The art of medicine

Free-floating anxiety

A 45-year-old woman complains of headache and "all over numbness". The machinery swings into action; she is admitted to my medical unit. "Her CT brain was clear on arrival", reports the intern. I have concluded that the history suggests a migraine. We look through a few CT slices and next discover a list of completely normal blood tests—from albumin and thyrotropin to cholesterol and HbA_{1C}. Several more samples of blood and urine await collection. "Someone did a thorough job", I say, hiding my dismay at the indiscriminate testing for a clinical diagnosis.

The resident is too busy ploughing through the results to notice. 'Shall we see the patient?', I ask. But what the resident passes me is the MRI. "She scored an MRI?", I ask incredulously. "Her numbness wasn't settling, so they did one." It is unclear who "they" are but the pictures look pristine. "Such clear views", I admire, rising from my chair. "There are four tiny T2 white matter lesions scattered through the brain, demyelination cannot be excluded", says the intern. It has taken us 25 minutes to trawl through the results of a patient I haven't yet laid eyes on. "We need to consider the clinical context", I reply.

Sensing my impatience, the resident says apologetically, "Do you want the carotid Doppler report?" I read the brief report that confirms normal results. We finally draw back the curtains. The patient, who is overweight and looks well, hangs up her cell-phone. "Finally, a specialist", she says. I don't tell her that she has seen a few so far. She tells me that she is divorced, works full-time as a carer, and has two children. Her job is stressful but she describes herself as being "super organised". She feels guilty about not spending enough time with the kids. "Like every normal mother", she shrugs. She places her index finger on a spot on her head. It hurts right there. And while she previously felt numb all over, now a straight line from head to toe divides the normal from the numb side. She is a bit dizzy. No, she hasn't experienced an aura. Recently, another hospital did an MRI but unsuccessfully tried to reach a diagnosis. The leg doesn't feel normal. Sitting feels odd. Her neurological examination does not reveal a single concrete abnormality.

I turn to my team. "Has anybody treated her for migraine?" No one has, and I ask why not if migraine was suspected initially. "I guess we are still hunting", the resident replies sheepishly. Prescribing migraine treatment, I reassure the patient there is no sinister problem. "But what about my MS? Google says white matter changes and neurological signs mean MS", she responds.

"In the right setting. This is not MS", I reassure her. "'But that's not what the other doctor said", she says. "She was an overnight junior doctor reading from a report", I explain patiently, "and reports need to be interpreted within some context." When the patient's lips curl up petulantly, I realise I have a problem. 20 minutes later, she is even more dubious although I have tried to navigate between empathetic concern and factual explanation. It dawns on me that she is actually not interested in my dismantling her diagnosis. In fact, my reassurances just keep striking a growing wall of anxiety and somatisation. "Are you sometimes an anxious person?", I ask. "Not the sort", she scoffs, her body language belying her claim. Despondently, I realise that I have spent nearly an hour trying to convince a patient that she "only" has a migraine.

Tomorrow comes and her headache is better. She chats on her phone but snaps at the nurses. When I express relief at the resolution of her headache, she says, "But I still feel numb." She has a list of questions with her. Why did we check her urine if infections are not a sign of reduced immunity from MS? Why has no one compared her two MRIs to see if those white things are new? Why is her haemoglobin high normal? And then after a sustained volley, she asks the clincher, "With all due respect, you are not a neurologist, so how would you know about MS?"

I think longingly that in another time, a physician who had spent 2 hours assessing a patient would simply not have brooked such a question. But in an era of seemingly untrammelled patients' rights, I am forced against my better judgment to find a neurologist. He diagnoses a migraine. But for good measure, he advises a stroke consult. Before I can object, she declares she will wait another day to consult the stroke team, which excludes a stroke but "given patient anxiety", schedules a repeat MRI.

"You are safe to go home", I encourage her, feeling exasperated and acutely mindful of the queues of people waiting in trolleys. "It's just not right", my resident mumbles, tired of dealing with the same questions worded differently. But this is a public hospital, where no patient can be turned away. "No one knows what's wrong with me", she says plaintively on her fifth day in hospital. "We have excluded serious problems", I reply. Unhappily, she finally goes home but returns 2 days later, complaining she is no better. A new receiving unit assesses her, ordering fresh tests. My immediate response is to celebrate that she is not my problem, but the reaction that follows is one of frustration that an individual patient, on a whim, can be the cause of so many tests that waste taxpayers' money and, more worryingly, hold doctors to ransom.

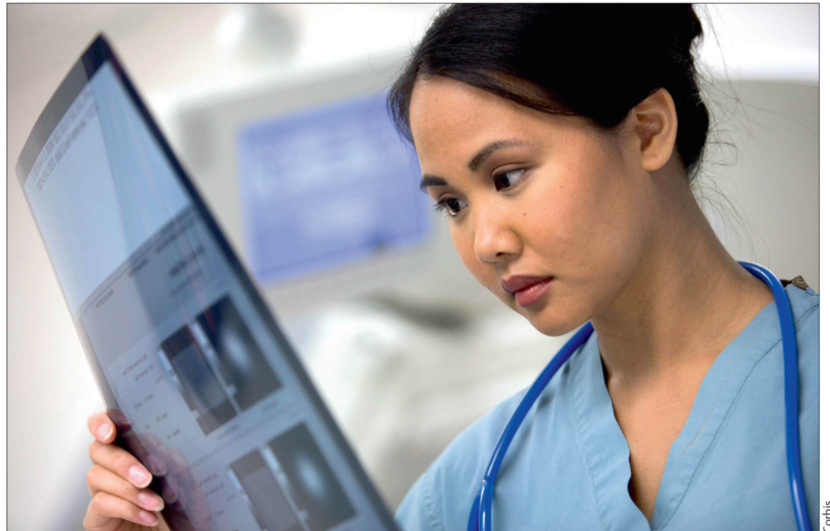
In subsequent months, I track her progress through the dreaded circle of outpatient care where one appointment begets another test which leads to another appointment and more theories. When I discuss my disenchantment with a colleague he has rivalling pessimistic stories. "Free-floating anxiety", he pronounces. Puzzled, I discover that the *Mosby* medical dictionary actually describes free-floating anxiety as a generalised, persistent, pervasive fear that is not attributable to any specific object, event, or source. The epithet describes many patients rather nicely but lately I have been thinking that it applies just as neatly to doctors.

A serious diagnosis was excluded early. Many doctors independently considered the diagnosis to be migraine, yet instead of standing by a perfectly sound clinical judgment, there was a collective anxiety to uncover a more exotic reason for the presentation. Soon, the array of normal tests came to signify our failure to put a finger on the problem while a single abnormal MRI, actually a red herring, became the symbol of a serious disease lurking in the folds of the brain. The ensuing anxiety affected the patient and contaminated the actions of her doctors.

But why? First, there was pressure applied by the patient. Implicit in her statement that we were "not getting it right" was the charge of negligence. Her medical management would withstand scrutiny but no one wanted to bet on it. This is because most of us fear that in times of jeopardy, doctors seldom support their peers, and institutions traditionally move quickly to limit damage, retain public faith, and sacrifice individuals.

There is also an evolving generation of doctors trained to rely heavily on investigations that were designed to confirm, not hunt for, a diagnosis. Why percuss for a pleural effusion when the CT can tell you how large it is? It's much easier to order an abdominal ultrasound than ask a patient to undress so you can feel the craggy, painless edge of the malignant liver. Why go through the pretest probability of a pulmonary embolus when a pulmonary angiogram can be done in the time it takes you to recall the criteria? The ordering of tests provides short-term reassurance to the patient that we are "on to it", but ill-considered tests beget more tests, more costs, and more free-floating anxiety.

Doctors who always want to be risk-averse ignore clinical judgment because inherent in the concept is the premise that sometimes one's judgment will be wrong. But we ignore clinical judgment at our own peril, and we risk becoming doctors who stand to lose this underused skill. "Working on a hunch" is beginning to sound like a quaint anachronism, like relying on an examination to determine the lesion in the brain. An intern recently expressed surprise that a full neurological examination should be done before ordering the MRI, EEG, and nerve conduction studies.



Corbis

I imagine that the poor resident who took it upon herself to tell my patient at midnight that she might have MS was simply anxious about sitting on a finding so profound. But what would have happened if the resident had held on until the morning and discussed it with a seasoned physician? One might have chosen to dismiss the non-specific findings, to tell the patient, to call neurology, and to do a lumbar puncture. Every decision would factor in clinical acumen but also a different degree of caution or anxiety.

If you have worked in medicine long enough, chances are you have attracted some kind of complaint, however minor. Just the memory of that complaint can be enough to colour future interactions. Of course, simply appearing to be more deliberate doesn't make one a more deliberate doctor, and ordering more tests doesn't make for a better doctor. By now we are all aware of the harm associated with overenthusiastic testing and in an era of exponentially rising health-care costs, the associated waste of money. It's also hard to reconcile the experience of the modern physician with the so-called master clinicians of the past. Their work sounds interesting, revealing; ours tedious, even unhelpful.

Sometimes our patients are anxious but many times it's us. An anxious doctor managing an anxious patient multiplies the effect. Tempting as it is to explain away the excesses of modern health care due to the anxiety of patients, we must recognise our own role in aiding it. Free-floating anxiety is certainly out there and it may well turn out to be a malady that affects both doctors and patients in equal measure.

Ranjana Srivastava
Department of Medical Oncology, Dandenong Hospital, Dandenong 3175, Victoria, Australia
ranjana.srivastava@southernhealth.org.au

Further reading

Srivastava R. Dying for a chat: the communication breakdown between doctors and patients. Melbourne: Penguin Australia, 2012