

HASLAM'S VIEW



Professor David Haslam
CBE FRCGP
Chair NICE,
Past President BMA,
Past President RCGP

Diagnoses may tell us more about the GP than the patient

HAVE YOU NOTICED HOW OFTEN YOU READ ABOUT A CONDITION, ONLY TO DIAGNOSE IT

for the first time within a few days? Sometimes a little cluster of cases will appear, and then just as suddenly will disappear again.

Some years ago, I remember reading a fascinating article on zoster sine herpete (shingles without a rash) and diagnosed about four clear-cut cases in the next six weeks. In the years since then, not one.

This phenomenon has almost certainly affected you as well, almost certainly with an entirely different condition.

There would seem to me to be two possible explanations. Either these cases really are genuine, and we diagnose them only when our minds become correctly attuned, or alternatively they exist only in our imagination when we try to fit vague symptoms into a new diagnostic straitjacket. In both cases, diagnoses will cease unless we get real positive feedback that we are on the right track.

For me, the most remarkable example of all this relates to what is now an increasingly common and important condition. Some years ago I was commissioned to write a book about bulimia, a condition that the late Princess Diana had both suffered from and talked openly about. I began to study, read, research, and contact patients with bulimia. As all this happened in the years before the internet made research infinitely

easier, I pored over MEDLINE in a library to find relevant studies. The eating disorders charity put me in touch with patients. The Princess of Wales kindly agreed to write the foreword once I had finished the manuscript, something that subsequent events ultimately prevented happening.

In the course of all this research and writing I started to ask more and more of my patients about their eating habits. In those days the extent of male bulimia was much less recognised, so my focus was very much on women.

‘One doctor’s diagnosis of depression is another’s ‘pull yourself together’

In general, my enquiries took the form of a permissive statement rather than a direct question. To almost every woman who consulted me with some psychiatric or psychological problem I simply said: ‘Many people who feel like you use binge eating as a form of comfort.’ I left it at that.

Patient after patient told me of their binge eating, and their purging, and their self-induced vomiting. I soon had far more patients in my relatively small practice with proven bulimia than simple statistics would ever have predicted, and many more with other eating disorders such as compulsive overeating. I could

think of no reason at all why my patients should be any different from any other group of patients in the UK.

It is inevitable that you will have a diagnostic interest in conditions that I kept missing. It’s pretty clear that many of our patients’ diagnostic labels may be greatly influenced by the interests of his or her doctor. Labels can have a profound effect. At a relatively simple, but important, level, they can have a financial effect through the impact of written insurance reports. Such reports treat diagnoses as simple facts.

But we know the truth. Diagnoses often tell us more about the doctor than the patient. One doctor’s diagnosis of depression is another’s ‘pull yourself together’.

My zoster sine herpete was almost certainly an overdiagnosis driven by my enthusiasm. However, more than anything, such diagnoses can impact greatly on how patients see themselves, and live their lives.

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