

## Right Place at the Right Time

### Inpatient Ward

**A**s a physician, did you ever get a “bad feeling” about a situation? Physicians are supposed to rely on scientific evidence, not emotion—yet how many times have we as scientists been humbled by the amazing human body? Medicine should allow room for instinct—when physicians rely solely on evidence-based medicine, the patients ultimately lose.

The following event occurred several years ago when I was working as an intern. I was paged around 1 AM to evaluate a 65-year-old man who presented to the emergency department in respiratory distress. When my resident and I arrived, the patient was responding well to oxygen (his oxygen saturation noted on oximetry had increased to 93% from 87% on admission) and his respiratory rate had decreased to 16 from 22 breaths/min on admission. However, the patient appeared apprehensive and pale, and he had copious phlegm at his stoma, which prompted him to cough frequently. In addition, he had a permanent tracheostomy after surviving laryngeal cancer, he had chronic obstructive pulmonary disease, and he was a heavy smoker. The patient also noted that he was recovering from bronchitis. Except for the patient’s occasional wheezing, the remainder of the examination was unremarkable.

The emergency physician thought that the patient had a mild infection, perhaps a relapse from an earlier illness, and suggested that my resident and I admit the patient to a bed on the inpatient floor. The patient’s attending physician confirmed that the patient was recovering from bronchitis and suggested that we start intravenous antibiotics and admit him to a regular floor room. I mentioned to the attending physician my concern that this patient had fragile respiratory function with very little reserves. I told him that I had a bad feeling about this patient and the fact that the patient seemed highly anxious only reinforced my opinion. I was trained to pay attention to a patient’s perceptions—if the patient has an ominous premonition or serious apprehensions, heed the warning! This patient needed more acute care and closer observation than what the nurses could reasonably be expected to provide on this floor (the section of the hospital with the highest patient-to-nurse ratio). The potential for an obstructed tracheostomy concerned me greatly, and my resident agreed with me. Unfortunately, neither of us could convince the attending physician to admit the patient to a more intensive care room.

The patient’s transfer to the inpatient floor was unremarkable; however, I still had a bad feeling about him. I took my time writing orders, and, despite the hour (2 AM), I lingered around the nurses’ station.

At 2:11 AM, the patient’s roommate came to the nurses’ station and asked, “Is a doctor available?”

“What can I do for you?” I asked.

“I couldn’t sleep,” he said, “I turned on the light and noticed my roommate was breathing heavy, making a funny gurgling sound and not looking too good. He’s sitting on the toilet now slumped against the wall.”

The nurse and I ran to the room. The patient was not breathing and we could not feel a pulse, so we immediately called a code blue. I soon discovered that my team of nurses had never performed a real code blue before!

Our code blue team might have been inexperienced, but they hustled. We immediately performed cardiopulmonary resuscitation. The patient’s tracheostomy was plugged, so I incised and extended his stoma. Using forceps, I cleared a large mucous and blood plug from his trachea and intubated him. After 15 minutes of cardiopulmonary resuscitation and aggressive ventilation, the patient regained a spontaneous heartbeat and sustained a palpable blood pressure. He was immediately transferred to the medical intensive care unit. Fortunately, he was discharged home 5 days later.

If anyone had told me that my patient would arrest just 30 feet away from me at 2 AM with his roommate fully awake to alert me, I would say that patient was incredibly lucky. That we could resuscitate him with a team of nurses whose only advanced cardiac life support experience was during a mock mega code was unbelievable. That this patient would walk away from the hospital healthy again is nothing short of miraculous.

Medicine and miracles are not mutually exclusive—just as important is the concept of clinical instinct. Physicians must trust our colleagues’ and patients’ intuition. When we review our careers as physicians, we become aware of experiences that affirm our gifts of heightened awareness. Medicine is more than just evidence-based practice; it is a noble and human profession. If medical practice is to flourish, medicine must continue to be both a science and an art.

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