knock on the door, walk in, smile and survey the room. It’s a pediatric visit. Both parents are seated; the child, a 7-year-old boy, lies in his mother’s lap. I have already perused the chart and saw the red flags: a series of recent ER visits. A strange series of lab tests—Lyme titers, surveys for Kawasaki disease, a Mono-spot—all with negative results. Seemingly random imaging tests.

I begin by taking a history, which evokes only a series of non sequiturs and logical perambulations. The timeline is difficult to construct. I find myself at times unable to understand even what the chief complaint is—the current presentation (fever, an old scalp abrasion, a sore throat) or this strange notion of chronicity. It’s as if all the random minor illnesses common in childhood were part of a larger syndrome that threatens to kill their child at any possible moment.

The mother hands me a folder containing printouts from all their visits since birth. It has the breadth and haphazard-ness of a cold-case file. I read a few of them—benign finding by an ophthalmologist, the seemingly bemused meditations of an ER doc. As much as I want to leave the room feeling reassured the child is perfectly fine, I sit at my desk, staring at a spot on the wall, running through my rather short medical student’s repository of knowledge.

That evening, still puzzled by the case, I peruse UpToDate for more than two hours, searching terms such as “recurrent fevers” and “Bell’s palsy.” With a patient like this, you are faced with one of two possibilities: “paranoid parents” or “Am I missing something?” As medical students, we hear both of these phrases used in practice. In fact, I heard a doctor call this boy’s parents “nice people, but a bit … you know …” the day of their visit, and two days later describe the time he nearly missed a serious diagnosis in a history that seemed perfectly benign.
I keep returning to the room. I check the boy’s skin. I check his eyes. I complete the physical exam to the best of my ability. I read some more. I repeat the tests looking for new findings. I ask the parents for more history. And still, nothing. I can’t even feel confident that the findings they report at home have actually happened. It’s clear that the kid has a minor illness today, but might it be related to something larger?

The word “diagnosis” embodies this internal tension. The etymological roots *dia* (meaning “apart”) and *gignoskein* (meaning “to learn”) suggest that we can pry apart our patients’ histories and physicals to truly “know” the nature of their disease and give it a label. A label has power. (Why else create ones such as “idiopathic?”) It gives certainty even to things that seem—if not implicitly, at least by current standards—grey.

A label has power. It gives certainty even to things that seem—if not implicitly, at least by current standards—grey. As I walk the family out of the exam room, I fumble awkwardly to give them the semblance of an answer. To “know” whether this is pattern or coincidence. To prognosticate so they know what to expect. But there is no certainty here. I am left grasping and say things I’ve heard more practiced physicians often say: “We’ll let you know when we get the lab results back.” “I’ll keep researching to see what else I can learn.” “It may be nothing at all. Let’s see how things play out.”

In private, I wonder: Would I join a chorus I have heard so many others fall back on? “They’re crazy.” “He’s probably healthy.” “I think they’re just making all of this up.” No one likes a cold-case file. We would all much rather have a label for our patients or their families.

To be honest, I don’t know which I would have chosen for this young man and his parents. I think of his case often. It remains unresolved. I find something truly unsatisfactory about that.

Dreaded diagnosis? I dread finding no diagnosis at all.

Patrick Boland is in his third year at the University of Minnesota Medical School.

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