

## EDITORIAL: PART I

## Why I Write, Review, and Generally Love Clinical Vignette Abstracts

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I have always been impressed with the way that some organizations support clinical vignettes. As an inpatient physician, part of my role is to identify and highlight learning points from cases that we see in the hospital. The challenge is to identify valuable educational tidbits in each patient and to recognize that some points are more appropriate for more senior residents and others are ideal for junior students. But having this range is, I feel, beneficial, as it provides me the freedom to discuss even the simplest aspects of the case. When geared to the appropriate learner level, even the basics can be eye-opening.

Not that this take on ward teaching is revolutionary, as clearly it is not. But the beauty of a clinical vignette abstract is that when trainees are involved, finding the learning point is thrust on their shoulders. Despite the aphorism encouraging trainees to find uncommon presentations of common diseases, very often trainees are focused (fixated, even) on the rare and unusual. These should be described, but when my trainees come to me with such cases, I challenge them to tell me what the learning point of the case is. Is it that X disease exists and should be added to an already exhaustive differential for weakness? Rather, I feel that the real learning in such cases is how the medical team rigorously evaluates alternative hypotheses, finds them to be lacking, and then settles on an answer. The process of finding the answer is what needs to be described and replicated—not the an-

swer, since conclusions ought not to be drawn on an “n” of 1.

In describing the process of your case, did the team come across a key piece of the history or physical exam, which in hindsight made the diagnosis more obvious? I have been told that 80% of diagnoses can be made on the basis of the history alone; now that I run the first-year medical interviewing course at my home institution, I realize just how much disbelief one has to overcome to accept this fact. As internists, we record histories, not knowing which part of any given narrative will prove to be crucial. As we become more seasoned clinicians, I submit that we adapt the exhaustive head-to-toe history and physical to fit our own practices, time pressures, and clinical situations. I certainly do, and I am always delighted when I come across a case that vividly reminds me to go back to the patient and re-ask some questions or ask new ones. Perhaps the answer was in the herbal or folk remedies that the patient did not consider “medications.” I tell the medical interviewing students that while one does get better at asking questions, occasions still arise in which a key question was forgotten or new questions arise a day or two later. There is no shame in going back to ask these questions, and in many cases, especially when stumped, it is encouraged.

One area that is overlooked is identifying the barrier to making the diagnosis or enacting a plan of care. Was there a cognitive error that precluded the diagnosis? If so, what was the heuristic, and how could it

have been prevented? Similarly, can system errors that delay diagnoses or interrupt management be classified and addressed? Real-world applications of clinical knowledge sometimes run afoul of real-world problems. By cataloging these problems, similarities between one hospital or clinic system and another begin to arise. The solutions that are created may be innovative, and these should be cataloged, too.

Finally, by becoming involved in a case vignette abstract, trainees undertake a scholarly endeavor. While by no means as robust as a research project, the literature review required for an abstract does exercise skills that are desirable. Effectively searching the literature is the most obvious, but another less obvious skill is framing the case—that is, appropriately placing the case that you are describing against the backdrop of existing information. How does your case fit in with the current evidence? In answering this question, abstract authors demonstrate that they have searched the literature and identified a potential hole, which the abstract may address (albeit modestly).

From many of the abstracts that I review, I sometimes wonder if the authors are planning to develop the case and discussion into a manuscript submission. While this is not always feasible, I believe that conference abstracts provide a warm-up or litmus test for those cases that may have the potential for a more in-depth article. This more involved endeavor will require leveraging the experience of mentors, but the conference submission is a good starting point.