Life & Times

Each of our patients is unique:

the limits of biomedical entities

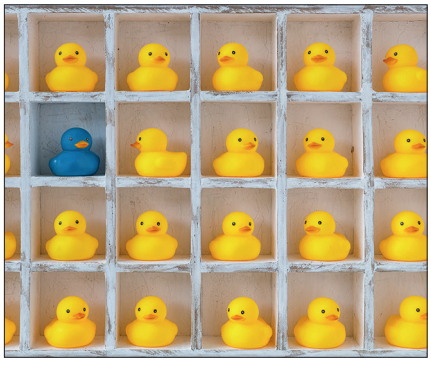
Termination of the coronavirus pandemic by vaccination will be heralded as a triumph for science. Indeed, vaccines are an incredible intervention, freeing us from the harms caused by a swathe of diseases.

A vaccine is a classical biomedical intervention, in this case targeted against a specific virus. The development of Koch's postulates for determining whether a specific microorganism is the cause of a given disease, and the work of Louis Pasteur, were key elements in the development of the model, which didn't just lay the basis for the development of vaccines, but also formed the bedrock of modern medicine.

MEDICALISING HUMAN TRAITS

The biomedical approach relies on categorising patients through agreed, standardised criteria for diagnosis, thence providing a basis for the development of effective treatments. Infectious diseases and a wide range of other conditions have been classified into distinct entities. This approach has been immensely successful and has created the conditions for the huge progress we have seen over the past century. A widespread assumption is that all human illness can be classified into specific biomedical entities, and all we need to do is look hard enough. However, we should never forget that these entities are not laid down by some higher power, rather they are defined by human beings.

Many of the diagnostic categories we use every day have no known biological basis. This applies to virtually all psychiatric diagnoses. The fluidity of defining entities in mental health is illustrated in the changes over time in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This categorised homosexuality as an illness until 1973.[1] Meanwhile, the number of psychiatric diagnoses increased from 128 in DSM-1 published in 1952, to 541 in DSM-5, published 61 years later, in 2013.[2] Thus many human traits have been medicalised, and the myth engendered that these disorders somehow represent a chemical imbalance in the brain, ever extending the reach of Big Pharma into everyday life.[3,4]



> *"For patients, acquiring such a* ['dustbin'] *diagnosis comes with the perception that many doctors have little interest in such conditions and show negative attitudes towards patients affected by them."*

'DUSTBIN' DIAGNOSES AND MEDICALLY UNEXPLAINED SYMPTOMS

Perhaps the greatest absurdity of this approach to defining entities is the 'non-diagnosis', such as 'non-organic pelvic pain' and 'non-cardiac chest pain'. These are popular with vertical specialists and often mark the point where they discharge the patient. Alternatively, the patient may be given a 'dustbin' diagnosis like irritable bowel syndrome or fibromyalgia. For patients, acquiring such a diagnosis comes with the perception that many doctors have little interest in such conditions and show negative attitudes towards patients affected by them.

The term 'Medically Unexplained Symptoms' is widely used as an overarching dustbin category; its adoption represents a hubristic extension of the biomedical model. Its use implies that there should be a single approach to the management of a wide range of patients seen in everyday practice. It serves to legitimate the idea that their symptoms are not as 'real' as those of say, a person with cancer, while it promotes the notion that further investigation may be needed. It reinforces the concept that mind and body are separate. It undermines the patient's own narrative, and other possible explanatory or treatment models.[5] Finally, as a label it can ultimately stand in the way of a specific diagnosis being made.

DON'T PIGEONHOLE PATIENTS

Modern general practice comprises less and less of interactions with patients with a single classical disease, which forms the archetype of the biomedical paradigm. Once the dust settles after the pandemic, our focus will return to patients with complex multimorbidity, those with chronic pain and distress, the 'worried well', and older patients with varying degrees of frailty and cognitive decline. Many of these patients cannot be neatly pigeonholed as suffering from a specific biomedical entity and we should not attempt to do so. They and their carers deserve to be listened to without judgement and responded to honestly. We should be judicious in our investigations, avoid unnecessary diagnostic labels, and accept uncertainty. We must not slip into lazy thinking habits.

Above all we should never lose sight of the uniqueness of every individual we encounter.

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This article was first posted on *BJGP Life* on 12 January 2021: https://bjgplife.com/unique

DOI: https://doi.org/10.3399/bjgp21X715133

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