Query

I was dressed down yesterday.

I saw a patient with hypertension. He was my colleague's patient. He came in asking only for a renewal of his medication. I asked him what the medications were; he said he didn't know, that they were "in the chart" and that one of them started with an "A." I looked through the chart quickly, finding the names of 2 drugs, 1 of which started with A. I said the names of those 2 drugs aloud, and the patient agreed that they were the right medications.

As I was writing out the prescription, the patient then said: "My gums are bothering me, and the information package for one of those drugs says that it can cause gum problems. What do you think?"

I didn't just take the patient's word for it, I looked up the drug that started with "A" and, sure enough a small number of patients did develop gingival hyperplasia. I told the patient that, in light of his side effect, I would change the "A" drug to another medicine.

In retrospect, one thing is obvious. I didn't take his blood pressure. I was in the mindset of the prescription refill: I was covering for another doctor, just putting out fires. Yet I should have switched gears when I changed his medications and taken a baseline blood pressure so that my colleague, when he returned, would have some information to work with.

The patient left the office thinking that he was now on *3* medications for his blood pressure, not just 2. I know this because my colleague stopped me in the hallway yesterday to berate me about my management of the case. Apparently the patient had a syncopal episode at dinner one evening, he actually lost control of his bladder and needed to go to the emergency department. What did they say when he got there? "Your blood pressure is too low, you're on too many medications."

It gets worse. Apparently the "A" medication I looked for in the chart was the wrong "A" medication. If I had read the notes carefully, I would have seen that one "A" medication made the patient sick with shortness of breath and that another "A" medication was prescribed in consequence.

I pointed out that I had clearly stated in the chart that I was substituting 1 drug for another, not adding 1 drug on top of 2. My colleague said that my notes in the EMR were too hard to understand, too many abbreviations.

I'm not sure how much of the blame here is mine. I told the patient I was substituting his medication; after all, who goes into a doctor's office complaining of side effects from a drug and then leaves with more drugs? Then there's the issue of my prescribing the drug that had previously made the patient ill. Certainly the patient bears some of the responsibility here. Yet I am the one responsible for prescribing the medication.

It was the sanctimonious tone of my colleague that really rankled. It was as if, since I didn't know the patient, since I hadn't been managing his blood pressure for months, I hadn't done the right thing. I kept thinking, it was just a simple prescription refill! I was just performing a simple task, I'm not automatically privy to a patient's medical history by virtue of being a doctor. And the thing that really irritated me was that his sermon happened in front of the chief of family practice, who had been walking with me down the hallway.

In retaliation, part of me, a small but malignant part of me, is now lying in wait for my colleague to make a mistake on one of my patients. What, I'll ask, mock-horrified, didn't you read the chart?

— *Dr. Ursus*

Fred Sebastian

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