

Preventing Overdiagnosis?

We need fewer systems and more philosophy

Part 2: Geology

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Contemporary medical practice now harvests two new and increasing tranches of diagnosis: first, subjective experiences of discordance, disturbance or distress; then symptomless but risk-linked biometric anomalies. These have led to a massive medicalisation of areas of life often better otherwise understood.

How and why has this happened?

This is the second of two articles.

A system is nothing more than the subordination of all aspects of the universe to any one such aspect

– Jorge Luis Borges. *Labyrinths* (1962)

The patterning of distress or risk into biomechanical models and language is one way to describe medical 'diagnosis'. The first article showed how such technical marshalling is sometimes entirely welcome, leading to decisive cures for many structural physical complaints: these are the kind of diagnoses that bring clarity, confidence and agreement. In these situations we pay little heed to questions of personal experience, meaning and agency: when, for example, Penicillin or Coronary Artery Surgery can rapidly cure an illness, we are likely to dismiss wider and more personal considerations as being peripheral and unimportant.

So, any kind of philosophical consideration matters relatively little when diagnosis operates confidently in this home territory: questions of personal history, significance or meaning are not important to either the patient or doctor at the time, say, of a massive gastrointestinal haemorrhage. Though if the patient recovers then such personal and existential factors become increasingly decisive: first in healing and then eventual prognosis. We can see how, while on home territory, our Substantial Diagnoses may be questioned for their accuracy, but hardly for their legitimacy.

Elsewhere such confidence and congruence is much less assured. Here is an illustration:

Example: Waleja

Waleja is a young mother of two children aged two and five years. For eighteen months she has had dozens of consultations with a succession of GPs, hospital emergency departments and specialists in neurology, gastroenterology and cardiology. Most of these have run batteries of tests, decreed a variety of in-house biomechanical diagnoses and then apposite remedies. Each may look competent but her protean symptoms continue.

After several fainting falls she received yet another referral, now to Dr F, a Falls Clinic specialist who arranged his familiar tranche of tests that crystallises his idiomatic diagnosis: 'postural orthostatic tachycardia syndrome'. This tells us little more than she often develops a rapid pulse and than faints when standing. An obscure drug is prescribed. Neither this, nor the arcane sounding diagnosis, changes the pattern of her faints.

Such diagnoses and their predicated treatments have been applied to Waleja for many months – none has been of enduring benefit: these are examples of Nominal Diagnosis, considered in the previous article. Medically they cluster symptoms into 'syndromes' but achieve little more.

What none of these practitioners, diagnoses or treatments attempts to engage is the personal geology of Waleja's experience and meaning. Who is she? What is her life? How might her symptoms reflect these?

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Waleja is caught in a maelstrom of, first, domestic uncertainty and, then, acrimonious litigation. Her relationship with Akbar has departed far from its beginning as a fascinated trans-cultural exoticism: it is now impacted in a poisonous pall of internecine strife. Akbar – now fuelled increasingly by tribally righteous anger and his family's oil-revenued wealth – is fighting for sole custody of their children and then (Waleja supposes) their extradition to his family, culture, nation and religion of origin. Akbar's clever and expensive lawyers are ingeniously constructing a campaign of 'evidence' of Waleja's maternal unfitness. Waleja – impoverished and on Legal Aid – feels increasingly overwhelmed and powerless. Her many symptoms express intensity of feelings that are beyond her vocabulary or, she fears, others' understanding.

What eventually helps Waleja most is the opportunity to develop her personal language and understanding, not the carousel of Nominal Diagnoses. As her symptoms become personally deciphered and

contained, they lose their terror, though not all their trouble. Her personal distress becomes clear; her protean illnesses recede. What enabled this? It was the skills and space made for Waleja, to accompany her and then to make personal sense.

Dr G, Waleja's most recent GP, has seen losses in these professional skills and spaces. Two or three decades ago Waleja's distress would have been humanly perceived and deciphered much earlier by most good GPs or General Physicians of his acquaintance: she would have received less rapidly and readily packaged diagnoses and treatments, but the human understanding and response would have been much more evident.

Dr G is thinking of Dr F and the many doctors who in a similar way seem, increasingly, to process their patients into formatted biomechanical templates while remaining – apparently – uninterestedly oblivious of the larger matrix of patients' lives and personal meanings. How and why is this happening? If we follow Dr G a while we can draft some answers.

Example: Dr G and his colleagues

There are no conditions to which a man cannot become used, especially if he sees that all around him are living in the same way.

– Leo Tolstoy, *Anna Karenina* (1879)

Having recently offered Waleja some guiding and comforting support, Dr G thinks that more cardiovascular investigations and treatments are inapposite, burdensome and more likely to create than solve problems for her.

After much administrative difficulty he manages to contact Dr F on the telephone. Dr F sounds busy, distracted and then disconcerted by unfamiliar colleagueial contact. Dr G begins a brief précis of his understanding of Waleja and his recommendations.

Dr F listens with a brief, polite hiatus for about ten seconds before interrupting: ‘Look, I’m in the middle of a busy clinic. If you’ve got a lot to say, just email me. I’ll look at it later.’

‘Because it needs a personal discussion. I know Waleja well and I don’t think this diagnosis – “postural orthostatic tachycardia syndrome” – is the best way to understand her. I think we should parry further tests and treatments.’

‘Look’, says Dr F again, now more tersely, ‘I don’t see what there is to discuss. I’m doing what I’m paid to do by my Trust: to provide your Trust with an expert opinion and plan. There are numerous research papers in the specialist journals substantiating the diagnosis. I have a pile of references, if you care to inform yourself. In my view nothing here needs much discussion. If you disagree with my diagnosis you’re perfectly entitled to disregard it – you’re accountable to your own employers ...’

Dr G sees any conversational path now impassable with thorned thickets. As he beats a courteous and rapid retreat he feels a deep tug of sadness: he recalls very different conversations many years ago with senior hospital doctors who were then interested in his other perspectives – about patients’ lives and stories – about the many other constructions and responses that might be possible. Two words come to him now about those exchanges: *fraternalism* and *philosophy*: he had not used those words then, but as he sees them now imperilled he thinks it important to name them, before they disappear.

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Sebastian (see the first article) faces Dr G with bustling impatience and a large envelope of contended papers. He leans forward to claim proactive space. His voice, too, soon occupies the space:

‘You’ve got to help me, doctor ... I’m in trouble and it could go to Court...’

Not just one Court, Sebastian explains. His juggling of credit card debts has finally exceeded his stealthy choreography. More serious (to Dr G) is his failure to pay paternal maintenance to a woman he can hardly remember for a child, that, until recently, he did not know he had.

‘You see, doctor, I need a medical report telling them I’ve got ADHD and that I take tablets for it. I can’t get it from Dr P because he’s left the country, so you’ll have to do it...’

No; Sebastian didn’t want ‘any of that Counselling and stuff’, he just wanted the report.

Dr G is thinking how thirty years ago no doctor was using the idea or language of ADHD. What happened with – and to – people like Sebastian?

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It is the end of a morning of medical-all-sorts and Phrep, the pharmaceutical representative, bids for Dr G’s rapidly sinking energies. He is youthfully smart and suited, smiling with amiable diplomacy. His presentation is glossy-brochured and PowerPoint perfect. Today’s sales mission is to get Dr G to prescribe two products: an oral Vitamin D preparation and a new prophylactic asthma aerosol.

Phrep then artfully employs his prepared bait and leverage: mouse-clicking between graphic and rhetorical data to explicate the importance of the problems and the potency of his products.

‘I want to show you also how these conditions can present in so many, and often atypical, ways and, therefore, how doctors are massively underdiagnosing – and therefore undertreating – these serious conditions. The risks to patients become evident...’

Phrep's delivery is polished and sounds sincere. Dr G admires its apparent cogency but is doubtful about its integrity. Phrep sounds like a sophisticated politician working a tired electorate and Dr G is aware his script accords entirely with the commercial interest of his employer, Big Pharma Inc, and thus Phrep's pay.

Dr G thinks, too, doesn't every specialist and researcher, lobbyist or fundraiser, maintain that their area of interest receives too little recognition, interest and money?

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Dr G prepares to leave his long working day: a vortex of so many kinds of demands and dilemmas. He is dizzied into a state of vigilant exhaustion: a kind of sediment from his navigated compromises. He sits quietly now to mull and settle this kaleidoscopic professional world.

He is thinking about the word 'diagnosis' and its implication of compact authority and precise pragmatism, and how – in its many derivative roles and guises – it often takes on very different qualities. How and why does this happen?

Dr G can see that 'diagnosis' often starts as an essential device to dissect out common knowledge in any particular situation: it finds and defines what is generically 'true' with any kind of problem. But this involves an important exclusion: to do this diagnosis must cut out individual considerations and variations, treating them as a kind of extraneous and contaminating 'noise'. So in order to assure a system, diagnoses must first eliminate human vagary and meaning. Yet it is only through these latter, speculative, considerations that we can best understand *this* person and *this* situation.

In this way systems and philosophy are countervailing: systems attempt to extinguish doubt and ambiguity; philosophy attempts to ignite them.

Over many years Dr G has found that while his diagnoses work well with evident and acute biomechanical breakdown, this is very different if he attempts to cluster and systematise human complexity. Usually he soon realises that the ineffectiveness of diagnosis here needs much imaginative adjustment and compensation.

But discretion in these matters is not easy: because diagnoses work so well with their initial task (clear physical illnesses) they have become aggrandised, promoted and executised to deal in a similar way with any and every kind of discord or discomfort that presents to a healthcareer. Diagnostic thinking then becomes the bedrock of interactions and exchanges throughout healthcare: it becomes the convention of the consultation and its Mother Tongue: if we are not very careful its only tongue. Healthcareers speak it because all others do, and it is assumed as the one language they can be confident and fluent with. Dr G thinks that Dr F felt empowered by, but was also in thrall to, this convention, and that their tense discord was due to the convention being broken – a taboo.

So diagnostic and technical language can convey – or at least illusion – many things: authority, a sense of professional belonging and identity, an aura of clear, definite – even powerful – knowledge. But the latter may be specious and the diagnosis becomes an Emperor-without-clothes. Yet our need for a magical sense of containment or undoing often resists this unsettling reality.

Dr G thinks now of Sebastian and his insistent hunger for a diagnosis. Probably Sebastian thought that ‘having a diagnosis’ could lead effortlessly to his ‘not having’ a complex human problem of identity and integrity. Sebastian’s psychiatrist, Dr P, colluded with this self-alienation, forming a cordial, but shallow, bond. The psychologist, Si, risked a tack of greater integrity but was quickly cut off.

Dr G has seen these kind of diagnoses mushroom in the last two decades. Why are they increasing in this way? He can see how an increasing number of people – like Sebastian – want their problems to be split off,

taken away from them and 'fixed' by an expert. This is not surprising, for our ever-increasing advances in technology have rendered us a push-buttoned world where equivalent expectations throughout our lives become not only possible, but our prerogative.

And, of course, the specialists become similarly invested: they necessarily create their careers, professions, salaries, faculties and academic exchanges by elaborating their particular systems of diagnosis and, then, requisite treatments. Belief and sincerity usually follows such social economics: in medieval times Papal emissaries selling after-life heavenly plots – 'indulgences' – wrote with impressive fluency and rhetoric of their commitment.

And what of broader commercial interests? NHS Trusts now commodify diagnoses and treatments, and then tariff and trade in them. So then both individual and institutional professional survival depends on diagnosis being invented, manufactured, distributed and sold. And beyond our health services are the gigantic pharmaceutical industries. To assure their stake in the growth-economy they need more patients to have more treatable diagnoses. For Big Pharma Inc and then Phrep it is essential to recruit practitioners like Dr G to do this.

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The lure of short-circuiting human complexity and ambiguity to the apparent objective clarity and certainty of diagnosis is hard to resist. When that lure is redoubled by vast, multi-tentacled economic forces it is hard to stop the original pragmatic sense of our older, traditional diagnosis becoming destructively mutated by overgrowth. Overdiagnosis then behaves like a neoplasm – it derives from healthy tissue but will propagate in such a way as to destroy the health of the host tissue, and beyond.

So what can Dr G do? He can, at least, understand and identify these lures and traps and then buttress himself against them. To do this he needs to secure his autonomous head-space and heart-space to not merely tolerate –

but then embrace and find meaning in – each person’s complex humanity.
That is one essence of holism.

This mixture of philosophy and fraternalism lies behind whatever healing or palliating influence Dr G can muster. Many decades ago the work of Michael Balint introduced him to the importance and possibilities of such work. That wisdom has now all but vanished in the ineluctable rise of our healthcare’s managed industrialisation and commerced commodification. Overdiagnosis is just one – though serious – symptom.

What else can Dr G do?

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God is on the side not of the big battalions, but of the best shots
– Voltaire, *The Piccini Notebooks* (c 1750)

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