



An Unforgettable Case

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We all have one ... a case you cannot forget ... a patient experience that haunts you throughout your career ... an episode that, as you reflect back on it, is a source of lifelong learning. Mine happened almost 40 years ago.

I was an intern in a rural New Jersey hospital. It was a time when you could look out of the hospital's windows to see cornfields swaying in the breeze, and hear stock cars racing on the nearby track. Medical giants still roamed the halls of the hospital, the legendary residents who could work without sleep or supervision. Our family medicine residency had one first-year resident on call covering the hospital's emergency department (ED) alone, with a second-year resident in the hospital available to answer questions. Attending physicians were just a phone call away, but only the weak would call them.

On the night of my unforgettable case, all of the ED stretchers were empty except for one with drawn curtains. As I opened the curtain, my heart started racing upon seeing two armed prison guards standing over my patient who was staring at the ceiling, handcuffed to the stretcher. After calming myself, I asked the patient what was bothering him. Making no eye contact, all he said was that he had chills, felt hot, and "just didn't feel well." A thorough exam yielded no specific findings to explain

his low-grade temperature, and overall, he did not really look sick. With nothing to go on, I ordered some lab tests, a chest x-ray, and urinalysis. While the lab tests were normal, something did not look quite right on his chest x-ray. Breaking with protocol, I hesitantly called my second-year resident to review the x-ray. The image of that patient's chest x-ray has remained imprinted on my mind ever since.

As the two of us huddled around the view box, I asked my second-year resident what he thought about the two small, fluffy looking infiltrates on both sides of his lungs. "I'm not sure, but it doesn't look like pneumonia." With only some vague findings on a chest x-ray, we decided to discharge our patient and asked the guards to arrange follow-up with the prison doctor.

A few days later, the patient's follow-up came in the form of a phone call from the medical examiner to let me know he had died in prison. The medical examiner determined that the cause of death was right-sided, acute bacterial endocarditis due to drug abuse. I was devastated, overcome with guilt and remorse. I felt like a failure; how could I have let this young man die? What should I have done differently? Reading frantically about right-sided endocarditis, I learned—too late—that his chest x-ray findings represented septic emboli, and that patients often do not

have a murmur with this disease. It took me months—with hours of talking in our resident support group—to regain some semblance of confidence. As I continued residency and accumulated more positive patient experiences, my self-doubt faded, but remembering this patient and knowing I was capable of making a major mistake has always remained with me.

After residency, I took a faculty position at another program. In my effort to answer the question, "What should I have done differently?" I developed an interest in teaching residents about medical decision making. I wanted to help learners avoid the anguish of making major mistakes. I learned about common cognitive biases that contribute to mistakes and the importance of context in medical decision making.^{1,2} Despite being familiar with patients suffering with addiction from my Bronx medical school experience, in rural New Jersey an IV drug-related illness did not enter my first-year resident's mind.

As time passed and I became director at a different residency, my understanding of this case broadened from that of personal failure to include a failure of the educational system. I continued to harbor anger

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at the call system I had experienced as a resident. The danger posed to patients by unsupervised residents is one of the factors that stimulated the ACGME to make systemic changes to ensure appropriate resident supervision. Today, first-year residents would rarely see ED patients without direct supervision. Had an attending been present to review my patient's x-ray, he might have been admitted or kept in the ED for observation instead of being sent back to prison.

More recently, this case taught me another powerful lesson. My patient, a young African-American man, died in police custody. Like most physicians, I am committed to treating all patients equally and had thought my practice reflected that principle. Yet, over the years of caring for an underserved population, I have seen first-hand the health disparities caused by race and poverty.³ Then, after reading *Between the World and Me* by Ta-Nehisi Coates and learning more about structural racism in the wake of recently well-publicized deaths of African Americans in police custody, I have come to understand on a societal level how

I had inadvertently played a role in a structurally racist system.^{4,5} I now know it was naïve of me to expect close medical follow-up of an incarcerated African-American man. Had I been sensitive to this issue at that time, I would have kept the patient in the hospital, where his care and treatment may have led to a different outcome.

The meaning to me of what had happened in the ED so long ago has evolved over the course of my career. It originated with a concern about cognitive errors on an individual basis, grew to include resident supervision on an institutional/systemic level, and finally incorporated an awareness of structural racism on a societal level. Now, whenever I think I know what I am doing and risk becoming over confident, I recall this unforgettable case. As a source of lifelong learning, my patient has had a lasting impact on me as a person, as a family physician, and as a teacher.

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