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Diagnosis: Are we medicalising human experience? A radical review.

Medicalisation is the process by which human conditions and problems come to be defined and treated as medical conditions. The act of diagnosis can be described in almost identical terms – a process by which a person comes to understand, with the help of a doctor, a set of human experiences as symptoms and defines them under the label of a known illness. Across medical practice, research and policy increasing focus has been placed over the study of medicalisation and more specifically over medicalisation and attempts have been made to shift practitioners away from over diagnosis and overtreatment (in particular over medication). However, arguably the call for these changes has yet to take hold in practice.

Mental health conditions, and in particular depression have long been at the forefront of the debate surrounding medicalisation. With the new DSM-V criteria, announced in 2013, came controversy in the form of a redefinition of major depressive disorder to no longer exclude those who had recently experienced bereavement from the diagnostic criteria. In spite of the justification, that we are missing diagnoses and therefore depriving patients of the appropriate treatment (1), this has triggered concerns that we are treating what would previously have been considered as a normal human experience of sadness (2).

An increasing body of evidence suggests that mild depression is over diagnosed and treated. A meta-analysis of patients in primary care showed that depression was more often wrongly diagnosed, than missed or correctly diagnosed(3). Another showed that only 38% of adults with identified depression met the diagnostic criteria over the previous year using validated structured measures (4). Prevalence of depression appears to be stable and yet prescriptions of antidepressant increased 10% each year between 1998 and 2010 in England (5). While in part these numbers can be explained by changes in prescription patterns, there does appear to be a trend to diagnose more depression where patients do not meet the full criteria. Furthermore, while the NICE guidelines suggest that drugs should not be the first line treatment and should not be a treatment at all in mild depression unless resistant (6), prescriptions in these cases appear still frequently occur.

Medicalising the human experience: What's the harm?

I recently witnessed a consultation in general practice that for me perfectly exemplified the current tendencies towards over diagnosis. A 75 year old presented with dizziness, but on questioning had no specific symptoms leading to a clear differential. When asked about her social life she became emotional over the recent loss of a very close friend. She left the consultation with a diagnosis of depression and a prescription for antidepressants. Overall the consultation felt successful and by the end, the patient left gratified and I believe felt cared for. However, the shift from the patient's expectations from an inner ear problem to depression was dramatic and the prescription of drug treatment felt premature. I was left reflecting on the progression of the following days for this patient.

Whatever the condition, the implications of a diagnosis on a person's life can be far-reaching. In the immediate aftermath of a diagnosis patients grapple with coming to a personal understanding of their illness through internet searches, reading information packs and talking to friends and family.

The process of disclosure may raise innumerable questions; who should I tell? What should I say? How will they react? Will it change our relationship? Will it affect my work? Many illnesses expose the patient to stigma, which has been shown to impact on their self-esteem and their resilience (7). Soon after diagnosis comes any behavioural change associated with the condition, often large lifestyle changes are recommended possibly going against habits of a lifetime. They may have to adjust to the burden of taking daily medication, learning how to deal with any side effects and developing strategies to remember to take their pills. With the diagnosis of a long term illness expectations for the future may need to be considerably readjusted. All, some or none of these experiences, along with countless others not mentioned here can occur and the response is unique to the individual.

When a diagnosis is given for what could otherwise be defined as a normal human experience we expose the patient to all these downstream effects. The aim of a diagnosis is to enable access to the appropriate course of treatment but even with this good intention patients are often exposed to more harm than good. Beyond the immediate psychological and social impact of the diagnosis, where a person is over treated they are exposed to side effects that may again expose them to undue risk. Antidepressants, for example, among a whole range of side effects have been shown to be a major contributor towards falls in the elderly (8). Beyond the personal impact of a diagnosis and treatment come the wider implications to health systems. Concerns have been raised about the impact of medicalisation on allocation of resources; with more resources being used for milder disease those with severe conditions may be deprived. The side-effects of treatments also come with their own costs, with falls in the elderly forming a major component of the NHS budget (9).

Towards an explanation for medicalisation?

While many articles have been published pointing out the prevalence of medicalisation there seems to be considerably less research into an understanding exactly why and how it happens in practice. A doctor's consultation is an extremely complex and intricate social interaction that can be led in a thousand different directions at any point. Many contributing factors come together to cause a tendency to diagnose where it perhaps may not be necessary.

The role of Fear: One explanation for the phenomenon of over diagnosis was eloquently worded by Edwards on discussion of the topic "the fear of both the patient and the doctor can sometimes override the best knowledge, research and information known to man" (10). For the both doctor and patient the fear of a missed diagnosis may be greater than that of an unnecessary diagnosis (11).

The role of habit: Through years of medical school the focus of lectures is on diagnosis and management: identifying the problem and fixing it. A disproportionately small amount of time is spent on approach to patients with sub-clinical problems, undiagnosed impairments and those with difficult to manage conditions. As such when faced with a patient, out of learned habit, all efforts may subconsciously be made to fit the patient into the first category.

The role of Empathy: Empathy forms the cornerstone of a successful medical consultation (12), but with empathy for someone's pain comes a desire to solve it with whatever tools you have at hand. Along with habit this may lead to a desire to diagnose and treat wherever possible.

The role of time pressures: Trying to address all of a person's expressed problems, expand that to a full history, order any investigations, make and explain any diagnosis and similarly make and explain any management plan over the course of 10 minutes is no small feat. It takes a long time to learn enough about a person's experiences to define the subtle line between sadness and depression. With all those time pressures in mind, it is far easier to end the consultation with a diagnosis and a prescription than a broad conversation covering lifestyle changes and possible self-help techniques.

The role of patient understanding: The vast majority of doctors are not disillusioned about the efficacy of antidepressants and are well aware of the lack of evidence for their use in mild depression. However a patient from a non-scientific background has no reason to doubt that the drugs on offer work. Without explaining this in detail, which there is rarely time to do, even when offered a decision about drug treatment it cannot be truly informed.

All of the above factors and more come together to a varying degree in general practice to create the perfect setting for diagnosis of a normal human experience as depression.

Conclusions

The moment at which a person receives a diagnosis part of their human experience becomes medicalised. In the majority of cases this achieves its aim; placing people on the correct treatment course to improve their overall experience. However there is a current tendency in medical practice to diagnose conditions more frequently than may be necessary, thereby over medicalising individuals. This exposes them to many potential risks as a consequence of the diagnosis and the overtreatment that may follow. By reflecting on the many psychological and social factors that contribute to this over diagnosis, individual doctors can adapt their practice to try to minimise these harms.

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