

The Trivialization of Diagnosis

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May 6, 2011

What is a diagnosis?

What is a disease?

- Making the diagnosis = identifying the disease entity.
- Disease entities - coherent, organizing concepts.
- A specific disease - a condition with characteristic manifestations – clinical, histologic or pathophysiologic.
- Thus, **anemia** is not a disease. **P. A.** is. **Arthritis** is not a disease. **R.A.** is

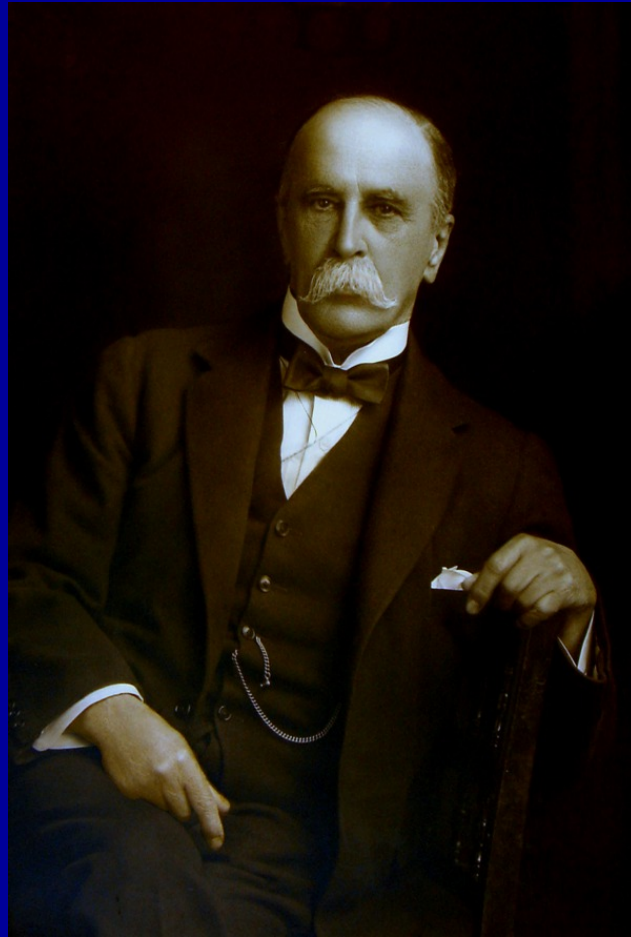
A Few Reservations

- **Admittedly, concepts of what constitute specific disease entities are not fixed; they evolve with time.**
- **Not all diseases have been identified.**
- **The underlying etiology may or may not be known.**
- **Nonetheless, diseases are recognized as specific entities, distinct from other diseases.**

Why is making the correct diagnosis important?

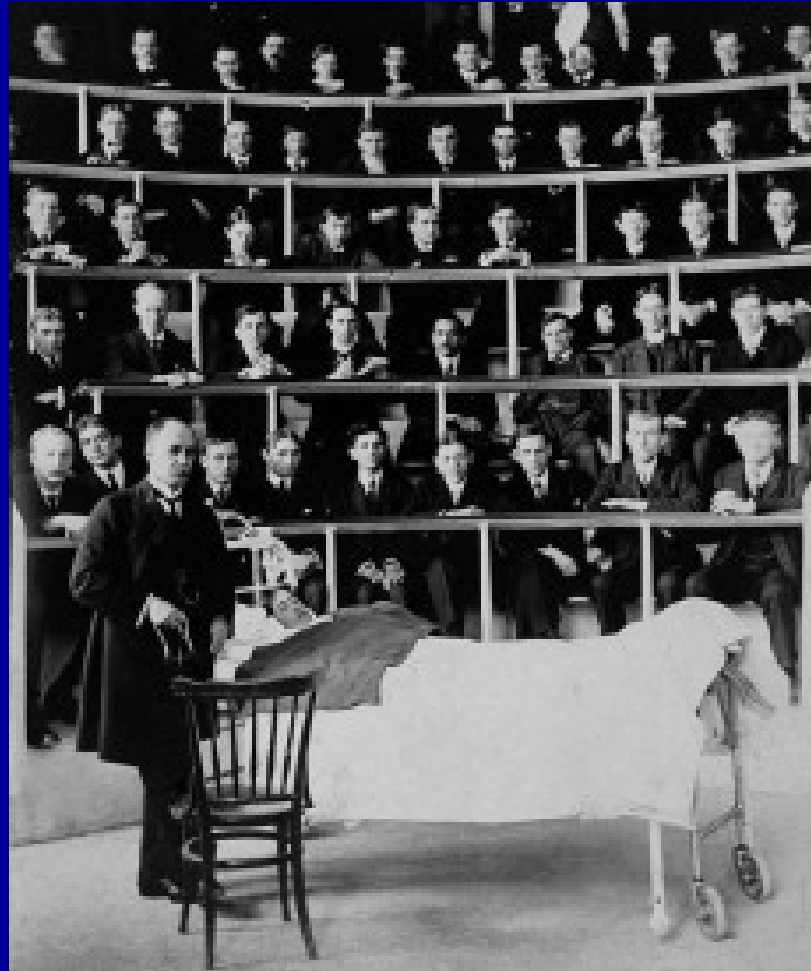
- A guide to treatment.
- Assessment of prognosis.
- Indicates what complications to expect.

William Osler 1849 – 1919



Diagnosis

Osler teaching



Diagnosis

Osler was renowned for his diagnostic acumen



Diagnosis

**In those days Internists were referred to as
“Diagnosticians”.**



Osler in the almshouse

Today

- **This is no longer the case.**
- **Internists are not really specialists.**
- **Internists are now primary care physicians.**
- **And diagnosis is no longer the Holy Grail the way it used to be.**

The main questions a generation ago



1. What has this patient got?
2. What do I do now?

The main questions now:



1. **What do I do now?**
2. **Triage to observation or to admission?**
3. **If the latter, how soon can he be discharged?**

Powerful forces are denigrating the primary role of diagnosis.

- 1. Diagnosis often gets short shrift:
 - our therapies are better
 - the perceived urgency of discharge.**
- 2. There is no way to say “I don’t know”.**
- 3. “Billable terms” are replacing traditional medical diagnoses.**
- 4. Incorrect working diagnoses become hand-me-down diagnoses.**
- 5. The problem oriented record: problems.**
- 6. Apparent disparagement of diagnosis.**

Diagnosis often gets short shrift

- **A couple of generations ago we had few effective therapies.**
- **Therapeutic capabilities are much greater now than then.**
- **We can often do good even when we don't know the diagnosis.**
- **As a result, making the correct diagnosis has lost its urgency.**

How we respond to the presence of a symptom.

- Try drug **A**.
- If that doesn't work, try drug **B**.
- If that doesn't work, consider making a diagnosis.

Diagnosis often gets short shrift



Financial considerations lead to a strongly perceived need to discharge patients rapidly.

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Don't mind them. They are just insurance company representatives telling us how to practice.

“I don’t know what you have, but I have to discharge you now”



When patients are discharged without a diagnosis having been made:

- **Outpatient physicians (themselves under harsh time pressure) have to manage them without a clear idea of what they're dealing with.**
- **Patients often need to be readmitted for the same as yet undiagnosed condition.**

“Gee, I don’t know”



Diagnosis



- **Sometimes the diagnosis is not yet known, and it is not possible to enter a true diagnosis.**
- **There is no way to say “I don’t know.”**

Billing Department



The term “diagnosis” has been hijacked by the billing office

- **When used for billing, “diagnosis” doesn’t necessarily mean a medical disease.**
- **Rather, there is a list of “billable terms” which includes a lot of symptoms, lab abnormalities and signs.**
- **When you enter such a diagnosis, you may be fooling yourself into thinking that you know what’s going on, when you really don’t.**
- **But what must be done must be done. Just be aware.**

Some Possible “Diagnoses” That Can Be Entered into the Electronic Medical Record:

Abdominal pain

Abnormal blood test

Back disorder

Coagulation defects

Eye disorders

Fluid/electrolyte disorders

Joint disorder

Pain in joint

Splenomegaly

Urinary symptoms

Visual disturbance

Vomiting

Wheezing

Incorrect presumptive diagnoses become immortal

We often have to make presumptive diagnoses before we have a firm diagnosis. .

We can't always make it clear in the medical record that what we have entered is only presumptive – a working diagnosis.

Even if wrong, such diagnoses often remain in the record and are mindlessly repeated in subsequent notes: Hand-me-down diagnoses.

Hearsay diagnoses

- It is not unusual for a diagnosis to be entered based on the patient's history alone.
- Such diagnoses are not always correct. The patient may have arrived at the conclusion herself; she may have misunderstood what she was told, or the physician may have been in error.
- Such inaccurate diagnoses also often achieve immortality in the medical record.

Example #1

From: EMR supervisor
To PCP
Subject: Patient Diagnosis

Dr. Irving Kushner called me about this patient and wanted the Rheumatoid Arthritis Dx removed from your encounter of 5/24/07.

I told Dr. Kushner I would contact you to see if the Dx could be changed. Please call Dr. Kushner to discuss this patient.

#2

From: PCP

Hello Dr. Kushner-

I am confused as to why you would want us to remove the diagnosis of rheumatoid arthritis from this patients first encounter.

The patient came to our clinic and stated he had a history of rheumatoid arthritis. As it turned out this was not true.

However at the patients first visit I feel it was appropriate to trust him and use this as the diagnosis.

#3

Me to PCP

Someone saying he has RA, or that he was told he has RA, does not mean that he has RA.

Once it is entered in the chart, however, it is there forever.

**All subsequent presentations will start:
“ A so and so year old man with RA for many years.”**

- I don't think diagnoses should be entered unless you are willing to stand behind them.
- You are signing your name – attesting that you think that he has a specific diagnosis.
- You are putting your own reputation for accuracy and reliability behind that diagnosis.
- I know that you have to enter *something* in the diagnosis box. How about arthralgia – pain in the joints?

#4

PCP to me

I am not certain that I agree. Why would all further presentations start with "patient with RA" based on a one time diagnosis entry. I would think the clinician might actually read the note, look at the problem list or look at the lab values.

Part of the issue I have is trust in the patient. If a patient presents to me as a new patient my first inclination is to trust him/her.

#5

Me to PCP

Medically, I think that diagnoses in the chart should be as accurate as we can make them. Busy physicians tend to take them as definitive.

My colleagues in rheumatology can tell you of many instances in which mismanagement resulted from incorrect “hand-me-down” diagnoses in the medical records.

#6

Me to PCP:

The medical record is also a legal document. I wonder what will happen four years later when a physician gets on the witness stand.

The lawyer aggressively asks him "On what did you base this diagnosis you made?"

The physician replies, "The patient told me".

The lawyer's jaw drops, he stares at the physician in disbelief, and says, "You mean, doctor, that all it takes for you to make a diagnosis is for the patient to tell you what she thinks she has?"

"Why bother going to medical school?"

The problem oriented record poses problems

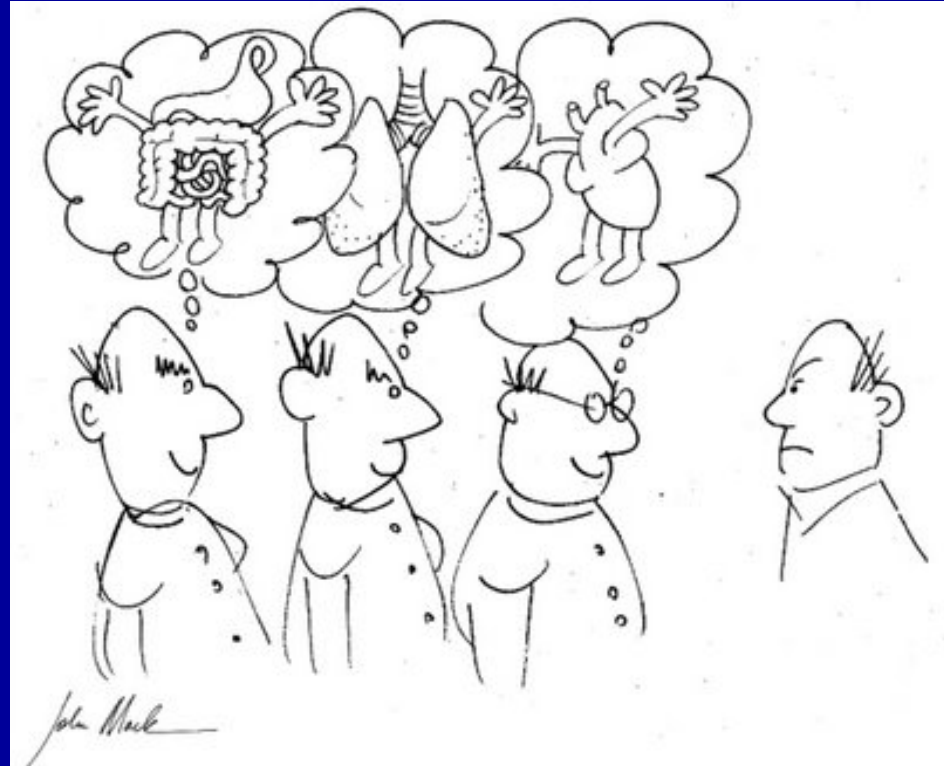
The major emphasis: is often identification of problems and tracking their progress, rather than on synthesis.

This often leads to muddy rather than clear diagnostic thinking.

Assessments and progress notes frequently consist of lists of symptoms, of organs, of abnormal laboratory findings, or even of medical specialties.

Problem list in a progress note:

1. GI
2. Pulmonary
3. Cardiology



Some critics are disparaging the emphasis on diagnosis.

A number of publications express concerns about an emphasis on diagnosis.

We read that there are negative consequences of emphasis on diagnosis: when we know what is wrong we focus less on the individual and more on the disease.

The Tyranny of Diagnosis
PAULINE W. CHEN, M.D.
NY Times online: 9/18/2008

“Over the last century and a half, medicine has increasingly decoupled disease from the individual. This decoupling has given rise to the concept of precise, objective ... diagnoses.

Diagnosing a patient requires placing that single person’s narrative against the larger predetermined trajectory of a diagnosis.

When the individual’s story fits into the diagnosis’ trajectory, ... we know what is wrong. **But when we know what is wrong, we focus less on the individual and more on the diagnosis.”**

C E Rosenberg
Department of the History of Science
Harvard University

- : “It has become..fashionable among humanistic and social science-oriented commentators to dwell on the distinction between illness and disease, between the patient’s felt experience and the constructions placed on that experience by the world of medicine.”
- Their opposition..reflects the...mutual incompatibility (real or apparent) of science and art, of reductionism and holism .

What to do?

We need to relentlessly impress on our students and trainees the importance of arriving at an accurate definitive diagnosis.

They should be aware that the job is only half done if the diagnosis has not been made.

What to do?

We ought to be able to enter “diagnosis uncertain”, or to add the phrase “ cause unknown” after the manifestation of concern, when we don’t really know what is going on.

What to do?

We should routinely indicate when a diagnosis is merely presumptive.

What to do?

We need to correct the current confusion between diseases and billable terms, perhaps by designating separate “billing codes”, with a separate entry for actual medical diagnoses.

What to do?

We ought to be skeptical of hand-me-down and hearsay diagnoses.

We should look into the record to see if those diagnoses, which may have been merely presumptive, are really justified.



Do you think anyone will listen to what Dr. Kushner is saying?



Diagnosis