

## A healthy sign

### ANONYMOUS

It is early in our medical career that we become Grand Masters of the 'spot diagnosis'. But it can take a little longer to spot signs of good health.

Before we graduate from medical school, as we go about our lives we are 'spot-diagnosing' patients. Waiting at the traffic lights, we spot the man with Parkinson's disease who has stalled at the kerb and is unable to initiate the climb; the stooped woman with osteoporosis whose varus waddle advertises her osteoarthritis; and the child with the lazy eye who has the mydriatic pupil. After graduation, when a patient presents, we look for the pathology; health, it seems, is a diagnosis of exclusion.

### Maria's monstrous migraine

My excuse was that I was a green intern... It was perhaps my third day in the emergency department. I was just beginning to realise that despite being able to recite entire chapters of Harrison's *Principles of Internal Medicine*, I did not have a clue.

My problem was a woman whom I shall call Maria. As I walked into the department at the start of my shift, I was promptly handed Maria's file. A nurse pointed innocently in the direction of cubicle 3 from which loud moans and groans were exuding. I headed quickly into the cubicle.

Maria was 40 years old and had a 'monstrous migraine', and a monstrous medical file to match. Before I could examine her, she complained to me about how long she had been waiting (20 minutes), how much pain she was in (10 out of 10) and how the nursing staff had refused to make her tea (normal policy). Rather than answer my questions, she complained about her life and demanded a shot of pethidine (only 150 mg would work) for her headache. I would have to examine her first, I explained. She reluctantly agreed.

Examination was unremarkable; her provisional diagnosis was migraine. I went to organise some pain relief and run the case by a more senior doctor. The senior doctor perused her notes and said he would pop his head in to check on her in a moment.

### Fred's fatigue

In the meantime, I picked up the file of the elderly man whom I shall call Fred. Fred had been brought in by his daughter and



was in cubicle 5. He didn't complain and seemed quite comfortable. Before I had a chance to speak with him, I was summoned by the escalating groans arising in cubicle 3.

Maria was not happy waiting for a second opinion. However, her groaning began to decrease as I explained that the senior doctor would not be too long. I returned to Fred.

Back in cubicle 5, Fred's daughter was quite concerned. I learned that Fred was 75 years old, lived at home and was usually well, taking only a diuretic for blood pressure. For two days, he had been too tired to rise from bed. He had no specific symptoms to indicate a cause.

On examination, Fred was in atrial fibrillation with a ventricular rate of 120 beats per minute. He was haemodynamically stable, but ECG revealed some ST flattening in the lateral leads. I wondered if perhaps he was experiencing myocardial ischaemia and asked the nursing staff to put him in a monitored bed.

### One crash after another

In response to a loud crash from cubicle 3, I left Fred while he was being moved to a monitored bed. Maria was literally wailing now and rolling on the floor grabbing her head. I didn't know what to think, and I rushed out to ask the senior doctor for some help.

The senior doctor, looking a tad annoyed, saw Maria and prescribed some aspirin and intravenous Maxalon. Maria was not impressed, and the moaning continued and she

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looked pleadingly at me, complaining that the pain was intolerable.

Suddenly there was the ominous sound of the triple buzz – someone had arrested. I stuck my head out of the cubicle; it was Fred. I raced over, with an enraged Maria on my tail.

At the same time as the crash cart arrived, I reached Fred's bed. An organised resuscitation procedure followed. As it turned out, Fred was in ventricular tachycardia and had not arrested but was acutely hypotensive. New deep T-wave inversion was apparent on the monitor. A cardiology registrar who materialised from nowhere defibrillated Fred and arranged an urgent trip to the cardiac catheter lab.

### All in the family

I had momentarily forgotten Maria, until I saw her running with Fred's daughter alongside Fred's bed, which was being wheeled up to cardiology. She must be confused, I thought, and suddenly questioned whether I had missed an obviously-about-to-rupture cerebral aneurysm. Perhaps Maria was to be my next near death experience.

I raced over to coax her back into her cubicle. As I became closer, I found that not only was she running alongside Fred's bed, but she seemed to be holding his hand – Fred must have been too ill to notice. I gently suggested that she make her way back to her cubicle so we could sort out her headache.

'I am just fine. I am staying with my father', she snapped sharply at me.

It turned out that Maria was Fred's other daughter...and was indeed, as she said, just fine.

### Diagnosis: health

So here was my first inkling that health need not be a diagnosis of exclusion, that complaining could be a sign for health. It was later that I learned that certain patient complaints could correlate with certain clinical improvements. For example, in hospital complaints about:

- food could mean 'resolving ileus'
- lack of a wine list could mean 'alcohol withdrawal complete'
- neighbouring patients could mean 'delirium resolved'
- staff could mean 'fit for discharge'.

This relation flows into general practice. When my patients complain about taking their medications, it can mean they are on the mend, while those complaining about the waiting room literature are probably well enough to be seen less often. And the practice receptionist wonders why when she informs me that yet another patient is complaining about the long wait, I reply: 'good'... The more my patients are complaining, the better I think I'm doing my job. **MT**