Hickam Dictum

Idea In Short

Do not force every finding into one diagnosis when the evidence points to more than one process. Hickam Dictum is a practical counterweight to overzealous diagnostic parsimony: patients may have multiple simultaneous diseases and clinicians should continue investigating material findings that a favored diagnosis does not explain. The dictum matters most when a seemingly coherent diagnosis creates false confidence, particularly in older patients, patients with substantial comorbidity, or cases where time course, probability and causation do not align. It does not license indiscriminate testing or a long list of disconnected labels. It requires disciplined reassessment: establish the primary diagnosis, test whether it truly explains the presentation, then distinguish related conditions, pre-existing disease, incidental findings and genuinely independent pathology. The operating principle is simple: pursue unity where evidence supports it, but do not mistake simplicity for truth

Hickam Dictum is a corrective against a seductive diagnostic error: finding one plausible explanation and then treating every remaining inconsistency as noise. The aphorism is deliberately blunt, but its operational purpose is precise. A patient can have several conditions at once and a diagnosis should not become so elegant that it stops reflecting the evidence. In clinical practice, the dictum is most useful not as a license to multiply diagnoses, but as a safeguard against ignoring material findings that do not fit.

The dictum in context

Hickam Dictum is commonly stated as: patients can have as many diseases as they damn well please. It is generally presented as a counterweight to the medical use of Occam's razor, which favors a single unifying explanation when competing explanations are otherwise comparable1. The dictum is associated with John B. Hickam, although the provenance of the exact phrase is not fully settled2.

The wording matters because it resists a common habit of clinical reasoning. A coherent narrative can feel like proof. Once a clinician identifies one condition that explains several signs or symptoms, remaining anomalies may be recast as atypical manifestations, measurement error, or irrelevant background. Hickam Dictum interrupts that move. It asks whether the diagnosis actually explains the evidence, rather than whether it merely provides a satisfying story.

The dictum does not oppose parsimony in principle. It opposes forcing parsimony after the evidence has stopped supporting it. That difference protects against a form of diagnostic overconfidence that becomes more dangerous as patients accumulate age-related disease, treatment effects and overlapping pathology.

The tension with Occam's razor

Occam's razor is useful because medicine can generate an almost unlimited number of possible explanations. A single condition that accounts for the time course, symptoms, examination and tests is often more likely than several unrelated conditions assembled merely to preserve a favorite hypothesis. Clinical reasoning therefore needs a bias toward coherence.

Hickam Dictum introduces the necessary boundary condition. Coherence is not the same as completeness. A patient with pneumonia may also have atrial fibrillation. A person with an established autoimmune disease may develop an infection that produces a second, different pattern of symptoms. A diagnosis can be real and still be insufficient. Clinical discussions of the two maxims describe this relationship as a tension between diagnostic parsimony and the possibility of multiple simultaneous processes3.

The practical challenge is not choosing one maxim permanently. It is knowing when the current explanatory model has become too narrow. That requires attention to findings that remain unexplained, discordant, or temporally inconsistent with the leading diagnosis.

Why premature closure occurs

Premature closure occurs when a clinician accepts a diagnosis before verifying that it accounts for the clinically significant data. It is often reinforced by time pressure, pattern recognition, early test results and the relief that comes from converting ambiguity into a

plan. The first correct diagnosis can therefore become the source of the next error.

Hickam Dictum provides a cognitive forcing function. Once a working diagnosis is established, the clinician should ask which findings it leaves unexplained and whether those findings are clinically important. A symptom that began before the proposed disease, a laboratory abnormality that conflicts with the expected physiology, or a treatment response that fails to appear should trigger a reassessment. The task is not to generate a longer differential for its own sake. It is to protect the integrity of the causal model.

Case literature has framed Hickam Dictum as a reminder that diagnostic parsimony can fail when distinct diseases coexist in the same patient and when satisfaction of search causes clinicians to stop after the first plausible answer4. The aphorism keeps unexplained evidence visible after an appealing diagnosis enters the chart.

Multiple diagnoses are not random

A simplistic reading of Hickam Dictum assumes that multiple diagnoses are unrelated and equally likely. Current work suggests a more structured picture. In a 2024 analysis of multiple diagnoses, researchers found that the additional diagnoses often fell into categories: incidental findings, pre-existing disease, conditions causally linked to the primary diagnosis and only rarely a causally unrelated second disease contributing to the acute presentation5.

This matters because it replaces a false binary. Clinicians do not need to choose between one diagnosis for everything and an undisciplined collection of independent labels. They can model several diagnoses through time, probability and causation. A chronic condition may change the presentation of an acute disease. An intervention may generate a complication. A test may reveal an incidental finding that should be managed but does not explain the presenting complaint.

That framework improves both diagnostic accuracy and communication. It allows the team to say which condition is primary, which findings are related and which issues coexist without being causally central. The distinction prevents both underdiagnosis and needless fragmentation of the case.

A disciplined application

A clinician can apply Hickam Dictum through a sequence of focused questions:

1. What diagnosis best explains the acute presentation and highest-risk findings?
2. Which clinically material findings remain unexplained by that diagnosis?
3. Are those findings temporally linked, causally linked, pre-existing, incidental, or independent?
4. Would a second diagnosis change immediate treatment, prognosis, or disposition?
5. What new evidence would make the current explanation untenable?

This approach preserves the efficiency of parsimony while preventing it from becoming dogma. It also makes uncertainty explicit. Rather than asserting that every abnormality belongs to one condition, the team can state where evidence is strong, where a second process is plausible and what will resolve the uncertainty.

The distinction becomes particularly important in complex presentations. Atypical cases, multiple disease processes and unusual patient populations often lend themselves more to Hickam Dictum than to strict parsimony6.

Clinical communication and safety

The dictum also has implications beyond differential diagnosis. When clinicians document a case as one disease with unexplained exceptions, downstream teams may inherit the same narrow frame. The exceptions can then disappear during handoff, rounds, or discharge planning. Explicitly naming unresolved features keeps the diagnostic process open and reduces the chance that new data will be discounted.

Patients benefit when teams distinguish the primary problem from coexisting conditions rather than blending them into a vague composite. It clarifies why different treatments are necessary, which symptoms should prompt reassessment and which findings are being monitored rather than immediately treated. The result is a more accurate and more usable care plan.

At the same time, Hickam Dictum does not justify indiscriminate testing. Every additional test introduces false positives, incidental findings and downstream decisions. The point is not to search without limits. It is to investigate when the existing explanation cannot account for evidence that matters to safety, diagnosis, or treatment7.

A better diagnostic standard

The best diagnostic standard is neither maximal simplicity nor maximal complexity. It is explanatory adequacy. A strong model explains the important findings, accounts for their timing, fits the relevant probabilities and directs appropriate action. When one diagnosis meets that standard, parsimony is efficient. When it does not, Hickam Dictum protects against the temptation to preserve elegance at the expense of accuracy.

The dictum remains useful because patients do not organize their biology around a clinician's preference for a tidy narrative. Comorbidities, complications and incidental conditions coexist. A diagnostic process that can distinguish among them is more robust than one that demands a single answer from every presentation.

Hickam Dictum therefore works best as a disciplined challenge. After identifying a plausible diagnosis, ask what it fails to explain. If the unexplained findings are important, investigate them. If they are not, document why. That is how the dictum improves reasoning without turning complexity into an end in itself.

- 1Hickam's Dictum
- 2John Hickam
- 3Occam's Razor And Hickam's Dictum: A Dermatologic Perspective
- 4Hickam's Dictum
- 5Hickam's Dictum: An Analysis Of Multiple Diagnoses
- 6Hickam's Dictum, Occam's Razor And Crabtree's Bludgeon
- 7The Causes Of Vascular Insufficiency And Hickam Vs Ockham

Summary

Hickam Dictum earns its place in clinical reasoning because it checks a predictable error: premature closure after a plausible unifying diagnosis appears. Its force is not that every patient has many unrelated diseases. Multiple diagnoses often have causal links, represent known conditions, or prove incidental. The useful discipline is to explain each clinically material feature, maintain a time-aware differential and revisit the model when new evidence does not fit. Clinicians should use Occam's razor to avoid multiplying assumptions, then use

Hickam Dictum to avoid suppressing data that challenge the preferred explanation. The goal is neither maximal simplicity nor maximal complexity. It is a causal account that matches the patient, the evidence and the clinical stakes