Description of Illness: Limitations and Approaches

Charles B. Freer, MB, ChB, MCISc
Glasgow, Scotland

The collection of health information by diaries has raised questions about the limitations of existing diagnostic terms and taxonomies in describing ill health in an holistic fashion. Despite the advantage of the problem oriented medical record system in recognizing the social and psychological dimensions of illness, problem lists do not communicate the unique mix of problems for any individual. An argument is made for more anecdotal description of illness in medical records and more research to develop a systems approach to describe ill health.

Clyne's "nagging feeling that our traditional diagnoses and the treatments and prognoses based on these diagnoses bear no relationship to the true circumstances of the patient's condition,"[1] is shared by many in the medical profession. However, this feeling is far from new,[2,3] and it is of some concern that despite a longstanding awareness of these limitations, it remains very difficult to describe and quantify health problems in a whole-person fashion.

This paper uses health information from a recent community based study to illustrate the shortcomings of the conventional diagnostic approach to clinical data and suggests areas which require more attention and experimentation.

A Recent Study

Twenty-six women in the 35- to 44-year age group who were without chronic organic medical problems were randomly selected from the patient register of a family medical center in London, Ontario. They kept a structured health diary for four weeks. The diary was designed to collect information on all or any health related problems perceived by the women and any actions or other responses to these. The women were encouraged to record any problems, no matter how trivial, and to include anything that upset their well-being. They were told that it was their diary, not the physician's, and that they should record the problems as they saw them and in their own words. It was hoped that these instructions would provide a patient oriented holistic view of common health problems. Details of the study and results are described elsewhere.[4]

Limitations of Existing Recording Methods

Whole-Person Illness

Table 1 summarizes the problems recorded by one of the study participants on four successive

From the Department of Family Medicine, Faculty of Medicine, The University of Western Ontario, London, Ontario, and the Department of Community Medicine, University of Glasgow, Ruchill Hospital, Glasgow, Scotland. Requests for reprints should be addressed to Dr. Charles B. Freer, Department of Community Medicine, University of Glasgow, Ruchill Hospital, Glasgow, G20 9NB, Scotland.

0094-3509/80/050867-04$01.00

days. These are not unusual or atypical, but conventional diagnostic labels are unlikely to capture the unique mix for this particular patient. To list her problems for that week as depression, marital and domestic problems, menstrual symptoms, and headache seems to detract from the reality of the problems as seen in the diary context. Furthermore, we know that common medical symptoms, such as headache and palpitations, do not always reflect underlying organic pathology. Perhaps one man's backache is another's indigestion, and such symptoms are indicators of more fundamental whole-person states which cannot be measured or described given current knowledge and medical taxonomies. In fact, a recent unpublished survey of symptoms in a Scottish health center population produced some support for this. When the distribution of psychological scores in this population was examined, it was found that the higher the psychological score the greater the frequency of physical symptoms such as dysuria and dizziness.

Non-Organic Components of Illness

Few would dispute that non-medical factors influence ill health and well-being. Social problems, for instance, have an important influence on patients' decisions regarding whether to visit their physicians or not.[5] However, non-medical problems that may be listed by patients are difficult to label in a specific or meaningful way. If identified, they are likely to be described by a general label such as family or domestic problems. An individual patient may even find himself/herself classified as belonging to a "problem family," a malady that appears to be reaching epidemic proportions in case notes. These descriptions of non-organic factors are probably as useful as labels such as "body problems" would be to organic illness.

Illness Bias in Diagnoses

Inevitably, most of the diagnostic information in patients' records relates to episodes of ill health, and generally includes only those episodes which have been presented to physicians (ie, from those occasions when the patients could not deal with the symptoms on their own). To have a more complete and more holistic view of these patients, physicians should have information on them in health and, more particularly, on the many occasions when they cope successfully with health problems. Despite the prevalent view to the contrary among physicians,[6] patients cope with many minor health problems. The diary study confirmed earlier findings by Banks and his colleagues[7] that women in this age group report only about 1 in 40 symptom episodes to physicians. A further interesting finding was that high attenders did not appear to be a homogeneous group. Some of these women coped much better with their frequent problems than others, and yet this important information is unlikely to be appreciated by their physicians or be available in their medical records.

Problem Oriented Medical Records

The widespread use of problem oriented medical records has provided an approach to medical care that is not restricted to the purely organic and pathological factors of ill health. Their contribution to the encouragement of a patient oriented, rather than a disease oriented, approach to clinical assessment is inestimable. However, the quality of problem oriented records seen in many places in recent years leaves much to be desired. It seems that many physicians who use the system have never read Weed's original text.[8] Furthermore, the problem oriented system did not, and never intended to, produce the vocabulary and taxonomies necessary for whole-person descriptions of illness. Lists of physical, social, and psychological problems cannot claim to be holistic statements.

Useful Approaches

The development of new diagnostic systems is no easy task, and this may account for the paucity of suggestions in the medical literature. One

Table 1. Summary Extract of Recorded Information on Perceived Health Problems and Responses to Them on Four Consecutive Days from One of the Health Diaries in a Study of Self-Care

	Continuing Problems	New Problems	Self-Care Response
Monday	Nervous and depressed	Argument with husband—gets mad when I go to bed before him Son mad with me	Valium Had a drink with neighbor Worked in garden
Tuesday	Depressed	Low backache—period due Headache Argument with husband	Coffee Wore more make-up
Wednesday	Depressed Headache Still having differences with husband	Menstrual cramps	Had a few drinks with neighbor
Thursday	Depressed	Husband told me that house was a pigsty Husband drank all night	Valium Drank too much myself

widely read and quoted paper[9] did propose new taxonomies that would integrate clinical medicine and behavioral science, but for most of us seems to have held no more than academic interest. What are the possibilities of making some practical progress in the establishment of a holistic diagnostic system? Two suggestions, one short-term, the other long-term, are made.

Anecdotal Diagnosis

A high standard of record keeping should be demanded at every level of practice and should be a central aim of medical educators. A renewal of interest in the problem oriented record system is indicated. Not only does it offer a comprehensive and fluent structure, but it encourages a whole-person approach to medical problem solving. Problem lists, as proposed by Weed, are important but, as indicated earlier, terse, diagnostic labels cannot convey the "true circumstances of the patient's condition." However, a brief anecdotal statement may. For example, the patient whose diary is shown in Table 1 could be summarized thus:

Continuing Problems

Constant feelings of depression with severe marital discord. Only communication with husband (? drinking problem) is in arguments. Problem with son also. Finding support from female neighbor, alcohol, and ad hoc use of Valium

Episodic Problems

Headache
Menstrual aches and pains

Of course, many physicians make such notes in their records. What is being suggested, however, is that a summary statement should be structured into our record keeping, particularly for those

patients with multiple and/or psychosocial problems. The entry could be underlined or highlighted by colored pen and provide an instant and up-to-date reminder at the next visit. This would not replace but supplement the problem list. The use of anecdotal diagnostic summaries would free us from the pressure and the temptation to force available clinical information into a firm problem label while providing the opportunity to include the whole-person dimensions of the problem in a more realistic way.

A Systems Approach to Diagnosis

Those who have given their support to the whole-person approach have recognized, as has Dubos, that "it is therefore essential to investigate situations in which several interrelated systems function in an integrated manner. The most important aspects of life fall outside the net of reductionist analysis."[3] Two quite different individuals can have similar, or even identical problem lists and not simply because the diagnostic labels have failed to capture the other components which would distinguish them. The uniqueness and individuality of any person is further explained by the interactions between the various components that make up the whole person. These interactions explain the definition of holism, viz, that the whole is greater than the sum of the parts. Although it is probably not appreciated by all who use them, the traditional diagnostic approach assumes that the whole can be understood by the separate study of its parts. The limitations of the current interest in large scale morbidity studies is that the synthesis of problem lists reduces what may be meaningful clusters of problems to frequency distribution of problems whose meaning and validity is difficult to assess.

Systems theory[10] recognizes the existence of an organized whole with overlapping, interacting systems. Unfortunately, to date its applications to the diagnostic method have been purely theoretical and the continuing inability to describe and measure these interactions necessitates the analytic and organic description of illness. Nevertheless, it is in this area that more intensive thought and work are required. The inherent difficulties do not diminish the importance of the challenge. There has been too much talk about holistic medicine and already one is aware of some in the profession who have grown tired of listening to the words without witnessing any real practical advances.

Implications for Family Medicine

Family medicine is a young and rapidly emerging academic discipline. Holistic concepts of health and illness are central to the clinical content which distinguishes it from other disciplines. It will be the responsibility of original and creative thinkers in this field to tackle the problem of developing a more whole-person approach to diagnosis. The task may yet prove too daunting, but the effort must be made. In a scientific world, concepts will not survive without measurement, and disciplines will not survive without establishing their claims to uniqueness.

References

1. Clyne M: Six minutes for the patient: Interactions in general practice consultation. In Balint E, Norell JS (eds): Mind and Medicine Monographs, vol 23. London, Tavistock Publications, and Hyattsville, Md, Harper and Row, 1973
2. Menninger K: Changing concepts of disease. Ann Intern Med 29:318, 1948
3. Dubos R: Man Adapting. New Haven, Conn, Yale University Press, 1965
4. Freer C: Self-Care: A Health Diary Study. London, Ontario, University of Western Ontario, 1978
5. Robinson D: The Process of Becoming Ill. London, Routledge and Kegan Paul, 1971
6. Gough HG: Doctors' estimates of the percentage of patients whose problems do not require medical attention. Med Educ 11:380, 1977
7. Banks MH, Beresford SAA, Morrell DC, et al: Factors influencing demand for primary medical care in women aged 20-44 years: A preliminary report. Int J Epidemiol 4:189, 1975
8. Weed L: Medical Records, Medical Education and Patient Care. Cleveland, Ohio, Press of Case Western Reserve University, 1969
9. McWhinney IR: Beyond diagnosis: An approach to the integration of behavioral science and clinical medicine. N Engl J Med 287:384, 1972
10. Von Bertalanffy L: General Systems Theory. New York, George Braziller, 1968