

ADDRESS LETTERS TO

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Failure to diagnose

Dear Editor

In her discussion on a case of failure to diagnose bowel obstruction, Dr Sara Bird gives a fairly comprehensive breakdown on the general causes of missed or delayed diagnoses (*AFP* November 2008).¹ The leading overall cause was a failure of judgment. In my medicolegal experience, the leading causes of failure of judgement have been a failure to recognise that the patient is very ill, not thinking about the possibility of a diagnostic entity and stubbornly sticking to a diagnosis even when the patient fails to respond to increasing doses of the same treatment. A Harvard University professor of medicine, Jerome Groopman, has called this latter phenomenon, 'diagnosis momentum'.² All the above three causes were present in this case of intestinal obstruction.

In addition to Dr Bird's recommendations, there are two strategies that could reduce failure to diagnose. The first is to refer to the appropriate 'safe diagnostic strategy' table in Murtagh's 'General practice'.³ Each table can be perused in less than a minute. The list under the heading 'serious disorders not to be missed' may act as a reminder about those disorders that a doctor may not have considered.

The second strategy is for the GP to swallow his or her diagnostic pride and ask one of their GP colleagues to formally review the medical record and the patient whose diagnosis is obscure or who is not responding to medical treatment.

Max Kamien
Claremont, WA

References

1. Bird S. Failure to diagnose: bowel obstruction. *Aust Fam Physician* 2008;37:949-50.
2. Groopman J. How doctors think. Scribe Publications, Melbourne, 2007, p. 128.
3. Murtagh J. General Practice 4th edn. Mc Graw-Hill, Australia, 2007, p. 312.

I just don't feel right

Dear Editor

Dr Carolyn Ee's article 'I just don't feel right'¹ (*AFP* November 2008) presented the problem of vague malaise, a common one in general practice. It produces a great challenge to the doctor's skills of communication, history gathering, physical examination, data collection and analysis, knowledge of the natural history of disease, and reasoned decision making. Further skills needed involve discussing the problem with patients and establishing a working relationship with them to achieve a primary diagnosis and its management. All this in the context of the ambience of 'the doctor of first contact' with its time management constraints and lack of ability

to immediately delegate some of the tasks involved in the 'I just don't feel right' consultation.

I would like to suggest that the consideration of the fairly complex differential diagnosis immediately after the brief presenting complaint suggested by Dr Ee is premature. I believe that the presenting complaint should be explored further plus the usual social, past medical, family and emotional histories. Then a general and possibly focused physical examination should follow.

After that, the collected data can be analysed and a differential diagnosis formulated. Without such data I do not consider it possible to make an informed differential diagnosis with its subsequent investigations and management.

The sequence is more time and cost effective. Making lists of possible diagnoses and deciding upon their priorities is difficult and the more data one can collect the easier the task. I would also add depression to the list of 'red flags'.

Frank Mansfield
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Reference

1. Ee Carolyn. I just don't feel right. *Aust Fam Physician* 2008;37:904-7.

Spirituality in medicine

Dear Editor

I have no problem with the notion that it is a valuable thing to know and give due deference to a patient's religious beliefs. I do, however, bridle at being asked to administer to them.

Craig Hassed (*AFP* November 2008) reports that 'doctors with strong religious beliefs are less likely to refer to psychiatrists and more likely to refer to clergy or religious counsellors for mental health problems'.¹ Aren't the appropriate referrals psychiatry for mental health problems and clergy and religious counsellors for spiritual matters?

Mark Nelson
Hobart, Tas

Reference

1. Hassed C. The role of spirituality in medicine. *Aust Fam Physician* 2008;37:955-7.