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That 'gut feeling'

■ **Upper abdominal pain can be a dilemma in general practice. Sometimes the likely diagnosis is clear in your mind after the first sentence of the patient's history is revealed – and only gets confirmed the further you delve into the history and examination. On other occasions the diagnosis is far more elusive. In this issue of *Australian Family Physician*, Sprio Tsipouras raises the importance of the doctor's 'gestalt' in managing these elusive cases. What is gestalt? How do we develop it?**

Gestalt is defined as 'an organised whole in which each individual part affects every other, the whole being more than a sum of its parts'.¹ While gestalt is a good description of what we experience and project to the outside world, in reality it is more complicated than that – although it has been noted that we may never be able to describe the process we went through to make the successful diagnosis.²

When starting out as a clinician you had an extensive list of questions you methodically asked the patient. As a novice all histories and examinations are long and thorough. As you gained more knowledge and experience, something changed. That change was, that you had seen it before. The idea of what might be the problem had already entered your mind when assessing the patient. Over time this progressed to focusing the history and examination to seek features that confirm or dispute the diagnosis and its significant differential diagnoses. One theory of this process is that diagnoses are based on pattern recognition or developing 'illness scripts' which are based on knowledge gained and related to presentations. However, we each develop our own scripts based on our own experience and knowledge. The process of using these scripts to help us make a diagnosis has been described as 'nonanalytical reasoning'.³

Even novices use a mix of both analytic and nonanalytical reasoning.⁵ However, it has been noted that 'clinicians often unconsciously use multiple, combined strategies to solve clinical problems, suggesting a high degree of mental flexibility and adaptability in clinical reasoning'.⁴

So given this is all happening unconsciously, when do we make mistakes in clinical diagnostic reasoning? When does our gestalt fail us?

It fails us each differently; as we each have our own experiences and knowledge that we unconsciously use, we cannot predict

accurately where it will fail colleagues. It also fails us as we may misinterpret ambiguous findings to support the diagnosis we are considering.³

An essential part of becoming an expert is to recognise when the findings do not fit the pattern that we are trying to match to confirm or refute a diagnosis.² It has been shown that using a combination of approaches, both analytical and nonanalytical, can improve diagnostic accuracy.⁵

So the elusive diagnosis of abdominal pain requires all your approaches to clinical diagnostic reasoning to be activated. It may be that you cannot name the diagnosis, but that you can have 'correct patient disposition'. And then as Tsipouras points out, 'time and observation has been shown to improve diagnostic accuracy'. Which I suspect will surprise no general practitioner!

Also in this issue of *AFP*, Grimpen and Pavli provide a framework for decision making about investigations for upper abdominal pain. Zantuck, Wong and Mackay consider the surgical causes that we should contemplate; and the role of *Helicobacter pylori* is considered in the article by Stenström, Medis and Marshall. In the continuing TAPS series, Meredith Makeham and colleagues discuss an example of when the right test was done, but the system failed so no one acted on the results. Right thinking, but that is only part of the story for good patient outcomes.

References

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