TRANSCRIPTION

cpsi Canadian Patient Safety Institute
iscp Institut canadien pour la sécurité des patients
Dr. Amy Nakajima
Gynecologist

[0:00:10] This story is about a case that had happened to me 14 months into my practice. I thought about it daily for the first ten years. It never left me. It, I think, in many ways, made me the physician that I am, the person that I am.

[0:00:32] We had a patient who was in labour and I was asked to see her just as she was pushing because the baby's heartbeat was dipping. And the family doctor had already initiated doing a vacuum. And I'd come in and taken over doing the vacuum delivery. And that went quite well. But she was bleeding a bit. I couldn't see very well to do a repair of the tear in the vagina so we'd taken her to the operating room. And so it seemed to be pretty standard up to this point.

[0:01:08] And then I started struggling in the operating room. So we repaired the tear. I expect her to stop bleeding. She doesn't stop bleeding. Then I work through the usual algorithm of when women are bleeding after delivery. What are the common things? And we worked on that. And still, she continued to bleed. And I called my second on-call in to give me a hand. And then the anesthesiologist said that he was struggling, too. So he called the second anesthetist to come in and help. And then it became clear that we were having trouble even accessing IV lines. So the general surgeon came in to do a cut down. And then it started drifting into, “This doesn't feel right.” This isn't working. She's not responding in the way I expect her to respond. We're all struggling now. It's not just me. Like, the entire team, every set of providers were all struggling. I was doing all the things that I was trained to do. I was doing all the right things. And yet I wasn't getting the results that we typically get when we respond in the way we do.

[0:02:30] And it turned out that she had a very rare event called the amniotic fluid embolism. And at the time, while we're all trying to make things better, I think we're feeling frustrated. We're feeling lost. We're feeling bewilderment. There's controlled chaos because there's so many people coming in and out. And then when we finally closed and we brought her into ICU, she coded and she died.

[0:03:07] And I sat there that night doing my dictation and going over notes and notes and then starting to tease out things about her care about, while she was induced, did she need that? Actually, she probably didn't. And that was what set this ball rolling. And it became a very acute, painful, unscheduled teaching for me about how to do an incident analysis. And yet, nobody told me how to do this. I had just the entire chart in front of me and trying to put it together so that I could actually dictate.

[0:03:52] And I had called the chief of staff and told him briefly what had happened. And his response was disbelief. You're telling me what? I'm telling you that we lost a mom. You know, that hasn't happened. I know; it hasn't happened in decades.

[00:04:10] I was on call, so I stayed in hospital that night. But I felt so shattered. And even in the middle of this, I went I had to go and see another patient because I was on call. And that was the patient that I ended up seeing in the office sometime later. So I felt absolutely drained.

[0:04:37] And when I called the chief of staff, I let him know that, “You're going to have to find a replacement to cover me starting 8:00 tomorrow morning because I'm not safe to work.” I was off for two weeks.

[0:04:48] So I had told him that – and it sounds melodramatic now, but I really did feel at the time that if this was not an embolus of some kind, that I would quit because I should have been able to save her. We should have been able to save her as a team. And we waited for the autopsy results to come back. And it had been an embolus.

[0:05:14] I attended her funeral and it was amazing. I don't think I'll forget that, ever. It was completely full. And I felt so sorry for this family.

[0:05:35] And I came back to work two weeks later and I'd come back to a hospital that had lost a patient and not one word of blame. Incredible support everywhere I turned. So in hindsight now, knowing what other second victims encounter and endure, I feel so very fortunate for having had that support. How was I supposed to talk to the patient's family? What was I supposed to say? I had no teaching. I had not been coached in my residency program. I'd never watched a provider have an event like this. And having to talk to the family afterwards, to provide information, to provide emotional support to the family, and then also to figure out what happened, what exactly happened here. So for all those reasons, I felt really, really inept because I hadn't been trained, hadn't encountered this before.

[0:06:38] And on the other hand, I had such support from the team and from the hospital through hospital administration. So for someone who had had this encounter very early on in practice with very little training for this – in fact, no training to deal with this – I was really lucky because I was in a very supportive environment.

[0:07:02] So having experienced that event and other experiences, it really inspired me to advocate for more patient safety teaching in undergraduate and postgraduate education. So I'm currently in Ottawa and in the last couple of years, we have a new patient safety lecture in the medical students’ third year. And last year, we set up a patient safety elective for students in their pre-clerkship and their clerkship. In the post graduate program, we started doing simulations for disclosure. And it's really interesting. So people, when they hear about health care simulation, they think about this $45,000 mannequin. But in fact, one of the most effective forms of simulation is a role play. And it's a really

effective way of teaching, training, assessing these really difficult encounters that you can't arrange in advance.

[0:08:10] I would say that I was one of these people who felt this guilt that this had happened. I didn't feel ashamed. And I think that's a key point, that I was supported. I wasn't ostracized. I wasn't shamed. I wasn't blamed. People were incredibly supportive and empathetic.

[0:08:34] It is such a challenging discussion to say to a family, “I'm really sorry we couldn't save your mother.” And some people have made a parallel to breaking bad news curriculum in undergraduate medical education. But I think it's fundamentally different because in breaking bad news, I could say, “I'm really sorry. Remember the test that we did last time? It shows that you have cervical cancer.” Well, it's terrible news for a patient. And I will feel terrible giving that news to her because I know what's coming. But that's fundamentally different from me saying, “I'm really sorry. You have breast cancer; we removed the wrong breast.” It is a very different, very different conversation because you now have to take ownership of your participation in the harm that came to this patient through health care. And I think this needs to be part of undergraduate education and post graduate education because we can't expect our trainees, if we don't talk about it, if we don't teach it, if we don't assess it during training, how can we possibly expect them to be competent at such an emotionally challenging time for them?

[0:10:02] I see, at the mega level, the Canadian Patient Safety Institute providing education, advocating for patients and for providers. So I do think that I see change over time.

cpsi Canadian Patient Safety Institute
iscp Institut canadien pour la sécurité des patients

FIN