Survive & Thrive: A Journal for Medical Humanities and Narrative as Medicine

Volume 7
Issue 1 *General Issue*

Article 4

2022

Reckoning of the Divided Self

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Reckoning of the Divided Self

Part I: The Patient Story

We are in the final stretch. I've been caring for the mother for 40 weeks, and I know her and her family well. What I'm witnessing is familiar. The grandmother, the family's matriarch, is sitting by the bedside, knitting a hat, encouraging her daughter with few words, "You can do it." The sister, also pregnant, is holding the mother's hand tightly, lovingly interjecting jokes, taking a seat when her own pregnancy pain overwhelms her. I try to coach the mother on pushing, but the epidural has worked well, too well. She needs to push but has no sensation below her belly button. The initial excitement in the room transforms into weariness as the baby, who is mere inches away from meeting the world, cannot and will not make the passage. Then, the mother accidentally coughs, and the baby jolts forward. The room erupts and yells, pleading her to continue. With a sputtering cough, the baby enters the world.

The initial days after the birth are unremarkable. Ileana (not the patient's actual name) sleeps, poops, and eats. Her blood tests are all normal, except for the bilirubin—a test for jaundice — which is mildly elevated. Ileana is ready to go home. I arrange a follow-up on the coming Saturday with another provider.

When I return to clinic the following week, it surprises me to see Ileana on my schedule. She has not had the expected weight gain, so the weekend provider made another appointment with me. She is checked in and weighed. I am shocked by the numbers: weight loss of 18% less than birth weight and transcutaneous bilirubin 19. It's normal for babies to lose weight, but it is almost always less than 10% of their birth weight as they learn to feed and wait for the mother's milk to come in. She is sick and needs additional care, but I see she is alert and crying as I examine her. Hungry but still with some energy.

I know she needs more care, more calories, and more fluids. But I didn't know the best option to get her better; the first case of COVID-19 had been identified in the state a week ago, and the governor had called a state of emergency. In my shock, I think I have some time to confirm the bilirubin level. Then, I could coordinate logistics for her care. Ileana's family asks if they can go home and wait there for me to call them later—they're just a few blocks away from the clinic. I agree and hug the mother, who is frustrated and in tears and feels that she can't care for her own child. A few hours later, the labs return, worse than expected. I need help. I contact the on-call hospitalist to coordinate logistics for the patient and ensure I talk to somebody directly about her case. However, the hospitalist isn't ready for the question because she is concerned and focused on the numbers.

"You did what? Why isn't she at the ER right now? You sent her home?!"

I fumble a response, not ready to be questioned. There is a brief silence, and the hospitalist, stumbling over the awkwardness, tells me where the family should go. I call the mother and tell her they need to go to the ER for the baby's safety, and the baby will likely be admitted to the hospital. I tell them there's no other choice, so they agree to go. By the time the baby arrives at the ER, she is sicker but okay. She is admitted to the hospital, is supplemented with formula, and gains weight. After 36 hours in the hospital, she is sent home. Within the next week, she gains enough weight to be back at her birth weight.

Although the patient's story ends here, this is where my story starts. I made a mistake by not sending her to the ER right way, and although she was okay, I wasn't prepared for the wide range of reactions that I would experience after the event. Here's my story.

Part II: My Story

Although I see her thrive after being discharged from the hospital, I ruminate over the decision I had made. I should've sent her to the ER immediately rather than wait a few hours for more information. I made a mistake but was saved by grace—a different decision would not have changed the outcome. In my first year out of residency as a family medicine doctor, I unconsciously still held on to the belief that if I read wide enough or tried hard enough, I could avoid making mistakes. The fragility of this belief became apparent as even a near-miss situation ushered in a heavy emotional burden. I did not sleep well nor think clearly for many months. To heal, I promise myself to do better. I read where I went wrong, ask others for advice, and learn. I hope for closure. In time, the emotional burden lifts.

Time goes by. One month. Two Months. Three Months. Then, four months after the scare with Ileana, I receive an email that reads, in part, "You are receiving this notification on behalf of the Peer Review Committee. Please review the attached letter and send your response at your earliest convenience." Before this email, I had not been notified I was under consideration for Peer Review. The letter states, "Your case will be reviewed in 2 weeks. We would appreciate your thoughts and perspective on the following questions or concerns: In retrospect, given the infant's 18% drop in birth weight and bilirubin of 19, do you believe follow-up later that day was appropriate, or should they have been referred emergently?" It concludes, "Once your response is provided, case points are discussed among committee members, then a determination is made by vote." An attached primer explains that it is a confidential review by peers to improve patient care and allow staff the opportunity to submit concerns for a formalized, fair, and objective process.

I had accepted I made an error already, but as I imagine my peers judging my actions and behavior, I begin reliving the moments again. The email is a surprise reminder that drudges up memories that I think I had neatly tucked in with lessons learned, emotions conquered. I reread the question, "In retrospect, given the infant's 18% drop in birth weight and bilirubin of 19, do you believe follow up later that day was appropriate, or should they have been referred emergently?"

Although I had accepted my mistake before, now I feel I need to defend myself and my reputation. I don't want to, but I think I need to. I worry that my peers will judge me as a doctor and person. Seeing that the only information they had about the case was from the chart, I realize I have no advocate in this process. Imagining this, I forget that I had already accepted my mistake and become defensive. The certainty and anger fill my internal response and undermine the acceptance of my mistake: you don't understand the context, it was a pandemic, it was just a few hours. Why is this happening when I did not harm them? Would it have changed the outcome if I had sent them to the ER a few hours earlier? No.

Quieting the self-righteous voice in my head, the response I write is measured—providing justifications while acknowledging the mistake. I write hastily though because the committee had sent the letter to my medical director and me. I want to be quick with my response, adding in my

words, emotions, and justifications before I lose face with the people I know. I am fighting a sense of humiliation, worried that the original email was devoid of the context of my experience. Don't these things require a conversation in-person? A back-and-forth? I send the response. Then, I wait.

I continue to work. Keep showing up. The paranoia seeps in. Is this the time that I'll make another mistake? Is this when someone will look at my notes and determine that I screwed up? Better be thorough with my documentation, write down everything. Now, I know they won't talk to me; they'll look at my notes before sending an email about my mistakes.

Then one day, I am called into the office again because another Unexpected Occurrence is filed. This time it is something that had occurred 2.5 years ago. Why now? No one knows. My director says I likely didn't do anything wrong, but maybe I could've caught something earlier. At this moment, it clicks. I'm forever vulnerable. Every decision I have made is available to be analyzed, judged. Waiting to be caught. To be reviewed. To be improved, objectively.

The paranoia deepens, and I overact when I see patients. You have what? Let's order all the labs. Who cares about the cost? You have a problem that seems unusual, maybe dangerous; you better go to the ER. Who cares about utilization? Need to protect *me*. No one will blame me for doing more, referring more. Overtreatment and overdiagnosis: I knew they were problems but not in my purview anymore. Neither patients, lawyers, nor my peers will judge me for that.

A few weeks later, another email comes, "You will receive an email shortly with the committee's verdict." I wait. One day, two days, three days. What does "shortly" mean? I send another email to a follow-up asking when I should expect their reply. I finally see the result: "The committee has identified a significant opportunity for improvement and has recommendations for the Index Provider. They will be required to perform an Early Quality Improvement Plan." Anger overcomes me. Didn't I already know that? Five months after the event, after all the readings and conversations, I must do it again. It didn't matter what I had learned up to that point. It's for my learning and my improvement, they say. You need to create a plan and let us know you completed it, they say.

I'm unable to accept the outcome. I'm infuriated at the unfairness, the injustice. What I've seen my colleagues miss: epidural abscess, abnormal pediatric heart murmur, misdiagnosis of skin cancer. The number of times I sent them to Peer Review? Zero. I'm okay sending messages to them directly, talking to them directly. They already carry enough of a burden in a profession that claims to make space for humanness but expects perfection. Now, who was the one who felt they couldn't talk to me directly and instead needed to report me to the tribunal?

I carry my anger with me as I complete the required tasks for the early improvement plan: take a medical education course, send cases for chart review to the medical director and help create a weight-loss pathway for newborns. Witnessing my disillusionment, my wife interjects, "I think you made a mistake. What scares you about that? You are a good doctor. You did the best you could, but you made a mistake". The trance is broken, and I realize I have lost control of my emotions and reactions. I strive to return to the space of loving awareness that I had worked hard to cultivate, acknowledging my humanness and capacity for mistakes. It was okay; I made a mistake. It could've been worse; I could have seriously harmed the patient; I could've been sued, and my career could've

ended. These aren't farfetched possibilities; it happens. This incident is merely an opportunity for me to improve so it doesn't happen again.

After I complete the required tasks, they ask me to give feedback about the process, but I struggle to articulate how it could've been better. Initially, I blame myself for the emotional reactions, which seem to be a product of my fragile ego and rigid attachment to my identity as a doctor. I want to face suffering courageously and not succumb to my unruly emotions. But I couldn't in this instance. As I reflect though, I realize that my institution's particular Peer Review process also exploited my specific vulnerabilities, in places where I already struggled.

Nearly all hospitals and medical institutions have a Peer Review process. They vary, but the best are timely (sometimes conducted monthly), balanced (views of physicians are reviewed, considered, and recorded), and consistent (have a reasonable standard for referring cases). The Peer Review process that I had gone through did not meet many of these characteristics.

The process wasn't timely. The verdict of my case occurred nearly six months after the incident. Although this may seem fast compared to litigious cases, I had already discussed the matter with many peers and reviewed it with my medical director in an initial case review. I was puzzled to see a notification months later that I was under Peer Review, which I did not know was even a possibility or a consideration. Mistakes need closure, and an opaque, prolonged process contributed to repeated psychological and emotional trauma. After an error, ruminating thoughts and sleepless nights are expected; after overcoming them initially, I was shocked by the tenacity of negative thoughts once the case was reintroduced and I was asked to explain the situation. It wasn't that I wasn't willing to present the case, but I was asked to explain it again, and again, and yet again.

I also want a process that does not require me to justify myself. Committee members asked me to add my perspective with a single question in an email, but I wanted someone as an ombudsman to listen to what had happened fully. I didn't want to defend; I just wanted to explain. I wanted a conversation and a dialogue, not sterile emails devoid of human connection. I wanted to be heard, but I also wanted to feel and believe that the committee fully and correctly understood the root of the problem—my confusion at the moment, ignorance of logistics, lack of urgency—to ensure an accurate verdict.

Finally, I felt alone because I felt unlucky. While theoretically, I knew I could make mistakes like this, it felt unjust that another provider's judgment about my decision-making initiated the review process. Rather than my case being identified as one among others where all babies who were hospitalized for weight loss were reviewed, it was singled out because my colleague felt that this case was especially deserving of Peer Review. When I witness errors, I directly contact the provider to give feedback in many cases. For some reason, though, this case was egregious enough that this provider believed that was not enough.

The Peer Review that I had gone through was created for mistakes and errors of all sizes—the unintentional, the negligent, and the ignorant. This process needed to protect patients and the organization's brand. I could see why the process was created this way, but it was ill-suited to give providers authentic feedback to improve care quality while holding space for providers' well-being. I hoped that, with my feedback, we could move towards a process where we could strive for a culture of safety that acknowledges the humanity and inevitable fallibility of medical providers. This kind of

process may not prevent the range of reactions on the journey to acceptance, but it would seek not to exacerbate the inescapable emotions that accompany any medical error. I believe it's possible to create this culture, but until then, I repeat to myself that I made a mistake, I did not know, I was unlucky, I can be better, I will be better.