Lost in the Numbers

Category: Stories
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A nurse entered the operating room; her eyes—the only part of her face visible above her surgical mask—held a look of mild distress. She stood quietly until the surgeon noticed her.

“What is it?” he said.

“It’s your patient in 208, Doctor. His pressure is 82.”

“Systolic?”

“Yes, Doctor.”

The nurse was referring to Mr. Johnson. The previous week, we’d removed a small tumor from his lung without difficulty—and, until now, without complications. He’d been transferred out of Intensive Care to the main surgical floor, and that very morning we had removed the last drainage tubes from his chest. He was scheduled to go home the next day.

Now his blood pressure was plummeting.

“Doctor Stewart, break scrub and go see what’s going on. Nurse, grab that retractor.”

Grateful for the break in a mind-numbing routine (as a surgical intern, my job in the OR was to stand for hours, holding the incision open as the surgeons worked), I stepped away from the table and out of the room, removing my sterile gown and gloves along the way. Running up the stairs to the second floor (surgical residents, like the military, take the steps two at a time), I hurried toward Mr. Johnson’s room.

Normal resting blood pressure is 120 over 80. The higher number reflects the force of blood within the vessels during heartbeats; the lower number tells how much pressure remains between beats. Mr. Johnson’s higher number had just fallen to two-thirds its normal value. His lower number was undetectable. This sudden loss of pressure meant that there could be a leak somewhere—a big one. This man might be bleeding to death internally.

There was no time to waste.

As I rushed along the hallway to his room, I thought through the possibilities: The staples in our patient’s lung might have given way. Part of his wound might have ruptured, leaking blood into his chest. We might have ripped a small artery while removing his chest tubes that morning. He could be suffering from a sudden, overwhelming infection or an allergic reaction to a medication. The stress of the surgery might have caused bleeding ulcers in

his stomach—or a heart attack. Whatever the cause, I expected to find him in bad shape—pale, lightheaded, possibly unresponsive.

I tried to plan ahead: Push IV fluids. Order blood transfusions. Get an EKG—and a chest x-ray. Would he need emergency surgery? Gastric endoscopy? Cardiac consult? Stool sample? Just weeks out of medical school, I felt all these tests and treatments bouncing around in my head like numbers in a lottery. Somewhere in the mix, I felt certain, lurked the *real* problem—the one I hadn't thought of, the one I might continue to miss until after my patient had expired.

First things first: Examine the incisions, listen to the patient's chest. Check his temperature. See if his blood pressure was still falling.

I rounded the corner to room 208, knocked and entered, then stopped short, shocked.

Mr. Johnson was sitting up in bed, smiling and chatting with his wife. His skin was pink. His lips were rosy red. His eyes were clear.

He said he was feeling fine. I believed him.

"No lightheadedness?"

"No."

"No new pain or distress?"

"None."

"No complaints at all?"

"No—except that the nurse keeps bothering me about taking my blood pressure."

Right on cue, the RN rolled in a portable blood-pressure cuff. "Doctor, I'm glad you're here. This patient's pressure has been hovering around 80," she said. "Something needs to be done—quickly."

I hesitated, confused, trying to reconcile her concern with Mr. Johnson's obvious state of health.

"Check it yourself!" she said, thrusting the apparatus toward me.

Just then an orderly (now they're called nursing assistants) walked in. He gave the nurse a sideways glance, then said, "That cuff's readings have been all over the map. It needs to be fixed—or thrown out."

Utter relief washed over me. The long list of possible diagnoses, complications and treatments wafted out of my mind, replaced by an enveloping sense of solace and calm—a rare experience for a surgical intern.

I bade Mr. Johnson goodbye and told him that we'd return in a few hours for evening rounds.

Back in the OR, I gave my report.

“The patient was fine.”

“What was his blood pressure?” asked the surgeon.

“I didn’t check it. The cuff was broken, and there wasn’t another one available.”

“What did his lungs sound like?”

“I didn’t listen to them. He was sitting up and talking, with no shortness of breath, no anxiety, no distress.”

“How was his wound?”

“I didn’t see it. The nurse had just applied a fresh dressing; she said that it looked fine.”

“What was his temperature?”

“I glanced at his chart. His temp was normal a half-hour ago, and it’s been stable for days.”

The surgeon looked up at me sharply, his eyes blazing over the top of his mask. His reaction shook the room.

“You *didn’t* examine your patient? You *didn’t* check his blood pressure? You *didn’t even take his temperature!?!*”

My neglect and incompetence, he told me, could mean the end of my patient—and maybe my medical career. I was to return to the floor immediately, conduct the indicated tests and report back in short order.

Of course I complied—only this time, I took the stairs one at a time.

A thorough exam revealed that the patient’s blood pressure was normal. His wound looked fine. His lungs were clear. His temperature was 98.6…

My initial assessment was confirmed to the satisfaction of the floor nurse and the attending surgeon. But the importance of my being able to make that assessment, based on my own powers of observation and clinical judgment, had seemingly gotten lost in the numbers.

The surgeon was right about one thing. In the new era of defensive medicine, with its increasing demand for objective data, the kind of medicine I’d imagined practicing was quickly slipping into history. In every sense, my days as a doctor were numbered.

About the author:

Don Stewart earned his bachelor’s degree in biology and art at Birmingham-Southern College, where he enrolled in art classes as a change of pace from

his premedical studies. Don continued to pursue artistic interests as a hobby at the University of Alabama School of Medicine and during a surgical internship at the Mayo Clinic, where he received awards for both short fiction and poetry and published his first two composite drawings. He has since worked as an artist and writer at the DS Art Studio, where he continues to refine his signature style of visual humor.

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