Medical Mysteries

continued from page 41

vented!” the pulmonologist asks. “Did he have a catheter that was in for an unreasonably long period or is this just an unavoidable risk associated with critical illness?”

“Well, this is the high-risk population in which you expect these infections to occur—in the ICU for a long time, multiple antibiotics, and other lines in place,” answers the infectious disease specialist.

“Back to once again what was done well,” says someone else. “We’ve got an otherwise healthy 32-year-old guy who . . . was barely hanging on. We see some trauma patients like this as well—people who are this young but that sick—and they’re going to crash very shortly. He probably wouldn’t have survived except that he was in the ICU. I think that was a critical decision to put him right in the ICU, not say, ‘Well, he’s kinda sick, let’s watch him out on the floor.’ He probably would have died that night. So if you get somebody this young who should be healthy but is this sick, there’s only one place they need to be and that’s in the ICU.”

“On that note, I think we’ll stop,” says Ross (who reflects on the ritual of M&Ms in the adjacent box). “Thank you very much.” The audience applauds in appreciation for an especially interesting presentation.

As people file out of the room, Ross and Feltquate stop to chat with Hare, who is visibly pleased. He says he thought the presentation and discussion went well. And he learned something by being involved with—and presenting—the case. “I learned that the suppression of myocardial function is within the limits of what can be expected for a very sick patient,” he said in an e-mail to Dartmouth Medicine a few days later.

But some element of mystery remains still. Although M&M discussions usually contribute to a better understanding of what went on in a case, they don’t necessarily answer all the questions. The diagnosis “is about as clear as it will ever be,” Hare says.

As best he can figure, the patient had “the mycoplasma infection and this was complicated by the sepsis and polyneuropathy. This is as close as I can come to a diagnosis.”

Next week it will be another resident’s turn to be in the spotlight. And Jonathan Ross will once again host the hour of suspense known as M&M. ■

Reflections on M&Ms

By Jonathan Ross, M.D.

Jonathan Ross, an associate professor of medicine and of community and family medicine, has been directing the DHMC Department of Medicine’s “Morbidity and Mortality” conference since 1987. He was recently appointed DHMC’s Almy Clinical Scholar, a three-year post that is named in honor of the late Thomas Almy, M.D., former chair of medicine.

I have tried to create a safe learning environment in the Department of Medicine’s M&M conference: Where faculty can model their humanism, analytic skills, and knowledge for students, residents, and faculty colleagues. Where humor creates a lightness of spirit, even while we grapple with the difficult work of medicine—differential diagnosis, pathophysiology, pharmacotherapeutics, ethical and social issues, end-of-life issues, and cost issues.

It’s been a successful conference when many have participated in the discussion, when areas of controversy have been explored openly, when the focus of the discussion comes back to the individual patient, when we have learned from each other.

This is the one conference that serves as an antidote for the fracturing of the department into work zones. When we were back on the Hanover campus we fit the entire department—it was much smaller then—into the old Bowler Auditorium, and we often spoke with each other as we saw patients at Desk 200. As we’ve grown, the interaction between sections has been reduced. M&M restores a collegiality in problem-solving and connections and models a departmental ethos.

The radiology and pathology departments have provided wonderful support for our conference. Radiology residents discuss the films and offer a differential diagnosis from a radiological standpoint. The pathologists often have the ultimate word in discussing pathology or autopsy findings.

We have searched for ways for the M&Ms to reach a larger audience. Last year, we experimented with digitally recording the conference and placing it on a password-protected portion of the DMS Web site. We even explored the idea of video-streaming to allow real-time viewing on the Web. Currently, only the VA in White River Junction, Vt., receives a real-time video feed. (The VA also has an excellent weekly M&M, run by the chief medical residents.) A more conservative project is to archive the PowerPoint presentations in a viewer-accessible format. I can also envision linking the presentation to relevant studies, editing in transcribed comments after the presentation, or providing questions for self-assessment of comprehension of the material. But such projects will take more faculty time and resources than are currently available.

Directing M&M over 15 years has been a very positive experience for me. I have certainly learned a lot of medicine, like any participant. I have had the pleasure of working closely with residents. I have had a chance to influence the culture of the department—promoting the careful care of the individual patient, while celebrating medical knowledge in the service of that care. To me, the tradition of our M&M is one of holistic care—whole-person care that is informed by expert pathophysiological reasoning and evidence-based medicine, cognizant of social and financial issues, and always respectful of the ethical challenges inherent in caring for the ill.