In the early part of his professional life Wittgenstein developed the 'picture theory' of language. He believed that there were 'atomic propositions' in language which mirrored the structure of reality. Language thus described an independent reality and, indeed, the structure of reality could be inferred from the structure of language. Wittgenstein believed, however, that only 'fact stating' language could be said to be meaningful. He believed that all philosophical problems (and many personal ones) arose because people used language in circumstances when it had no meaning. He was advocating a highly technical and restrictive use of language to avoid error. 'Of that which we cannot speak, thereof we must be silent.'[6]

This theory is analogous to the biophysical model of a diagnosis. In this form a diagnostic label mirrors some biochemical or physical process that leads to malfunction of the organism. Some doctors believe, like the early Wittgenstein, that serious errors arise when we stray from this formal discipline and create 'woolly' diagnostic categories that do not mirror biophysical reality.

Wittgenstein wrote his first work — the *Tractatus Logico-Philosophicus* — while in the trenches on the Eastern Front in the First World War.[7] With typical Wittgensteinian humility he believed he had solved the problems of philosophy with this work. After the war he gave up philosophy, gave away his massive inherited fortune, and became a (bad) primary school teacher in rural Austria.

When he returned to philosophy in Cambridge in 1929 his thinking was dramatically different. Wittgenstein had come to believe that language did not represent a reality 'out there' but was an instrument or tool woven into human practice. In the *Tractatus Logico-Philosophicus* he believed that the meaning of language came from its logical form. His later belief was that language is an elastic, social, and sometimes ambiguous structure that necessarily defies simplistic definition because of its scope and complexity. Language's meaning, he believed, is defined by how it is used in daily life rather than by any logical structure that underlies it. It is meaningless to look at language divorced from the society within which it takes place. Wittgenstein had shifted from believing that language reflected reality, to seeing language as a metaphor for reality. It is in its very messiness and adaptability that Wittgenstein believed the essence and power of language lies.

I believe that there are useful analogies between Wittgenstein's theories of language and the nature of diagnosis in medicine. Arguments about the existence and definition of diagnoses like 'ME' and 'PTSD' have striking similarities between themselves,[8] and with the philosophical problems of existence and definition that preceded Wittgenstein.

A diagnosis of a fractured femur is different from a diagnosis of depression in both content and form. The attributes that make each a 'diagnosis' are very different. Errors can arise if we use the same tools (of evidence-based medicine, for example) to analyse these entities as though they have objective reality and commonalities as 'diagnoses'. For example, diagnoses that are more 'biosocial' than 'biophysical' are more meaningful when applied to a class of patients than to an individual. We are potentially just as much in error if we say that 'chronic fatigue syndrome (CFS)' does not exist, as if we say that 'ME' has the same attributes as a disease as mumps encephalitis. It maybe helpful if we, like the later Wittgenstein, recognise that our categories of 'diagnosis' are more complex entities than mere mirrors of an external biophysical reality.

A diagnosis is, in the end, defined by its utility in both medicine and society rather than by any formal categorisation. Attempts to 'define away' loose diagnostic entities, such as post-traumatic fatigue syndrome or ME, fail to make explicit these social and utilitarian aspects of 'the diagnosis'. However, it is equally unhelpful to treat iron deficiency anaemia and CFS/ME as though they are the same type of categorical entities.

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Unhappy French doctors

A non-French observer would probably be astonished that doctors in France regularly participate in the national sport of going on strike even though their health system, according to the World Health Organisation, is supposed to be one of the best in the world.

Although France spends about 9.5% of its GDP on health care,[1] which means that it is among the top of the OECD nations, the public health insurance deficit is currently at €12.9 billion.[2] This chronic deficit is the result of the difference between the contributions taken from salaries on the one hand, and expenditure on hospital and ambulatory health care on the other. There is no cap on expenditure and therefore there is no waiting list.

Despite the fact that a budget is voted every year by the Parliament, expenditure has always exceeded the amount fixed. Hospitals, too, have a fixed annual budget, but public authorities often have no choice but to inject more money during the fiscal year, especially when the media are scandalised by stories of overwhelmed emergency services, or the mismanagement of last summer's heatwave, which caused an increase of about 15 000 deaths among the aged and the infirm.

Expenditure in private practice is also unregulated, apart from the fixing of rates to be charged for medical services by the public authorities. Unfortunately rates are set at levels below their real economic value. For example, a consultation with a GP is fixed at €20. The result is an inflation in the number of consultations in ambulatory care and an overloaded timetable, in order to compensate for the meagre rate. According to the French Ministry of Health, on average, GPs work 56 hours per week for a income of €73 500.[3] This trend of always going after more does not help to contribute to the quality of services for patients.

In private practice, as well as in hospitals, the number of doctors has never been as high as at present. The problem lies in the lack of supporting staff (paramedics, medical secretaries) and the relentless increase in bureaucracy and paperwork — for the average French GP at least 2 or 3 hours per day.

Doctors are disillusioned, with large numbers contemplating early retirement or changing professions.

1. World Health Organisation. Country information: France. http://www.who.dk/eprise/main/WHO/countryinformation/country?AreaCode=FRA (accessed 2 May 2004).
2. Guélaud C. M. Douste-Blazy va soumettre à concertation une réforme globale de l'assurance-maladie. *Le Monde* (http://www.lemonde.fr/web/recherche_resumedoc/1,13-0,37-852278,0.html (accessed 7 May 2004).
3. Paillard J. Dossier d'actualité professionnelle - + 15% sur les bénéfices, la hausse historique! *Le Généraliste* 12 September 2003, 2257.