Innocence

Innocence revisited

Shortness of breath on a Sunday evening

Maintaining skills in performing invasive procedures is more difficult now that medicine has become so compartmentalised. Dr Thomson, a Canberra gastroenterologist, recalls when he performed an invasive procedure he had not done for many years – an ironic tale of scarcity amongst plenty.

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The confusing message from the nursing supervisor of the private hospital startled me: 'You did a barium meal on a lady called Mrs X today and she's now got severe abdominal pain.'

The supervisor was insistent, saying a patient's husband had rung the private hospital directly, looking for a bed for his wife. The only things I had done there that day were to consult and do a ward round. I didn't feel inclined to remind her that gastroenterologists do not 'do' barium meals and nowadays in fact rarely order them.

'Well, if she needs to come into hospital and she has private health insurance, I'll look after her.' I was busy and not looking for banter.

By the early evening, the patient and her caring and comparatively youthful-looking husband were in the medical ward. The normally sanguine duty medical officer rang me straightaway. The patient was indeed in a lot of pain, with a tachycardia and laboured breathing. I had met her a week earlier, a pleasant woman in her 50s who had metastatic ovarian cancer. She had developed abdominal pain, which her treating oncologist wanted evaluated. I had ordered a small bowel series as the pain had a colicky quality.

PLEURAL TAP NEEDED

An urgent CT scan excluded perforation but disclosed a large pleural effusion. Her abdominal pain and, to a lesser extent, the shortness of breath resolved overnight, but she became much more short of breath two days later on Sunday evening. A different duty medical officer rang me with the news. Even to my eyes, desensitised by years of gazing at colonic mucosa, the appearance of the urgent chest x-ray was arresting – a complete white-out of the left hemithorax with slight midline shift of the mediastinum.

Almost with an air of resignation, I turned to the duty medical officer, who had graduated from medical school some years earlier. 'Have you ever drained a pleural effusion?'

Not unexpectedly the answer was in the negative. For some years now, not only pleural aspirations but also lumbar punctures and ascitic taps have been done largely under ultrasound guidance by radiology staff.

WHO TO DO IT?

It was over 15 years since I had tapped a pleural effusion. I cannot remember who taught me to do it, but I do remember one of the surgical registrars rambling on about how one had to go 'above the rib below', by which he meant you go above the rib rather than below it so as to avoid the neurovascular bundle.

I thought about the options. The referring oncologist's recent experience in aspirating chests was likely to be similar to mine. I could have called in the on-duty intensive care specialist but draining pleural effusions is hardly their core business, particularly for those of them who originally trained as anaesthetists. I thought about one of the older respiratory physicians and of course there was the option of sending the patient over the road to the public hospital and asking the on-call radiology registrar to do it. The problem was that in terms of localising the effusion, I did not need his help and the entire private hospital, not just myself, would thus lose face and be seen as technical dunderheads – the technique of aspiration of pleural fluid is, after all, quite simple. Not only that but the obstacles, bureaucratic and otherwise, in transferring the patient would have been significant.

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What about that younger, female chest physician? She might just be old enough to have done her basic physician training in an era where medical registrars still had the opportunity to gain practical skills. As with many of the newer consultants, however, I had not actually met her – there have been so many appointments that it is impossible to keep track of all the faces and names. In any case, at 10.00 pm on a Sunday evening she was probably enjoying some quality time with her husband after finally getting the kids off to bed after an exhausting weekend, carting them around to sports games and piano lessons. Disturbing her really would be rude.

So in the end I resolved to do it myself. I had forgotten how thick the chest wall was and, yes, piercing the pleura even with a small gauge needle was painful. However, I did like the new aspiration needles that have been designed to protect against pneumothorax development by snapping back into a sheath once aspiration begins.

REFLECTIONS

I suppose it was fun in a way but it did make me think. I was in the shadow of a large tertiary referral centre where thousands of health professionals, many with international reputations, congregate daily. Is it not thus particularly strange that, for various reasons, many albeit somewhat irrational, an invasive procedure was performed by someone who had not done it for many years?

Hospital medicine has become very compartmentalised, with large silos of people who aggregate in their own little worlds. This approach works well in the management of complex single system diseases but sometimes the inherent de-skilling can lead to inaccessibility or, at best, perceived inaccessibility. Perhaps one can liken it to people still falling through the cracks in modern, ever more wealthy, impersonal and complex societies.

Maybe it would have been better if the patient had ended up at the public hospital to be confronted by a maelstrom of people whom she had never met before, asking dozens of personal questions before slipping away into their anonymous neon-lighted refuges to enter the details on a computer. Sure, one of those energetic emergency department registrars probably would have drained the effusion at presentation, but think of the crowded cacophony that she would have faced lying on a bed in a cubicle or, worse still, a corridor of one of the few places in Canberra that is still open after 10 pm – not very restive for a terminally ill patient.

At the end of the day there was a good result and a grateful patient. Who knows? One of these days, I might find myself delivering another baby! MT