A Case of Medical Uncertainty

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Please send scenarios to Caroline Wellbery, MD, at afpjournal@aafp.org. Materials are edited to retain confidentiality.

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Case Scenario

At the urgent care clinic where I work, a 38-year-old uninsured woman presented while en route from another part of the country. She expressed severe anxiety about muscle twitching in her hands and feet that started three days prior, along with her other symptoms. She also had abdominal pain, nausea, and diarrhea, and mentioned several engorged ticks she had pulled off her forearm that day. She admitted to possible earlier exposure to ticks. She denied any rash, but on further probing at the end of the interview, she mentioned a red, inflamed-looking area on her torso that comes and goes. Her social history included smoking and significant psychological distress due to job loss and other lifestyle factors. Her physical examination was unremarkable except for an unsteady, narrow-based gait.

Finding no additional clues after a review of other possible contributory factors, I checked her electrolyte and creatinine kinase levels, and treated her for Lyme disease. I referred her to a neurologist, and told her to go to the nearest emergency department if her unsteadiness worsened. I spoke with her about the acute nature of the illness and the possible meanings of her symptoms, and my feeling that although a specialist's input was warranted, her condition was not life-threatening.

This discussion relieved her anxiety. I also felt satisfied with my management. After the patient left, however, I reflected on the fact that I had experienced a great deal of discomfort about the patient's symptoms, as well as her abnormal gait. I wondered if my own relief at the end of this patient encounter had more to do with my formulating a plan—any plan—rather than with making the correct assumptions about her diagnosis and treatment, especially because I was conscious that she was paying for her care out of pocket.

Commentary

Medical uncertainty (i.e., not knowing how to proceed with a patient-related problem) can stem from any number of potential situations in daily clinical practice. The causes of uncertainty are many, but the feeling of stress or discomfort it creates is a familiar constant, though it may vary in intensity. Medical uncertainty is similar to the experience of irresolution or indecision in everyday life, but with additional responsibility for the patient. Along with raising concerns about patient safety and physician liability, medical uncertainty is likely to contribute to overall health care costs due to increased and often unnecessary testing. It is therefore important to learn to manage uncertainty.

All physicians experience uncertainty—some on a daily basis, others less frequently. What changes with increased clinical experience is the tolerance of uncertainty.[1] In an informal survey I conducted at a conference of general practitioners and family physicians, one seasoned physician commented, "For me, the challenge is not to get rid of my uncertainty, but to get into a good relation to my uncertainty." In the case presented, the physician is confronted with a slew of symptoms, some of which appear to be related, whereas others suggest a separate diagnosis. Neurologic problems such as those described can be particularly challenging to explain, but in addition, the physician must assemble the symptoms to fit one diagnosis.

Uncertainty arises when the physician must weigh probabilities. Diagnosis and treatment of Lyme disease are driven by pretest probabilities: a patient with evidence of erythema migrans can be treated without testing; however, when neurologic symptoms are consistent with Lyme disease, serial serology is useful.[2,3] But in this patient, there was no documented evidence of erythema ▶

migrans, and the unsteady gait was inconsistent with early neurologic symptoms of Lyme disease, leaving the physician without clear guidance on how to pursue the diagnosis and whether to treat.

Uncertainty does not always originate with the physician. Uncertainty has powerful psychosocial dimensions transmitted by the patient. The patient in this case has severe anxiety, and the physician must determine the extent to which stress contributes to the experience and expression of symptoms. When a patient experiences uncertainty, the physician shares responsibility for resolving it. Even in situations in which there is less clinical ambiguity, a patient's demand for diagnostic tests or treatments reflects a need to resolve his or her own uncertainty. As if the physician's own uncertainty were not enough, patients' low tolerance for uncertainty presents a significant clinical challenge.[4,5]

Additionally, many uncertainties are exacerbated by other factors. For example, this patient had no insurance and was from out of town, casting further doubt on the role of serologic testing and arrangement of follow-up.

The management of uncertainty is complex. Several studies and reviews have identified commonly used, though unproven, strategies for managing uncertainty.[6-8] These include, but are not limited to, (1) exercising good communications skills; (2) articulating the background information the patient needs to interpret his or her symptoms; (3) being thorough and open-minded with the diagnostic process; (4) negotiating a plan with the patient; (5) allowing time for clinical findings to evolve; and (6) forming a contingency plan.

In the case presented, the physician attempts to resolve his or her uncertainty by creating a plan, developing a short differential diagnosis, and devising a cost-effective, though not definitive, approach to the patient's symptom complex. Backup is provided with a neurology referral and advice to go to an emergency department if symptoms worsen. The physician's context is urgent care; therefore, within that context, this plan should suffice to resolve the physician's uncertainty.

Ideally, any resolution of uncertainty should satisfy the patient and the physician. The best setting for resolving uncertainty is one in which there is continuity of care. A primary care office supports two important ingredients for resolving uncertainty: cultivating a supportive relationship with the patient, and the watchful waiting that allows symptoms or circumstances to evolve into greater clarity.

Being honest about uncertainty and willing to share difficult decisions can help patients and physicians. As the aforementioned physician explained, "I can stand a lot of uncertainty as long as I can share it with my patient. I have learned that not every problem needs a solution. Sometimes, it helps just to talk about it."

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Author disclosure: No relevant financial affiliations to disclose.

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