

Virtual Mentor

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CLINICAL CASE

Psychosomatic Elaboration of Distress

Commentary by J. Wesley Boyd, MD, PhD

It was a typical night at St. Matthew's, a large community hospital with a busy emergency department (ED), and Dr. Allison was the intern on duty. The past couple of weeks had been interesting, though tough, for Dr. Allison—making clinical decisions without a lot of time to consult with others.

About half-way through Dr. Allison's shift, a young man, trim and healthy-appearing, lurched in through the ED doors clutching his chest. "I can't breathe!" he rasped. "I'm having a heart attack!" Dr. Allison ran over to help this desperate man. He described crushing substernal chest pain and appeared to be in respiratory distress, based on his rapid shallow breathing and wheezing. The man said that it had started suddenly, a couple of hours earlier; nothing like this had ever happened to him before. He was drenched with sweat. Quickly, Dr. Allison ordered an EKG and a chest radiograph (CXR), and called for a crash cart in case he needed to intubate the young man. Dr. Allison informed the chief resident and the attending physician of the situation and they approved of the plan.

The EKG came back completely normal—a healthy 25-year-old heart. Neither the cardiac enzymes nor chest radiograph showed any abnormalities. Puzzled, Dr. Allison informed the patient of the findings and noted that he already seemed much calmer as he sat hooked up to the telemetry monitoring. Upon hearing that everything was normal, the patient smiled, his breathing normalized, his sweating ceased, and he reported that the squeezing sensation in his chest had passed.

Intrigued, Dr. Allison researched the patient, Mr. Wagner. His name appeared in recent hospital medical records. Dr. Allison learned that a month prior, Mr. Wagner's parents had been brought to St. Matthew's after a fatal motor vehicle accident. Middle-aged and healthy, both had died in the emergency department from their severe injuries.

A week later Dr. Allison was again on call when Mr. Wagner stumbled into the ED late at night, again in obvious distress. He was sweating, clutching his chest, and grossly tachypneic. Barely able to speak, he described tight squeezing around his chest and appeared to be in great pain. Dr. Allison reported the case to the attending physician and mentioned that, on the previous occasion, Mr. Wagner's very real distress was alleviated by the CXR and EKG reports.

Dr. Allison's chief resident said, "The guy needs a shrink, that's all. Put him back on the street. No need to waste money on imaging when we know there's nothing organically wrong."

Commentary

It is never ethically acceptable for people perceived to be neurotic or experiencing psychosomatic elaboration of distress to receive less than the standard of care. Providing anything less would be, in essence, gambling with the patient's health without his or her consent. After all, even though there was no physical basis for Mr. Wagner's complaints the last time he was in the ED, there is no guarantee that he is not having a heart attack this time. Furthermore, irrespective of whether or not he is actually having a heart attack, Mr. Wagner is obviously suffering a great deal, and for this reason he deserves compassion and humane treatment.

This case prompts me to offer a couple of clinical vignettes (with certain identifying features changed) from my own practice. The first centers on a young woman I saw when I was a resident in the psychiatric emergency department after the medical ED had dismissed her complaints of left-sided weakness as "somatic" and "hysterical." She had her share of reasons to be hysterical: she was pregnant, newly divorced, and had just been fired from her job. During the course of my interview, I twice called the medical ED and asked if they were absolutely certain that she hadn't had a stroke, given that they hadn't obtained a CT scan. The ED medical staff assured me that her symptoms were psychiatric and that they would not reconsider their clinical decision.

While I was on the phone the second time, through the exam room window I saw her lift her left arm—the same one she couldn't lift when I'd asked her to do so earlier—push her hair out of her eyes, and then drop her arm again. That arm motion convinced me that the medical ED was right. (I've since educated myself about those brain lesions that don't affect reflexive, unthinking movements like pushing hair out of one's eyes even though they obliterate voluntary muscle movements.) I ultimately discharged her that night from the psychiatric ED, but, given her level of impairment, I asked her to return 12 hours later for a check-in. When she returned she was still very impaired, so I admitted her to the inpatient psychiatry unit. A nurse immediately suspected a stroke, easily convinced the psychiatrist on the unit to order a CT, and the diagnosis was confirmed.

Fortunately, the delay in diagnosing her stroke did not cause the patient any permanent harm. More recently, though, I have been all too close to a case in which mislabeling based on assumptions about the patient turned out to be deadly. The 30-year-old husband of one of my patients was found by EMTs slumped over the steering wheel in his truck. As they were frantically trying to revive him, one of them picked up his cell phone, redialed the last number called, and reached his wife—my patient. They asked her about his medical history. When she told them, among other things, that he was a recovering heroin addict who'd been clean for several years, she heard their urgency to help him all but evaporate.

The EMTs told her where they were taking her husband, and when she arrived at the hospital half an hour later he was still unconscious. She told anyone who'd listen that he hadn't overdosed and that they needed to get a CT scan. She told the attending physician that her husband's father had died from a stroke when he was young. But the ED staff insisted that her husband had overdosed. A nurse even slapped him on the face to "arouse" him. Three hours passed before he finally was scanned—almost as an afterthought—which confirmed that he'd suffered a massive cerebral bleed. He never regained consciousness and died several days later. Had 3 hours been the difference between life and death?

I offer these vignettes as cautionary tales about the dangers of failing to adhere to standard of care, even when there appears to be an obvious explanation that doesn't require a full workup.

In Mr. Wagner's case, even though his symptoms are identical to those he displayed on his previous visit, there's no way to tell *a priori* that he is not actually having a heart attack this time. The only way to confirm the chief resident's impression of what's wrong is to run tests to rule out medical conditions. As an added wrinkle, I'd say that, even if all tests were to come back negative, it is still possible that the problem has a physical basis. Our testing apparatus and medical knowledge are so sophisticated and awesome in their scope and nature that it is easy to believe that, if all tests turn up negative, the suffering at hand cannot be physically based. Although this line of thinking is common, it is also fallacious because there are always limits to our testing methods and to the science underlying their application.

Physicians' Duty to Alleviate Suffering

How can we educate physicians not to be too quick to write off something as "psychiatric," which in medical language often means that it's either not real or unworthy of attention? Teaching humility in the practice of medicine would be a great start. We don't know everything. We're not infallible. Our daily practice of medicine is filled with uncertainty, and the more we take this fact to heart, the less arrogant, cocksure, and potentially demeaning we will be toward our patients. Would the chief resident have been forceful in telling Dr. Allison to get Mr. Wagner out of the ED if the chief understood, in a visceral way, the extent to which uncertainty permeates medicine? I would guess not.

So, even though Mr. Wagner's initial evaluation in the ED did not reveal any cardiac disorder, we cannot assume the same is necessarily true when he returns a week later. What if this time he really is having a heart attack? Should anyone be willing to take that chance and send him away without running a basic set of tests to rule out a myocardial infarction? And even if they were willing, they would be trampling upon Mr. Wagner's rights as a patient.

All of the above notwithstanding, if I had to bet on the outcome, I'd wager that all of Mr. Wagner's current symptoms are in fact psychiatric in nature. But the likelihood

that his suffering is psychiatrically based does not change the fact that Mr. Wagner *is* suffering, and it is a physician's moral duty to attend to suffering in whatever form it takes. Dr. Allison ought to attend to the full scope of his duties as a physician and address Mr. Wagner's suffering, irrespective of its source. For example, after running tests that came back negative, he could sit briefly with Mr. Wagner, talk to him just a bit, and facilitate a referral to a psychiatrist. Doing so will help get him the treatment that he needs and probably also lessen the likelihood that he'll return to the ED in another week with similar symptoms. This would also help prevent further overcrowding in the ED. Until Mr. Wagner's suffering is addressed, he will continue to cast about seeking help, be it in Dr. Allison's ED or some other.

Just as it's true that being paranoid doesn't mean that someone is not in fact out to get you, the hypochondriacal, somatizing patient might just be having a heart attack. Without medical evaluation to know with certainty what the source of the symptoms is, the physician is gambling with the patient's health without the patient's permission, and that is never ethically permissible. Patients deserve to be treated according to the standard of care, and it is the physician's duty to do so. If such treatment does not turn up any cause, the physician should remind himself that his calling is to alleviate suffering and proceed accordingly.

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