Sense and sensitivity

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Our prejudices may be leading us to the wrong diagnoses. This holiday season is a time for us to reflect on our practices and renew our efforts to look out for the vulnerable.

Physicians are skilled at looking inside the body in a sensible and systematic way, and arriving at a diagnosis. In certain contexts, however, our diagnostic sensitivity may be diminished by other underlying factors, a situation known as "diagnostic overshadowing." This refers to the misattribution of physical symptoms to a pre-existing mental illness, or intellectual or developmental disability, and is often viewed as a form of bias and discrimination.[1] The concept of diagnostic overshadowing is being used more widely today to indicate the overattribution of symptoms to any underlying or chronic condition, resulting in missed diagnoses and improper management of conditions. This is especially problematic in people with mental illness, because they have higher rates of morbidity and shorter lifespans than the general population.[2]

Take, for instance, this common scenario I encountered on several occasions in my medical training. Known to emergency department staff as a "frequent flyer," a patient arrives in the emergency department with abdominal pain or other somatic symptoms. The patient usually has a medication list with multiple psychotropic medications, from benzodiazepines to antipsychotic agents. One initial reaction might be to dismiss the patient's symptoms as yet another manifestation of psychiatric illness, whereas a more attuned clinician may probe further to determine if there is another diagnosis that may better explain what the patient is experiencing. Depending on who is doing the assessment, the large bowel obstruction secondary to a previously undiagnosed colon cancer, for example, may be found — or not.

I would like to think that such episodes are rare, but diagnostic overshadowing appears to be more prevalent than we realize and may be increasing in frequency. This may be due, in part, to the fact that patients are now living longer and have more comorbidities, which may result in increased competition for physician time. As well, with many current billing structures, physicians need only 1 diagnosis to bill and are remunerated the same as if there were 3, which provides even less incentive to go digging for additional conditions that may or may not be easily treatable. The interest in diagnostic overshadowing re-emerged with the recent release of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, and concerns raised over psychiatric labels and overmedicalization.

There can be several challenges in diagnosing other conditions in the presence of a chronic illness, all the more so when it is a mental illness. The presence of mental illness can make obtaining a proper history a challenge, as well as a thorough examination, if the patient is agitated or uncooperative. There remains a certain stigma around mental illness, which can be compounded when such patients present with a list of psychotropic medications that may make some physicians uncomfortable. There is also evidence that such skewed attitudes can start when a physician is still in training.[3]

The sequelae of diagnostic overshadowing are multiple. Patients with mental illness are more likely to delay seeking future care, which is likely a contributor to the increase in mortality among these patients. It has also been shown that people with mental illness have less access to primary care, and receive inferior management of myocardial infarction[4] and diabetes.[5]

There may be no straightforward solution to the problem of diagnostic overshadowing, but a start would be to acknowledge its existence. We must also, with impartiality, attempt to gauge our own diagnostic approaches and answer to ourselves, "Am I offering to this person the same level and quality of care that I would if he did not have 'x' condition?" It may be helpful to engage the patient's family or support network to gain a better understanding of the history and context of the presenting symptom. As well, increased physician empathy has been shown to improve patient satisfaction and adherence to medical recommendations, as well as increase clinician well-being.[6,7]

It is important for us to remember the vulnerability of people who present to us in our clinics, hospitals and emergency departments, in various states of distress and disrobed, as they reveal sensitive and personal details about themselves. As well, we must see the patient as a person first and not as a diagnosis or disability. Having earned the right to care for these people, do we not owe them our best standards of care?

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