Small Mistakes, Tragic Outcomes

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I steadied my hand and pierced her lip with the suture needle. "You need to be precise," the emergency room attending physician urged. "The vermillion border is involved." I felt my pulse start to quicken. I certainly did not want to ruin this 3-year-old girl's lip. What a terrible way to remember my first laceration repair as a resident. Could such a small mistake create larger repercussions for my career down the road? I drowned my fears and the patient's wailing with the soothing voice from the instructional video I had reviewed moments ago. The patient's mother, with perhaps the most essential role, held her child's arms on the examination table while gently reminding her of the Happy Meal that awaited her afterward. I adopted a similar technique to remain calm; I envisioned their gratitude once this was all over.

I spent my first year as a resident seeking moments such as this, eager to finally serve and be valued. This involved much more than just learning suturing and medication doses, as I quickly learned. More often than not, the path was paved with feelings of inadequacy and self-doubt. Like when a patient seesawed from agitated delirium to overly sedated from the medical team's interventions. Or when a patient who experienced a kidney injury from insufficient fluid intake started requiring supplemental oxygen after receiving surplus parenteral fluids. Or when I pronounced a patient dead for the first time. Was my care suboptimal? Had I made any mistakes? "Mistakes are inevitable and part of the learning process," a lecturer had told us early in the year. Why, then, did I feel so ill-equipped to handle them? Rather than reflect on possible past mistakes, I retrained my focus toward my unending workload: those pending H&Ps, discharge summaries, and handoffs would not write themselves. No amount of workload distraction, though, could stop me from ruminating about "Sam."

I met him barely a month into my first medicine wards rotation. "Sam is a former resident in his mid-thirties with a history of depression, previous suicide attempt, and alcohol use disorder with severe liver failure." I did a double-take. *Did I hear that sign-out correctly?* As I entered my patient's room that summer morning, I found Sam sitting in the pitch-black hospital room. He spoke softly and slowly, sometimes frowning, sometimes expressionless. He described his symptoms without prompting: "I've gotten much weaker. I can barely walk now." He was not eating either, as evidenced by his 9-kilogram weight loss over the past month. My flashlight revealed jaundiced eyes and skin and a very distended abdomen. He could barely hold his hands up long enough for me to check for a flapping tremor.

Although I rounded on Sam every day, we never discussed my burning questions*: How did a fellow young physician find himself admitted to the hospital under these circumstances? Why had he once tried to take his life?* Instead, we talked about his love of comic animation that helped him de-stress while he earned his MD and PhD. He shared some of his sketches with me. I complimented him on his drawing of Batman, garnering a rare smile from him in the process. His mom proudly told me that Sam had been at the top of his medical school class, but his academic journey was not without difficulty. She relayed instances when he had been harshly picked on in grade school, "whether for being too small, too intelligent, too quiet. Sam always excelled in his studies and hoped the mean kids would be quieted by his success." I appreciated these conversations and admired Sam's determination, but in the background, I watched Sam's lab values worsen. His energy and appetite remained poor, his Ensure shakes unfinished. Ultimately, the medical team decided the best option was for Sam to obtain a liver transplant at another facility.

Before the transfer, Sam's primary care physician visited him at the hospital. "Do you know what happened?" she asked me. "Sam was bullied at his residency program, became very depressed, and started drinking." I was taken aback. Bullied more? Even in residency? Was I naïve to think this behavior was screened out at this level? She encouraged me to talk to Sam about it, but I could never bring myself to do it. Maybe I was just tired after so many long days on the wards. Maybe I became a little too good at rationalizing my way out of the conversation. *How would talking about this help? It would just force him to relive traumatic events*. Perhaps, more likely, his likeness to me as a young physician made me too uncomfortable to broach such topics.

DOI: http://dx.doi.org/10.4300/JGME-D-19-00072.1

"Good news!" I told Sam and his mother days later. He smiled softly, knowing that I was referring to his transfer. His mother thanked me, though I didn't feel worthy of any gratitude. "Best wishes," were my last words to Sam as I held back tears. I prayed for Sam's recovery, and I truly believed that his tragic story would have an uplifting outcome.

It was months later that I received the news from his primary care physician. His transplant request had been declined, and Sam passed away shortly after. Saddened, I tried to piece together Sam's story from his medical chart, a story that now, more than ever, I wished I had been able to understand while he was still alive. He described "grueling working conditions" during residency. And then there it was, mentioned in multiple encounters: the small mistake. A small mistake he made as a first-year resident had changed everything. *Berated. Bullied. Hounded. Targeted. Condescended. Made life a living hell.* These were the words Sam used to describe how program leadership made him feel after his mistake. "Every day I get up and feel like a failure," he told another physician. His self-esteem and self-worth vanished. I was in disbelief. Mistakes never feel good. They shouldn't. But a culture focused on error avoidance can produce trainees unable to psychologically handle errors when they do occur. While error reduction is a critical part of training, equally as critical is the understanding that mistakes are an inevitable part of the learning process. If this principle was reflected in our culture and not just stated in lectures, Sam's story may had been a different one.

A few deep breaths and knot ties later, the gaping wound on my patient's lip was closed, tears wiped, cartoon Band-Aid placed, and all was well with the world. I was overjoyed with the results, as was her mother. Her thank you made the discomfort I experienced worth it. "This is me nitpicking, but . . ." my attending started outside the room, commenting on my form and speed. I took the comments in stride. I think of all the thank yous I might receive over the course of my lifetime. It will always be hard for me not to think just how many of those thank yous could have been for Sam too.

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The author would like to thank the parents of the patient for kindly allowing the publication of this story. They hope sharing their son's story will in some way help others.

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