Walk the line

Science, art, and chance

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Ms V. was a 27-year-old woman who came into my office looking for a family doctor; she was moving into the neighbourhood and her sister was my patient. She had not had an FP in years, having gone to a walk-in clinic for minor medical problems.

Ms V. told me that she was a generally healthy person. When questioned, she mentioned that she occasionally had migraines—unilateral, pounding headaches with nausea and photophobia but no aura or localized neurologic symptoms. The migraines were not triggered by anything in particular, but she had about 6 of them a year. She had not been hospitalized, was not on any regular medication, and her periods were regular. She was not sexually active at that time and was not using any form of birth control. She had smoked half a pack of cigarettes per day for about a decade. She wished to quit this habit, but stated, appropriately, that because she was in the process of selling her house, it was not the right time for this change. On the whole, nothing seemed amiss.

Ms V.'s mother, on the other hand, had a complicated medical history. She was overweight, had type 2 diabetes, had high cholesterol, and had had a "blood clot in her heart or lung" in her 40s. Ms V. stated that her mother had had extensive bloodwork and other investigations for the clot, but was assured that it was "not genetic."

A certain feeling

Ms V. returned for a routine examination. She was overweight, but the other results of her examination were unremarkable. She asked if she could be prescribed oral contraceptive pills (OCPs); she was not in a relationship, but some of her friends were taking them "just in case." I had a medical student working with me that day. While Ms V. was getting changed, the student and I reviewed her history and examination results and discussed the OCPs. I did not feel comfortable prescribing Ms V. OCPs and said so. The student pointed out that Ms V. did not have any absolute contraindications to the pill. I replied that, in some cases, you just get a certain feeling about a patient. This was part of the art of medicine: knowing when the whole was greater than the sum of its parts. Science can usually provide an answer, but often it is the combination of science *and* art—feelings, intuition, experience—that provides the *right* answer. Ms V. was overweight, she smoked, she had migraines (admittedly not ominous sounding), and she had a family history of an early clot of some type (although worked up as not genetic). None of these in and of themselves were absolute contraindications; however, they did add up. We went back in and I told Ms V. that if she quit smoking we could discuss OCPs again.

By chance

Three weeks later I received a note from the local hospital. Ms V. began experiencing chest pain the day she moved, which she attributed to anxiety. When it worsened over the course of the day, and then became associated with shortness of breath and nausea, she went to the emergency room. Her D-dimer test results showed values over 2000 ng/mL and her computed tomography scan revealed a massive saddle pulmonary embolism.

Ms V. was admitted to the hospital and started on dalteparin. Her hospital stay was uneventful. She was seen by a hematologist, who began a coagulopathy workup, and she was discharged to my care with a prescription for warfarin. A few weeks later, her bloodwork revealed that she was positive for lupus anticoagulant. Her sister and mother have now also been tested.

The case of Ms V. made me stop and reflect. The timing was entirely coincidental. After not having had an FP for years, Ms V. sought one out, only to have a serious medical problem a few weeks later. Further to that, I could easily have given Ms V. the OCP prescription the day of her initial examination. She was young, her migraines were not associated with any neurologic symptoms, and her family history had apparently been "worked up." Had I given her the prescription, she might have died from her pulmonary embolism. Regardless of the outcome, the event would have likely been attributed to the OCPs. (Why else would an otherwise healthy 27-year-old, who had just started taking OCPs, have a pulmonary embolism?) I would have felt personal guilt and likely second-guessed my medical decision making.

I am now supporting Ms V. as she deals with the medical and psychological sequelae of her experience. Every time I see her, I remember the fine line we walk in the decisions we make every day, and how the art of medicine—and chance—play a role in patient outcomes and the care we provide.

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Competing interests
None declared