THE ERROR OF OUR WAYS

WHAT MISMANAGED CASES TEACH US ABOUT CLINICAL PRACTICE

Jason Blalack

Charles Chace

Chen, a 76 year old, had suffered from colon cancer 15 years previously. Consequently, part of his colon was removed and had remained healthy ever since. Recently, he had not moved his bowels for an entire week and he had developed a palpable mass in his lower abdomen on the side of the surgery. Chen went to several hospitals for further examination, where all [of his medical council] recommended surgery and noted that the prognosis was poor.

Although Chen requested Chinese herbs, [his physicians] felt this was pointless and refused to prescribe for him. After this, the patient unexpectedly voided a hard pellet and immediately felt his lower abdomen relax.

又如一76歲老人陳某，15年前患結腸癌，曾手術切除自後身體一直健康。近1周來，大便不通，少腹手術一側又捫及一塊狀物，幾個醫院均要患者入院作進一步檢查，并認為手術也無希望。要求中醫服些中藥，也覺無能為力而未給處方。後病人竟排出一粒硬屎，頓覺少腹輕鬆。

The object was removed from the chamber pot with fire tongs, washed off with water, and then carefully examined. It was a "duck butt." The patient had attended a banquet about 10 days previously where he ate a piece of under cooked duck meat. Because of the circumstances he was too embarrassed to spit it out and reluctantly swallowed it resulting in the illness described above.

用火鉗從便桶中鉗出硬物，用水沖洗之後仔細辨認，原來是一個“鴨屁股”，是十幾天前赴宴，揀得一塊鴨肉，覺得未燒酥，礙於親朋面前不便吐掉而囫圇吞下，於是發生前述的病 證。

This curious and amusing case illustrates a simple but crucial point upon which all clinicians can agree. Without a proper inquiry it is difficult to make a proper diagnosis. Chen's physicians should have remembered their Sun Simiao (孫 思 邈, 581–682?), who said, "Those who through inquiry derive knowledge [of a condition] and then differentiate the seriousness of disease are considered skillful physicians" 問而知之，別病深淺，名曰巧醫. [1] Ye Tianshi (葉天士, 1667-1746) wrote that Sun "refrained from diagnosis until he had made a [proper] inquiry, and thus always avoided acting in error" 未先，最不事. [2]

Sun Simiao
孫 思 邈
(581-682?)

Chen's medical council leapt to the conclusion that the mass in his abdomen was a recurrence of his cancer and recommended an unnecessary surgery. As appalling as this blunder may be, at one time or another, we all make erroneous clinical assumptions. Such errors may be based on our biases and personal beliefs, our incomplete or incorrect medical understanding, our patient's misreporting or failure to report information, or as in this case, a simple lack of diligent inquiry.

In this column, the first of a series, we will explore clinical reality through the lens of its diagnostic and therapeutic pitfalls. Each installment will address a theme, some way in which other physicians, or we ourselves, have failed to accurately perceive the clinical landscape or to respond appropriately or effectively. This might include an erroneous assessment of etiology, the misattribution of a key symptom to a given pattern, an incorrect or incomplete identification of treatment principles or strategies, or the use of the wrong herb at the

wrong moment. There is, of course, an almost infinite potential for misstep.

The primary means by which we will navigate this complex landscape is through the rich case history literature of Chinese medicine, both pre-modern and modern. Case records are the textual equivalent of clinical practice and as such, they are the next best thing to personally witnessing a physician at work. They are the records of theory and discourse put to practical application. The development of case records is virtually synonymous with development of Chinese medicine.

The first case records are traditionally attributed to Chun Yuyi (淳于意, born 205 BCE). Si Maqian's (司馬遷) biography of Chun Yuyi in the Annals of History (Shiji 史記 first century BCE) contains twenty five cases detailing Chun Yuyi's use of pulse examination as a key criteria for diagnosis. In the ensuing twenty three hundred years, case records have taken a variety of forms, many of which bear little resemblance to what we would consider a proper case record today. The style in which these are written is often very terse, presenting only what the author thought to be the most essential information. For example, a large percentage of case records, especially pre-modern ones, mention no results and contain no follow-up visits. The purpose of these cases is to reflect a particular way of thinking as opposed to telling an elaborate clinical tale.

In a sense, such cases represent a code that one must learn to decipher if one hopes to extract their most important ideas. One facet of the rosetta stone for reading case records concerns the spirit in which they should be read. The reader is likely to glean the most from them if one focuses on trying to understand how particular doctors were thinking and why they made the decisions they did, rather than mulling over how one might have approached the situation oneself. As we present various cases we will point out some of these issues, exploring how to become more effective at interpreting and using case records.

Case records are most often recorded to illustrate how master physicians deal with real-life situations. Famous case studies are usually chosen because they demonstrate some important lesson that may not be readily apparent to other physicians. Most case records highlight something unique. Those records illustrating generally understood treatment methods for common diseases and patterns are of marginal interest. For example, for us, there is no point in documenting a case where ***Gui Zhi Tang*** (Cinnamon Twig Decoction) was given to a patient with fever and chills unrelieved by sweating, headache, nasal congestion, no particular thirst, a thin, white, and moist tongue coating, and a floating lax pulse. More common are interesting, difficult, complex or serious conditions, special disease patterns, or a unique variation of a "standard" treatment approach.

This is not to say that case histories should only record fringe occurrences. They often document frequent deviations from the textbook strategies, which correspond to a large percentage of the patient population. For instance, the benchmark formula for wind heat in the protective aspect is Wu Jutong's (吴鞠通, 1758–1836) ***Yin Qiao San*** (Honeysuckle and Forsythia Powder). As students we learn a codified set of symptoms that go with this prescription. Yet, if we consider Ye Tianshi's case records upon which Wu based this formula, we see a full spectrum of wind-heat presentations with highly nuanced use of herbs, selected to match each patient's individual presentation.

Ye Tianshi
葉天士
(1667-1746)

Taken as a whole case records constitute a major genre of our literature; one that we believe is of utmost importance when it comes to translating concepts into actions. Most significant for us are the records of mismanaged or failed cases, which represent a significant subgenre. The influential 20th century physician Qin Bowei (秦伯未1901-1970) was a vocal advocate of the mismanaged or failed case. Qin believed that "we should not limit ourselves to those cases that achieve a cure. Cases where the treatment had no effect, where the patient is first mistreated and then the case is redeemed, or even cases where the patient dies, all equally merit collection. Failures are also a basis for experience and can keep us from repeating past mistakes as well as give us material for further study." It may well be that mismanaged cases are among the most useful kind of case records available to us.

Mismanaged case records illustrate an error that any of us could easily have made. Assuming that a specific symptom implies a specific pattern, regardless of the larger context in which it is presenting, is a classic example of erroneous thinking For instance, one may mistake the subjective sensation of feverishness for a pattern of heat. The physician might then mistakenly administer a cooling formula even though the other signs and symptoms do not support this assumption.

Qin Bowei
秦伯未
(1901-1970)

The following case by Liu Duzhou (刘渡舟 1917-2001) precisely illustrates this point.

[Patient] Li was a 53 year old female that suffered from paroxysmal feverishness and sweating for over one year. This would occur 2-3 times every day. A previous doctor had treated her for a yin deficiency fever, but after taking over 20 bags there was no result. When questioned, her diet, urination, and bowel movements were normal. She had a pale tongue with a white coat and a slack and soft pulse that lacked strength. The [correct] differential [diagnosis] was a pattern of disharmony between the nutritive and protective, whereby the protective was not safeguarding the nutritive. It was appropriate to harmonize the nutritive and protective, yin and yang, and use the method of promoting a sweat in order to stop a sweat. She was given two packets of ***Gui Zhi Tang***: ***guizhi*** 9, ***bai shao*** 9, ***sheng jiang*** 9, ***zhi gan cao*** 6, and ***da zao*** 12 p. The medicinals were sipped warm with water gruel, and then she covered up obtaining a light sweat. After this, the disease was gone. [3]

李某某，女，53歲。患陣發性發熱汗出一年余，每天發作二到三次。前醫按陰虛發熱治療，服藥二十余劑無效。問其飲食、二便尚可，視其舌淡苔白，切其脈緩軟無力。辨為營衛不和，衛不護營之證。當調和營衛陰陽，用發汗以止汗的方法，為疏桂枝湯：桂枝9克白芍9克，生姜9克，炙甘草6克，大棗12枚，2劑。服藥後，吸熱稀粥，覆取微汗而病愈。

The patient described above presented with feverishness, sweating, and with a tongue that was not red, but pale. Hers coating was not scant, yet white, and the pulse was not thin but moderate. This was not a case of yin deficiency producing fever. It was in fact a disharmony between the nutritive and protective. The nutritive and protective are the body's yin and yang, and it is more appropriate for them to work together than for them to work apart. If the nutritive and protective are harmonious, then yin and yang are coordinated, and the protective qi secures and the nutritive qi guards. If the nutritive and protective are not harmonious, then yin and yang work against one another. Nutritive-yin fails the protective-yang resulting in fever, protective-yang does not secure the nutritive-yin and there is sweat. This scenario is an example of the use of Gui Zhi Tang to first promote a sweat which then produces a cure.

The two cases recounted above illustrate the scope of our potential for blunder. In the first case, the physicians made the most general kind to error possible. They failed to do a proper assessment. In the latter case, the original physician latched onto single symptom upon which he evidently built a therapeutic castle in the sand. Both cases demonstrate that our inherent preconceptions can lead us to make assumptions that just do not fit the patient in front of us. The more we are exposed to the errors of others, the more sensitized we become to potential pitfalls in our own approach. In this, mismanaged case records are an antidote to complacency in one's clinical thinking.

As important as mismanaged cases are in helping us avoid specific errors in our clinical practice, they also teach us to think about our own mistakes in a more useful manner. We all occasionally and inevitably give treatments that are suboptimal or quite simply incorrect. Such treatments almost always produce some side effects that we must make sense of within that specific clinical picture. While unfortunate, such missteps are in fact potential clues to the proper course of therapy. Unfortunately, there is no magical formula that states that side effect X means Y, which can be remedied by giving Z. A given side effect presenting in one patient may mean something completely different in another. In our next column we will specifically address this issue, further illustrating how the study of mismanaged cases helps us to better navigate each individual's clinical terrain.

References

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The Authors

Jason Blalack M.S., LAc is the author of the forthcoming book, *Qin Bo-Wei's New Guidelines for Treatment: 56 methods. With clinical commentary by Wu Bo-Ping* (working title), to be published in 2011 by Eastland Press. He maintains a private practice in Boulder, Colorado and runs a website highlighting Chinese medicine case studies (www.ChineseMedicineDoc.com).

Charles (Chip) Chace has been a student of Chinese medical literature for thirty years. He is the the translator of a wide variety of books and articles on premodern acupuncture and Chinese medicine including the first textbook of acupuncture from 100 C.E., *The Yellow Emperor's Systematic Classic of Acupuncture and Moxibustion (Huang Di Zhen JiuJia Yi Jing),* and Li Shizhen's *Exposition on the Eight Extraordinary Vessels (Qi Jing Ba Mai Kao)*. He is the translator and editor *A Qin Bowei Anthology,* the first English language collection of writings by one of China's most influential modern physicians. Chip has a longstanding interest in the case history literature of Chinese medicine and has published extensively in this genre as well. He is the translator and editor of *Fleshing Out the Bones: Case Histories in the Practice of Chinese Medicine,* one of the first publications of its kind in English. He is on the faculty of the Seattle Institute of Oriental Medicine where he teaches herbal medicine and palpatory approaches to acupuncture. He maintains a clinical practice in Boulder, Colorado.