

Make Your Own Mistakes

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One of the many adages that we collectively pass on to our medical students and residents is the concept of “making *your own* mistakes.” In other words, one should not compound the mistakes of others by failing to make one’s own assessments and treatment decisions. I frequently recount certain stories to my house-staff in order to illustrate how easily even conscientious doctors can violate this rule! Here is one such story.

Between the autumn of 2008 through the spring of 2009 I was assigned to Joint Base Balad in Iraq, flying Critical Care Air Transport (CCATT) with the U.S. Air Force. I was the physician on a 3 person team with the task of providing en route critical care for ICU/Trauma patients during our standard air evacuation flights on cargo aircraft. Our transcontinental flights were on the C-17, an enormous aircraft designed to transport large cargo like main battle tanks--not the critically wounded! Our patients were often on ventilators with every imaginable tube emanating from them. The typical patient was intubated and possessed many of the following: chest tubes, a suction tube coming from their still-open and packed abdomen, a ventriculostomy, external fixators on shattered limbs, or outright missing limbs. As we were often charged with flying more than one of these complex patients we had to rapidly assess them and ensure they were adequately stabilized and try to predict any of the things that could go wrong with them in flight. Once we were airborne and on our way to Germany, we were essentially on our own! Anything we failed to anticipate and have a response for could prove catastrophic as we only had the ability to run a few basic labs on a portable i-STAT device. With the noise of the aircraft I could not even use my stethoscope to any effect. We were always pressed for time as the air crew was always determined to takeoff well before the sun came up. The reason for this being that large cargo planes parked on airfields in locations where insurgents are looking to shoot anything they can at you are ripe for disaster. We typically flew these missions at night to improve our odds of reaching a safe altitude before anyone could try something nefarious. Our equipment allowance and procedures allowed for us to care for up to 6 patients at a time with up to three on ventilators. It was quite common to have last minute patient's added on—“as we were going anyway” and “had space.” These continual changes added to the chaos, but I had at least learned to always expect my eventual patient mix to look nothing like the initial briefing that we would receive after first being alerted.

It was in this milieu where my nurse, who I might add is a veritable icon of clinical virtue, prevented me from egregiously violating the aforementioned rule. It was shortly before midnight local time when we entered our ICU in order to get our allotment of patients

ready for transport to the flight line and situated on the aircraft. This particular mission was atypical as we only had two patients assigned and neither was on a ventilator. While I was still reviewing the first patient's chart, one of the ICU nurses made a point to approach me and tell me that our other patient was being "nasty" and "drug seeking." I made a mental note of this and took a quick glance at him across the small ICU bay. I could tell he at least looked stable and apparently had a broken leg. My nurse was at his bedside talking to him. At this point, I diverted my attention back to what I was initially doing. It was mere moments after this that one of the ICU doctors came over to complain to me about what a "jerk" (he used much stronger language) this patient was being! The doctor was describing the patient as disoriented and abusive. Of course, the first thoughts that came into my mind were along the lines of "I so don't have time for any nonsense from this guy..." and "just my luck to have to deal with a disruptive and difficult patient."

Now that the figurative poison was starting to diffuse in my mind, I felt myself start to get indignant. I was telling myself that I was in no hurry to go over and assess the second patient. Fortunately, a few moments later my nurse was next to me wearing one of her expressions I knew so well. I was immediately relieved to realize I was not the object of her frustration (this time.) I had flown with her long enough to have a few of her annoyed looks cataloged. It was apparent that our colleagues were greatly failing to meet her expectations! In no uncertain terms, she informs me that this unfortunate soldier had a substantial hip fracture and was in immense pain. Furthermore, he was sorely under medicated. Of course, he was agitated and not on his best behavior! My sense of indignation rapidly gave way to pangs of guilt as I realized I was on the crux of perpetuating this mistake! My pen flew from my flight suit pocket to the order sheet she held to correct this omission. This "difficult" patient's demeanor and mental status improved dramatically once we started to get better control of his pain. During the bumpy ambulance bus ride to the flight line my team and I wedged our thighs underneath his stretcher to try to lessen the bouncing and improve his comfort. He was remarkably patient with us considering how much the extra bouncing hurt him. Over the next several hours, on the flight from Iraq to Germany, I learned more of his story. He was a middle-aged soldier who had fallen approximately 30 feet from a Blackhawk helicopter landing on unforgiving concrete below. In addition to the physical trauma, he had been subjected to the added mental torment of not being able to get into this helicopter as it was taking off. He found himself clinging frantically to the wheel, reportedly unseen by the pilot, until he could maintain his grip no longer and fell. With that mechanism of injury it was amazing that the only thing broken was his hip and a few ribs and that he was still alive! In addition, the CT scans revealed he had a relatively small amount of intracranial bleeding and some parenchymal contusion of his lung. Despite significant continued pain--especially associated with all the bumps involved in transferring someone from one continent to another using an array of stretchers, ambulance busses and military cargo planes--the patient was in pretty good spirits by the time we arrived at the ICU in Germany the following morning. He was now a huge fan of my nurse and rightfully so! A couple of days later, when we were back in Iraq my nurse presented me with a challenge coin, a small coin bearing his unit's insignia, from his assault helicopter battalion. He had called a friend in his unit expressing immense

gratitude for my team and asked his friend to convey these coins to us. Anyone who has served in the military will tell you that these seemingly small trinkets are often used to mark highly meaningful events. It was at this point that I finally reflected on my own thought processes that cold desert night and heard the voice of one of my attendings from twenty-plus years ago – ***“Chesser, make your own mistakes.”***