

# dear residents

Who Holds the Patient's Story?

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Dear Residents,

Not long ago, I watched a conversation unfold around a patient with persistent fever. An **Epic Chat** had been started. Infectious Diseases was looped in. Rheumatology joined soon after. Then hematology. Messages began to populate the thread.

*"This does not seem infectious."*

*"We are not seeing clear evidence of autoimmune disease."*

*"Flow cytometry results are negative."*

*"Perhaps additional autoimmune testing would be helpful."*

*"Agree, though would also consider expanding infectious workup."*

The conversation was thoughtful. Collegial. Responsive. And yet, something was missing. The intern, who knew the patient best, was quiet in the thread. Not absent, but peripheral. The discussion had begun to move laterally, between consultants, rather than through the primary team. The patient's story, once held centrally, was now dispersed across a series of well-intentioned exchanges.

**No one had done anything wrong. In fact, everyone was doing what the system now makes easy.** This is the world we are practicing in.

There was a time when requesting or responding to a [consult](#) required a moment of pause. A question had to be formed. A clinical uncertainty had to be named. A recommendation had to be given. The intern often stood at the center of this process, not simply relaying information, but synthesizing it. Different perspectives were gathered, weighed, and translated into a plan.

**Today, our tools allow us to bring everyone into the same conversation instantly.** Coordination has improved. Access is easier. Silos are more permeable. There is also real value in what these tools allow. We can engage referring physicians more easily. We can bring in expertise from clinicians who may not be physically present in the hospital. Perspectives that once required multiple steps can now be gathered in a single space. For patients with complex or unclear conditions, this kind of access can be meaningful.

**But ease has a cost.** The conversation that unfolds in a thread still needs to be translated into a plan. Someone must document it, reconcile differing opinions, and ensure that what is discussed becomes what is done. That work often falls to the primary team, and frequently to the intern. What appears

seamless at the level of communication can create additional layers of cognitive and practical work at the level of care.

**What is easy to start is not always easy to complete.** When multiple consultants speak directly to one another, the role of the primary team can blur. Ownership can diffuse. The responsibility to synthesize, to hold the competing possibilities and arrive at a plan, can become less clearly defined.

At the same time, the very tool that enables this coordination also tethers us to a constant stream of communication. Messages arrive continuously, often indistinguishable in urgency. The mind shifts from patient to message, from message back to patient, again and again. Attention fragments. Thought is interrupted. **We have solved the problem of reaching one another. We are still learning how to think together.**

As you navigate this environment, I would encourage you to hold on to a few principles.

- Formulate the question, even when the medium does not require it.
- Stay at the center of your patient's story, even when others enter the conversation.
- Be mindful that adding voices does not always create clarity.
- When needed, step out of the thread and reassemble the plan.
- And remember that ownership is not about control, but about responsibility.

If you are the consultant:

- Before responding in chat, ask: What is the question we are trying to answer?
- Be mindful of who is not in the thread. Bring the primary team back into the center.
- When a conversation becomes complex or consequential, consider stepping out of the thread, pick up the phone or walk to the bedside. A formal consult will often be the better option.

The tools will continue to evolve. The expectations around responsiveness will likely grow. But the core work of medicine remains unchanged. Someone must still hold the whole. In the end, the patient does not experience our messages. They experience whether we have made sense of them.

Warm regards,

Dino Kazi