Patient Safety and a Young Medical Student

Night hung heavily on the Labor and Delivery Floor as the neonatal nurse rolled M's, stillborn at 40 weeks, out of her mother's room. Wrapped in the pink blanket we used for all newborn girls, M's jaundiced features were breathlessly frozen. Only three months into my third year, I turned away ashamed, and huddled with the nursing staff. In a frenzy of activity, my attending physician was dictating to various nurses; "Write that you had called the mother at 11am and told her that she absolutely must come in. Write she ignored your advice." A confused look crossed the charge nurse's face. "But you didn't tell me to call her," she responded. "Of course I did, I wrote it on a Post-It note…" he yelled back, as he scattered papers to the floor looking for a note 15 hours late in delivery. Flustered, he stammered "Well, it must be back at the office."

My mind rewound the torrent of the last 6 hours, retracing each moment I'd spent with M's mother. She was a woman in her late thirties, large dark brown eyes flickering in and out of her waist length walnut brown hair. It was early in my shift as I sat bedside to take her history. Her husband sat unconcerned on the couch, tapping away at his phone. She had a scheduled Caesarean section tomorrow, but her baby had been moving with less regularity that morning, so she'd called the clinic at 8am to voice her concern. No one had picked up the phone, so she left a message asking to be contacted. In the frenetic life of a parent, she hadn't remembered to call again until 1pm. On this second occasion, she had talked to a nurse, who had said the doctor would call her back. When the doctor didn't call, she made childcare arrangements for her other children, and came to the hospital. By the time she'd made it through admissions and met me on the floor, it was after 7pm. Concerned by her story, I interrupted my history taking to retrieve the floor Obstetrician and an ultrasound machine. Moments later, as I stood bedside straining my eyes at the ultrasound display, the diagnosis was painfully clear to the medical staff in the room. There was no heartbeat, no fetal movement. M had become a 40 week demise. Her mother and father stared stone faced at the Obstetrician as he attempted to deliver this horrific news. Only seven hours before her scheduled Caesarean, my attending arrived and performed an elective caesarian, but to her dead child.

Haunted by the moments I'd spent with M, and emotionally devastated by her parent's grief laden questions, I started looking for answers. I wanted to know if anything could have been done to prevent her demise. Speaking with the mother, I uncovered that it was her third lost pregnancy, but no documentation appeared in her medical record to suggest a high risk pregnancy. I found that the clinic medical assistants were dogged by a perpetually full office answering machine, often unable get to voice messages

for days. A Post-It note was later discovered lodged in another patient's file that read, "Call Tonya W. back."

Were these the reasons M would never know her mother; poor communication, full answering machines, and a misplaced Post-It note? Nothing had prepared me for the banality of this tragedy. I'd buried years of my life into studying the intricacies of medicine, but the first medical tragedy I encountered was bureaucratic. I had been trained in physiology and pathology, but it was provider communication and safety protocols we needed. The solution was stingily straight forward. Low hanging fruit in the garden of medical care: Poor documentation prevented the recognition of Tonya as a high risk pregnancy; Medical assistants were isolated at clinic, having too little time to return calls, and no idea of which calls were deathly urgent; The nurses were located far from the physician offices, and so communicated in brief hallway encounters and a pile of Post-It notes. It was an office of silos, isolating each member of the care team, and in between each silo were spaces large enough to swallow life itself. M didn't die because her parents were stupid, or because her physician was malicious. She died because of *how* we deliver our care.

We cannot graduate another generation of physicians who vigilantly watch for drug interactions, but are careless with provider interactions, who obsess over pre-existing conditions, but ignore communication and checklists. Spurred by such convictions, I worked under a professor to help create a 16 week Quality Improvement and Patient Safety course now taught within our medical school. Now, each year, new students receive essential tools including Process Mapping and Fishbone Diagrams alongside their pathophysiology. They are being trained to fix systems as opposed to fixing blame. Moreover, our students are now working on their own projects across the university and in our local clinics.

We can live in a country were each doctor vigilantly re-evaluates the way our patients are treated. Under the gaze of tens of thousands of providers, our systems will improve. We will deconstruct our offices so that we can work as healthcare teams. We can close the gaps in our system, so that no one, child or adult, falls between the outstretch hands of those who have sworn to "do no harm."

Student by student, we are getting the news out. Each class we graduate, equipped to instigate change, is M's legacy for me.