Hard Cases: What Happens When a Medical Mistake Has an Unthinkable Outcome

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This article is part of LinkedIn's Hard Cases series, where doctors share the toughest challenges they've faced in their careers. You can read more about it here and follow along using hashtag #HardCases.

"I have colon cancer."

My heart stopped.

One of my favorite patients, Mr. H, called me after I had moved my practice in Santa Rosa to Mammoth Lakes in Southern California.

Mr. H became my patient a few years before while I was in family medicine residency training. Each resident had his or her own patients in the clinic across the street from the hospital. First year residents inherited patients from the previous year's third year residents when they left training to set up their own practice. New patients also found their way to the family practice residency clinic. Some because their friends recommend they go. Others because they were Medicaid patients and couldn't find care elsewhere. Still others came because we welcomed all comers.

Mr. H Was My Patient and I Failed Him

Mr. H had initially came to my office for a physical exam and I later saw him in follow-up. He always came to his appointments dressed in navy slacks and a newly laundered shirt, hair slicked back and with a whiff of aftershave. He was about my father's age.

Treating an older man who seemed to like me and whom I thought was dressing up for me made me uneasy. I was flattered but also anxious about feelings that I didn't want to bring into a patient-physician relationship.

When his routine blood tests came back with a low red blood cell count, I presented his case to my attending physician. I don't remember the details of Mr. H's workup. But I do remember that I did not do a rectal

exam to check for masses and for hidden blood in his stool, a sign for colon cancer. My anxiety about the basic, but personally invasive, examination got the best of me.

Would I have felt this way if I had been treating a woman instead of a man? No. I would have just gone about my business, conducting a thorough history and physical examination, including a rectal examination. But I didn't do that for Mr. H. And now he had colon cancer.

Medicine is about objectivity and emotional connection not just with selected patients, but with all of our patients –no matter what. The problem is that many of us have treated, and continue to treat, patients differently according to their looks, their political beliefs and their insurance status – but we don't want to admit it.

If Only You Had Looked for Blood in My Bowel Movements

Mr. H. went on to say, *"If only you'd checked my stool, you probably would have found blood. And I could've been diagnosed and treated sooner."*

My heart sank. I had not performed the most basic of tests that are done when someone has a new anemia and now my patient had colon cancer. I thought he was calling to tell me to expect a malpractice suit, but before I could respond he said, *"You probably think I'm going to sue you. I won't. I wanted to let you know so you'll be sure to check your patients in the future."*

My overwhelming relief was dueling with shame and guilt. I wasn't going to be sued. But I had failed Mr. H. *Failed him*. He could die from a disease that I might have caught earlier.

Mr. H. Was My Lesson

One of my fellow residents recently told me that when she started medical school she knew she would inadvertently kill someone. After it happened, she said she was relieved because she could move on with becoming a doctor.

I had made a terrible mistake, one that could cost Mr. H his life. The acceptance and generosity of spirit he showed me was my lesson. I will never forget this Hard Case and the lesson I learned.

We physicians live in a blame and shame world, a rigid hierarchy, one where Mistakes. Are. Not. Allowed.

I never heard from Mr. H. after that last call. And, I was too ashamed to track him down. This story stayed buried within me – I was too humiliated to share it with anyone.

I Exposed My Mistake to the Light

A few years back I blurted out the tale during a keynote presentation. Some members of the audience came up afterward to tell me their stories of shame in treating patients. They validated my bravery in sharing my mistake, the deep secret I had never revealed .

The world did not come to an end.

By sharing my Hard Case, by accepting my shortcoming, it gave others permission to do the same.

We All Make Mistakes

We all make mistakes, but physicians tend toward rumination when this happens and we beat up on ourselves more than anyone else ever could. Sometimes things go wrong in medicine, sometimes the result is too horrible to contemplate. We need to acknowledge that we can't be perfect. Admitting it, forgiving ourselves and moving on helps us become good doctors. And more effective leaders. As Gandhi said, *"If we could change ourselves, the tendencies in the world would also change. As a man changes his own nature, so does the attitude of the world change towards him. We need not wait to see what others do."*

My training to become a physician leadership coach has taught me it's OK to be open and vulnerable. That's how trust grows. And, as Leonard Cohen wrote in Anthem,

“There is a crack in everything, that's how the light gets in.”

Margaret Cary is CEO of The Cary Group Global. She coaches and develops physician executives and their teams to increase productivity, decrease patient error and maximize their joy in work and at home. She co-founded A Whole New Doctor, her passion project, the initiative to create resilience in and provide executive coaches for medical students.