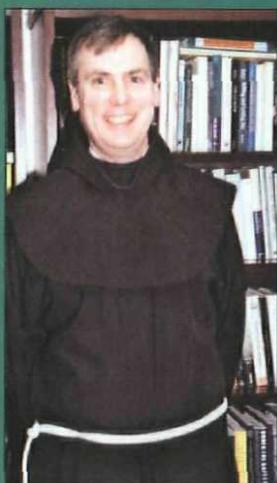


Dignity, Vulnerability, and Medical Error

A Young Physician's Toughest Trial May Be Confessing Mistakes



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“Love” is a dangerous word in philosophy or theology. But a Christian cannot escape using it in describing the spiritual life. In love, one puts one’s own person at risk—exposing one’s own dignity for possible rejection, disappointment, and even possibly annihilation. Love requires the exposure of the soft underbelly of one’s person. The vulnerability of another requires a response in love. And love requires vulnerability.

Vulnerability is at the core of love, because love requires risks. It means, at the very least, exposing oneself to the risk of rejection. It means focusing on the needs of another and thereby forgoing some of one’s own (often unconscious and reflexive) self-protective mechanisms. If another human being has been made vulnerable and one reaches out in genuine love, one is thereby also made vulnerable.

I can best illustrate this with a story. Early in my internship year, I cared for a patient with advanced breast cancer who had developed a pleural effusion (fluid between her lungs and her chest wall) as a result of the spread of her cancer. She was certainly dying, but awake and alert and having great difficulty breathing because of the effusion. We decided that she needed to have the fluid removed by a procedure called thoracentesis. In thoracentesis, the skin is anesthetized and a needle is inserted through the chest wall, between the ribs. A small plastic catheter is inserted through the needle, attached to a syringe, and the fluid is drained. When the appropriate amount of fluid has been drained, the catheter is then removed. In her case, this procedure had a palliative purpose—removing the fluid would help her shortness of breath. The oncology fellow asked me to perform the procedure.

Now I had seen this done a few times as a medical student, and I had helped to perform it once, but I had

never done one on my own. It was clear to me, however, that the fellow expected as a matter of course that I was already quite skilled in this procedure. Fearful of seeming less skilled than expected, I answered, "Sure," and proceeded to prepare the equipment to perform the procedure.

I spoke to Mrs. Hertz,* explained what we planned to do and why, obtained her written consent, and proceeded to perform the thoracentesis. With a slight give, the needle penetrated into the space where the cancerous fluid was located and a straw-colored liquid flowed effortlessly back into the syringe. The patient appeared comfortable, with no pain or additional shortness of breath.

I breathed a sigh of relief. I had done it.

I next proceeded to thread the sterile plastic catheter through the needle so that I could take off a large volume of fluid. We thought she needed to have at least one, or maybe even two, liters of fluid removed in order to make her feel more comfortable. But then, as I was inserting the catheter, the flow of liquid suddenly stopped. Thinking that the catheter might have become kinked, I pulled it back into the needle to try to reposition it. The catheter seemed stuck for a second, then suddenly came back easily. A moment later, the catheter was out of the needle and I realized that the end of it had sheared off somewhere into the fluid filled space between her lungs and her chest.

I broke into a sweat. "How are you doing there?" I asked.

"Just fine," she replied. "It doesn't even hurt a bit. You're a great doctor."

I wasn't sure how to respond. I blurted out, "Well, for some reason the flow of the fluid has stopped. I'm afraid we didn't get much out, and this may not have helped so much. But we're going to have to stop."

"OK," she said. "You're the doctor."

My heart was pounding in my chest. What had I done? I should never have tried this without more supervision. Not only was I stupid, I was clumsy. I had visions of the plastic floating around in there. I wondered if its jagged edge might get stuck somewhere between her chest wall and lung and cause a puncture. Maybe it would become infected. I wondered what I could do or should do.

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WISDOM FROM THE ELDERS

So I ordered an X-ray (which was standard after such a procedure anyway) and with trembling hand I paged the fellow.

I remember vividly how very kind he was. I had expected an upbraiding, but he was calm and constructive. He told me, first things first, that the patient was stable and at least for now seemed no worse for the wear. We looked at the X-ray together, and the catheter tip was just sitting there at the bottom of her lung cavity. He told me that everybody makes mistakes, and that I should not be too hard on myself. He told me that I should make this a learning opportunity—first, that I should never be afraid to ask questions or ask for help out of fear of what someone else might think of me, especially when this put patients at risk. Second, in this specific case, that one should never pull back on this type of catheter, whether it is inserted into a body cavity or a vein, because the design makes shearing off the tip very likely.

He said he wasn't sure himself what to do about it, and thought that we should consult a lung specialist who might be able to insert a lighted scope and remove it. And that after that we would have to talk to the patient about what had happened.

Talk to the patient? I thought to myself. Is he kidding? All I need is to be sued in the second month of my internship year.

"Can we wait until after the pulmonary consult?" I asked, stalling for time, and trying to get my wits about me.

"Sure," he said.

And so I waited.

The pulmonologist, Dr. Tsang, was an older Asian man of few words and superb technical skills. He was regarded by everyone in the hospital as something of a clinical sage. He looked at the X-rays, looked at the patient, and then said to the fellow and to me, "No problem. Inert material. She die of cancer with plastic sitting there or die of cancer after I take it out. Not worth taking

*The names have been changed to protect confidentiality.

A week later she was dead—gone to heaven with a piece of plastic inside her chest.

out. No problem. Have nice day.”

For a brief moment I was ecstatic. I would not be responsible for her death. It wasn't so serious after all. But then, in the ebb and flow of my emotional riptide, I realized that I still had to talk to the patient. And I was terrified once again.

“Do you want me to go with you when you tell her what has happened?” the fellow asked.

“Yes,” I said. “I think your presence in the room might help her and I know it will help me.”

“But you'll do the talking, OK?”

“Alright,” I said. “I'll do the talking.”

WHAT WILL THE PATIENT SAY?

I was extraordinarily nervous. The overhead fluorescent lights had been switched off and the room was rather dimly lit by soft, incandescent bulbs. My palms were cool and sweaty as I sat down beside her bed. The fellow stood behind me, closer to the door. She will think I'm incompetent, I thought. She'll be angry. I'll offer to transfer her case to another intern. She'll sue anyway. My career will be over before it starts. Regardless, I'm just so embarrassed.

“I'm sorry,” I started, muttering through trembling lips.

Then I just kept talking. Five minutes of monologue must have passed in which the room seemed to separate itself from time. All that mattered was in this room and now. I must have said, “I'm sorry,” a dozen times in a dozen ways. I explained what I had done, what had happened, and why. I told her that the pulmonary consultant had recommended just leaving it there.

Then came her turn to speak. I realized that most of my words until this moment had been a way of avoiding what I feared most—her response.

Yet Mrs. Hertz must have been trained by the same mystic guru that had trained Dr. Tsang.

“I'm dying anyway,” she said, “so I guess it really doesn't matter, does it doctor? I'm sure these things happen. Thank you for telling me. But there's really no need for all these apologies. I know you were trying to help me. I know you did your best”

I touched her hand, and we both began to cry. She wiped her tears with a tissue and then, with a small, embarrassed laugh, she offered one to me.

“Thank you,” I said, smiling and flushed, with the taste of salt on my lips.

And the fellow and I quietly left the room.

A week later she was dead—gone to heaven with a piece of plastic inside her chest—a keepsake from her intern.

I tell this story as a way to illustrate the vulnerability that love for patients requires. I learned this lesson early enough in my career, at least in part through this experience, and I am grateful for the lesson. Trying to escape my vulnerability had gotten me into trouble, and it was only through embracing that vulnerability that I could get myself out of trouble. Real respect for my patient demanded honesty and vulnerability.

Love for patients is always an exercise in vulnerability. The idea is radical and dangerous. But it is essential to genuine spirituality in health care. ■