tients who can be given this diagnosis before one patient is offended (see figure on bmj.com). This value assumes an ideal world in which no one is ever offended, and we used standard calculations for number needed to treat.[5] A comparison of "medically unexplained weakness" and "functional weakness," two of the most popular labels in use, revealed that "functional" was much less offensive (P<0.05 for all categories of negative connotation, McNemar's test).

Comment

Many diagnostic labels that are used for symptoms unexplained by disease have the potential to offend patients. Although "medically unexplained" is scientifically neutral, it had surprisingly negative connotations for patients. Conversely, although doctors may think the term "functional" is pejorative,[6] patients did not perceive it as such. As expected, "hysterical" had such bad connotations that its continued use is hard to justify, although it is the only term in this list that specifically excludes malingering.

Diagnostic labels have to be not only helpful to doctors but also acceptable to patients. Many of the available labels did not pass this basic test, but "functional" (in its original sense of altered functioning of the nervous system[3]) did. This label has the advantage of avoiding the "non-diagnosis" of "medically unexplained" and side steps the unhelpful psychological versus physical dichotomy implied by many other labels. It also provides a rationale for pharmacological, behavioral, and psychological treatments aimed at restoring normal functioning of the nervous system.[4] We call for the rehabilitation of "functional" as a useful and acceptable diagnosis for physical symptoms unexplained by disease.

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RAPID RESPONSES FROM BMJ.COM

Following are edited excerpts from Rapid Responses generated by this article, which can be read in their entirety at http://bmj.com/cgi/eletters/325/7378/1449.
–Editor

Can't we deal with uncertainty?

Why can't we just say, "I'm terribly sorry but at the moment I don't know what's wrong with you"? Why can't we be honest and declare that the cause of the symptoms isn't clear? Honesty will not offend half as much as using terms with meanings likely to be misinterpreted—and which stop us from looking, or send us in the wrong direction. Some of my fellow mental health professionals find it hard to deal with uncertainty. It's actually quite a primitive response and something which deserves further attention. In essence, we can either admit to not knowing, or guess. To rely on words like 'functional' generally says more about us than about the patient's problems. It's better that we learn to deal with feelings of inadequacy and not give our patients misleading labels and inappropriate advice.

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Perpetuating ignorance

When a label applied to an individual or group we don't like causes offense, we invent a euphemism to replace it. This will serve us until the euphemism itself becomes offensive, whereupon we must invent the next euphemism, and so on. However it's not the euphemistic term itself that is offensive, it is the murky concept continuing to lurk behind it.

In this article the authors seek to re-euphemize "hysteria" with "functional," but the shabby concept remains, and in time the term "functional" will cause just as much offense. Witness how their most recent version, "medically unexplained symptoms" failed to stick and became offensive in record time.

They say that one way to reduce your prejudices against a group or individual you dislike is to become thoroughly familiar with your subject. In most instances you will then discover that they do not conform to the stereotype and that your concept of them was just plain wrong. No doubt many can bring to mind at least one acquaintance who has received a psychiatric label, and who has wasted valuable time before finding an accurate diagnosis.

Seeking to persuade physicians to accept your latest euphemism will mean that even fewer stones are turned for individuals who are up against chronic and badly researched illnesses. Thus, ignorance about these diseases will persist, and when your latest euphemism in time becomes transparent, doctor-patient relationships will be further damaged by the deceit involved.

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The need for history (and epistemology) lessons

I think if the *BMJ* is going to publish papers like this, it should also publish information about the history of "medically unexplained symptoms" and how patients of many currently recognized diseases would have been told in the past that their symptoms were "medically unexplained" or "hysterical" (eg, patients with multiple sclerosis, formerly known as "hysterical paralysis" up to a few decades ago). Overconfidence in medical professionals of the day meant that many patients suffering from diseases we recognize today were exposed to inappropriate psychiatric treatment and lack of support from families, the medical profession, and society in general.

The history of currently recognized conditions and how they were characterized in the past, often based on psy-

chological speculation, should remind people not to be overconfident that "modern medicine" (as each generation calls its medical knowledge) can easily distinguish between diseases and "non-diseases." Sometimes medical technology of the time can pick up physical abnormalities in patients and groups of patients, but the (psychological) speculation of doctors can be more influential.

Information about the changes in medical views over the years could also be given to medical students so that future generations are not left as overconfident about the ability to "know" things as some of the current medical profession. Lessons in epistemology might also be useful. Then, some doctors might be more willing to think that it is acceptable to think (and say), "I don't know what is wrong with this patient" rather than feel that their medical training encourages them to conclude that "this patient's symptoms are functional/hysterical/all in the mind" (or whatever euphemism is in fashion at the time).

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No brainer

The answer to the authors' question ("What should we say .....") lies in the fact that we have an incomplete understanding of human biology. Implicit in their question is the notion that understanding is complete within the mind of the doctor. The arrogance of this position is beyond belief. Patients who present with inexplicable physical symptoms are clearly suffering: Why else would they bother seeking medical help? They clearly have a "disease" or sense of unease with regard to some aspect of their bodily or psychological functioning.

The challenge for physicians is to examine their preconceptions, be prepared to accept that they have an incomplete understanding of the human condition, and confess this to patients. This has the dual benefit of "empowering" patients and allowing physicians to move their thinking along in terms of their understanding of mental and physical disease.

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The number offended

I am surprised by the bitterness of the Rapid Responses. The problem is real. When I have taken a full history from child and parent, performed a full physical examination and reviewed the results of appropriate tests available to me, in some cases there is still no clear diagnosis. I need to know how to communicate this to my patient while maintaining a therapeutic alliance. The article clearly indicates the words not to use and attempts to find something better.

For what it is worth, I usually start by acknowledging the real and distressing nature of the symptoms. I use words like "His headaches are very real, he is not imagining them, and he is certainly not putting them on ...." I then review the lack of physical findings, using positive statements such as "There is nothing on the history or my examination to suggest a sinister cause at this stage." I review test results in a similar way, pointing out that "negative tests" and normal images are good things, not defeats. I admit that although I have no diagnosis it will be important to review the situation again, and I ask the patient if they have any further ideas as to cause or treatments that might be useful. Finally, I admit that "I know of no other investigations that are likely to help us at this stage."

Does this approach work? Not often. Perhaps your responders could tell me why not. Sometimes my cynical side surfaces and I think the magic words might well be "Next please ...."

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Extra vigilance required

While working as anesthesiologists and intensive care specialists over the past few years, and in talking to our colleagues around the world, we have noticed that extra vigilance and attention is required when our surgical colleagues voice certain concerns or comments. The list below is a compilation of those comments.

You know you should worry when the surgeon says:

1. She is 91 but otherwise healthy.
2. This will take me two minutes. I'll just be in and out.
3. He was initially admitted to the medical service.
4. Just give him a quick general anesthetic.
5. There is no need to intubate him; just put in an LMA.
6. I need lots more relaxation.
7. Can you show me that computed tomogram one more time?
8. Are you sure you white balanced the scope?
9. This aorta is like paper.
10. How many units did you type and cross?
11. You are not using nitrous oxide, are you?
12. Get me some suction that works.
13. Do we have that fibrin glue stuff?
14. These scissors are blunt.
15. This is not surgical bleeding . . . are the blood products here yet?
16. The intern will be closing.
17. It must be mostly irrigation. There is no way I lost so much blood.
18. I think we should start broad spectrum antibiotics.
19. What do you mean she received 5 liters of crystalloid?
20. Let's start some renal dose dopamine.
21. She needs a PA catheter STAT!
22. Do not feed him quite yet.
23. The anastomosis is fine, but just to be sure, keep the BP below 150.
24. Just keep him in the intensive care unit one more day.
25. In my personal experience . . .

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