Lessons From Our Learners

William D. Grant, EdD
Feature Editor

Editor’s Note: Submissions to this column may be in the form of papers, essays, poetry, or other similar forms. Editorial assistance will be provided to develop early concepts or drafts. If you have a potential submission or idea, or if you would like reactions to a document in progress, contact the series editor directly: William D. Grant, EdD, SUNY Upstate Medical University, Department of Family Medicine, 475 Irving Avenue, Suite 200, Syracuse, NY 13210. 315-464-6997. Fax: 315-464-6982. grantw@upstate.edu.

A Golden Rule or a Golden Guide?

Mark Su, MD

Fifty-year-old Sam Jones was in the emergency room where he reported chest pain on exertion. Because he had an angioplasty 5 years ago, recurrent coronary artery disease was my leading concern. Over the next several hours, Mr Jones gave varying characterizations of this chest pain to several different residents, attendings, and the cardiology fellow. Medical management produced little effect, and an echocardiogram reflected no new changes. Eventually, he “stuck to one story,” which led to my diagnosis of right bicipital tendonitis and bursitis. I found myself knocking my head against the wall, frustrated at the workup over such a simple diagnosis usually made by sound history and physical alone.

The history, I had been taught over and over, is the most important component of the patient interview, the diagnosis, and even the management of disease. It is the golden rule. There are those times, however, when the patient is simply unable to give an accurate or precise history. Alzheimer’s patients are often such patients, since they are simply unable to give me information to help diagnose infections, pain, etc. But if I rely on family members’ reports to give me the basis for my reasoning, diagnoses, and management decisions, even this information is often at its best an educated guess. As noted by Mary Winnett, MD, regarding her own mother’s Alzheimer’s dementia:

My strongest diagnostic tool—the patient history—is rendered completely ineffective by the tangled neurons of Alzheimer dementia. I have no idea how I should take her ailments. My sense is that they are not serious, but I feel myself caught on the thin line between overreacting to a minor problem and underreacting to a major one. I have taken her to the doctor, but even there I am the one who has to answer to the best of my ability questions that usually would be directed to the patient!

I have admitted a few of these “happily demented” Alzheimer’s patients to the hospital and found them to be quite pleasant. Similarly, I rarely find a peer who is frustrated with such Alzheimer’s patients. This is in contrast to the many medical students and residents who, along with myself, have been profoundly confused and frustrated when working with mildly psychotic, patients with certain personality disorders, and even malingering patients. In contrast to the Alzheimer’s patients, I find that these individuals often communicate similarly to the average person but are slightly odd enough in their presentation, speech pattern, behavior, or requests that I question not only their insight but often my own judgment. Such patients usually make me cringe when I find their names on the daily schedule. My wrestling with the fact that I cannot trust their spoken history, or that I cannot trust my own judgment when interpreting their presentations, leads me to a point of loss and lack of direction.

Then there are those patients whose diagnoses are confounded by their past medical history or the misleading nature of their current presentation. Ms Rodriguez, a woman in her mid 30s, presented...
to the ER one weekend complaining of possible food poisoning. She was afebrile but very nauseated and somewhat dehydrated after having eaten some slightly undercooked rice earlier that evening. She was disproportionately agitated and repeatedly asked me if she had meningitis. Despite a mildly sore neck, she displayed full range of motion and did not appear very ill. I rehydrated her, reassured her, and discharged her home with a friend who expressed no particular concerns regarding her unusual behavior. The next night, she represented with similar complaints, without neck soreness. She was still afebrile and nauseated but now even more disheveled and agitated. Throughout the night, she displayed increasingly odd behavior—attempting to remove her shirt while talking to me, defecating in the garbage can, throwing the bed linens all over the floor. In the morning, after psychiatric consultation was obtained, the results of an LP led to the diagnosis of bacterial meningitis. Her illness’ effect on her mental status influenced her ability to fully explain her symptoms and even led me to believe she had a substance abuse or psychiatric condition.

Our inpatient service had managed a man in his late 20s for intractable low-back pain. Mr Jordan, a known methadone clinic patient with a history of heroin dependency, claimed he was unable to physically “get around on his own” at home after being discharged from a different ER 2 nights ago with the diagnosis of a low-back muscular strain. A recent MRI had shown only nonspecific midline inflammation, so we discharged him after 2 days of pain management and physical therapy, chalking up his continued complaints of back pain (including the inability to get out of the car) to medication-seeking behavior. He was later readmitted for antibiotic treatment elsewhere several weeks later on the basis of a repeat MRI that showed a spinal abscess! Here, again, our team was wrongfully influenced by this patient’s checkered past.

While I am still a firm believer in the power of a detailed, accurate history, sometimes, even many times, I am learning to know when to rely on the power of a good physical exam, relevant investigations, and clinical rationale as well to prepare for when the Golden Rule fails me. Our population diversity is growing, and more patients are unable to communicate their concerns due to language or cultural barriers. The geriatric population continues to expand, leading to a higher prevalence of dementia. And, arguably, more individuals are abusing the medical system for alternative motives. We need to be cognizant that the patient’s history alone may not always be as valuable as we always once thought.

Correspondence: Address correspondence to Dr Su, Cornerstone Family Practice, 181 Main Street, Rowley, MA 01969. 978-948-3902. drsu@cornerstone-ma.com.

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