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Harm by Omission

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The window couldn't possibly be thicker today. Every unit in the hospital was a mirror image of itself, perfectly symmetrical and without variation. I was also comfortable with the notion that glass doesn't typically grow of its own accord. I had seen her with perfect clarity just a few days prior, sitting cross-legged at the edge of her bed. But she looked distorted today, warped by additional layers of crystallization, like silica cobwebs. The mark of an untouched door.

To speak frankly, Anna* was not a fantastic candidate for visitors. She was admitted for the protracted, painful management of a rare GI disorder and happened to contract COVID on her fourth day of hospitalization. On top of her respiratory isolation, her first language was not commonly spoken in the US. Consequently, communication was either broken or required the begrudging involvement of a translator only to be reached between 3 and 6 AM. So, on morning rounds, we would less often enter the room than peer through the looking glass. Anna peered back.

In the lull of a quiet evening at the hospital, I decided to sacrifice a deck of cards to Anna's isolation chamber. Resembling a cast member of The Martian, I strolled in with full PPE and asked if she wanted to play. It turns out that poker transcends language, and Anna was out for blood. She beat me handily three times in a row.

Anna was only a few years younger than me, and the hours passed as easily as they would with a younger sister or a friend. I paid several visits to her that week. During one of our

innovative late-night conversations (I use the word "innovative" because it involved a healthy mix of hand gestures and Google Translate), she began describing something hurting her at night. At first, I thought she was describing her illness; after all, Anna was no stranger to pain. But it quickly became clear that she was describing a person, not her disease. Someone had been hurting her.

Recruiting the off-hours help of the elusive translator, my team and I learned that Anna had experienced abusive conduct by a staff member several times that month. The

week became a blur of writing reports, offering testimony, and helping Anna recount her experience. Thankfully, the unit was responsive, and the staff member was dismissed. But the obvious thought lingered unpleasantly in my mind: Could this have been stopped sooner if we had taken the time to earn Anna's trust? And how many times had this happened to other patients, right under our noses?

One of the most impactful books I encountered during my clinical rotations was Danielle Ofri's "When We Do Harm." In it, she describes the intense personal shame experienced by physicians who commit medical error, despite such events often stemming from systemic and cultural issues in medicine. Long before reading Ofri's work, the idea of medical error was a core fear of mine. To me, it represented betrayal of the exceptional trust between a patient and their physician. I know that I'm not alone in this: Among seasoned providers and medical students alike, the fear pushes us to work harder, study longer, and know our material as if life itself depends on it.

There is no denying that the idea of active harm — making the wrong incision, administering the wrong dose — is incredibly visceral. But having read Ofri prior to meeting Anna, I began to wonder if passive harm should scare us just as much, if not more. Just as Ofri frames medical error as a systemic issue, so too are the steps we don't take to care for our patients. Anna's story is horrific, but at least it provides some sense of closure. I would be remiss not to point out that hers is an exception to the rules of contemporary medicine. It's easy to recount Anna's story, but the patient stories I never learned weigh heavily on me.

The mental, physical, and temporal bandwidth of physicians and their colleagues are exploited to an extreme. With this comes the necessity to move as quickly as possible without committing error. As someone who has found her home in surgery, the discipline notorious for taking rounds at a run, I've made peace with this reality. But we cannot deny that patients unfamiliar to their providers culturally, linguistically, and even diagnostically are at higher risk in a profession starved for time. How do you earn your provider's limited attention when you cannot communicate with them? When your behaviors and needs may be perceived as unfamiliar or startling? When your body refuses to provide an easy answer to its maladies?

Apprehension at the unfamiliar is a human affliction. None of us are immune. But I have reason to believe that failure to notice this uneasiness within ourselves carries serious consequences, particularly for

our most vulnerable patients. Rounds will likely be at a run for the rest of my career — I can’t and wouldn't change that — but not at the expense of knowing when to slow down. For myself, the presence, self-awareness, and emotional openness required of a physician will be a lifetime pursuit and a daily act of cultivation. It is the best way I know how to protect my patients. I have Anna to thank for that.

**Names and identifying details in the events described above have been appropriately altered or omitted to protect patient privacy*

Biography

Nicole Charland is a third-year medical student at the David Geffen School of Medicine. A graduate of Fordham's Institute for International Humanitarian Affairs, Nicole worked with UNHCR, the Jordanian Ministry of Health, and Massachusetts General Hospital prior to medical school while pursuing her love of literature through narrative medicine. She is a current researcher with the Dumont-UCLA Liver Transplant Program and a member of the AMA Standing Committee on Scientific Issues. She plans to apply into general surgery.