My greatest mistake

True confessions

In October Minerva asked readers to submit their tales of clinical, career, or other mistakes, for publication in this issue. First to respond were Dave Sackett and Richard Smith, followed by others, some of whose confessions are printed below. You can see all the responses and add your own contribution on bmj.com (http://bmj.bmjjournals.com/cgi/content/full/329/7474/DC3)

BMJ 2004;329:1494-6

Skoda's fool

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As the solo intern in charge of a Chicago emergency room one August night in 1960, I was grappling with three dozen former passengers (by then, aspiring personal injury claimants) of a city bus involved in a minor collision. Most had demanded x rays in hope of fracture, and groaned to potential witnesses as they limped about the emergency room.

Into this cacophony descended a thirty-ish scrub woman who said she'd developed a non-productive cough and increasing shortness of breath over the previous two weeks. She wouldn't wait for blood work or a chest film, so I conducted a quick exam in a noisy cubicle. All I found were hyper-resonance to percussion over her upper lung fields and an evanescent wheeze. I prescribed the contemporaneous asthma regimen, arranged a follow up appointment in the medical clinic, and promptly forgot about her . . . . . until she was presented at grand medical rounds six weeks later as an interesting patient whose lymphoma had presented as bilateral pleural effusions. When she described being told by a doctor in the emergency room that she had asthma, the audience snickered in derision, I froze in mortification, and the physician in chief did three remarkable things: he didn't call me out of the audience to chastise me before my peers and betters; he took me aside after the round, both to discuss my error and to teach me about "Skodatic resonance" above pleural effusions; and he didn't hold my dumb mistake against me, but became my mentor during my first residency in internal medicine.

Competing interests: See bmj.com

A fool such as I

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Making mistakes is an essential part of being human. Ralph Waldo Emerson said: "All life is an experiment. The more experiments you make, the better." He might have written: "All life is mistakes. The more mistakes you make, the better." Mistakes are great teachers, but they also allow us to get through the day. Try to spend a day without making a mistake, and you'll do nothing. So I find it hard as I survey 52 years of mistakes to pick my biggest. I'm spoilt for choice.

But since this is a medical journal I think back more than a quarter of a century to a man in his 50s who was admitted to the ward on which I worked. He was a true cretin with congenital hypothyroidism. He had pneumonia and was in respiratory failure. Should we treat him? All we knew about him was that he lived with his elderly mother. After much debate—a debate, in retrospect, that was wholly uninformed by ethical analysis—we decided that we wouldn't. He was tucked up in bed, and I went home.

When I arrived the next morning he was sitting up in bed, reading a comic, and surrounded by visitors. He was, I discovered, the most popular person in his village. His mother was devoted to him, and I soon came to like him. After a few days he went home.

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This was a mistake that had wholly positive outcomes. The patient did well—and might not have done if we'd tried some heroic treatment. I learnt about the severe limitations of medicine and that I was a fool. Only unthinking fools could have decided to leave a man to die without learning more about him and talking directly to his relatives. I couldn't claim now not to be a fool, but that mistake made me a wiser fool.

Competing interests: None declared.

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Thanks to the experienced patient

Milind M Deshpande

It was my first week in the postgraduate MS(Ortho) course. I had already seen my senior apply plaster of Paris slabs to injured limbs and was overconfident of doing the act independently. I was sent to the casualty on my first weekend to splint an injured arm. As I started applying the plaster of Paris slab, the patient pointed out that previously he had an injury to the other arm and a similar plaster was applied, but over a cotton padding and not over the bare limb. I immediately realised my mistake and felt so ashamedabout my overconfidence—but I told the patient that if he was more comfortable with a cotton padding inside I would definitely apply it, and I quickly removed the plaster that was on his arm, cleaned it up, and reapplied the slab over a cotton padding. The experienced patient had taught me my first lesson over my first weekend, or else it might have been the last weekend for me and my senior.

Competing interests: None declared.

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The fog of expectation

Edwin P Kirk

The demented elderly man arrived in the emergency department with a note from his nursing home: "cough and shortness of breath worsening over the past 7 days." He had a low grade fever but did not seem too unwell, and my examination revealed only some crepitations at the base of the right lung. Chest infection, I thought, and the x ray did show some patchy opacification in the right lower lobe. I started some antibiotics and sent him to the ward. A couple of hours later, the medical registrar phoned me and gently informed me that the opacities I had seen were, in fact, the entire lung—collapsed as a result of the huge pneumothorax which ought to have been impossible to miss.

One Saturday night a few weeks later, I found myself the only doctor on an island, home to an Aboriginal community. A 14 year old girl, 32 weeks pregnant, a shy and diffident historian, attended the island's hospital complaining of lower abdominal pain. She too had a low grade fever. I suspected urinary tractinfection, and a very cloudy urine specimen was positive for blood and protein. I sent her away with antibiotics. Fortunately for us both, and very fortunately for her baby, she re-presented soon afterwards, giving me the chance to make the correct diagnosis (labour) in time for a helicopter to take her to someone more qualified than I to manage the footling breech delivery of a premature baby. The urine had been cloudy because it was full of vernix.

I was young, inexperienced, and overconfident. In each case, lacking a clear history, I made things harder for myself by doing an inadequate examination. But the biggest mistake, common to both of these stories, was of leaping to a conclusion early and then seeing what I expected to see. Expectations can fog your vision. It's best to wait until all the evidence is in before attempting a synthesis.

Competing interests: None declared.

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An easy operation gone wrong

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I was operating on a 4 year old girl with unilateral inguinal hernia. Hernia is rare in girls and the inguinal variety is rarer still. In female inguinal hernia the inguinal canal contains only round ligament, which can be sacrificed, and unlike in males, there are no hassles of dissecting cord structures meticulously.

I made an inguinal incision and deepened till the external oblique aponeurosis, then I opened the inguinal canal, dissected the round ligament, and hooked it up on my little finger. I freed the hernia sac, ligated it, and excised at its highest point. Next, I placed two haemostats slightly apart on the round ligament, intending to excise a segment of the ligament so that the inguinal canal could be completely obliterated. When I cut at one end of the segment, to my utter horror, the "ligament" showed a lumen. I had hooked up the femoral artery instead of the ligament, applied haemostats, and gone ahead and cut it. Disaster.

What had gone wrong? Rather than opening the inguinal canal, I had incised the inguinal ligament: in children the structures are quite close. This had exposed the femoral artery, which I had hooked up onmy little finger, mistaking it for the round ligament. Once it was hooked and hence stretched, the pulsations were either absent or not appreciated. As I had done my residency in the cardiovascular unit, I applied bulldog clamps at the two cut ends, removed the haemostats, andset about suturing the vessel. Unfortunately, the distalbulldog clamp slipped and the vessel retracted into the thigh. Another disaster. With great difficulty, the vessel was found and the anastomosis performed, but the pulsations did not appear in the limb. I panicked and requested help from a cardiovascular surgeon. He made a T incision into the thigh, and we saw that I had inadvertently anastomosed the profunda femoris branch of the femoral artery with the proximal cut end of the femoral artery. I had sectioned the femoral artery at the level of origin of the profunda, and so there were two cut ends distally. Ultimately, all anastomoses were successfully done and the limb was salvaged.

Fifteen years later the girl is a beautiful young lady who stands tall on her own two feet and continues to call me her living god. And that ill-fitting bulldog clamp still adorns my consulting room table to remind me how clay-footed her god is.

What I had I learnt was (to paraphrase Hippocrates) that no surgery is too light to be casual about nor too severe to be despaired of, and it is always beneficial to all to call in a second opinion in times of distress.

Competing interests: None declared.

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BMJ: first published as 10.1136/bmj.329.7480.1494 on 16 December 2004. Downloaded from http://www.bmj.com/ on 26 April 2024 by guest. Protected by copyright.

A call I never made

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When I was working as a resident in Patan Hospital, Kathmandu, on one busy on-call day, I was called by the emergency room resident to see a patient with possible myocardial infarction. The patient was being treated for congestive heart disease and had fainted that morning. His vital signs were stable and an electrocardiogram showed ST segment elevation and widened QRS complex, which were new findings. I made a quick diagnosis of acute myocardial infarction while chemistries were pending. I called an intensive care resident to find out if any beds could be arranged, but no beds were available. I decided to transfer the patient to the Heart Centre in the other side of the town. I rang the Heart Centre and made arrangements and finally transferred him, escorted by an intern. Later the blood chemistries came back. He had potassium levels of 6.7 mmol. The typical ECG findings were due to hyperkalaemia, probably not to myocardial infarction. I sent the report with the patient and forgot about him that day, as I was very busy.

Later my assistant informed me that the patient I had referred had died of an arrhythmia. The Heart Centre had told my assistant about the patient's death. He said only that I could have telephoned the centre about the hyperkalaemia. Then he said no more and went away. That was enough for me. A gush of electric current passed from my head to my feet; I started sweating and my heart started racing: I had made a serious blunder; what kind of doctor was I? When it came to transferring the responsibility of the patient care from my head to others, I was doing all I could. I was making phone calls, wherever I could. But when it came to real patient care I was so indifferent. I acted as if once the patient had left the hospital, it was not my duty. I told myself that my attitude, knowledge, and skill cost a patient's life and I was deficient in all those qualities that a doctor should have.

The incident taught me the meaning of that most talked about topic, the doctor-patient relationship. The doctor-patient relationship doesn't end when the patient leaves the physical boundaries of our care. Most of the time, it haunts me that if I had given a call, the patient's life could have been saved. These thoughts lead to a concept of universal doctor and universal patient, analogous to health and disease respectively. There are no individual doctors or individual patients. Because I identified myself as a different doctor from those in the other hospital, I thought the patient was no longer my responsibility: there was somebody else to look after him. Had I thought that he was just a patient and I was just a doctor, wherever he was and whoever was treating him, this incident would have been avoided.

Competing interests: None declared.

No time to talk

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Think carefully enough and mistakes come flooding to mind—a missed pneumothorax, an unnecessary resuscitation, and a pacing wire that tickled a tricuspid—memories of follies that influence individual practice more than they ultimately affect patient outcomes.

Yet, one memory still haunts me. I was a junior doctor in a busy specialty, rushing to manage patients and pass exams. My peers were coping with the same competing demands in their own firms and in their own ways. Some responded with machismo, their spirits unbowed; some by internalising their pain; and others with an equal calm.

One colleague stood out. He was from overseas and a loner, but we struck up a friendship over pizzas, televised football, and black humour in the doctors' mess—the lifelines of a night on call. In six month posts these friendships ebb and flow, from endless hours in the mess on a quiet night to barely an acknowledgment when busy. And we got busier and we talked less.

One day his firm had just swept through our ward, but he hung back, wanting to begin a conversation it seemed, a conversation I had no time for. I moved on, with a promise to talk later. The next day he wasn't at work. He was still in his room—directly across the corridor from mine—an insulin syringe lying next to his dead body. The next day, his mother flew in to reclaim her son. But how must he have suffered—alone, miserable, a long way from home, in an endless and thankless job, patients too ill to be grateful, colleagues too wrapped up in themselves to care.

Would it have a made a difference if I had talked? My greatest mistake was not to find out. As the royal colleges strive for a new definition of medical professionalism, what will we do to ensure that professionalism extends to consideration for our colleagues?

Competing interests: KA is acting editor of the BMJ and responsible for its content.

Festive fare and Christmas competition

Eat healthily, eat well

To complement the article on the Polymeal (p 1447), bmj.com carries Raymond Blanc's recipes for one such repast—watercress soup, grilled mackerel with a tagine of winter root vegetables, and chocolate mousse. To fulfil all the Polymeal criteria, add some nuts before or after the meal, and a glass of wine during it. And if these inspire you to culinary creation, submit your recipes to our Christmas competition—details are at the start of the journal, on the Editor's Choice page.

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