

Why Did I Choose That Diagnosis?

AT FIRST glance, the purposes of diagnosis are clear-cut: to enable the formation of a plan of action; to allow the physician to define the probable extremes of prognosis, on the basis of which the patient and his or her family can make decisions; to trigger secondary prevention, as with the administration of antihypertensives; and to facilitate communication between physicians. The diagnostic process has uses in addition to those just mentioned. In primary care, a diagnosis is often applied as a retrospective label to make the therapeutic urge more respectable.¹ Holmes² has shown, in a classic but neglected report, that giving a diagnosis may be a way of ignoring the patient's real problem. Diagnosing a patient's condition can serve, too, as a permissive factor in family dynamics, freeing the members from the constraints of uncertainty.³ Finally, since reassurance is arguably the most important duty of the family physician (Jack Froom, MD, oral communication, 1992), a diagnosis can be useful in suggesting what the patient does *not* have.

Furthermore, diagnoses possess attributes determining their usefulness to the patient. A discussion of some of these attributes, including the relevance and the historical and geographic "environments" of the diagnostic process and two paradigmatic contexts in which the diagnostic process transpires, makes up the remainder of this editorial.

RELEVANCE

If a person is hospitalized because of acute abdominal pain for which no cause can be found, he or she may benefit from the incidental discovery of hyperuricemia or elevated blood pressure, but neither label is relevant to the chief complaint. It has been shown that as many as 37% of patients in whom a duodenal ulcer can be demonstrated endoscopically are unaware of their condition.⁴ Similarly, many patients with peptic disease continue to experience pain after healing is observed by gastroscopy,⁵ so that the question of what the diagnosis really means arises. Does it bespeak a predilection to bleeding

of the upper gastrointestinal tract or to pyloric stenosis? Might something else be causing the pain? Even a successful therapeutic trial, as proposed in a set of guidelines delineating the correct approach to dyspepsia,⁶ cannot settle the issue, although we often behave as if it could. A herniated disk can be seen in 20% of asymptomatic subjects who undergo computed tomography of the lumbar spine.⁷ This being the case, how far can we trust a positive result combined with findings typical of sciatica as a basis for referral to a surgeon? Unfortunately, there will always be people who fulfill the diagnostic criteria perfectly but for whom the outcome of surgery is unsatisfactory because the diagnosis was not explored to a sufficient depth.⁸ I can recall the time when I was a clerk on the medical service and a gastroenterologist was summoned to the bedside of a woman with gallstones to consult about the need for operative intervention. He took a careful history and came to the conclusion that she should not be referred because, as he said, she gave evidence of a "prepostcholecystectomy syndrome"! In other words, he believed that the diagnosis of cholelithiasis, which was not in doubt, had no relevance to her symptoms.

A few weeks ago, a youthful-looking man in his early 70s presented with increasing dyspnea. Although emphysema stood at the head of his problem list, he continued to smoke. The nurse, who knew him well, said that his pride and joy was the beautiful garden surrounding his modest home. Every flowering shrub, every patch of grass, and every tree was planted and lovingly tended by him, right up to the present. This information, together with the fact that he was able to walk to the clinic, should have served as a warning that the painfully obvious diagnosis might not be related to his distress. I considered three possibilities: infection, the need to increase his dose of steroids, and heart failure. Opting for the last mentioned, I weighed him and prescribed a diuretic. He returned a few days later with no change in weight, but reporting a slight improvement. On this occasion I asked what he thought might account for the exacerbation, and he wondered out loud if it could have a psychological origin. Seeing my surprise, he went on to explain that his wife of 50 years had, in the past, been

under psychiatric care because of paranoid delusions concerning his alleged relations with other women. She had now discontinued her medication, and matters at home had come to a bad pass. He expressed his sense of hurt that, at an age when he should be enjoying retirement, grandchildren, and his garden, he had to contend with her jealousy and bickering. The following day, he returned to have his arm bandaged where she, in a fit of rage, had slashed him with a kitchen knife. In this instance, too, there was no question about the correctness of the diagnosis that had been confirmed by laboratory tests and any number of specialists, but it had surprisingly little to do with his dyspnea.

The relevance of a diagnosis can also be a function of whether or not treatment is available. The possibility of effecting a cure or providing complete relief from symptoms puts a premium on diagnosing such disorders as tuberculosis or hypothyroidism and may even promote awareness of them, leading to an apparent increase in prevalence.

HISTORY AND GEOGRAPHY

A recent essay on curriculum reform states that medicine as a whole possesses social and economic environments that can influence the interpretation of data.⁹ As a corollary, this is true of diagnosis, since it is a category of medical practice. The process, undergoing refinement over time, has frequently been buffeted on the tides of history, and its essentials can vary with place, inducing changes in relevance. Behçet's syndrome, originally characterized by recurrent oral and genital ulcerations and hypopyon iritis,¹⁰ is now diagnosed in 70% of Israeli patients without ocular involvement.¹¹ When this disorder was described, all the instances were typical, else Behçet would not have recognized what they had in common. However, once physicians become accustomed to working with an explanatory model of disease,¹² they begin to recognize atypical cases that do not fulfill all of the diagnostic criteria. In time, these cases come to outnumber the typical ones so that, today, we have "incomplete" Reiter's syndrome affecting the joints alone, with a pattern of rheumatological findings similar to that seen in the full-blown condition.¹³ Thus, the sensitivity and specificity of certain tests and criteria for diagnosis vary not only according to the stage of the disease in question,¹² but also with the historical period in which it is considered.

Jewish women of Yemenite origin living in Israel have an 11% prevalence of leukopenia (Michael Weingarten, MD, written communication, 1991), and if one considers that only three additional criteria have to be fulfilled¹⁴ for a person to be said to have lupus erythematosus, the effects of geography on the sensitivity of the criteria for the diagnosis are apparent. A hematological disorder in a patient with systemic lupus erythematosus is an indication for steroid therapy¹⁵ so that, in Israel, mis-

classification and an attendant treatment only a little less dangerous than the disease are clear and present dangers.

OTHER CONTEXTS

The patient-centered diagnostic process is an integral part of the biopsychosocial paradigm and an important means to its realization.¹² The paradigm requires that the physician explore meanings, fears, illness attributions, and explanatory models.¹⁶ The explanatory models, in particular, may differ from the biomedical interpretations, and, when they do, an attempt to foist a traditional diagnosis on the patient under the guise of the physician's having superior knowledge will lead to frustration and poor adherence.¹⁶ The patient-centered diagnostic process emphasizes negotiation and maximizes relevance.

A further context for diagnosis is that of romantic science.¹⁷ This paradigm preserves "the wealth of living reality," in contrast to analytical science, which reduces it to abstract schemas. Sacks¹⁸ points out that biomedicine looks on empathy and humaneness as moral obligations not belonging to science and, consequently, not contributing to diagnosis. He writes: "But our mental processes, which constitute our being and life, are not just abstract and mechanical, but personal as well, and as such involve not just classifying and categorising, but continual judging and feeling also." Thus, empathy is an essential part of medicine, the patient and the physician being "coauthors and collaborators" in a single context with moral overtones.¹⁷ According to Sacks,¹⁸ one must examine not only the primary lesion, but the patient's reaction to it, which is composed of symptoms involving his or her "I."¹⁷ In this sense, disease is not a random occurrence, but is somehow meaningful, expressing the character of its "victim." If it cannot be cured (perhaps it is not even desirable to do so), it can be lived with triumphantly. Sacks¹⁸ goes so far as to speak of a patient's "choice" of disease, something that can be understood if it is conceded that personhood consists of more than a sum of neuropsychological properties.¹⁷ Diagnosis, then, must consider the possibility that the patient has something wrong with his or her molecules, morals, or relations with the world. Will and moral being may be no less important than heredity and lifestyle in determining who will sicken.¹⁷

Balint⁸ enjoined the family physician to develop self-awareness, a kind of higher-level audit that can avert a somatically fixated physician-patient relationship.^{8,19} Self-awareness is as necessary to good practice as reviewing the extent of diabetes control in the population and should certainly apply to the diagnostic process, leading the physician to reflect on why he or she determined the nature of the disorder presented by the patient in one way rather than in another. The critical question then would be: "Why did I choose that diagnosis?" Over a century ago, Sir James Paget wrote that "to treat a sick man rightly requires the

diagnosis not only of the disease but of all the manners and degrees in which its supposed essential characters are modified by his personal qualities, by the mingled inheritances that converge in him, by the changes wrought in him by the conditions of his past life, and by many things besides."²⁰ One can only guess at what he had in mind when he spoke of many additional things that modify the way a disease manifests itself in a given individual. Nevertheless, it can be stated with certainty that all the modifiers speak directly to the diagnostic process.

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REFERENCES

1. Howie JGR. Diagnosis: the Achilles heel? *J R Coll Gen Pract Occas Pap*. 1972; 22:310-315.
2. Holmes J. Varicose veins: an optional illness. *Practitioner*. 1970;204:549-554.
3. Weiner Z, Abelson A, Herman J. The diagnostic process: some unwitting uses. *J Clin Epidemiol*. 1989;42:377-379.
4. Kaneko E, Ooi S, Ito G, Honda N. Natural history of duodenal ulcer detected by the gastric mass surveys in men over 40 years of age. *Scand J Gastroenterol*. 1989;24:165-170.
5. Peterson WL, Sturdevant RA, Frankl HD, et al. Healing of duodenal ulcer with an antacid regimen. *N Engl J Med*. 1977;297:341-345.
6. Health and Public Policy Committee, American College of Physicians. Endoscopy in the evaluation of dyspepsia. *Ann Intern Med*. 1985;102:266-269.
7. Weisel SE, Tsourmas N, Feffer H, Citrin CM, Patronas A. A study of computer-assisted tomography, I: the incidence of positive CAT scans in an asymptomatic group of patients. *Spine*. 1984;9:549-551.
8. Balint M. *The Doctor, His Patient and the Illness*. London, England: Pitman Medical; 1973.
9. Fletcher RH, Fletcher SW. Teaching preventive medicine and health maintenance. *Ann Intern Med*. 1992;(suppl 12, pt 2):1094-1098.
10. Bouros D, Karras D, Panagou P. Azathioprine in Behçet's syndrome. *N Engl J Med*. 1990;323:195.
11. Arber N, Klein T, Weinberger A. Azathioprine in Behçet's syndrome. *N Engl J Med*. 1990;323:195.
12. McWhinney IR. *A Textbook of Family Medicine*. New York, NY: Oxford University Press; 1989:111-158.
13. Arnett FC, McClusky OE, Schachter BZ, Lordon RE. Incomplete Reiter's syndrome: discriminating features and HLA W27 diagnosis. *Ann Intern Med*. 1976; 84:8-12.
14. Tan EM, Cohen AS, Fries JF, et al. The 1982 revised criteria for the classification of systemic lupus erythematosus. *Arthritis Rheum*. 1982;25:1271-1277.
15. Shearn MA. Arthritis and musculoskeletal disorders. In: Krupp MA, Schroeder SA, Tierney LM Jr, eds. *Current Medical Diagnosis and Treatment*. East Norwalk, Conn: Appleton & Lange; 1987:492-531.
16. Kleinman A, Eisenberg L, Good B. Culture, illness and care: clinical lessons from cross-cultural research. *Ann Intern Med*. 1978;88:251-258.
17. Wasserstein AG. Toward a romantic science: the work of Oliver Sacks. *Ann Intern Med*. 1988;109:440-444.
18. Sacks O. *The Man Who Mistook His Wife for a Hat and Other Clinical Tales*. New York, NY: Harper & Row Publishers Inc; 1987.
19. Van Eijk J, Grol R, Huygen F, et al. The family doctor and the prevention of somatic fixation. *Fam System Med*. 1983;1:5-15.
20. Strauss MB, ed. *Familiar Medical Quotations*. Boston, Mass: Little Brown & Co; 1968:98a.