primum emendare numeros

Tomas G. Rios [trios@ipc-hub.com]
Sent: Monday, September 14, 2015 12:24 PM
To: Houston Texas Med Center Pod [Houston.Texas.Med.Center.Pod@ipc-hub.com]

Dear team,

As you may or may not know, there have been several RRT experiences that have left me scratching my head and wondering what my role is in the hospital. I want to bring to your attention the case of patient [redacted] Although Epic will provide all the specific details, he is a patient who has been admitted for the last 40+ days. He is on the transplant list for SLK and this morning a rapid response was called sometime around 0730. The concern was for altered mental status.

The decision was independently made to transfer the patient to the ICU without consultation of the listed primary physician. Instead, an unsolicited consultation with critical care was performed who subsequently approved the ICU transfer.

[redacted] got the checkbox approach in the ICU including arterial line and central line (even though he was never hypotensive), fluid boluses (with a normal white count and normal venous lactate), and intubation (with no chart evidence of lack of protecting his airway). Not sure what his GCS was either since it was either not assessed and/or recorded.

The title of this email is "primum emendare numerous" which means "first, improve the numbers." although there may be many objectives, I feel that this is the current **primary** objective with the RRT system. This patient underwent at least 3 unnecessary procedures (art line, central line, intubation) based on few objective parameters that do not necessarily point to sepsis.

Sometimes, less is more, and not **every** patient with a fever or tachycardia or AMS requires the above aggressive approach. A suggested revision to the primary objective of the RRT system is "primum non nocere."

Sincerely,

Tomas Rios

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Tomas G. Rios, M.D.