

CLINICAL CASE REPORT

The Clinical Case Method in Teaching Comprehensive Approaches to Illness Behavior

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Over the years, those of us who have attempted to teach medical students, residents, specialists, and general practitioners comprehensive approaches to the patient and his symptom have increasingly despaired that didactic methods, with their oftentimes inherent moralisms, fail in conveying the message and frequently lose the student in a morass of technical jargon derived from the several conceptual languages we attempt to familiarize them with. On the basis of our researches, we have attempted to synthesize bridging languages between the conceptual and methodological approaches of biology, sociology, and psychology by using such formulations as the illness-onset situation; behavioral patterns and personality styles—the emotions and defenses modifying these in reaction to conflict; the interview method; the patient-physician relationship; phases of illness—premorbid states, acute, convalescent, and rehabilitative; the intensive care unit syndrome; reactions to illness—acute and chronic; delirium and altered states of conscious-

ness; grief processes—denial, ventilatory, defensive, adaptive; therapeutic aspects of interviewing; modified conversion hypotheses. However, we have found ourselves becoming tedious and losing the interest of our students who frequently find these formulations esoteric and extraneous to their interest in an approach to the patient and his problem.

The techniques of live and prerecorded audio- and video-taped presentation of interviews of ourselves and students before groups of students, while extremely valuable in semester-long courses, are time consuming and usually attend to only small segments of the interviewer-patient interaction, oftentimes interfering with the very synthesis we are attempting to introduce into the students' thinking.

Believing that the essential challenge facing modern practice and research in medicine is the development of the physician who, despite his major therapeutic orientation, can move with facility in his approaches to the patient and his problem from one conceptual orientation to another, many of us have attempted to devise and utilize innovative approaches by which this may be accomplished. Fundamental to these attempts is a return to the case method presentation (1). Secondly, attempts have been made to return more toward a Socratic method of teaching in

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which there develops an active dialogue between teacher and students. In this way, the teacher, similar to the therapist, stays with where the student is, attending to his needs and following his lead. At the same time, the teacher's objective is to shape and orchestrate the discussion in such a way as to accomplish his agenda by incorporating both conceptual approaches and substantive content in the course of the seminar. This allows not only for a discussion of didactic material introduced by the case and the instructor, but also for a consideration of affectually determined reactions of the students to the material presented.

An example of one attempt to accomplish these objectives is presented in the following case. The instructor presents the material identified in the left-hand column, more or less in the paragraph form indicated, pausing at the end of each paragraph or before, if indicated, to attend to the students' responses. At this point, the instructor elicits the first associations of the students to the material presented, attempting to identify the sources of the students' biases. The instructor objectifies these in order that they be subsequently ruled in or out in light of further data to be supplied. During the discussion, the instructor may move ahead and supply additional information obtained during later phases of the interview, note information that students would like to have, which may not be available at this point (or later) in the interview, and attend to observations and associations that he had not previously anticipated. In the right-hand column are notes for the instructor suggesting those approaches that he might utilize in directing the discussion. In no sense is it the intention to restrict the free-flowing nature of the discussion by urging the instructor to adhere to either a verbatim presentation of the case or of the discussion. The discussion notes may be further ap-

pendent by precisely delineating those aspects of the case that the instructor wishes to elaborate, by the inclusion of specific references that he intends to suggest to the student for further reading.

The case presented here has been modified for presentation to a number of different audiences. It has been used in working with a small number of psychiatric residents learning consultation-liaison skills. In this context, the presentation and discussion was a continuing one over 6 weeks, during the course of which the discussion might deviate into a discussion of conversion reactions at one time, the syndromes of depression at another, etc. In these discussions, the problems encountered in consultation-liaison activities were discussed and readings on this subject were incorporated into the course (Lipowski, etc. (2-4)). It has also been used as a single 1½ hour presentation before groups of general practitioners, social workers, and clinical psychologists, in which obviously the discussion is less detailed. When used in this setting, the instructor-large group interaction was especially stimulating with active exchanges occurring between members of the group. Psychologists were frequently challenged by going beyond the data while social workers were criticized for confining themselves overly with the social field. Physicians, on the other hand, while commencing with a preoccupation with a physical interpretation of the symptom, gradually became absorbed in the social and psychological facets of the problem. When specific subjects came up for discussion, e.g., delirium, the instructor used slides to suggest the stages of delirium and the symptoms and signs relating to them. In teaching an undergraduate course in the behavioral science department in *Determinants of and Integrated Approaches to Human Behavior*, the au-

thor modified some sections in order to bring into the discussion concepts of learning theory and conditioning techniques. In this course, after having considered this case over several sessions, both instructor and students were able to refer to it throughout the remainder of the course in the discussion of other topics. For this class, an expanded version of the case with appended references was distributed. This method proved so provocative of discussion for the undergraduate that other case presentations have been prepared for the discussion of the pain-prone patient (as a model for conversion processes), covert depression, and childhood symptoms. The presentation has also been used for a single session discussion with second year medical students about to em-

bark onto the wards for their introduction to clinical medicine experience. Students in this group, while impressed, indicated that they were not buying the formulations until they had had an opportunity to try it out with their own patients. Feedback later in the course suggested that students indeed were attempting to look for correlations such as the illness-onset situation and grief responses in their workup of patients.

In reading this case, it is advisable to read the left-hand column first, keeping a list of associations and questions. Subsequently, the reader may check these with the comments in the right-hand column, noting areas that he might modify were he to use the case in a teaching session.

THE UNFOLDING DRAMA OF MR. S'S ILLNESS

Recorded History and Observations

Mr. S is a 36-year-old white, recently separated father of three and police sergeant who comes to the Emergency Department complaining of chest pain.

He tells the triage officer that he thinks it may be indigestion, that he has taken a couple of TUMS and ALKA SELTZER, but they didn't do any good. He says, "I'll be all right. Just let me see the 'doc' to give me something for pain so I can get home to my kids."

The triage officer notes that the sergeant appears tense, pale, is sweating profusely, and unable to sit still. He records that the pain developed about 10 hours prior to the patient's arrival at the ER, that it developed during sexual intercourse, and that it has increased in severity, beginning in the stomach and moving up into the chest.

For Discussion

First impressions

Who is the patient?

(race, age, family, work)

What reactions to expect?

What explanations for symptoms? (5)

Patient's rationalization of symptom

Where is patient's preoccupation?

First observations of patient (6)

Development of symptom complex

Illness-onset situation (7)

Development of symptom

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Presently, the pain is radiating to the left shoulder.

The patient says that it is really nothing, probably just indigestion or perhaps pleurisy, that he has never had anything like it before, in fact that he has never been ill before, and that he just needs a chest X-ray and something for pain so that he can get along home before going on to work.

Pt's rationalization of symptom (8)
(denial)
Pt's previous illness history
Pt's preoccupation in "here and now"

The triage officer records a normal temperature, a pulse of 120, a blood pressure of 120/90, and shallow respirations at 20.

Physical observation

Further history indicates that the patient is a Catholic of Irish descent who has worked for the Chicago police force for 13 years.

Further history
Social factors
Professional factors

He has never been hospitalized and has no known medical history. His last physical, a routine police examination, was 6 months ago. He has smoked one pack of cigarettes a day over the past 20 years, increasing this to 1½ to 2 packs a day over the last three months "since my wife left." He admitted to drinking several cocktails and a couple of beers daily.

Further medical history (9)
Personal habits

Seen by a physician after admission to the ER the patient had an ECG, which was read as normal and emergency blood work, the results of which were not immediately reported. The physician's examination corroborated the findings of the triage officer, without substantial new observations.

Further physical observations

Admission to the hospital for further observation was suggested. The patient refused admission, saying that he only wanted something for pain, repeating that he had to get home before the kids left for school and that he couldn't waste time lying around the hospital when there wasn't anything really wrong with him, but perhaps a little indigestion. After further cajoling by the ER staff, the patient

Reaction to admission (10)

accepted admission to the hospital and was sent to the CCU for further observation with the presumptive diagnosis "myocardial infarction."

Upon admission to the CCU, the patient appeared increasingly apprehensive. He said, "This is a lot of nonsense, there's nothing wrong with me; I just have this pain, indigestion, and want something for pain." Shortly after receiving 50 mg of demerol IM, he appeared somewhat quieter. Vital signs remained stable. BIPr 120/80, P 120, Resp 23 shallow, T 38°C. The CCU house officer took a history over the continued protests of the patient that there was "nothing wrong with me; why do you have to ask me all of these questions; I only came in for my chest pain." Further history added that the patient's father had died "around the age of 40, suddenly, maybe his heart"; that a sister and a mother, now 70, were alive and well; that the patient had always been well, "in top-notch shape, never missed a day because of illness." Throughout the interview the patient continued to be preoccupied with being in the hospital, unable to get home to the children. He demanded that he be allowed to call home, to try to "get hold of my wife," whom he said had moved out three months before, because "she couldn't take it anymore, wanted to be by herself and figure things out." He said he "didn't blame her, really, she's been depressed for a long time and nothing seemed to please her, maybe it's my fault, but anyway I sure hope she comes the hell back."

During the next 8 hours, the patient remained apprehensive and hypervigilant although he complained of less pain, receiving two subsequent IM injections of demerol. He complained of the noises of the monitors and of being in a "roomfull of

Patient's behavior
Physical factors
Further history
Father's death
Preoccupations of patient
Children /wife

CCU course
Physical
Reaction to environment
Preoccupations
Professional /children /wife

'gooks'." He said, "I'll be ok tomorrow, just call the station and tell them I'll be there tomorrow evening; call the house and tell the kids I had some business to attend to and I'll see them tomorrow; tell my mother she'd better look after them, see that they eat and get to bed on time, try to get hold of that wife of mine, there's money in my wallet if she needs any."

(12)

An ECG taken during this period showed developing q waves in III and AVF, a rhythm 120 and regular. Respirations decreased to 18 but remained shallow. T 39°C, BIPr 120/85. Results of laboratory blood work and chest X-ray taken previously were reported as normal.

Additional physical course

The patient was told that he had suffered a heart attack, but was doing well. He responded saying, "Like hell I have, there's nothing wrong with me, just a little muscle pain, maybe, and I'm getting the hell out of here tomorrow. Right now, just leave me alone and let me get some rest if I can with all the . . . machines going." He tossed and turned, frequently dislodging ECG electrodes, causing alarms to sound, which made him as well as the staff irritable. When pleaded by the staff to "take it easy, just relax, try to sleep, don't move around so much," he replied, "Why don't you lie here and see what it's like, maybe you don't have so much to do, like three kids at home and two jobs, where the hell is my wife anyway." At this time he was placed on Librium, 10 mg IM.

Reaction to diagnosis
Denial
Minimalization
Reaction to environment
Preoccupations
Job /wife /children
Medication

Over the next 24 hours, he remained restless and apprehensive, sleeping little. He continued to complain about being in the hospital, about the noise, about getting hold of his family, about getting to work. He said the pain was better, he was ok now and was ready to go. He demanded his clothes, said he felt like a prisoner, said he had to call his office and make sure the

Patient's behavior
Preoccupations
Illness /sexual
prowess /environment /children

place was covered, call home and make sure the kids were doing ok. He demanded to see the doctor, so he could get things straight and make sure he got "the hell out of here by tomorrow." He demanded a cigarette. When a nurse attempted to placate him, he told her she was "real cute, maybe we can get together when I get out of here and really make it." He told her she had a "nice bottom," at which point she left him. He yelled after her that she probably was "just like the rest of them." Despite increased amounts of LIBRIUM, he continued to remain agitated, sleepless, and hypervigilant, often demanding to know the time, when the doctor was going to come, that he felt like a prisoner, that he needed to make a call.

Repeat physical and laboratory examinations indicated a stable course. The ECG showed a deepening of q waves in III and AVF. Blood work showed elevations of SGOT and LDH. The house officer confirmed his impression to the patient that he had had a myocardial infarction, but was doing well. The patient replied, "Yeah doc, maybe just a little strain, huh; now when are you going to let me out of here?"

On the third night, after sleeping fitfully, the patient wakened yelling that he was "being kept a prisoner, and being tortured," that "them blacks had finally got me" and were going "to do me in unless I get out of here," that "I really hadn't done anyone any harm, including my wife, she's the one who left and I just needed another woman." He said, "I'm going to get out of here away from all these machine guns, before they take me out like they did to that guy in the next bed." He began pulling at his bedclothes, taking his johnny off, and rattling the side rails. He threatened to pull out the IV if they didn't get the "doc right away." Another time, he said that the

Physical course

CCU course
ICU syndrome (13-15)
Delirium (16)

Concepts and stages of delirium
Fluctuating and reversible
EEG definition
Associated behavioral phenomena

Koreans were after him. After the house officer came, he appeared somewhat calmer. He complained that he couldn't sleep, that there was too much going on, saying, "this is a hell of a place for someone to get some rest, I'd be better off in jail."

He said he was afraid, "had never been so afraid, even when I was in the marines." He began to cry. He said he missed his wife, that it was all his fault, but that he was going to do better "if I ever get out of here." Physical examination revealed BIPr 130/90, P 140, R 26 shallow; pupils were widely dilated. He was perspiring profusely. The bedclothes were in disarray. After talking with him further, the house officer suggested he talk with the consulting psychiatrist. The patient's response was "so you think I'm crazy, so you're going to call the shrink." After further talking, he reluctantly consented, saying, "but I'm not going to let them put me away." The house officer agreed. The psychiatrist saw the patient later in the morning. After a half-hour interview, Mr. S. appeared somewhat calmer. He was able to tell the psychiatrist that he had a lot of problems: he was concerned about his kids; whether he could get his job back; that he felt bad about his wife leaving; that he wondered if he could work again; that maybe he would be put out to pasture; that he felt bad about a relationship he was having with another woman; that he had a lot of thinking to do.

The psychiatrist suggested that "yes, these are important concerns" and that "we shall need to talk about these, but first you need to get some rest and get better; then we can get to work and try to resolve some of these; now I want you to get some sleep; I am going to give you some medicine that will help; and I'll come back and see you later." The psychiatrist prescribed a phenothiazine after discontinuing the LIB-

Psychiatric consultation (17)
 Ventilation of affect
 Talk
 Being with where the patient is at

Reassurance

Staying with the patient (18)
 Medication
 Phenothiazine vs. hypnotics

RIUM; talked with the nursing staff and house officer about their concerns, suggesting that they let the patient talk with them, that they not become upset by what he said, but first to help him get some rest by controlling his agitation with medication and by reassuring the patient that things are going along smoothly and that he would be out of the CCU in a few days.

Attending to the professional staff (2-4)

Later in the day, when seen again by the psychiatrist, Mr. S was much less agitated. He had slept first fitfully and then soundly for 4 hours. He said that he felt better; that he looked forward to getting out of the CCU; out of the hospital and back home to the kids and work; maybe even to the wife; that he was going to take it easy; he had been working too hard, taking everyone's problems as his own.

Over the next 24 hours his physical course remained stable, without further change in the ECG. He slept soundly much of this time. In talking with the psychiatrist, his concerns were with what he was going to do after he left the hospital; about his kids, wife. He began to talk about his father's death when he was 8; his difficult childhood; his anger about his mother taking over his home and managing the children; how he had always worked hard, at several jobs, in order to give the kids what he had not had as a kid; whether the police force would take him back; how during the past year he had first had his mother move into the house, at his wife's insistence, because she could no longer support herself; how after 13 years he had been promoted to desk sergeant and could only occasionally get out on the "beat, where the action is"; how he had had to give up his second job as a clerk in order to take care of the kids, after his wife left; how broken up he had been when she left; how he had transferred the new car to her name and had given her half of the credit cards; and how he had attempted to woo her back to no avail; how

Further talks and history

Reactions to illness

Father
Childhood
Mother

Job

Wife

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he probably deserved this because he had left her alone for so many years. The psychiatrist listened, allowing the patient to express his feelings of anxiety and anger, letting him cry. After half an hour, Mr. S said he felt better, that he had never told anyone "any of this stuff before." He apologized for being soft and crying. He vowed he would do better, take better care of himself, get on top of things again, make everything right; if the old lady didn't come back, he couldn't help it, it was water over the dam; he'd just have to do the best he could, that was all; maybe he'd go back to school, get some college credits.

Grieving (19)
Stages of grieving
Denial
Ventilation
Defenses
Adaptation

Mr. S's physical course remained stable. Plans were made for his discharge to a general nursing floor. As the time for transfer approached, he appeared quieter. When the nurses talked with him about this he said he had a lot on his mind, that they would be glad to see him go, "to get rid of me, because of all the trouble I've caused," anyway he wasn't going to let them torture him anymore. Prior to discharge occasional premature contractions were noted on the ECG associated with a rhythm of 140 at one time. When seen by the psychiatrist, he said "they're trying to get rid of me, throwing me out; now I'll be all alone; those other nurses will know all about me and leave me alone; I won't have any visitors." The psychiatrist suggested that he be visited by several of the floor nurses and that they tell Mr. S what to expect after transfer. The patient appeared calmer after this. His pulse slowed and the premature contractions ceased. Transfer to a general nursing floor was accomplished without further incidence.

Separation-anxiety at time
of discharge from ICU (20)

Following this acute phase of illness, Mr. S's convalescent period began. He approached this enthusiastically, determined that everything was going to be all right. Immediately, he began to see that things were ordered. He demanded a tele-

Stages of illness
Illness-onset—prehospital
Convalescent phase—hospital
Rehabilitation phase—posthospital /
home /community /work

phone and began to call home every 2 hours to find out what was going on. He called the Station at least once during each shift. He tried, without success, to get hold of his wife. He had two newspapers delivered daily. He saw to it that he was attended to first for his morning toilette. He sat up longer than he was supposed to, walked further than suggested, got to know most of the patients on the floor, talked with them freely and offered advice as to what they should do. With the psychiatrist, he talked about what he was going to do when he got out, "maybe I'll begin a garden, dig up some dirt and plant vegetables," "I hate to sit still," "if I look at television, I got to be doing something, anything, with my hands, fixing something, working on a cross-word; maybe I can fix up the house a bit, it sure needs it, lacks a woman you know, not that I don't keep it clean, but a little paint, maybe new chair covers." When the psychiatrist suggested that maybe Mr. S had other things on his mind, he responded saying, "oh, you mean work, I figure they'll let me back in 6 weeks or so, if you docs tell them to; they'll probably put me on the bench, but what the hell, I know plenty and I'm going to go to school part-time anyway." When asked if he had other concerns, he said "Oh yeah, the wife, well I haven't thought much about that, she's only been to see me once and it was ok, not much though, I mean there was a kind of distance between us, gee it was tough . . ." At this point, Mr. S began to sob. After a while, he began to express his fears and anger about his wife and children, later about himself—that he really knew he wasn't the man he was; that maybe he wouldn't make it; maybe they wouldn't let him back to work; maybe he was all washed up—wife, health, job, money-wise, maybe even sexually—"what good am I to anyone with a bum ticker?"

Underlying behavior pattern
Pattern type A (21)

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By the next interview Mr. S was his old self again. He had a lot of new plans. "If they don't want me, I can go into business, I know a lot about the liquor business, maybe I could set up a partnership. I got a friend with a bit of cash, maybe I could get him to back me; anyway I'm not going to worry now, I'm just gonna get better, get out of here, get home and rest, put the kids in order . . ." He then began to wonder what restrictions were going to be placed on him, diet-wise, smoking, sexual activity, physical activity, saying, "no one's going to make an old lady out of me; why, look at my mother—she's 70 and going strong." The psychiatrist suggested that it sounded like Mr. S had some real questions to ask the house officers and that maybe he could begin asking these. Mr. S's reply was, "aw, they're too busy, now that I'm better they just come in in the morning and say 'hello'; well, maybe I'll try anyway; hey, doc, how would you like to meet my kids, the other doc says I can go downstairs Saturday and see them, maybe you could come too?" The psychiatrist assented.

Concerns over illness (22)

Group counselling (23)

Family counselling

Over the next several sessions the interviews moved back and forth over the regrets of the past, focusing occasionally on the immediate situation and anticipations over the future. As his course continued smoothly and he made preparations for leaving the hospital, Mr. S allowed as how it sure had helped to have someone to talk with, he was sure going to miss it, maybe he could ring the doc up some time to chat or maybe even visit. On the basis of this, the psychiatrist and Mr. S agreed to meet weekly in the clinic to talk over how things were going and to see what kinds of adjustments might be necessary.

Extension of the contract

At the last interview in the hospital, Mr. S appeared quite agitated. He greeted the

New worries

psychiatrist, saying "Hey, you know what they want to do to me now, they want to send me to the pound, I mean, they think maybe they should do surgery, on my heart, that's right, do one of those new operations like a graft, what do you think about that, huh?"

After discharge, Mr. S and the psychiatrist met weekly over the next 6 weeks and thereafter monthly over the next year, charting Mr. S's course, his attempts to resolve some of the conflicts about his marriage, children, illness, jobs, and school. His physical condition remained stable. Surgery was decided against.

Summary

Substantiated hypotheses

Unsubstantiated hypotheses

Areas where further information is needed

Speculations as to future course of patient and physician-patient interaction

Problem-oriented review

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