PART ONE

SYMPTOMS, SIGNS, SYNDROMES, AND ILLNESS

The Path to Understanding Why You Feel Sick

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You, Your Symptoms, and Your Doctor

Sarah Jones, a thirty-four-year-old married lawyer with no children and a busy professional and social life, visited my office complaining of progressive fatigue. Her lack of energy had become so severe that she was forced to cut way back on her activities. Yet, because she'd always seemed so full of nervous energy, Mrs. Jones's doctor dismissed her complaints, telling her she was just a worrier who focused too much on how she felt. Simply put, there was "nothing wrong" with her.

Symptoms, Illness, and Disease

When you don't feel well, it's normal to worry about what might be wrong. When the connection is clear and the problem not so bad, you may cope with the problem by yourself. For example, if your ankle becomes swollen and painful after you take a misstep and twist it, you might try to treat it yourself by putting on an elastic bandage and taking some ibuprofen. But if it hurts to stand on the ankle and you fear that the problem is worse than a minor twist, you may decide that you need medical care and go to see a doctor. The moment you seek medical care, you become a patient.

Some of the things that make people seek medical attention are fairly typical, while others are unique to specific personal

characteristics. Seeking medical help if you're well one moment and in obvious trouble the next—for instance, if a bloody nose fails to stop bleeding or abdominal cramps go from trivial to awful in the course of a few hours—is a no-brainer. But when problems develop gradually, all bets are off. When I was a medical intern, I was called to the emergency room to admit a sixty-year-old woman with a seventy-five-inch waist. Why, I asked, did the family wait until that day to bring her in for medical attention. The answer was simple: "She got so big she could not get out of bed by herself." The medical evaluation was completed in a day or two and revealed an enormous ovarian tumor.

You'll probably find the family's answer to my question jarring. I know I did. How, you will ask, could the patient and her family not have known that something was wrong? The answer is that illness recognition and the decision to seek medical help are very personal issues. Medical sociologists have made this a point for study. Low socioeconomic status and poverty are two factors preventing many people from seeking medical attention until they can no longer get to their feet. Gender is another factor. The popular medical press is full of stories of men attributing their crushing chest pain to indigestion, often with fatal consequences. Women, statistics show, are more health conscious, more attuned to their bodies, and more willing to ask professional opinions about why they feel the way they do.

The question of who seeks medical attention, and when, gets murkier when an individual just feels lousy. Symptoms are the sensations that make a person feel unwell; they may bother, annoy, or hurt you. Neither the person with the bloody nose nor the woman with the enormous girth had any symptoms; instead, they had obvious abnormalities. When a person goes to the doctor feeling unwell, she reports how she feels to the doctor. The doctor then examines the patient and tries to find abnormalities that would indicate some underlying disease process. These are signs. So bleeding from the nose or having an enormous waist circumference are signs of a medical problem. For example, the patient with the twisted ankle will complain of the symptom of pain and the doctor will detect signs of the traumatic event, in the form of

swelling and an area of black-and-blue skin reflecting a hemorrhage beneath the skin.

With the nose bleed, there really are no symptoms, just the evidence of blood coming from the nose. If the hemorrhage were in the stomach and not in the nose, the patient might eventually develop the symptom of lightheadedness when he or she stood up. This would occur because the gradual loss of blood into the stomach would reduce the volume of blood in the circulation, leaving insufficient blood for the brain at the moment the person stood up. Here the doctor would have to find the sign of underlying disease—either pressure-induced tenderness in the stomach suggestive of an ulcer or a positive test for blood in the stool.

When the doctor can connect the symptom with some sign, he or she is on the way to the diagnosis of a disease. If an otherwise well, middle-aged woman complains to her doctor of dizziness when she stands and a feeling of gnawing pain in her abdomen after eating, the doctor may think of the possibility of a bleeding ulcer. Finding blood in the stool makes the doctor quite sure of the diagnosis. But in order to clinch the diagnosis, the doctor will have to order a test to visualize the gut, either by X-ray or by direct observation using a flexible tool called an endoscope. When the ulcer is seen, the logic chain ends with a diagnosis: a bleeding ulcer.

One way of understanding what is meant by the term *disease* is to think of it as an all-or-nothing idea: either you have a disease or you don't. A healthy person would not have a touch of cancer; instead, the person goes from being healthy to having cancer. Although this is a bit of a simplification—precancerous conditions do indeed exist and are common—this all-or-nothing idea still helps us to understand the difference between disease and illness. In the greater scheme of things, disease is uncommon, while illness is extremely common. When a person has symptoms, she feels ill; that is, she has an illness. So while you probably have no idea what it is like to experience cancer, you have certainly experienced symptoms like pain that was there one day and not another. A temporary headache or a bellyache is a symptom, and so is severe, exhausting fatigue.

Sometimes, symptoms can be explained easily; maybe you partied too much the night before you experienced feelings of achiness or of exhaustion. Going to bed very late while still waking up at 7 a.m. is a common cause of fatigue. A day of vigorous physical activity without months of preparation at the gym is another common cause of achiness and fatigue. That's what bed rest and aspirin are for. But when your symptoms go on and on for days and the doctor finds no signs, the health-care system often begins to fail the patient. And two of the symptoms that often appear in the total absence of clear signs of disease are fatigue and pain. These are symptoms that everyone has experienced at one time or another, usually with an appropriate cause. But when a person develops fatigue or pain nearly everywhere in her body, and the doctor can find no obvious medical cause—even if the fatigue is bone-crushing or the pain is widespread—the doctor may be inclined to dismiss the patient's symptoms as "all in her head."

Sad to say, this problem is extremely common. One study evaluated the records of 1,000 patients in an internal medicine clinic over a three-year period. Complaints of pain and fatigue producing real problems for the patient were incredibly common. Although expensive diagnostic testing was usually done, a diagnosable cause or disease was identified in only 16 percent of cases. These medically unexplained symptoms and their most serious manifestation as medically unexplained illnesses are to a large degree a problem in women's health. And medical school usually does nothing to prepare doctors to help you with this problem. If you're going to get well, you'll need to take your health into your own hands.

The Doctor-Patient Relationship

All too often during an office visit, both patient and doctor think they're on the same page when in reality they're reading different books. For simple health problems, like a broken finger or a sore throat with a fever and swollen glands, communication between doctor and patient is usually fine. But when the patient simply does not feel "right" or is unsure of just what's bothering him or

her, the doctor visit can prove unsatisfying. The reason is twofold: the way the doctor is taught to think, and changes in American society that influence how patients talk to doctors. Neither of these, of course, has anything to do with the way the patient is really feeling.

Doctor-patient relationships may be in a state of flux for a number of reasons, but the way physicians are trained hasn't changed much in recent years. So let's start with the way patients and doctors talk and listen to each other. People go to the doctor when they're unable to answer their health concerns by themselves. Since patients see doctors as experts, their relationship assumes a certain traditional, hierarchical quality: the doctor is in charge; the patient is there to listen. We can see this in the way that visits to the doctor usually proceed. The doctor controls the patient interview and rarely leaves time for the patient to voice all of his or her concerns.

While this scenario is often followed even today, education and the Internet have begun changing the doctor-patient relationship. A few years ago, a fifty-two-year-old pilot went for his annual physical exam and had his blood checked for prostate-specific antigen (PSA) levels. Although standard medical texts (and insurance companies) do not endorse using PSA as a screen for prostate cancer, it is well known that patients with prostate cancer often have elevated levels of PSA. So when the pilot's PSA rose from normal levels of 1.1 and 1.6 in prior years to 3.9, he became concerned. His doctor told him not to worry since the levels still were within normal limits, but the pilot said he wanted his prostate gland biopsied. This was done, and a tiny area of malignancy was found. When it came time to determine what to do about this cancer, the pilot was better informed than the doctor. And perhaps not surprisingly, more recent information indicates that prostate cancer is not a rare occurrence even with low levels of PSA; the pilot was right to be concerned about the change in his levels. As we all know, medical knowledge is always evolving, for doctors as well as for patients. What is fact today might not be correct tomorrow.

Such stories are not unusual in this era of easy access to medical knowledge. Even though I consider myself an expert in my field,

it's not unusual for one of my patients to tell me about a new study on medically unexplained fatigue or pain about which I was unaware. Access to information and knowledge empowers the patient and often makes her more demanding of the doctor, who is bound to notice. The well-informed patient wants to be treated more as an equal rather than in the usual role of someone who asks for advice and then is expected to take it. But despite the American public's growing interest in medicine, most elements of the traditional doctor-patient relationship remain unchanged. For example, I always address my patients as Mr. or Ms. and never use their first names. Very often, a patient will ask me to use his or her first name. Many doctors will do so, but I prefer not to. I explain to my patients that I can't use their first names because I wouldn't want them to use mine. Strange as it may seem, being Dr. Natelson carries magic with it that may lead to better outcomes for my patients than we'd see if I were Benjamin to them. Later in this book, I'll explain how positive beliefs can be health enhancing while negative beliefs can make a sick person sicker.

But even when a physician makes major efforts to understand the patient's concerns, beliefs, and opinions about his or her health—and strives to communicate clearly back to the patient—it is amazing just how often doctor and patient really are not on the same page. During my own office visits, the last thing I do is to go over the plan of treatment with my patient, listening to any questions or concerns he or she may have and doing everything possible to make sure that he or she understands how we'll be proceeding. I carefully note my recommendations on the patient's chart so I can check on his or her progress at the next office visit.

But things don't always go as planned. Although people often agree to try a medicine or to see a recommended consultant, when they return to see me I'm often surprised by what they did (or did not do). Some tell me they either did not try the medicine or took it only once with horrible side effects, or decided that the consultant I suggested was just too far away for convenience. Of course, if the patient had called me, I might have been able to intervene more quickly, perhaps adjusting the dosage of the medication

or explaining why a visit to the specialist was so important. But regardless, it becomes clear that a disconnect has developed despite our best attempts to communicate, and the goal at a follow-up visit is to fix this. Very often, this means less prescribing (I leave that for when we're communicating better), and a greater effort to understand how the patient copes with his or her illness.

If a patient decides not to follow my advice, I assume that he or she wasn't completely satisfied with the visit. I tell myself I must work harder to understand how the patient is feeling in order to get into agreement about how to proceed. So I encourage the patient to feel empowered and tell me at the end of our time together if we haven't covered everything that's still troubling him or her. Although this doesn't always solve the problem, it does acknowledge that there's still work to be done, that I'm trying to understand what my patient is saying, and that the patient, too, may be trying to reach a clearer understanding of my recommendations and the reasons I reached them. Doctors and patients have a lot to tell each other, especially when the patient has a clear sense of his or her symptoms but the doctor hasn't been able to identify the signs of a clearly defined disease. It's important for me to learn what the patient thinks is causing the problem. Sometimes there is a huge difference between what I think the patient is thinking and what's actually going on in his or her mind.

None of this may seem revolutionary, but it's a departure from the usual relationship between physicians and patients, where the doctor is in charge and the patient follows "doctor's orders." And, in fact, all of this flies in the face of our medical training, which teaches us to figure out the patient's chief complaint as quickly as possible, so that a diagnosis can reached. How quickly? Amazingly, one study reported that, on average, doctors listen to their patients for only eighteen seconds before jumping in and taking over the direction of the conversation. This means that patients had better know just what is bothering them, and they had better communicate it to their doctor very quickly. That's a lot to ask of the patient under any circumstance; when the patient is having a hard time describing the symptoms, it sets up an almost impossible situation for doctor and patient alike.

A number of my patients are veterans of the first Persian Gulf war, and many of them experience severe, medically unexplained fatigue. Many of these vets believe they got sick due to some exposure they experienced while on military duty, or perhaps to a vaccination they had to have for their military service. Although there is little evidence to support their beliefs, I don't tell them they are wrong, because we may never really know what triggered their illness. Being dismissive of a vet's deeply held conviction before our discussion has really gotten under way is less important than listening and setting up the groundwork for real two-way communication. So I don't worry about cause but instead focus on the symptoms themselves, remembering that the symptoms are certainly very real.

If I took the other tack and simply told the Gulf war veteran that his or her assumptions were wrong, that first visit would probably be the last. If the doctor is insensitive to the discrepancy between his or her take and that of the patient, the doctor will find the patient uncooperative and perhaps angry, and the patient will feel as if the doctor does not care or understand why he or she is there. Obviously with such a negative experience, the patient will never return. That's not what a good doctor wants to have happen.

Doctors have begun studying just how well they communicate with their patients. One study was done on 565 patients who had general medical examinations, or GMEs, at the famous Mayo Clinic in Rochester, Minnesota. Although doctors are under a great deal of pressure to reduce the amount of time they spend with patients, they usually devote up to an hour to GMEs, since they are often done on new patients or on patients who haven't visited for an extended period. The researchers studied how often the doctor and the patient agreed on the reason for the office visit. They found that agreement was high in 80 percent of the visits, but low in the remaining 20 percent. Three factors were predictive of poor agreement between patient and doctor: when the patient was a woman; when the patient had more than one reason for seeing the doctor; and when the doctor knew the patient from a previous visit. If you're reading this book, chances are you fit into one

or more of these categories. You can see why finding yourself on the same page as your doctor and reaching a coherent diagnosis and treatment plan may have eluded you for so long.

The Doctor-Patient Disconnect

During a visit, the doctor is looking for simple and straightforward explanations, but you and your problem may not fall into that category, and your physician's training may not help when the cause is unclear or you're experiencing more than one problem—for example, fatigue and pain at the same time. The kinds of problems that perplex doctors are not uncommon. Complaints like lower back pain, fatigue, dizziness, and abdominal pain are all among the top twenty-five reasons that patients set up an appointment for either an initial physician consultation or an annual checkup. How does the average doctor deal with patients whose symptoms are hard to explain?

Unfortunately not too well, and the problem is worse when the doctor is a man rather than a woman. The doctor will be aware of an extensive psychiatric literature labeling patients with unexplained symptoms as "somatizers" or "hypochondriacs." We'll discuss these labels in more detail later, but they've been around long enough to cause many generalists, family doctors, and internists to apply them in all too many cases. You see your symptoms as real; your doctor looks skeptical and makes a mental note that you're a "crock" or a complainer. Your doctor becomes dismissive, saying that he can't find anything wrong with you, that there is nothing he can do for you, or that your problem is "all in your head." He might tell you just to grin and bear it or even refer you to a psychiatrist. Certainly, he thinks there's "nothing wrong."

By dismissing you and, in essence, telling you to take care of yourself, the doctor is abrogating his job. If you're like most patients facing unexplained illness, you'll respond by becoming even more anxious to get an answer, so you'll make another appointment or decide to find another doctor. This vicious cycle often continues until you find a doctor who will listen and attend to your complaints. And what if you can't? In my experience, it is

not uncommon to learn that the patient turned toward some form of alternative medicine—chiropractic, naturopathy, homeopathy, or the like—to find someone who would listen and try to help. I will share my thoughts concerning some of these alternatives with you in chapter 10.

Your original doctor not only hasn't done his job, he's risked letting things get worse by leaving you to fend for yourself. That physician either has no appreciation for how medicine progresses or for what a doctor's responsibility really is. And sadly, I see the roots of this phenomenon all the time when I try to teach these important lessons to new medical students.

Have you ever heard of dropsy? Don't be too hard on yourself if you haven't. When I make clinical rounds with fourth-year medical students—a few short months before they attain their M.D.'s—I ask them if they've ever heard this word. Only the rare student replies yes. Dropsy, in fact, is a diagnosis never made in the twenty-first century. But in the eighteenth century, dropsy was a household word. Whenever a physician saw a patient who had swelling in the feet and lower legs and whose breath gave out after minimal exertion, he would make the diagnosis of dropsy. Then, in the middle of the eighteenth century, British physicians started doing autopsies and learned that diseases in many organs could produce the same set of signs and symptoms. Although the name "dropsy" didn't disappear from medical textbooks overnight, eventually laboratory tests were developed to pinpoint the actual causes of disease in different organs. Blood tests identified kidney and liver disease, and X-rays heart disease. Patients with sick hearts that could not pump adequately often had swelling of the legs and complained of shortness of breath when they walked. What had once been labeled "dropsy" could now be attributed to congestive heart failure or some other specific disease. So dropsy became a quaint term from yesteryear. Today we know the myriad things that can lead to a failing heart: infection, coronary artery disease, toxins, and so on. The challenge for tomorrow's researchers is to understand the causative factors in order to identify an "etiologic disease entity": a definite disease with a definite cause.

Sometimes when we don't yet understand the direct cause of a certain set of symptoms, we nonetheless realize that the same symptoms repeat themselves over and over in thousands of patients. We call these identifiable sets of symptoms "syndromes." Fibromyalgia, one of the conditions we'll look at in this book, is a syndrome. Giving a name to a set of symptoms is a major step forward for two reasons: it stops the patient's search for a diagnosis while providing a framework for research, even though we don't yet know enough about its causes to make a definitive judgment (although, as we'll see later in this book, we're beginning to know a lot more). It's safe to say, though, that when no biomedical marker exists for a syndrome, doctors are sometimes too willing to attribute it to psychological factors.

A splendid example of this phenomenon is a syndrome called *torsion dystonia*. This illness, which occurs predominantly in Ashkenazic Jews, causes certain muscle groups to twist into weird-appearing shapes, causing odd, disabling movements. In the heyday of psychoanalysis, patients with torsion dystonia received hundreds of sessions of intensive psychoanalysis with no positive results. Their symptoms failed to lessen. With more intensive scrutiny, researchers learned that torsion dystonia occurred in population groups besides Ashkenazic Jews. Although no biomedical marker was ever discovered to diagnose this disorder, medical progress was finally able to identify an irregular genetic mechanism for this abnormality that was passed from parents to children.

Similarly, when I was a medical student, schizophrenia was thought to be a psychological disorder. Slowly the pendulum of medical opinion has swung to the other extreme: although there is no specific diagnostic test for schizophrenia, the illness is thought to be due to a disease of the brain, and patients with schizophrenia of long duration are known to develop evidence of chronic brain disease in the form of loss of brain tissue, or atrophy. Using advanced computer techniques, researchers at the University of Pennsylvania are developing methods to add up these defects to an actual diagnosis. Even migraine headaches are a syndrome. We don't know what causes them, although we've begun to identify

more of their characteristics. But at least we've learned enough to develop drugs that can nip a migraine attack in the bud.

When medicines that don't affect psychiatric status achieve positive results in an illness, physicians can see that the symptoms are not "all in your head." Instead, physical abnormalities must be making the patient ill, without necessarily providing the concrete signs that would enable a doctor to diagnose a specific disease. So the "crock" patient is not a crock. The illness isn't made up, but really exists—just not in a form with which doctors are comfortable.

In time, the medical profession should come to understand more of these hard-to-diagnose syndromes, providing a template for medically unexplained illness: chronic fatigue syndrome (CFS), fibromyalgia (FM), irritable bowel syndrome (IBS), and others. For some people the cause may be psychological, but not for others. And regardless of what is causing these ailments, people with these symptoms will still be suffering and in need of treatment. As I will make clear throughout this book, helping patients deal with suffering is the job of the doctor.

How Medicine Is Organized

So let's return to the doctor-patient disconnect: the idea that your physician's preconceived notions may be getting in the way of his or her ability to treat you. Unlike surgeons—who are trained to carry out specific procedures that cure people (or, at least, dramatically reverse a disease)—most physicians aren't procedure-driven but *patient*-driven. Their job is to identify and understand the problems affecting the health of their patients and then help both the patient and the patient's family cope with the problem. The number of diseases that a physician can cure remains terribly small, limited for the most part to infections, vitamin deficiencies, and the rare cancer. Thus instead of curing, the physician must be satisfied with caring, and with reducing the suffering and loss of quality of life produced by a patient's symptoms. Your job as a patient is to find a physician who understands that this is his or her job. Such a physician will not reject you because you are "difficult" or because he or she does not understand your problem.

Finding such a doctor is not simple, however. The doctor with a new MD degree may be initially idealistic and understand the nature of the job. But life intervenes. The doctor finds the demands on time to be so great that he or she can't "afford" the time to listen to patients. And those demands are only getting worse, since the medical practice is now managed by businesspeople who require delivery of more services in less time. In today's environment, even many idealistic young doctors begin to prefer "easy" patients to "difficult" ones. I've seen this unfortunate transformation in some of my younger colleagues.

Part of my practice has to do with clinical immunology, and I have tried repeatedly over the years to enlist a colleague—a talented allergist and clinical immunologist—to join me in my practice. He says, "Why would I want to do that? Your patients are really hard!" In contrast, his are easy. A twenty-eight-year-old woman with horrible hay fever comes into his office with her nose stuffed and her eyes teary. In ten minutes my friend can arrive at a diagnosis and recommend treatment. In two days, the patient is completely free of symptoms. Contrast that clinical anecdote with the forty-four-year-old woman who comes to her doctor complaining of horrible fatigue. When all the lab tests come back normal, her doctor is stuck. Yes, he can continue to do tests, but these could *all* turn out to be normal. Instead, he tries to send her on her way, even though he knows he's failed to deliver for his patient. Failure is always uncomfortable, and so it is easy to understand why this doctor might not want to see this patient again.

Remember the Mayo Clinic study we discussed earlier? What it really tells us is that "complicated" patients aren't all that unusual. Yes, 80 percent of the patients evaluated reported that they and their doctors agreed on the reasons for the office visit. But what about the remaining 20 percent? One recent medical paper concluded that a critically important task for twenty-first-century internists is to actively take on the health concerns of such patients and to be aware that in some clinics—especially those dealing with neurological and gynecological problems—caring for these complicated patients "constitutes the majority of the work." It is about them that I lecture my students. Doctors have not gone to medical

school to diagnose and treat only sore throats or mild hypertension. Their own physicians' assistants can easily do this, with far less training. We doctors have learned all the material we have been taught so that we can take on difficult problems: operate on the brain tumor that looks like a killer and help the patient who has illness but not disease.

So what happens to you when you are in the doctor's office? If you find yourself speaking to a physician who either doesn't listen or cuts you off after listening for only a few seconds, you too have seen a symptom: your doctor is exhibiting what I call the three Bs—brash, boorish, and overbearing. This doctor will not be of much help to you.

Finding the appropriate doctor is often difficult, but you have the right to a physician who listens, takes you seriously, and tries to help. For whom should you look? For starters, try to find a doctor trained in family practice. These doctors are the closest to the general practitioners of yesterday. In contrast to specialists who have to be expert in a tiny part of the body, the family practitioner is a generalist and has extensive training in marrying the principles of psychiatry to those of medicine. The broad training of such doctors makes it less likely that you'll find yourself cut off in midsentence as you describe your symptoms.

Another way to reduce the chances of getting a doctor with the three Bs is to turn to a female physician. It's actually been shown that male doctors tend to be more dismissive of unexplained symptoms than female doctors. We did an early study in which patients with CFS reported feeling stigmatized by male doctors more so than by female doctors. In addition, female physicians are usually better listeners than their male colleagues. Moreover, female doctors are much less dismissive of complaints when test results come back negative. So a female family practitioner could be the best bet for someone who has symptoms for which the doctor can find no cause.

Finding a sympathetic and caring female physician, however, is partly a matter of geography. California has the highest percentage of female physicians—12 percent of the country's total. After California, there are seven states with high numbers of female physicians—New York, Texas, Illinois, Pennsylvania, Massachusetts,

Florida, and New Jersey. Female physicians in those states make up an additional 39 percent of the total for the entire country. So if you live in one of these eight states, you may have an easier time finding a female physician than you'd have in one of the other forty-two states. But with more and more women entering medical school, these numbers will improve in the near future.

I've laid out some of the reasons for doctors' inability or unwillingness to communicate not to scare you, but to show you why you need to be careful not to fall through the cracks of orthodox medicine. If you already find yourself in this situation, I hope you'll see that your frustrations *do* make sense and *shouldn't* be dismissed. Understanding the reasons why these cracks exist should empower you to find a doctor who can help you with your health problems. And understanding what modern medicine knows about these syndromes—clinical disease entities characterized by widespread pain, bone-crushing fatigue, and difficulty with attention and concentration—should help you cope better, too.

Tips on Choosing a Doctor

A couple of things will naturally help you communicate with your doctor. If you have been seeing the same doctor for a period of time, you will have developed a relationship. That helps. The opposite of this is going to an emergency room or to an urgicare center ("doc-in-a-box"). These doctors do not have time to take care of anyone who has an illness more complicated than a sore throat or a sprained ankle. Doctors in academic centers often have surprisingly large amounts of time to devote, especially to people with complicated or hard-to-diagnose disorders. So if you have been ignored by one doctor too many, try to find a doctor in a medical school. And again, you will probably feel more comfortable with a female doctor.

Where Do We Go Next?

Up to this point, I just wanted to set the stage and give you some answers to why you have felt so frustrated in trying to find out

why you feel so lousy. The major thing I have done thus far is to give you some ground rules to help you find a doctor who does not have the three Bs. Some of you may have gotten to the end of this chapter and are thinking: "But I've looked all over for a doctor who will help me, and I've had no success." What then? Well, basically, that's the rest of this book.

In the first part of this book, I am going to show you how I take care of a patient new to my practice. First I listen, then I think about that specific patient's story. Then I do a set of diagnostic tests that I will detail for you in the next chapter. The results of that testing allow me to make a diagnosis, usually a syndrome. Just getting a diagnosis is often a relief. No more "nothing wrong." But it is not just the need for a diagnosis that drives many to keep searching; it is the relief that comes with being listened to and being understood.

Let me be clear: I don't want you to act as your own doctor, but I do want you to be informed. Furthermore, I want you to understand the best of what is available for you and your symptoms. My goal is to lay out a strategy for wellness that you can share with your doctor.