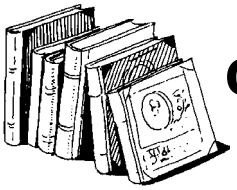

Commentaries

A Great Case!

Doctors get into trouble when they confuse the patient and their disease. We do this often, without thinking about it, partly as a sort of shorthand, and partly out of a need to insulate ourselves. I am thinking of the people who the housestaff describe as, "this 50 year old drug addict," "this unfortunate 37 year old schizophrenic" or "an elderly alcoholic." I initially thought that we do this only when the patient has disorders that are at the lower end of the "moral" scale we often use in thinking of medical disorders, with rare somatic diseases at the top, mental illness at the lower section and drug abusers at the very bottom. But this turns out not to be true. We often hear about, "60 year old diabetics," 25 year old leukemics," "40 year old vasculopaths," in which diagnoses do not register on the moral scorecard, so I've been thinking about what it means when we speak of "a diabetic" rather than "a diabetic woman," or "a leukemic," rather than "a man with leukemia." Why should we be insulating ourselves from these disorders but not when we speak of a person with AIDS, or coronary artery disease? When do we speak of a "dement" rather than a "demented person," an "epileptic" rather than a person with epilepsy? I don't know the answer and it troubles me. Labeling our patients by their disease certainly distances us from them but does it diminish them? I tend to think it does, but I'm not sure. It shortens a clinical presentation by only a single word.

One of the issues related to this is the "interesting" case and the "great" case, measures of enthusiasm, usually by house-officers and fellows, occasionally students or young attendings. "Come see this 'great case.'"

During my residency, my mentor-in-chief, a deservedly famous neurologist remarked, after hearing a resident say, "I've got a great case to tell you about," "When a resident tells me he has a great case, it's never good news for the patient." I can't recall whether I, too, talked about "great cases" or not before that observation, but I've tried to distinguish "interesting" cases from "great cases," and, in all cases, distinguish the problem from the patient. We all learn early on that the nicer the patient, the worse the disorder.

An interesting case is just that, an unusual problem, an unusual collection of problems, a challenging diagnostic or treatment problem, something perhaps we've not heard of, or something we have heard of but never seen, or something we "know" that we know but the tests prove us wrong.

A "great" case is a challenging problem from which the patient gets better and the doctor looks like a genius. An interesting case is a rare enzyme-deficiency state, whereas a great case is an enzyme-deficiency state in which we can supply a remedy via a special diet or some other intervention.

My greatest cases involved solving a problem of paroxysmal spells of abnormal behavior that looked to all the world like intoxication in people who didn't drink or use drugs, but who had had a myriad of tests repeated at a myriad of institutions, all of which were normal. The greatness of the case lay in the simplicity of the diagnostic tool, and the outcome. These patients had to be brought to the office during a spell and had to agree to have blood and urine tests, which proved they were, in fact, intoxicated, although they denied it. After detox programs they got their lives back.

An interesting case was a man who had been to the "world's greatest hospital" in Boston where the expert failed to recognize a skin problem, most likely because he saw the patient during the winter and I saw him during the summer when he was wearing shorts and noticed a peculiar color change in the legs. I can guarantee that I would not have raised his trouser legs to look at his calves had he been wearing pants, and made the observation purely by chance. Now I raise the trouser legs to look for this discoloration when I'm stumped, but only because I would have missed the diagnosis in the last case.

I missed a case of Wilson's disease once. I thought the patient had a rather routine and unremarkable diagnosis of essential tremor, but several months later his second-opinion neurologist, a professional friend, contacted me to let me know about the Wilson's diagnosis. Unfortunately I never received his note so I don't know if he actually thought of that diagnosis, or simply runs lots of tests on all his tremor patients (something I pride myself on not doing). So, I don't know if he was brilliant, I was stupid or he just orders too many tests. Certainly this was a "great" find for the patient, saving him further grief from liver or brain deterioration, and, therefore a "great" case.

We need to be careful how we convey our enthusiasm to our patient. We need them to understand that we are interested in them even more than in their disease, that we serve them and do not simply get our satisfaction from solving difficult problems to burnish our reputations.

– Joseph H. Friedman, MD

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