Exhausted, I flopped back onto my none-too-comfortable call room bed. The clock on my pager read 3:48 AM. I had 4 hours to go until my relief arrived. I was a third-year internal medicine resident at a large Boston hospital, on rotation at a small, regional Veterans Affairs (VA) hospital outside the city. With the exception of a moonlighter who was covering the Emergency Department (ED), I was the only physician covering the Critical Care Unit, Medical Intensive Care Unit, step-down unit, and the medical ward. There were no attending physicians in-house at night, and I had no intern assigned to me on this rotation. The buck stopped with me.

I had just finished admitting a 63-year-old man to the hospital for alcohol withdrawal and was looking forward to getting a little sleep. At 3:54 AM, my pager went off. I shook myself awake and dialed the extension. It was the moonlighter in the ED.

"Got another one for you," he said, as I fumbled for a pen and index card in the semi-darkness. "He’s a 58-year-old man with chest pain. He came in twice last week with the same thing and was ruled out for myocardial infarction both times. He looks about the same now—precardial chest pain, mild shortness of breath. His electrocardiogram (EKG) shows some nonspecific anterior changes. I gave him an aspirin and some intravenous nitroglycerine. A chest film is pending."

"Did he get a work-up of some kind last week?" I asked sleepily.

"The moonlighter saw it," she answered, “right before he called you. He’s sleeping right now. Do you want me to wake him?"

"Forget it!" I said. "Let’s get some fluids running wide open. He’s going to need thrombolytics!"

Forty-five minutes after giving the patient streptokinase, his ST segments were significantly lower, and his pulse and oxygenation levels were normal. At that point, I moved the patient to the cardiac unit. The following morning, his first creatine kinase level came back from the lab at 3500 U/L, with an MB fraction of 18%. Later that morning, I transferred the patient to another site so he could have cardiac catheterization that same day and heard afterwards that he had had a 95% blockage of his left anterior descending artery.

Looking back, I will never know exactly how or why the patient’s EKG was so grossly misread on initial inspection in the ED. Maybe the moonlighter was as tired as I was, or maybe he just made a mistake. Maybe if I had an alarm clock in the call room I would have slept that extra hour, and who knows what would have happened to the patient. All doctors like to think that the care they deliver is always correct and appropriate, but mistakes can happen. That night, a patient lived because one of his doctors had no alarm clock.

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