

# The most memorable patient I never saw



Illustrations by Jim M'Guinness

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Soon after midnight, after a busy day on the inpatient psych unit, I slipped into a deep sleep. Then the phone rang in the residents' on-call room.

"Dr. Lazarus?" the voice on the other end inquired.

"Yes," I replied, half asleep.

"This is Dr. Hendricks (not her real name) in the ER. Are you the on-call psych resident tonight?"

"I am," I answered drowsily.

Every physician knows that nightly awakenings are part and parcel of being on-call. And like most residents, I had learned how to short-circuit several stages of sleep to quickly attain alertness when paged. But tonight it was really difficult to wake up.

"We have a patient down here. I don't think you need to see him, but I'd like to run the history by you and see if you agree with the treatment plan before we send him on his way."

I sat up in bed and said, "Sure. Go ahead."

"The patient is in his twenties. He has a diagnosis of schizophrenia, and he lives in a local boarding home. One of the staffers escorted him to the ER. The patient tells me he is hearing voices, but the voices are not telling him to do anything bad or hurt himself. Do you think it's okay to increase the dose of his Haldol from 15 to 20 mg a day and set him up with an outpatient appointment in the psych clinic?"

"Yeah, that sounds fine to me," I replied, still groggy. There were other aspects of the history that should have been explored, so I added, "Do you want me to come down and see him?"

"Oh, no. That won't be necessary," remarked the medical resident. "He looks pretty good. I'm just not too familiar with Haldol, and I want to know if bumping up his dose by 5 mg is appropriate."

"It could go higher," I explained, "but that can be evaluated further when he is seen in clinic."

"Okay, then, Dr. Lazarus. Thanks for your help."

"Is it quiet tonight?" I asked before hanging up. That was code for asking whether any other psych cases were pending and whether I could count on a good night's sleep.

"Not much happening," the resident replied. "Thanks again."

It took me less than ten minutes to reverse the sleep cycle. I nodded off with a good feeling, comfortable that I was able to provide consultation without having to see the patient. It's about time I caught a break, I thought, considering that it was spring and I was two-thirds of the way through my first year of residency.

The emergency department was run by the medical house staff, who liberally called upon psych residents to see depressed, addicted, and psychotic patients, even though these patients were supposed to be transported and seen at the community "crisis center" located at another hospital. I felt I was fortunate to be spared a midnight consultation. I also thought it was admirable that my counterpart in internal medicine attempted to handle the case herself.

Suddenly, the phone rang at 3 AM. I woke faster than before. "Dr. Lazarus, this is Dr. Hendricks again from the ER. You're never going to guess what happened!"

Before I could utter a word, the resident continued in distress, "Remember the patient from the boarding home? Well, the paramedics just brought him back. He jumped out the third-story window and it looks like he broke both legs. We're going to take him to X ray now, and he'll probably need surgery. I just wanted to let you know."

All I could say was, "Okay, thanks for letting me know. I'll make sure the psych consultation team sees him in the morning."

This time, I couldn't get back to sleep. I asked myself how this could have happened. The patient was stable, according to the medical resident. He did not have command hallucinations. He was not suicidal or self-injurious. I lay awake second-guessing myself—and the resident—until daybreak. I should have seen the patient, I bemoaned, rather than take the word of a physician with less experience in my specialty.

To make matters worse, in the morning, the ER staff notified the consultation-liaison (C-L) team about the incident before I did, and a rumor had spread that I had refused to see the patient in the emergency room. Shame and guilt set in immediately, like an IV infusion. I was interrogated by the upper-year resident on the C-L service. I assured the senior resident and the attending physician of the C-L service that I had offered to go to the ER at midnight, but I was told it was unnecessary. The C-L team appeared to be satisfied with my account but not with my judgment to do a telephone consultation rather than evaluate the patient in person.

Clearly, the damage was done. The patient had sustained serious injuries. The house staff dubbed him the "jumper," and I had become infamously associated with him. No matter how many times I replayed the incident, I could not forgive myself for not seeing the patient, even though a face-to-face consultation had not been requested. I berated myself, thinking I should have known better, that a bad outcome would ensue.



I became overwhelmed with anxiety. I began to dread being on-call. I tried to avoid difficult cases. I became depressed. My performance suffered, and it was noted by many of the faculty. I was placed on probation midway through the second year of my residency.

I sought the help of a senior psychiatrist, who became my therapist. He was a kind and compassionate man who understood what I was going through. He assured me that even a modest improvement in my defenses—unconscious ways of managing conflict and strong emotion—could result in a sizable improvement in my life. But he warned me, “Art, unless you can acknowledge that a patient’s fate is beyond your control, you will not survive in practice.”

My residency director opened my eyes to the fact that psychiatry, like other specialties, has a mortality rate—from suicide and homicide. He said I could not predict the behavior of my patients with any more accuracy than could a lay person, much less that of a patient I had never seen. In fact, research has shown that psychiatric residents are not able to predict violent behavior in patients any better than chance.<sup>1</sup>

Another psychiatrist pointed out that practice norms vary widely across the United States. Neither evidence from clinical trials nor clinical observation can dictate action—nor inaction—in particular circumstances. The management decision for a single patient is complex, requiring a synthesis of incomplete and imperfect information and medical knowledge. “What makes you think,” the psychiatrist probed, “this decision is made with any precision in the head of a sleep deprived resident?”

Intellectually, I agreed with all three psychiatrists, but emotionally, I was a wreck. I continued to blame myself for the incident, and I feared my reputation had been tarnished. I thought about leaving residency for a position in industry. I actually interviewed for a job and was offered the position—ironically, working for the makers of Haldol! I decided instead to stay and complete my residency, if possible.

I slowly regained my confidence, and my probation was lifted after six months. My performance evaluation contained a note from the chairman of the department: “There was some comment on your earlier fear of the psychotherapeutic role, but the consensus was that this has improved markedly.”

The director of residency training added, “The faculty felt you should be less concerned about making mistakes, that we all learn from making mistakes, and that nobody here is expecting you to know the answer every time.”

I knew I had “arrived” when, in my final year of residency, I was elected chief resident. I was now the senior resident on the C-L service. And what was about to transpire would have shaken me to the very core had I not had the benefit of therapy and additional clinical experience since my encounter with the “jumper.”

I was consulted to evaluate a man who had recently undergone extensive surgery for laryngeal cancer. While at home,

the patient had put a plastic bag over his head to suffocate himself. Alarmed by the incident, his wife took him to the hospital, and he was admitted to the surgical floor. I found him to be despondent and hopeless. I thought he would benefit from inpatient psychiatric hospitalization, and I recommended transfer to the psych unit.

However, the patient’s doctor, a powerful head and neck surgeon and the father of one of my medical school classmates, resisted my recommendation. I stood toe-to-toe with him and strongly argued for psych admission even though I had not yet had a chance to discuss my plan with the C-L attending physician. The surgeon capitulated, and the patient was transferred for treatment. He was discharged a week later in much better spirits.

Over the course of my residency, I went from turmoil to triumph. I was asked by the chairman of the psychiatry department to stay on-board and join the faculty. I spent the next four years in the department, initially as an instructor, and I was promoted to assistant professor. I was becoming quite the academic, and residents began to call me “Article” Lazarus, because I was either handing out articles on rounds or publishing my own.

Unfortunately, I never could come to terms with the “jumper.” I suffered from post-traumatic stress disorder (PTSD), and I experienced “anniversary reactions” every spring in the form of distressing memories of the event. I had difficulty delegating responsibility to medical students and residents, and I worried excessively about my patients, even about writing their prescriptions. On a few occasions I called my patients to “check” that I had written for the correct dosage.

As time passed, I learned to hide my fears, but the “jumper” clearly haunted me and left an indelible mark on my psyche. I left academia for a career in industry after all. Although the burden of caring for patients was removed, my PTSD morphed into a generalized anxiety disorder (GAD) that has persisted throughout my nonclinical career. Given that PTSD and GAD commonly co-occur,<sup>2</sup> perhaps it was only a matter of time until a different patient or traumatic event would have triggered such intense anxiety. In fact, prior to the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*<sup>3</sup> in 2013, PTSD was considered an anxiety disorder. It is now classified as a trauma- and stressor-related disorder.

The popular notion of PTSD is that symptoms of the disorder, such as flashbacks, intrusive thoughts, and feeling on-guard, coincide with highly stressful and specific traumatic events, for example, wartime combat, physical violence, and natural disasters. In truth, affected individuals may be exposed directly or indirectly to the stressful event. Exposure to the stressor may involve actual or threatened death, serious injury, or sexual violence. And although symptoms of PTSD usually occur within the first three months after the trauma, their onset may be delayed by six months or longer.

PTSD is usually not considered a result of medical training. But in reality, both residents and physicians suffer a high rate of PTSD due to medical practice, whether or not they treat trauma patients or patients with life-threatening conditions.<sup>4</sup> Apparently, the stress of practice alone is sufficient to cause symptoms characteristic of PTSD. PTSD has also been diagnosed in professionals exposed to repeated or extreme aversive details of traumatic events in the course of health-related work. Examples include first responders collecting human remains and police officers repeatedly exposed to details of child abuse.

Dr. James S. Kennedy, formerly at Vanderbilt University Medical Center, stated, “The resulting feeling that physicians [with PTSD] ignore most is toxic shame . . . the belief that one is defective. . . . Once in practice, patient care ‘retriggers’ the toxic fear, loneliness, pain, anger, and shame physicians experienced in training.”<sup>5</sup> I thought I was reading about myself when I read that passage.

PTSD is discussed in Dr. Danielle Ofri’s book *What Doctors Feel: How Emotions Affect the Practice of Medicine*.<sup>6</sup> Dr. Ofri, an associate professor of Medicine at New York University School of Medicine, describes the riveting story of Eva, a first-year pediatric resident who was traumatized when a senior resident instructed her to let a newborn infant die in her arms—in a supply closet of the hospital no less—because the infant was doomed to a quick death due to Potter syndrome. Dr. Ofri commented, “Eva’s residency was truly a traumatic experience in which survival was the mode of operation. And the PTSD that resulted was real. . . . Certainly, in the breakneck pace of Eva’s residency, there was barely a blip of acknowledgment for the wells of sadness that bloomed, day after day.”<sup>6pp106–7</sup>

Dr. Ofri, herself, experienced long-lasting shame and humiliation after committing an error that nearly killed a patient. Exactly two weeks into the second year of her residency, Dr. Ofri mismanaged the insulin therapy of a patient in diabetic ketoacidosis. She was severely reprimanded by a senior resident in the presence of her intern. “I could almost feel myself dying away on the spot,” Dr. Ofri remarks. “The details of my insulin error in the dingy Bellevue ER are crisply stored in the linings of my heart.”<sup>6p130</sup>

In medical school, many of us are told to “get over” our insecurities. It is only through a “hidden curriculum”<sup>7</sup> that we learn that not all patients can be saved or rescued. Over time, we realize the limits of our abilities. Recognition of what it really means to be a physician—the sense of power and powerlessness, of hope and helplessness—is both an attitude and a skill that must be acquired during training.

Still, it is legitimate to ask: Who provides physicians the necessary skills to cope with loss and despair? Who consoles us when our best turns out to be not good enough? Who teaches us how to deal with uncertainty inherent in medical practice? How do we rise above the scandal and

embarrassment of making a mistake? And how do we overcome our fear of making mistakes?

Despite psychotherapy and support from my colleagues, I was unable to resolve these issues. Assurance that I was a good doctor was insufficient. Guidance from my mentors didn’t sink in. Textbooks and self-help books seemed inadequate. Advice to “get tough” with patients—and, alternatively, to distance myself from them—was rejected.

I did learn, however, that caring for seriously ill patients, and those who have the potential to become seriously ill, can significantly impact our inner lives. “The inner life of individual physicians should, to some extent, be brought into the outer life of physicians as a collective,” remarked Dena Schulman-Green of the Yale Center for Excellence in Chronic Illness Care.<sup>8</sup> In that case, writing this article has been long overdue.

Anaïs Nin said, “We don’t see things as they are, we see things as we are.” Practice protocols may guide treatment, but our emotions, prejudice, tolerance for risk, and personal knowledge of the patient guide our clinical judgment. We learn how to obtain good outcomes even when care decisions are made with incomplete or flawed data—the so-called art of medicine. Along the way, we learn from our mistakes, and hopefully we learn how to forgive ourselves and seek forgiveness from those we have harmed.

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