Prejudice

by Guang-Shing Cheng

A physician's greatest fear is to miss a serious diagnosis that can result in a devasting outcome—an acute anterior myocardial infarction, a ruptured appendix, an early breast tumor. Nothing reminds us of our fallibility more than when a patient dies of a disease that we had dismissed or even failed to consider. Whether we miss the diagnosis for reasons of incompetence, fatigue, or lack of time, these are the patients who teach us medicine the hard way and mold our habits. *Think of sepsis in a patient with a low white count and hypothermia. Double-check the post-procedure chest x-ray with a radiologist. Never ignore a new complaint of chest pain, even in a young person.*

For me, the lesson came in the form of a patient I'll call Mr. Rennet. I met him at the end of a year of subspecialty training in pulmonary-critical care medicine. An intern approached me one morning for a consult: a thirty-eight year old man, morbidly obese and diabetic, admitted to the hospital a week earlier for congestive heart failure, a condition that causes excess fluid to accumulate in the lungs and other parts of the body. He had been treated and was discharged the previous night, but he returned because he still had difficulty breathing. The team wanted to know whether his symptoms could be due to a pulmonary embolus, a blood clot that migrates from large leg veins to the arteries of the lungs. They couldn't rule out pulmonary embolism because his size had hampered the work-up. The intern said, apologetically, "I think it's still cardiac," but my attending wanted the consult.

Later that afternoon, I went to see Mr. Rennet. A bare-chested man sat up in bed eating lunch, leaning a protuberant abdomen into the hospital tray. I introduced myself. A heavy-set older woman, his mother, sat next to him and related the story while he consumed meatloaf and mashed potatoes. A week ago he had the same symptoms: a hard time breathing while walking, and really swollen legs. He had gained forty pounds in a month. How much did he weigh? Around four-fifty. They got a lot of the fluid off by giving him the water pill, so they discharged him yesterday. He had no chest pain, no more leg swelling, but he could barely walk ten steps. He felt better the moment he got back into bed, and he felt good now. How much could he walk before he got sick? Not very far, to the mailbox and back. Was he always so heavy? Yes, but more so in the last few years. Did he work? No, never had a job, just stayed at home with the parents.

To listen to his chest, I asked him to lean to one side, then the other. The odor of dirty socks and unwashed armpit emanated from the exposed bedsheets. Lung and heart sounds were distant, indistinct. Palpating the overhang of abdominal flesh that rested on his thighs, I left marks in skin that looked like orange peel, a sign of edema, likely to be from chronic heart failure. His calves were ruddy but symmetric, nothing to suggest a blood clot. His mother observed me, perhaps for a clue of what I was thinking. I wondered how a mother could let her son get so fat.

I told them that the problem was most likely his failing heart, not a blood clot to the lungs, and that I just needed to review the studies that had already been done. This was clearly a young man with heart disease, a direct consequence of being obese. I flipped through the chart, noting the abnormal echocardiogram, confirmed by an abnormal cardiac stress test. A caveat: these were technically poor studies because of his extreme body habitus. The cardiologists deferred the cardiac angiography because the catheterization table had a weight limit. Pulmonary embolism was considered, but he could not undergo the definitive CT scan because the table cannot hold more than 350 pounds. Lower extremity dopplers did not show a clot in his legs, but a repeat study could not rule them out. Again, interpretation was complicated by the patient's weight.

One last test result gave me pause. A nuclear lung scan showed an abnormality that suggested a pulmonary embolism. Well, the obesity probably makes it hard to interpret as well. In any case, I said to myself, even if it were abnormal, his most recent episode of shortness of breath is due to his dilated and weakened heart.

I put my recommendations in the chart. Treat his heart failure, I wrote. If he doesn't improve then we can revisit the idea of a pulmonary embolism and proceed with invasive angiography, if technically feasible. I ran the case by a senior pulmonologist who was covering the service for that day.

The next morning, I was paged by Dr. Knox, another attending pulmonologist on the consult service. He had seen the patient and was alarmed by the high probability of pulmonary embolism and therefore had started him on the blood thinner heparin. I was dumbfounded. How could we have felt so differently about the same patient? Did I misjudge due to inexperience? Was it wrong to wait for the definitive diagnosis before starting anticoagulation? Dr. Knox explained: this is just the kind of patient who will drop dead from a pul-

monary embolism—obese, sedentary, recently hospitalized, with shortness of breath, a clear chest x-ray, and an abnormal lung scan. He couldn't be sure without the definitive angiography, but delaying the treatment of presumptive embolism could be catastrophic. As pulmonologists, we are obligated to be certain that he did not have pulmonary embolism. I reviewed the pertinent details of the case, and knew I had been wrong.

Pulmonary embolism is a common disease, one that I had considered and worked up in many patients before Mr. Rennet. But because he was morbidly obese, I had already consigned him to the pathway of cardiac disease before I ever met him. To rule out pulmonary embolism, I knew that it would be difficult to get the right studies, difficult to treat with anticoagulation therapy. I had remembered other seriously obese patients who were difficult to manage. My initial low level of suspicion for pulmonary embolism was informed by a certain cynicism, even repulsion, toward his overall condition, which I assumed to be from neglect, poor insight, and stupidity. Every piece of data that pointed to his cardiac disease and to the difficulty of test interpretation bolstered my case; it allowed me to disregard the abnormal lung scan as another example of an uninterpretable study. Mr. Rennet's weight had put him at a disadvantage right from the beginning. The impossibility of a good technical study dovetailed in my mind with the improbability of the diagnosis. No doubt if he were a person of average size, the diagnostic dilemma would not have existed.

As clinicians, we have a duty to treat every patient equally and objectively. In reality, how we feel about our patients, on a personal and emotional level, can affect how we assess their medical problems. We judge patients based on our own personal and social mores, often without realizing how these judgments play into clinical decisions. Sometimes a patient's habits and social identity have medical relevance—for example, obesity is a known risk factor for diabetes; an injection drug user is at higher risk for serious blood infections; a welfare mother of three may not be able to afford her asthma medications. But when we view a patient with prejudice, we compromise our ability to make decisions in the patient's best interest.

I never saw Mr. Rennet alive again. That day, a few hours after Dr. Knox observed that delay could be catastrophic, a code was called to Mr. Rennet's ward. By the time I arrived on the scene, half a dozen physicians surrounded him; one pumped on his chest, another shoved a tube down his throat. A bedside sonogram showed a heart that twitched faintly. The electrical tracing turned into a flatline.

His was a sudden death that smelled of an acute pulmonary embolism, although I will never know for certain since no autopsy was performed. But it doesn't really matter what ultimately killed him. My physician friends say that he probably would have died anyway, given his poor overall health, even if I had made the diagnosis and treated him the previous day. Other common excuses—fatigue and overwork, relative inexperience, and an inattentive attending—are also brought up to console me. But none of this makes me feel better. To this day I am sick when I think about him, not because I lacked medical knowledge or failed to gather enough data. The truth is that I had failed to do the best I could for him because he was fat, unforgivably fat.

A lesson learned, the hard way.

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