FROM THE EDITOR

Mistakes

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(Fam Med. 2021;53(10):833-4.)
doi: 10.22454/FamMed.2021.623606

In the fall of 1979, I was an intern at Eisenhower Army Medical Center in Augusta, Georgia. An elderly veteran named Homer Jones was transferred to our medical service from a community hospital for workup of weight loss and a pleural effusion. Mr Jones lived alone and had no close family members. He wore an untrimmed white beard and shoulder-length hair and he looked at me with piercing blue eyes. In those days, patients were assigned to interns, and we were responsible for them throughout their hospital stay. There was no night float, only an every-third-night coverage system in which we took turns being on call for 36-hour shifts. Mr Jones became my patient during one such call night. After presenting his case on rounds the following morning, our plan was to perform a diagnostic thoracentesis. There was limited CT scan and no MRI availability in those days and thoracenteses were usually done at the bedside without ultrasound or fluoroscopic guidance. When I explained the procedure to Mr Jones, he told me all he wanted was to go home to care for his dog. He seemed lonely and afraid, but he was clear that he'd rather just wait and see than undergo the procedure. My attending physician insisted that he was here for us to make a diagnosis and convinced Mr Jones to consent. Later that day, the senior resident and I performed the procedure. Initially things went well, but the next day Mr Jones developed a fever. His transudative pleural effusion became an empyema; a chest tube was placed, and antibiotics were administered. When Mr Jones died 2 days later, I was at his bedside, haunted by the thought that his thoracentesis was a mistake and that we had harmed and not helped him. We did not listen to him. We did not respect his priorities, instead pursuing our own.

As I write this editorial, our country is in the throes of the Delta variant wave of SARS-CoV-2. The pandemic's death toll has passed 680,000 in America.[1] In the first 2 weeks of September 2021 alone, more Americans died from COVID-19 than from the September 11 attacks (2,977),[2] the Iraq War (4,497)[3] and Afghanistan War (2,448)[4] combined. Those of us caring for these patients are tired and frustrated, but, more than anything, we are haunted by the chasm between what has happened and what should have happened. Our public health system has failed the country at almost every turn and our hospitals have failed to adapt quickly enough from a model based on revenue generation to a model based on caring for waves of acutely ill people. In many communities, family physicians have performed heroically, but in some places, we have been happy to sit on the sidelines and refer sick people elsewhere to protect ourselves, our staff, and our uninfected patients. This has happened. We cannot start over. We cannot restore the lives lost or the families broken. All we can do now is to learn from what went wrong and dedicate ourselves to being better the next time.

As teachers of the next generation of family physicians, we need to talk about these mistakes with our learners. But can we even agree about what lessons need to be learned? Answering this question begins by imagining what should have happened and confronting why it did not. Such discussions should take place soon in every residency and in every medical school, but also in every clinical practice, state academy, and professional association. Consider the following ideas as a starting point:

1. Early in the pandemic, there was a complete failure of case identification, contact tracing, and case isolation. When there is an epidemic of food-borne illness, our public health system can trace its origin to a particular restaurant, grocery store, or

food product within a few days. Doing this requires an efficient process to find individual cases, isolate those cases, and identify the cause; this is basic epidemiology. It is maddening to contemplate that isolating the individual person who was the first COVID-19 case in each community would have stopped the pandemic in its tracks. But it took us months to have accurate testing, and by the time such testing was available we no longer had the capacity to trace and quarantine all contacts. We rationed tests rather than applying them broadly until it was too late. We depended on the private sector to manufacture testing supplies and allowed prepandemic approval procedures to exacerbate the delay.

2. During the first surge in the spring of 2020, news coverage focused on shortages of personal protective equipment and ventilators in hospitals. We even advised people that masks were not necessary because of our fear of shortages. By the time we changed this message, many had already stopped listening. We are still arguing about mask use today. The public never had a good understanding of why we locked down the economy and we failed to carry out the lockdown sufficiently to stop the spread of the virus.
3. Communicating with the public was undertaken by politicians. In some cases, they were advised and informed by valid public health information. But too often, this was not the case. The regions that have done the best job have empowered the public health system rather than meddling with it. Our system was not designed to prevent such meddling, but it should be.
4. We were too slow to isolate nursing homes even though it was clear at the outset who the most vulnerable populations were likely to be. Perhaps we have always kept nursing home populations out of sight and out of mind, but this error proved particularly deadly. When we did turn our attention to nursing homes, it was focused on the residents living there and neglected the staff who care for them every day.
5. We rolled out the first wave of vaccination through hospitals and pharmacies without any regard for the primary care system. But people do not trust hospitals and pharmacies and they particularly distrust the pharmaceutical industry after decades of self-promotion and deceptive advertising. Imagine how the uptake of COVID vaccination might have gone if we had focused the rollout on primary care practices, churches, barbershops, and community organizations.
6. We have confused the concepts of choice and duty. Americans are obsessed with choice, and too many of us have viewed pandemic measures as individual choices for us to make. Case identification and isolation, vaccination, and the use of masks and social distancing are not choices; they are duties to our neighbors and our communities. Duties are expectations, not choices. After the September 11 attacks, Americans asked what they could do to help. In the COVID-19 pandemic, Americans mostly asked how to protect themselves.
7. We have become numbed by shocking casualty counts and learned to almost ignore them as we pursue other, far less important priorities.
8. Finally, we have blamed other people for the pandemic. We blamed China. We blamed immigrants. And now we are blaming the unvaccinated. In doing so, we have pursued unhelpful policies and sewn discord when we needed unity.

So, this brings us back to Mr Jones. For the past 42 years, I have thought about him often. I have shared his story with students and residents, particularly when we are trying to decide about diagnostic procedures in the hospital. Although we failed him all those years ago, I have borne witness to the mistake and tried to never repeat it. Caring for him made me a better physician and a better teacher; he did not die in vain. That is his legacy with me. Now we need to think about 680,000 Homer Joneses. How can we build a health system that will be their legacy and justify their sacrifice? The sooner we talk about this, the better.

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