

Different Story, Different Day: Medical Errors on a Teaching Service

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The only thing worse than making a medical error is making one when you are in charge of a resident team.

He was often homeless, always emaciated, and usually dehydrated. His short-gut syndrome didn't help, and his blood pressure was rarely above 95/50 mm Hg. The social workers knew everything about him without opening his chart. He was never the patient anyone gave to medical students—not because a student wouldn't have learned from him, but because everyone knew he wouldn't talk to one. He refused medical care on a regular yet seemingly haphazard basis. Most of the time he lay on his side facing the wall, eyes closed, meal after hospital meal taken away uncovered and untouched. The first time he came to my team, it was the classic “same story, different day” scenario. Two days later, volume replete, infection ruled out, we discharged him to a nursing home and honestly felt that we had provided him with the best care that we could.

And that time, we probably did. When he came back months later, skinnier than ever, I figured his story probably hadn't changed much. He'd come for a PCP appointment and was sent to the emergency department with a blood pressure of 80/51 mm Hg. Sure, a little lower than normal, worth getting an infection work-up, but he told the intern that he hated the food at the nursing home so he was on a steady diet of nothing but hot chocolate. We started fluids, and his blood pressure climbed into the high 80s. I saw him before going to the clinic. He didn't remember me (no surprise there), and he was tired of talking despite having declined to answer most questions.

But then the day got a little more interesting: his chest x-ray showed an upper lobe cavitary lung lesion that hadn't been there a few months prior to his last x-ray.

Hmmmm, how interesting! Cancer? Tuberculosis? No wonder he's so emaciated! Okay, negative pressure room, TB rule out, CT chest ASAP, HIV test, silent prayer of thanks that he hadn't been coughing.

Several hours and 6 other admissions later, I met with my team. My resident was great, and I knew he would have everything under control. We talked about the differential

diagnosis for cavitary lung lesions and how our patient was doing.

My awesome intern said, “He's still getting fluids and his blood pressure's hanging out in the low 90s. The CT is pending. I want to start antibiotics—I know he doesn't have a fever or white count and I'm a little surprised that he's not coughing or short of breath, but I sort of think of him as immunosuppressed since he's so malnourished.”

What a stellar intern: describes his clinical reasoning, puts his money down. I congratulated him on a great job and then promptly disagreed with him.

“If you guys want to, I'm okay with it, but I'm reassured by the fact his blood pressure is pretty much at baseline. I think cancer or TB is more likely since he's asymptomatic. I'd vote for no antibiotics, but we'll ask night float to keep a close eye on him tonight.”

Even though I gave my team the green light, of course they didn't start antibiotics. The attending usually wins, even when we're happy to lose.

I did not go see the patient again that night; I didn't make sure that anyone else on my team did either. I also did not reflect on the fact that I never saw any family or friends visit, a reality that should have changed my behavior much more than it did. He was the type of patient whose room was so easily walked past: I always left it feeling like I'd been more annoying than helpful. For me it was a constant battle to make sure my empathy won out over my frustration, although I hope that I disguised that internal conflict from my team. I wish I had reminded myself that it's the patients with whom it's toughest to connect that we most often get burned.

And get burned I did: I knew it as soon as my pager went off at 5 AM the next morning. The night float intern, also awesome, had checked on our patient every few hours. He'd been fine until his blood pressure was suddenly in the 60s. He'd been fine until he ended up in the ICU on vasopressors.

I was grateful to the night float intern for ensuring that our patient received the care that he needed. I was also grateful to her for giving me a chance to briefly bang my head against the wall in the privacy of my own home. And I was grateful for time to call my friend and former program director to process what had happened in the following order: first, was I the biggest idiot on the planet, or just in this hospital; and second, what was I supposed to say to my team?

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Medical errors are one of the most universal experiences of being a physician, and they're also the most devastating. When my colleagues and I talk about our toughest moments in medicine, from intern to department chair, it's not the busiest call nights or Thanksgiving dinners in the hospital cafeteria that stand out. It's the times when we feel we have let our patients down. And as a medical community, we do a poor job of preparing the next generation of physicians for this inevitable reality. It's probably in part because nothing can prepare you for what it feels like to make a mistake and see your patient suffer as a result. Nothing can prepare you for that feeling that hits you like a ton of bricks and makes you wish you could turn back time just a little and be smarter, more observant, more thoughtful, a better doctor.

So I sat down with my fantastic team. We talked through the previous 24 hours, and I reminded them that the buck stopped with me as the attending (they probably didn't need the reminder, they were all there the night before). And we talked about mistakes in medicine, including some of my own previous mistakes and how I'd learned from them. I don't know if it made more or less of an impact on the heels of my own clear misjudgment, but regardless, it had to be done. And we went to talk to our patient in the ICU, where I explained my role in why he was there. He rolled away from the wall and looked at me through sunken eyes.

"Thanks, Doc. I appreciate what y'all do."

What? He's thanking me *now*? When I deserve it the least?

I'd like to believe that he appreciated my admission of my mistake and coming to see him, but I know it was probably a coincidence. He was probably just happy to be in a nicer room.

I went off service 2 days later. The patient's CT showed a cavitating pneumonia, and he responded well to treatment. Sometimes the ones who seem to have the least reserve are the most resilient. Every time I go on service, I say a little prayer to Hippocrates, God, and the universe that I'll keep my patients safe and be a good role model. And although it's never as perfect as I wish it were, most of the time, it's pretty good. Except for the times when it's not.

We all look for the lesson when we feel we have failed our patients. Often, we learn more medicine from these situations, but sometimes, when the dust has settled (patients informed, teaching points made), the primary lesson is simply: reflect and then move on. A healthy amount of humility is critical for any physician, but too much self-doubt is detrimental to our mission. I can't start antibiotics on every patient I see in the future. I can use the experience to make me tougher, so that the next time it happens, I'm better able to manage the aftermath. Sure, I can hope there's no next time, but we all know that's not happening. For now I have another story to tell my next floor team.