Emergency doctor - what did I miss?

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Nothing can send a shiver up the spine of a doctor more than hearing your boss call you to the office, or ring at home after hours or on holidays, and open with the line: "Remember that patient you saw?"

You freeze. You do a quick mental scan, as much as you can, through the long list of patients you have seen and treated over the last few days, the last week, last month.

"Which patient was it? What did I miss? What has happened?"

It's usually not good news. We doctors are not good at giving positive feedback.

"No news is good news" ... a line made for the medical profession. It's not often you hear: "Remember that patient you saw, she's doing incredibly well and your diagnostic skills were excellent."

He was 11 months old. His mum had brought him in on a busy Friday night.

"Can you do me a quick favour?" the triage nurse asked.

"Sure," I replied.

"Sarah, you know Sarah? Works on triage. She has brought in her kid to get checked out. He's got a temperature and is a bit grizzly. It's probably nothing, but she just wants to be sure he's OK. Can I bring him into the assessment area so you can have a quick squiz? It's probably nothing, but you know ..."

"Sure."

I scanned the ED [emergency department] and took in the workload in front of me.

It was getting pretty late; the night guys would be on soon. I had to get a few things tidied up before they arrived.

Mrs B needed a lumbar puncture, Cubicle 17 needed a drug chart so she could go to the ward, the guy with chest pain needed his cardiac tests sorted out.

Not to mention the dislocated shoulder. Better do that one first, I thought.

Twenty minutes later, I was with Sarah and her baby.

"Hi," she said. "Sorry to be a pain, but Jed's not quite right. He's got a fever and he's a bit grizzly. He vomited once. He's really clingy; not like him."

"How long has he been sick for?"

"Just this afternoon," she explained. "We were at a party and he seemed to be pretty flat. He had a temp tonight."

"Has he been vaccinated?"

"Yep, but missed his last lot. Can't remember why. I think we were away."

"Sit him on your lap and I'll have a look at him."

A quick examination didn't show much: a bit of a fever, even after a good dose of Panadol.

Ears and throat OK, lungs clear. He was sleepy, but it was past 10pm.

"He seems pretty sleepy," I noted.

"Yeah, but it's pretty late and it's been a big day."

Assessing a patient, making the decision to either keep them for further observation or send them home, is always a bit of negotiation.

In this case I knew Jed's mum was a nurse, so she knew what to look out for, how to check the child.

"I think he's OK," I said. "But it's always a difficult call."

"Do you think we need to do any bloods?"

For any child, the decision to investigate with blood tests and a possible lumbar puncture requires a balance of probabilities, the parental angst, stress and trauma to the child, and a good deal of clinical gestalt.

Observation – just keeping an eye on the changes of the illness – is often prudent. I shook my head.

"Look, the most likely thing is that it's a virus. We could keep him under observation for a while and make sure he's OK, but you'll be stuck down here."

"That's OK," Sarah said, "I'll take him home and check on him overnight."

"OK. But bring him back if you are worried."

So Sarah took Jed home, and I went on with my work.

I didn't really think about Jed again. He's one of the many kids I've seen with a fever: not greatly unwell, probably a virus, but not diagnosed definitively.

I crawled into bed at 1am and tried to put all the stress, the niggling doubts and the work I'd left behind out of my mind so I could sleep.

It's 14 hours later when I get the call. I'm watching one of my own kids play basketball for his school.

"Remember that patient you saw last night? You know, the kid with the fever, Jed?"

"Sarah's?"

"Yeah, the little fella with the fever."

There is a sinking feeling in my stomach. I feel a bit nauseated, a bit light-headed.

"He's in resus. I thought I'd better let you know. Sarah checked him overnight. He seemed OK, but she didn't turn the light on. This morning, he had a rash . . ."

I don't hear anything else. I'm weak, sick. I sit down and hang up the phone. The basketball game keeps going. I don't hear the next 10 or so calls.

"Dad, we won."

I'm not sure how much time has passed.

"I scored 10 points. Did you see that shot at the end? Cool. Like Le Bron. Dad?"

"Sure," I say, "like Le Bron. Let's go home."

I drop the kids off and head into work. To this day, I still can't remember how I got there. All I can say is,"F***, f***, f***"

All I can think is that he is going to die. And I said he was OK ... f***.

Walking into the ED, the world slows again.

It seems like every set of eyes is looking at me.

Patients seem to go quiet as I walk past. The medical students seem to know. The staff definitely know.

They're all thinking the same things: Thank God it's not me. I hope Jed will be OK. Poor bastard, hope he's going to be OK.

The closer I get to the resus room, the further away it seems. The slower time passes, the faster my heart gets, the dryer my mouth. I have to stop.

A hand on my shoulder; I jerk back to real time.

"He's stable. It's meningococcus for sure. The rash, the seizure."

F****, a seizure.

Meningococcal meningitis and sepsis is one of those things you've probably read about in the paper.

When kids get septic, they can lose fingertips. It can kill people.

In Australia, kids used to die from meningococcal meningitis a lot, but now there's a vaccination programme for it.

So we do miss the diagnosis sometimes, but it's a potentially fatal disease for a baby.

This wasn't just missing a little fracture, or something like that; it was missing something that could be fatal.

"He's had antibiotics," my colleague tells me, "and he's going to ICU."

"Where is Sarah?" I ask.

"In here." They point me through the big double doors.

It's a moment etched in my mind. It will never go away. A tiny bub, pale, bruised, sedated, ventilated ... really, really sick. And I missed it.

And Mum.

She looks at me and stands up. She goes to say something, stops and sits back down. I come closer. "I'm sorry," is all I can get out without choking. She looks at me again.

"It's OK, you weren't to know this would happen."

I turn to see John, Jed's dad, come into the room. He gives me a nod. He doesn't know who I am. He moves to Sarah, hand on her shoulder, tears in his eyes.

"How's he doing?"

"Same," Sarah replies.

"Hi, I'm one of the docs here," I say. "I saw Jed last night."

The tightening grip on Sarah's shoulder makes her look up. "It's OK, John, he wasn't to know."

It's not enough for John. I can tell he doesn't want me there. "I'm sorry." I leave.

I spend the next days going over this again and again. Should I have done more?

Should I have ignored the "just have a quick look" comments? Should I not have taken on so much that night, let other patients wait a bit longer? Should I have kept Jed in? Where, in the ED?

I go over and over the consultation. Brief, but directed.

No warning signs when I saw him. But there were a few things to raise suspicion.

Sleepy? It was late. Vomited? It's not unusual. The vaccinations? They were just a bit late.

I was rushed, multi-tasking. Trying to handle too many patients in too short a time.

Is that my fault? Could I just say no, and make someone else wait longer? Or is it the fault of the system?

We are in a situation of constant balancing, constant risk assessment and risk taking in order to get through the workload we have no control over.

It's a stream of patients that never stops – just ebbs and flows from a trickle to a tsunami.

Diseases progress. It's not easy to make the right diagnosis in every patient because things change.

In Jed's case, it was a big change for the worse.

Kids can look really well and then the disease can progress very rapidly over a short period of time.

And it's not until they develop more significant signs of illness that it becomes obvious. Sometimes, by that stage, it's too late.

The decision of who to admit and who to discharge is based on a lot of different things: there's clinical acumen and there's a bit of an assessment of the parents and their capacity to look after the kids.

And it's hard to decide which kids you'll do blood tests on, because if you test every young patient who's a bit viral and grizzly, you'll be performing a lumbar puncture on hundreds of kids.

But if you look at the child and you think they look well, that nothing serious is going on, you'll let them go home.

Sometimes it's tough, that assessment.

If you happen to examine a patient early in the disease, they can look like any other kid who might have a virus. That's the challenge.

And it's always easier to make a diagnosis after the diagnosis becomes obvious. We call that the retrospectoscope, and it's the most powerful (and most misused) diagnostic instrument in medicine.

Despite that, I'll have to live with the "missed the meningitis" tag for a long time.

We don't forget the bad things; they just become less of an ache as time passes.

It's almost like going through the seven stages of grieving.

Initially, there's the shock. Then there's denial. After that, there's the time when you reflect on what you could've done better.

Sometimes you start to think that every child you see who has the same symptoms will have the same disease.

You over-investigate sometimes, so the next kid you see, you think: "Could this kid have the same thing?"

You start to think about whether you should do a blood test on the next kid, and the next kid, and the next kid.

I suppose you can lose a little bit of confidence in your own abilities. You start to question whether you should be doing this job. Then, of course, you feel incredibly guilty.

But after a period of time, when you see more and more of the same cases, that intensity or that angst starts to weigh less on your mind.

Eventually you realise that not every kid who comes in with a fever is going to have meningococcal sepsis or meningitis.

So you go back to your baseline – but you're always a little bit more suspicious.

It just makes you that little bit more wary, and it adds to that clinical gestalt.

You store the experience in the back of your mind, so the next time you think: It could be this, you have a bit of perspective. You never forget it.

In the end, Jed did well. Fortunately, the treatment he received from my colleagues was second to none.

They saved him and he recovered. He spent a week in ICU, another week in hospital and recovered at home. He was fortunate to survive.

He was unlucky that he got sick late at night. He was unlucky that he came to the ED when it was busy. He was unlucky that we knew his mum.

I think we don't do many favours treating people we know. It's very hard to be impartial and unaffected by relationships. We either over treat or under treat; it's not often we get the balance right.

Jed's lucky he was treated by a good team when he really needed it. He's lucky he won't remember any of this.

But me? I'll never forget.

This is an extract from Emergency by Dr Simon Judkins, (Michael Joseph, $37.00). It is also available as an e-book.