

Part C: Managing Emotions after Difficult Patient Care Experiences

Cases: Getting to Closure After a Medical Error

Case 1: Resident in the NICU

You are a third year resident on call in the NICU in May. It is one of your last calls of residency, and you are looking forward to being done! It has been a very busy night; you have had multiple deliveries, including the admission of 26 week twins, and have been up all night helping your intern with the procedures and the admissions. In addition to caring for the latest admissions, you have heard from your intern on a couple of occasions about a baby who keeps desaturating. At about midnight, you and your intern decide to order a chest x-ray on this infant. After some time, you ask your intern if she followed up on this chest x-ray and she tells you that it looked okay. The infant continues to have difficulty with desaturations, and you make adjustments on the ventilator with the respiratory therapist. Finally, everything settles down, and you head to the call room for the first time all night. At about 6:00 AM, you get called by the nurses to the bedside of the baby, saying that things have suddenly worsened and they need you right away. As you arrive at the bedside, your fellow is also there. The two of you look at the chest x-ray that was taken over 6 hours before, and you see a large pneumothorax. Your fellow asks you if you had seen the pneumothorax, and you tell her that you did not review the chest x-ray with your intern. Suddenly, a wave of guilt comes over you; you realize that you have let down your intern, your fellow, and most important, your patient.

1. How would you (as the senior resident) reflect on this situation?

In this situation, the senior resident did not check a critical chest x-ray. This may have happened for a number of reasons. Given the fact that it was May, the senior resident may have assumed that the intern knew how to look for a pneumothorax. The night was very busy with other admissions, and the senior resident was probably very fatigued, as he had been up all night. On another occasion the decision not to look at this chest x-ray may not have had any consequences, but this time it resulted in a pneumothorax being missed for 6 hours, and an infant's condition worsening.

It is important to reflect on the intention of the provider in this case. Was the provider intentionally negligent? Was the provider attempting to cut corners by not checking this chest x-ray? Was the provider delegating responsibility to the intern, not understanding that all interns do not know how to look at an infant's chest x-ray? It is critically for the provider to have some time for self-reflection and specifically reflecting on did he meet his professional responsibility in this situation.

Medical errors occur in any hospital, and this situation shows how easy it is to make one. The intern did not see the pneumothorax, but the senior resident was ultimately responsible for the intern. When an error like this occurs, it is important to acknowledge one's feelings of guilt. Since multiple people were involved in the error, discussing it with your fellow and your intern is important. Whenever an error occurs, it is important to see if there are any systems that can be improved to prevent errors such as this in the future.

2. How would you discuss this situation with your intern?

The intern probably feels guilty that she missed the pneumothorax. As the senior resident, it will be important to take responsibility for the not checking the chest x-ray with the intern. The senior will want to review with the intern how to look for a pneumothorax. In addition, it may be helpful to reflect on the night as a whole to discuss other resources available to you and the intern. As you were very busy caring for ill infants all night, it would have been appropriate to ask the fellow to look at the chest x-ray with the intern, if you did not have time.

3. If you were the fellow, how would you discuss this situation with the senior resident?

Residents are in a learning environment where mistakes are made. Discussion of this situation will help everyone learn to avoid this type of error in the future. The fellow plays a critical role in helping to teach the intern how to identify the pneumothorax, and teaching the senior resident to supervise safely. If this lesson is taught in a safe non-threatening environment, the discussion may help all learners focus less on their guilt and more on how to provide safe, high quality care. The discussion regarding the error may allow everyone to learn something from the situation.

Case 2: Complex Cyanotic Congenital Heart Disease

Caleb is a 6 month old male with complex cyanotic congenital heart disease s/p surgery who is in the PICU during your first PICU month as a second year resident.

You had worked the night before and Caleb was your patient. You had been up all night reviewing blood gases, labs, and adjusting his multiple drips and fluids. Caleb had a rocky postoperative course, was fluid overloaded, edematous, and had electrolyte abnormalities. You were caring for 7 other patients, most of whom were more stable, but others who also took a lot of your time.

Caleb's family had been at the bedside all night and asked a lot of questions. Each time you went in the room the family wanted to talk. You had a lot of other patient issues and what was going on with their baby was very complicated; you weren't sure you understood it all. When they asked you questions you gave short answers to their immediate questions and then stated multiple times that you would come back. Each time you came back you didn't have the time to sit down with them and explain what was going on or understand it fully yourself.

You come in the next night and the baby and family are no longer on the unit. Caleb developed an arrhythmia soon after you left the hospital and died shortly thereafter. When you hear the news, you feel incredibly guilty that you didn't take time with the family while the baby was alive.

You walk in to sign out and there is a lot going on. You know that because you were so busy, you ignored some of the nurses requests for you to come in to talk to the family, or at the least you put it off to have more time for the other patients. Now you wonder if the family understands what happened and whether you could have done more to support them and get their questions answered. You never got to tell the fellow or the attending that the family had questions, you were just too busy.

1. Should you, could you have done anything differently when you were on call?

During the night on call, there are support systems available to help the resident. As a resident, you always have your fellows or your faculty that are available to answer the resident's questions and/or the parent's questions. As the resident, if you discuss the case with your faculty or fellow, you may feel more comfortable talking to the family and not avoiding them.

2. Is there anything that you could have done to support the family better?

If the resident was still too busy to speak with the family, he could have informed the fellow/attending that the family had questions. The family needed someone to talk to, and the next day the resident would not have felt as much guilt for avoiding the parents' questions. It is important to remember that sometimes doing what you can means getting the right other people to support the family. That is why we are all part of team. In addition, sometimes the family needs additional support. You can offer to have social work come to speak with a family, as well as pastoral care.

3. Is there anything that you can do now at the beginning of your next shift to help you to focus on the duties that you have ahead of yourself for the night?

The next night, the resident needs help in focusing. The resident has a lot of tasks ahead of him for the night, getting sign-out, taking care of patients, and self-care. Self-care is critically important to long term physician mental health. There are a lot resources available in the hospital, such as faculty, peers, chief residents, and the residency program director. Often, residents who have faced a difficult situation can reach out to social work or the employee assistance program, which can be a good place to reach out to for assistance in dealing with guilt that a resident feels regarding a specific outcome. Residents should reach out for assistance - others will not necessarily know you need help if you don't tell them.

Case 3: Meningococcal Sepsis

It is 9am and you are busy working in the pediatric emergency department. A 2 year old fully immunized, circumcised male patient comes to the emergency department with a fever of 38.7 degrees. He is quite active, looks good, has some minimal rhinorrhea, and your review of systems is otherwise negative. His physical exam reveals no focal findings and you discharge him home with a diagnosis of probable viral URI. You instruct the family to return if he appears sicker.

At 8:30pm (30 minutes before your shift is to end), a 2 year old male patient comes in by ambulance. The parents of this child had called EMS after they went to wake him from a 2 hour nap and found him to be difficult to wake up and "not acting himself". At triage he is noted to be febrile, hypotensive, tachycardic, with poor perfusion, and is very difficult to arouse. As you are called to the bedside to assist with the care of the patient, you realize he is the patient you had discharged earlier. He is noted to have a petechial rash over his body. In the ED he is given multiple fluid boluses, IV antibiotics, requires intubation and dopamine to maintain adequate blood pressure. He is transferred to the PICU with the tentative diagnosis of meningococcal sepsis.

1. What would be your dialogue with the family?

Important, if it hasn't been done by someone else already, to retake a complete history including prior to the first ED visit to determine if there were any information that may have led to the diagnosis. Pay particular attention to what happened after the 1st ED visit, how was the child and what occurred when the family got home.

In addition, should discuss with the family that often diseases progress with time with new information, i.e. signs and symptoms, declaring themselves. While we look for hallmarks of more serious disease they are not always present. In addition, when a child represents to the ED we routinely review the first visit information again to see if we could have avoided the 2nd presentation.

2. How would you try to comfort and support the family?

The family will often be nervous, scared and/or fearful. You should offer to answer any questions they have and if you cannot answer them to get others that can. In addition, explaining to them what is happening, including the people who will be caring for the child, the next steps and who is in charge may be comforting to them. Also telling them about available support, e.g. social work, etc. You may also express your feelings; e.g., not being able to predict what would happen, frustration that we don't have tests that always give us the answers we need, or guilt that you cared for a child who is now sicker than you expected.

3. What might you do to try to reflect on this experience?

Sudden unexpected bad outcomes in patients are always difficult, and they often lead to the strongest emotions of sadness, anger and guilt. It is common that we, as health care providers, will second guess our decision-making and analyze the situation to identify our mistakes.

- You may want to review the original medical record.
- You may want to discuss the case with a colleague or supervisor to get another's point of view, as physicians we are not always the best judge of when we have made an error or what we could have done differently. Discussing it with a colleague can help verbalize your concerns as well as get another perspective.
- You may want to write about the experience, would not suggest writing about it in any online forum, e.g. Facebook, blog, etc.

4. How would you comfort yourself?

Strategies would be to debrief with a valued colleague, or perhaps go home and pursue active coping strategies such as exercise, or a quiet time reflecting, or going to sleep. It is important to emphasize that strategies should be individualized and no one size fits all. However, it is imperative for the well-being of this resident to have some venue to integrate the experience.

Case 4: Hemoglobin SS Disease

You are working in the inpatient unit and caring for a 5 year old patient, Marvin, who has hemoglobin SS disease. Marvin is admitted frequently with pain crises. He is your sixth admission within the past 3 hours. You evaluate him quickly and write an order for a morphine dose in order to try to alleviate some of his pain while waiting for the PCA to be initiated. You are anxious to help him and provide him some relief, but plan to return to do a more complete history and physical once you have attended to some of your other patients. About an hour later the nursing staff calls you because Marvin is acting very sleepy and difficult to arouse. You worry at first that perhaps he may have had some type of neurological event, like a stroke. The nurse working with him checks your orders, and notes that the dose of morphine which you ordered was 10 times the dose for his weight.

1. How would you explain this to the family?

The error should be discussed clearly and succinctly. In addition, what you have done, i.e. do you need to give naloxone, do you need to increase monitoring and what are the possible risks, i.e. more sleep, the need to give naloxone, need for oxygen or other support? You should also tell the family who you have informed, i.e. supervising resident and faculty. It is often helpful to have risk management involved in situations like this, as they can often be helpful in speaking with the families, and supporting you through this error.

2. How would you discuss this with your medical colleagues?

Should think about 2 pieces. First is to discuss it to get another person's perspective on the error, this can often help with you processing it and getting a sense of severity. Secondly, discussing ways to prevent this error from occurring in the future, either for you as an individual or the systems in place (or that should/could be in place) to prevent this type of error, including alerts in EHR, checks by pharmacy and nursing, etc. Often, providers feel comfortable to discuss these types of errors with their medical colleagues. But providers can feel shame, isolation, and a sense of not being understood when they discuss these issues with the important people in their lives outside of medicine. It can feel very isolating to only to have medical colleagues to lean on in times like this, and this is another reason for contacting risk management, as they often have support systems in place to assist providers with these feelings.

3. What might you need to do to reflect on this experience?

As mentioned above, discussing it with a colleague can often help you reflect on it. Writing about it may also help you reflect. In addition thinking through, either with someone else, or in writing, or quietly by yourself, the factors that led to the error, the possible ways to have prevented the error, the outcomes and possible outcomes of the error. In addition, what you will do in the future to reduce your chance of this type or other errors occurring in the future?

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1. How would you (as the senior resident) reflect on this situation?

2. How would you discuss this situation with your intern?

3. If you were the fellow, how would you discuss this situation with the senior resident?

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2. How would you discuss this with your medical colleagues?

3. What might you need to do to reflect on this experience?
