

Mutiny!

Conrad May, MD

A grizzled sailor was admitted to the hospital with complaints of profound weakness. He appeared every bit the ancient mariner—with sun-leathery skin, stubbly white beard, wiry build, and muscular arms corded with grapevine veins. He was about to embark on a voyage around the world with his girlfriend when he fell ill, now limp as a sail caught in the doldrums. We soon discovered the cause—his serum sodium levels hovered at dangerously low levels.

His attending physician was an esteemed nephrologist. I marveled at his breadth of knowledge and reasoning ability as he methodically eliminated one cause of hyponatremia after another, to deduce that a tumor was secreting antidiuretic hormone. He directed me to administer an agent to block its effects, and the patient soon regained his sea legs—almost miraculously. To the unseasoned intern that I was, this was a tour de force of logic-based medicine.

Not long thereafter, I cared for another one of this attending's patients. Mr. C had renal failure and performed peritoneal dialysis at home. Even in the most careful of hands, these patients often developed peritonitis. The patient was pallid and said little. His wife, a warmhearted woman with grey hair tied neatly in a bun, proudly told me that her husband was the best car mechanic in town. He could diagnose the problem in an instant, do a good job at a fair price, and never cheated his customers. I admired the faith she had in her husband. In a short time, I had come to love these patients—honest, hardworking people who managed to scratch out a passable living in this blue-collar neighborhood.

Mr. C's case of peritonitis did not seem so straightforward to me. A course of antibiotics, administered intravenously and infused through the peritoneal dialysis catheter, was usually curative. However, he continued to appear quite ill even after days of treatment. The fluid draining from the peritoneal dialysis catheter contained brownish flecks that resembled stool. Cultures of that fluid yielded multiple organisms that normally reside within the large intestine. Taking these clues together, I thought that the patient had perforated his bowels. I shared my concerns with the attending, but he reassured me that the peritoneal fluid sometimes contained debris with this appearance.

He was still confident that this was a case of catheter-related peritonitis.

I was not entirely persuaded. The attending's diagnosis ran counter to my common sense, if not experience. It puzzled me that he seemed to be overlooking the evidence in this case, in stark contrast to our previous patient. However, it did not come easily for me to question the judgment of the attending, especially someone whom I regarded highly. The attending was the captain of our crew, and he determined that we would stay the course with antibiotics. Still, I was uneasy about Mr. C's condition and would stop to check on him whenever I passed by his room.

Then I found Mr. C collapsed on the floor. The drainage fluid was even more feculent. His abdomen was eerily silent; I could hear the television in his room through my stethoscope pressed against his skin, but no bowel sounds. On palpating his belly, my probing fingers elicited soft moans. At this point, I was convinced that the patient had perforated, and the situation had turned critical. The nurse who helped me lift Mr. C back to bed looked on anxiously: "What are you going to do, doctor?" Why, call a *real* doctor, of course. I paged the attending, but he did not respond for what seemed to be an eternity.

I was buffeted by crosscurrents—on the one hand, the well-defined hierarchy of the medical institution was instilled in me, and I greatly respected the authority of the attending; after all, he had already served for many years at the helm, and I was merely the latest swab. At the same time, I felt the gravity of responsibility to care for the patient to the best of my ability. I did not want to mutiny, but I knew that if I waited any longer the patient would surely die on my watch. How could I bear that weight on my conscience? And how would I be able to face the kindly Mrs. C? I had to do *something*, to have the courage to act on my convictions—so I summoned the surgeon. Up to this point in my internship, I had dutifully carried out the orders of my superiors. This was the first consequential action I had ever taken on my own initiative, based on my own assessment.

Given the urgency of my report, the chief resident of surgery came to examine the patient himself. He concurred that the patient had very likely perforated and now had an acute abdomen. Arrangements for an emergency laparotomy were swiftly made. By the

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time the attending was apprised of these developments, the patient was already in the operating room. I was hoping that the attending would be pleased with my acumen and decisive action. He was not; instead, he was furious. He was still certain that the patient had *not* perforated and that I had sent *his* patient to surgery unnecessarily. To my alarm, he raced to the operating room, but it was too late to halt the laparotomy. The attending paged me from the OR, demanding that I join him there. “Get in here right now!” he roared. “Today you are going to learn more than you ever did in medical school!” Now I was thoroughly shaken. Was I mistaken despite all the signs and symptoms? The consequences of being wrong were too terrible to contemplate. I dropped what I was doing and hurried towards the surgical suites. On the way, I said to myself, oh well, this could be the end to a spectacularly short career.

Perspiring heavily, I donned a mask and slipped into the operating room to stand next to the glowering attending. Just then the chief resident was “running the bowels,” sliding the length of the intestines between his fingers to examine it. He held up 4 areas of perforation for us to see, yellowish blossoms

studding the greyish-pink surface of the intestines. Waves of relief and a sense of vindication washed over me. I turned to the attending to ask if there was anything else he wanted me to do, but he just stared dead ahead and said nothing at all.

As I ascended through the ranks to take the wheel as an attending physician myself, I reflected on the formative events that shaped my teaching style. I was mindful to give my residents the space to exercise their own decision-making skills and clinical judgment. To avoid falling victim to tunnel vision, I encouraged my teams to cast a wide net in formulating the differential diagnoses. I strived to foster a less formal and more collegial atmosphere so that no one would feel too intimidated to raise an issue, voice an opinion, or alert me to my blind spots. The attending was right. I did learn a valuable lesson that day, but not the one he imagined.



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