

A Physician's Personal Experiences as a Cancer of the Neck Patient: Errors in My Care

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Medical and surgical errors are very common in the hospital setting.^{1,2} They increase the number of malpractice lawsuits, the cost of medical care, the length of patients' hospital stays, and morbidity and mortality.³ As an infectious diseases specialist for more than 40 years, I was not aware how common these errors are until I became a patient myself after being diagnosed with hypopharyngeal carcinoma. My initial cancer was successfully removed, but there was a local recurrence 20 months later. I underwent pharyngolaryngectomy with flap reconstruction after attempts to remove the cancer by laser failed.

Although the care I received was generally very good, I realized that mistakes occurred at all levels of my care. I am sharing my personal experiences about the medical and surgical errors that occurred during my hospitalizations at 3 different hospitals. My inability to speak after surgery made it difficult for me to prevent all these mistakes. Fortunately, I was able to abort many of them.

I realized that my surgeons had failed to diagnose the recurrence of my cancer in a timely fashion although they examined me periodically after my initial surgery. I had been complaining of sharp and persistent pain in the right side of my throat for 7 months. The recurrence was finally observed by an astute resident who was the first to ask me to perform a valsalva maneuver (exhale while closing my mouth) during the endoscopic examination. This allowed visualization of the pyriform sinus where the tumor was located. I had wondered why my experienced surgeons never performed such a basic procedure. If they had done so earlier, my tumor (4 × 2 cm²) most likely would have been observed and removed much earlier.

Subsequently, my surgeons, using laser equipment, mistakenly removed scar tissue instead of the cancerous lesion. A week after the surgery pathological studies revealed that the tumor was actually farther down in the pyriform sinus. This error could have been avoided if frozen sections of the lesion itself, not just its margins, had been analyzed in the operating room. Accordingly, I had to undergo an additional surgeries to remove the tumor. The prior surgery made the repeat attempts more difficult because of swelling and postsurgical changes at the surgical site.

I also experienced hazardous situations because of nursing errors. One day after my laryngectomy, while still in the surgical intensive care unit, I experienced airway obstruction and reached for the call button. It was not to be found as it had fallen to the floor. I tried to call the attention of the staff but, even though I was only a few feet away from the nurses' station, I was ignored until, luckily, my wife arrived 10 minutes later. Without a voice, I was helpless to ask for assistance and was in need of air while medical personnel passed by me.

A similar incident took place on the otolaryngology floor a week later when the nurse did not respond to my call to suction my airway. I had difficulty in breathing as mucus in my trachea obstructed my airway. The nurse came to assist me only after 15 minutes. I learned that she was on the phone ordering supplies during all that time. Two physicians and several nursing assistants were on the floor, yet no one responded. Incredibly, even on a ward dedicated to people with airway issues, there were many distractions that prevented physicians and nurses from paying attention to their patients' immediate needs.

The most serious error after my major surgery was prematurely feeding me by mouth with soft food far too soon. Early feeding by mouth after laryngectomy with free flap reconstruction can lead to failure of integration by the flap. Only my persistent questioning brought this to the attention of a senior surgeon, who discontinued the feeding after it had gone on for 16 hours. The error occurred because the order to start feeding was intended for another patient and was erroneously transcribed into my chart. I wonder what would have happened if I had not continued to question the feeding and when (or if) the error would have been discovered.

Some of the errors by nursing and other staff included the following: not cleaning or washing their hands, not

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using gloves when indicated, taking oral temperature without placing the thermometer in a plastic sheath, using an inappropriately sized blood pressure cuff (thus getting alarming readings), attempting to administer medications by mouth that were intended to be given by nasogastric tube, dissolving pills in hot water and feeding them through the feeding tube (thus irritating the esophagus), delivering an incorrect dose of a medication, connecting a suction machine directly to the port in the wall without a bottle of water, forgetting to rinse the hydrogen peroxide used for cleaning the tracheal breathing tube (causing severe irritation), not connecting the call button, and not writing down verbal orders.

All these events made me realize that a hospital is the least safe place for patients. Most patients lack medical education and thus cannot recognize—let alone prevent—errors in their care. My experiences taught me that a dedicated patient advocate such as a family member or a friend is desirable for all hospitalized patients. Fortunately, despite these errors, I did not suffer any long-term consequences. However, I had to be constantly on guard and stay vigilant, an exhausting task during a difficult recovery process.

Despite these experiences, I am grateful to all the physicians, nurses, and other health care providers who supported and cared for me through my difficult and challenging hospitalizations. I am sharing my experience in the hope that it will encourage better medical training, greater vigilance, and increased supervision and communication between health care providers and their patients. It is my hope that these factors will contribute to the reduction of errors in patient care and lead to a safer environment in the hospital setting.

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