Against diagnosis

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The concept of diagnosis is so central to medical practice that it may seem provocative or even perverse to call it into question. But as with many apparent certainties in medicine, closer scrutiny shows up some unsettling problems and contradictions. Diagnosis has in fact been contested in all sorts of ways, both from within the profession and by others including philosophers and social scientists. I shall try to summarize some of the arguments against diagnosis here, and then suggest ways doctors might respond by changing how we practise.

One significant challenge to all forms of diagnosis is that they are socially constructed.[1] In other words, they demonstrably vary according to time and place, and with the social, economic and other contexts in which they were defined. This may seem counter-intuitive to anyone fresh out of medical school, and trained to believe the facts they were taught were all universal and permanent. However, doctors in mid-career or beyond will readily be able to cite diseases that were confidently diagnosed 20 years ago but are no longer recognized as having any substance or have been thoroughly redefined. It is also not hard to identify conditions that have been summoned into existence to offer coherence to phenomena that are not fully understood, or may be a ragbag of unrelated problems. Irritable bowel syndrome is an obvious example.

Going a little further back in history, it is equally easy to find constructions of illnesses that we find absurd or incomprehensible in modern terms. More disturbingly, the diagnostic terms we use nowadays may have been used previously for constellations of symptoms and signs that we can no longer recognize, and do not remotely map onto any current diagnostic criteria. Asthma is a case in point.[2] Much as we dislike the idea, it is unlikely that our own taxonomies may seem any less arbitrary in a generation or two.

Then there is the question of stigma. Diagnoses have their own psychological effects. One of my favourite quotes about diagnosis is from the German psychologist Arist von Schlippe: 'descriptions change what is being described.'[3] In psychiatry, there is an energetic debate about whether categories like 'borderline personality disorder' should ever be assigned to patients. Diagnoses like this may adversely affect their view of themselves, as well as prejudicing others including the professionals who meet them. The same applies to some physical disorders like 'heart failure' or 'chronic kidney disease', when the diagnosis may just reflect a result found on imaging or in the laboratory, with little relation to their fitness. Sadly, such labels may lead patients to give up hope and their physicians to regard them as disabled.[4] General practitioner Iona Heath has written eloquently of how patients' fears can lead doctors to overdiagnose and overtreat, which in turn escalates those fears even further.[5]

MISDIRECTION AND DISRESPECT

The problems do not stop there. Even in conventional terms, misdiagnoses are extremely common.[6] As well as the immediate harm these may cause, they often get passed on in medical records, providing misdirection to colleagues. To add to this list of indictments, diagnoses are fundamentally reductionist. They can easily be disrespectful, distract from the richness of the patient's narrative and induce an objectifying mindset in doctors. For example, elderly people are often described in terms of all their accumulated organ 'failures' and '-itises', or with the inelegant expression 'multimorbidity', when they might actually prefer to have doctors who are aware of what they could do with their grandchildren a year ago but are no longer able to.[7]

Deconstructing the notion of diagnosis can of course be taken to extremes. It makes sense to acknowledge the counter-arguments. If a patient shows you their big toe and asks 'Is this a bunion?', it would be absurd not to be permitted to say yes or no. Such patients are unlikely to welcome a lecture on multiculturalism or semantics. Even in psychiatry, many patients still prefer to have a diagnosis because it confirms that their distress fits within a recognizable pattern and connects them with others suffering in a similar way.[8] Diagnoses also provide a helpful shorthand for healthcare professionals who need to communicate information in terms that are recognizable by other contemporary doctors. It is unlikely that anyone could persuade the medical profession to abandon ways of thinking and speaking that are deeply ingrained, so there would be little point in advocating a ban on diagnosis. At the same time, it is quite easy to speak about diseases in an entirely different way, showing a better understanding of what a diagnosis represents, and what its limitations and effects might be.

MORE TENTATIVE EXPRESSIONS

One way of doing so is to use expressions like 'current working diagnoses' and 'diagnoses assigned by previous doctors', instead of talking about these in categorical terms. This acknowledges our susceptibility to error. It also invites others to treat diagnoses with scepticism. Another good habit is always to record what we believe to be the evidence for an assertion. Thus, 'ventricular ejection fraction recorded as 45% on 6 January 2019 with no impairment of exercise tolerance' is hugely more informative than 'heart failure diagnosed 2019.' We can also try to ensure that diagnostic labels are embedded in a narrative that includes a wider range of contexts. For example, we can teach students and trainees that 'Ms Tan has been referred with a diagnosis of rheumatoid arthritis' is a very impoverished way of presenting a patient. A far richer one would be: 'Ms Tan is a single parent with twin boys in their teens and works as a secretary. Her GP has established that her condition fits some of the current criteria for rheumatoid arthritis. She is understandably worried about how it might affect her work and income.' This narrative has clearly been constructed with the patient, rather than fitting the 'detective story' or 'problem-solution' formula that doctors often make up instead.[9] It is also more accurate medically.

I have proposed before that a diagnosis should generally be given to patients as a provisional offering, open to discussion about whether it makes sense to them and is useful.[10] For instance, rather than saying 'You have asthma', you can ask: 'Has anyone called this asthma before and what did you make of that?' or 'How well does the word depression fit your experience?' Although this can seem clunky at first, most practitioners become more comfortable doing this over time. Such ways of talking embody a more honest intellectual and ethical position than defining another person in your own terms. It also helps if you explain how often we treat people to alleviate their symptoms without having a label for their condition, especially in

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musculoskeletal disorders or persistent pain.

We have all learnt never to say 'the liver failure in bed 5' and to find more respectful ways of talking. Perhaps it is time to do the same with diagnoses and to teach this as well. As rules of thumb, I suggest: *avoid them when you can, be humbler about them when you cannot, and seek permission from their rightful owners whenever possible*.

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