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EDITOR'S PAGE

Anecdotes in Medicine: Do They Have Value?

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The established policy of the *Journal of the American College of Cardiology* is not to consider for publication any case reports. This partly reflects the fact that we all see so many interesting cases that we could be overwhelmed by the numbers of submissions. Since we have a fixed number of pages, and can only accept about 20% of submitted manuscripts, the acceptance of case reports would further reduce the opportunity to accept carefully conducted scientific studies. In fact, the current era is one wherein all the important clinical questions in cardiology appear to be best answered by large, prospective, randomized, controlled trials. Or is this really true?

In partial answer to the above, let me present an anecdote that is a powerful commentary on our current health care system:

A man in his late 50s, self-referred, presented to my office because of increasing dyspnea on exertion. He was a member of an out-of-state health maintenance organization (HMO). He could barely walk across the room without becoming obviously dyspneic. He also gave a history of an episode of syncope and other episodes of near syncope. He did not have angina per se. On physical examination, he had the findings of severe valvular aortic stenosis. I requested a fax copy of his electrocardiogram, which showed left ventricular hypertrophy, and his two-dimensional echocardiogram, which showed severe aortic stenosis, left ventricular hypertrophy and an ejection fraction ~35%. The patient indicated that the surgeons in his HMO had turned him down as a high risk surgical candidate. I was dumbfounded because he appeared to me to be an ideal candidate for aortic valve replacement, pending results from a coronary angiogram. Accordingly, I called his HMO to urge them to reconsider the possibility of aortic valve replacement. After much persistence, I finally got to talk to the "medical director," who didn't know much about cardiovascular disease but held firm with the surgical opinion that the patient was too high risk to consider. Finally, he gave me the name of the surgeon to call directly. My phone call to him was never returned. After discussion with the patient and his family and with our hospital administrators, we worked out a reduced rate for angiography and surgery that could be paid in installments. The patient had no coronary disease on angiography and underwent uncomplicated aortic valve replacement. As expected, he felt dramatically better after surgery. I subsequently called the HMO to inform them of the result, and they agreed to take him back.

This single experience is representative of the kinds of experiences that we are having with the current health care system. I suspect that every cardiologist in the country may be having similar experiences. Our current health care system may not be healthy for some patients. Many of the instances like the one above are unconscionable. To withhold care from the very patient who will benefit the most is a principle that turns medicine wrongside up. I would be interested in hearing whether others have had similar experiences. I will collect these and report back to you. It may be that some published collection of these in an appropriate forum might have some impact on the public and legislators. Please send me any experiences you wish to share, and we will see what happens.

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