top floor, and uh, we go into each room. It's myself and two of the senior residents, and we examine and talk with the patient and make a decision based on how they're doing. What we're gonna do that day, let them know what the plan is, and… move on.

Once we have seen everyone, we reconvene back in our call room. Every practice, by the way, has like a secret call room somewhere in the hospital.

Justin: Ooh!

Sydnee: If you open the right door, you will find a large table, covered in computers and paper, and very tired looking residents, and lots of coffee.

Justin: Sometimes there's a bedroom?

Sydnee: Oh, there has to be. There has to be a bedroom.

Justin: Oh, there has to be a bedroom.

Sydnee: Yeah, because the—I mean, at least one of those doctors is staying there every night. So there has to be a bedroom. And um, often, there's a bathroom. And a shower. 'Cause y'know…

Justin: And snacks.

Sydnee: Some of them shower, sometimes.

Justin: Usually snacks.

Sydnee: Yeah, ours has a refrigerator.

Justin: I make baked goods sometimes, so if you see one with baked goods in it, that might've been me.

Sydnee: And a holiday tree.

Justin: And a holiday tree.

Sydnee: It's not really Christmas. We decorate it all season long. It's a holiday tree.

Justin: That's good. Good for the spirit.

Sydnee: Yeah. Ours also had elevators, so it was kind of like the bat cave, but then they took those away.

Justin: Aww.

Sydnee: So, we reconvene in the call room. And at this point, I have seen all the patients. But the junior residents and interns have also seen all their patients, too. So, the way we're structured is, we go down the list, and one by one, the residents, uh, present the patients that they're assigned to. And they tell me what—

Justin: But you've seen them, too?

Sydnee: Yeah.

Justin: Okay.

Sydnee: I mean, I trust 'em, but this is still—

Justin: Right, yeah.

Sydnee: Y'know, it's still like… I was gonna say, kind of life and death, but like, literally.

Justin: Literally, yeah.

Sydnee: Life and death. So I've seen them, too. Uh, but they present to me what they found. Y'know, what questions they asked, their exam findings. And then they also, at this point, we have lab results and stuff back. It takes a little while for that stuff to happen in the hospital, so if we give 'em a few hours in the morning, by the time we sit down to actually discuss the patients, then we've got all your results.

So, when they took blood from you in the morning. If they did an x-ray, whatever, we have all that to look at. And so, then we can make final decisions on what to do for each patient each day. Um, we make all those decisions, and then… we're back to the notes.

Justin: Mmm.

Sydnee: So, if you, uh—if there's a change to the plan I already told you, or if you're gonna be discharged, a doctor is gonna come back to the room to kind of tell you what the change is, or to sum everything up and let you know that you're gonna be discharged, and answer any questions you have. That kind of thing.

Um, if not, if things are kind of status quo, then the resident's job is to just write a note on you. Put in any orders. All orders are put in electronically. So, basically, it's—at this point, if you walked in the call room, you would just find a bunch of doctors frantically typing away. Either putting orders in for new medicines or whatever, or uh, filling out discharge paperwork.

And then, on every patient, every day, there has to be some sort of note documenting what we did.

Justin: How they're doing, that you saw them…

Sydnee: Mm-hmm. And so, they type up all the notes and send them all to me. To read, review, edit, and then, append. A little thing that says, "Yes, I read this, and I agree."

Justin: Yeah, this is more of a full time… and I mean, like, literally, full time when you're on hospital service, right? Because there's stuff that you do in the evenings, too, even after you come home.

Sydnee: Mm-hmm. So, I work seven straight days when I'm on hospital service. I am on call seven solid days, from the first… I take over Monday evenings around five or six, and I hand off the following… Monday evening, at five or six.

Justin: Right.

Sydnee: And from that time period, I am responsible for those patients every single second. Uh, so, as a result, even when I finally leave the

hospital each day after all the rounds are done, the notes are signed, the plans are made, the questions are answered… when I go home, I still have to be available the entire time by phone, um, to answer questions.

In an emergency situation, I may have to come back into the hospital. But honestly, that's pretty rare. Because most of the time, if something has to be done quickly, the patient probably is gonna end up transferred to the ICU, which is a whole other set of doctors and stuff. And so, it's often not necessary for me to actually physically come there, because by the time I would drive there, it's already happened.

Justin: When you're on hospital service, how do you decide if a patient needs to go to the ICU, which is the intensive care unit?

Sydnee: Uh, so, there—

Justin: I know you know that.

Sydnee: [laughs] Thank you. There are a couple reasons. It may be because they've become unstable. And so, then we start to worry that they're gonna need something to provide extra respiratory support, like—

Justin: What's that mean, unstable?

Sydnee: That could mean that they are not being able to breathe on their own. Um, we're worried about their oxygenation. They're not getting enough oxygen in. It could mean that their blood pressure is dropping dangerously low. It could mean that their heart rhythm is out of control, and we are not being able to control it.

Justin: So, possibility of dying, basically.

Sydnee: Yes. Yes. They have—they have moved from a stable, uh, condition, to a critical condition. And so, at that point, they would be transferred there to provide a higher level of care. They can do things in the ICU you can't do in the rest of the hospital. You wouldn't be on a ventilator anywhere else. Things like that.

And you also have a, uh, like… the ratio of nurses to patients is much better. So, if you are in the ICU, your nurse may only have you and one other patient that they're responsible for. Whereas, on the floor, they would be responsible for many more patients.

Um, and then, the doctors in our hospital, for instance, in our ICU, it's a closed ICU. So you're only being cared for by intensivists. People who are trained in intensive care.

Justin: Um, you're—it can be a stressful time when you're in the hospital, and especially like, if you think about what Sydnee is describing, how rarely she is overlapping with patients, um… what is the—if you're in the hospital, or you got a loved one in the hospital, what do you think is the best way for people to sort of like, get what they… y'know, to get the care that they want?

Sydnee: I think the best thing, um… one is to—if you're—well, obviously, if you're the patient, you're gonna be there. I was gonna say 'is to be there.' [laughs] But if you're the loved one—

Justin: That's not so obvious. I've seen quite a few people smoking outside the hospital. [laughs]

Sydnee: Well, maybe I should say that, then. If you're the patient, the best way to get the information you want is to not leave the room all the time. I understand, if you're there for a long course, you gotta get up every once in a while. I understand. I don't blame ya. But um, this might be a great time to give up smoking.

Justin: [laughs]

Sydnee: Especially if you're admitted for something like pneumonia. You probably don't want to be smoking. And especially if it's like, really cold out or raining. And you have to walk pretty far away from the hospital now to smoke, because it's a nonsmoking campus.

Justin: Yeah, it's a hike. You're over at Tudor's, pretty much.

Sydnee: Yeah! So I mean—or, you're standing out—everybody's under that tree that's right out by the road. Anyway…

Justin: The smoking tree.

Sydnee: Yes. I would—

Justin: By Shel Silverstein. [laughs]

Sydnee: That would be one thing I would advise is, you'll get more contact and more answers, and you'll probably get better faster if you're not outside all the time. Um, the other thing is, if you're a loved one, if it's possible for you to come in, that's great. Especially in the morning. Now, that's not possible for everybody, and I understand that. We all got jobs. We all got stuff to do.

So, in that case, what I would say is, a phone call to talk to… one, the nurse can answer a ton of questions for you. So don't feel like, if the nurse is giving you answers, don't feel like, "Well, this isn't the real story. I need the doctor." No. The patients, nurses, they know what's going on. And a lot of the time, they can answer questions about like, what's the next step? Are they doing okay? Are they getting better? What do we think is going on? You can easily get those answers.

If you are feeling like there's more that you're not getting, or there's some confusion, or something changes… letting the nurse know that you want to talk to the doctor is always effective. Um, we will get back to you. We might not instantly, 'cause it's the hospital, and things are unpredictable.

But somebody will call you, and uh, if you're in the room on our service, if you call and say, "I need to talk to a doctor," unless there is something absolutely emergent going on, and we cannot leave it at that moment, somebody will come to your room and talk to you and answer your questions. We'll do that.

And write ‘em down as you think of them. I always tell patients that. If you're just sitting there, and you think, “Y'know, this isn't urgent, but the next time I see the doctor, I really do want to ask them this question.” Write it down. You'll forget by the time you see us. And then we’re gone. So, write down your questions. Don’t be afraid to ask. The nurses are your best conduit to the doctors. They know almost everything that we know, in terms of what the plan is. And when there are little changes, they can get that information from us right away.

I would say, those are the big things. Don’t be afraid to ask. I think a lot of patients are afraid to ask questions, ‘cause they're afraid like, “Is this silly? Is this obvious? Is this not…” What I'm getting at, “Is this a dumb question?” There are no dumb questions. I went to me—

Justin: Mmm…

Sydnee: No, there aren't, really. I went to medical school to understand this stuff, and it’s still hard, and it’s still a challenge, and I still continue to learn and continue to read and continue to, y'know, figure things out every day. I don’t expect you to know what’s going on. I expect—my job is to make sure that, by the end, you understand it. But if you don’t understand it, I haven't done by job, so tell me. That’s the big thing.

Justin: Um, and also, when you're on hospital service, I guess it’s worth mentioning that like, theoretically, you could get called at any time, right?

Sydnee: Yeah. Yeah, during those seven days, I could—I am at the beck and call of the hospital.

Justin: And you do check in nightly for a while.

Sydnee: Yes. Yeah. I uh… so, any questions, things that—urgent things that pop up throughout the day, I get calls on. And then, um… I actually have a secret doctor text.

Justin: Oh, that’s right! [in a seductive voice] Doc Halo, secure message.

Sydnee: That's right. It's secret. It's HIPAA protected secret doctor text that I get messages from sometimes from the residents.

Justin: And that is the—that is the notification noise. It is not like, woodoodoo! It is, [seductive voice] "Doc Halo. Secure message."

Sydnee: It is. That is what it is. [laughing]

Justin: It cracks me up so much that I don't let Sydnee turn her phone on silent while she's on service, 'cause I never want to miss a single… [seductive voice] Doc Halo. Secure message.

Sydnee: So, uh, that—I'll get those multiple times throughout the day. It's also a great way to connect with specialists. Like, if I have got consultants seeing my patients, that's a gr—we are—Doc Halo has improved communication between your primary doctor and their specialist so much, you have no idea. [laughs]

Justin: I won—

Sydnee: We are in constant communication now.

Justin: I wonder if there is another noise. If that's like, the default, but like, everybody has already changed it to like, "Woodoodoo!" Like, that. That noise I just made up.

Sydnee: No, 'cause I hear everybody else's while we're rounding and stuff, so, no.

Justin: There's no way to sample that, is there? Somebody really has to send you a Doc Halo?

Sydnee: If—yeah. No, somebody needs to send me a Doc Halo. If there is a way to change it, I guarantee you, there is not a doctor who has tried to figure that out, or has done it yet. Um, but no, every evening, I get a call from the senior resident who is on call that night, and we discuss every

single patient. We go through all the plans for the day. Any changes that may have happened. Um, any updates. And then, all the new people.

And then, I can get called all night long with new patient admissions and questions and all that kind of stuff.

Justin: Uh, we talked sort of about… this probably would've made more sense earlier, but it's just sort of come to me now as we're talking about the best way to sort of handle yourself in the hospital. When you are going to your doctor to visit, can you give people any tips for like, the best way to make their doctor's visit really effective?

I was gonna say "to get what they want," but like, ehh, there's a—that's not always the best outcome for your health, I guess. For you to get, y'know, quote unquote "what you want." Especially with how many people are just trying to score opiates. So, um, not any of you listening, of course, but like…

How would you advise people like, best comport themselves?

Sydnee: Well, I mean, I don't want to say that there… I don't want to—that's such a personal thing. I don't want to ever say that there's a right way to come receive medical care.

Justin: Well, and obviously, the impotence is on the doctor. But like—

Sydnee: Sure.

Justin: But y'know, I—like, attitude wise, like, I don't know. There's a lot of times where I worry that I'm, uh—like, if I'm having a problem, I wonder like, "Am I telling them enough? Am I telling them too much? Does this have nothing to do with anything, and I'm just kind of rambling?" Like…

Sydnee: Here's what I would say. Um, other than, it really helps if you can show up on time. I'm not trying to be… [laughs] I'm not trying to be tough on that, but it really does help to make sure that you get the full—y'know, everything out of your visit.

Um, I would… and if the doctor has asked you to do any, like, tests before they saw you, like, take this new medicine, get this blood test done, see this other doctor before I see you, and they've arranged for that to happen, I would really encourage you to actually do that.

'Cause I—sometimes I feel like I do the same visit. It's like déjà vu with some patients over and over again, 'cause like, I really need to see what their diabetes, how well it's being managed, get this lab test for me, and it'll be three visits before they get it done.

And so, every visit, it'll just be me saying, "I still don't know how your sugar is doing. I want to help you, but I have no data to base my decisions on." Um, so that would be one thing. And then, if you know… if you have a concern, what I would do is just, um, think about ahead of time what specific questions you have and what your worries are. And make sure you get to ask those.

If you go in, and you're waiting for the doctor to just like, figure it all out, uh… it's not like House. I think I've said this on a show before. It's not like you can drop a couple hints, and then I'll look at like… I don't know, something weird on exam, and be able to instantly tell you what your diagnosis is. Medicine never works that way. It'd be cool if it did.

But a lot of the time, it's a like, narrowing down the diagnosis process. You tell me a problem. You tell me what you're most concerned about, or what symptoms have bothered you the most. I ask some questions. We get to what we think it is, or a broad differential of, it's probably one of these things. We do some testing to figure it out, or we try a medication to try to address it.

And then, you come back to see, have we made progress? Are we on the right track, or did we start on the wrong track? Um, that's how medicine works most of the time. It is rare that you're able to come in, tell me something, and I go, "Ah! I know exactly what that is. This is what it is. Here's the treatment." So…

Um, think about it. Have some questions. And don't expect that your doctor is gonna have like, an a-ha moment. Those are rare.

Justin: Um, do you think we've covered everything? Is there anything else you wish people knew about what you do every day?

Sydnee: Uh… I think that—

Justin: And also, you come home, and then you research your podcast, and you record your podcast.

Sydnee: Yeah. And I do all the notes that I haven't finished, and I… I do all the tasks that I haven't finished. And I like to save calls sometimes for later, because um, people are off work. And I have more time.

Um, I would say this – medicine, at least, in this country, and especially in primary care… it is demanded of doctors that we see patients very quickly, because that is how the big businesses of medicine make money off of us. And that is not… please know, doctors are no more pleased with this situation than you are. Um, I think most of my colleagues, if they could like, have a wish list of things that they would ask of their bosses, um, high on that list would be more time to see patients.

The problem with that is, the more time you spend seeing each patient, the fewer patients you see each day, and so, the longer it takes you to get back in with your doctor. So it's a balancing act. There aren't enough primary care physicians, so, y'know, there's a limit. There's a rate limiting factor here.

But just be—try to be patient, patients. [laughs] When I am running behind, I promise you, it's not because I'm, y'know, golfing. I promise you it's not because I took a break to eat or pee. You don't know how many days I've finished seeing my last patient, and I literally run to the bathroom, because I've had to pee so bad for the last two hours. [laughs]

And I didn't want to slow myself down the extra five minutes it would take to run to the bathroom and run back, because that's five minutes I would steal

from a patient who has already waited for an hour, and is, y'know, desperate to see me, and needs to get back to work.

Try to be patient, because I promise you, if you're waiting, it's for a good reason. We are not messin' around. Um, and then, in return, I always make this promise to my patients – I will give you every minute you need. I will give your problem every minute that it needs, and I will not short change you. Just please be patient.

Justin: Um, uh, thank you so much, Sydnee, for that enlightening tour of your daily life. Next week, me. [laughs]

Sydnee: [laughs]

Justin: It's… a lot more relaxed.

Sydnee: I bet you pee more than I do.

Justin: I'm peeing right now. Um, this is the MaxFunDrive. One last note on that – if you like our show, if you like what we do, if you like the other shows on the Max Fun network, please, please please please. This only goes for two weeks, so—and after that, you won't hear about it again. But please, shut us up. Go to MaximumFun.org/Donate. Pledge or upgrade. Uh, it really does mean the world to us.

If you do, tweet at me, @JustinMcElroy or @SydneeMcElroy. We try to thank everybody that we see. We do have two kids, so it's not always the easiest thing. But it—we will catch as many as we can, I promise.

Sydnee: Sometimes, I'm up at three AM, nursing our seven week old, and I see those texts. Or, those tweets. So…

Justin: Um, folks, that is going to do it for us. Thank you to the Taxpayers for lettin' us use their song, Medicines, as the intro and outro of our program, and thank you to the Maximum Fun network. And thank you to you, if you have donated, or upgraded your donation, or, hey… just for listenin'. We appreciate you no matter what.

So, until next week, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don’t drill a hole in your head!

[theme music plays]

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