

## On the Sociological Anxiety of Physicians

*Nicholas A. Christakis*

Physicians do not speak calmly about prognosis.<sup>1</sup> Indeed, they seem quite anxious about the possibility or necessity of both formulating and communicating predictions about or to their patients. This observation about prognostication begs a more general inquiry into the response of individual physicians, and the profession as a whole, regarding potentially unpleasant sides of medical practice, and, more broadly, into the sources of doctors' anxiety. What is the nature and origin of this anxiety and what does it mean for our understanding of medical care?

Part of the reason physicians are anxious when it comes to prognosis is that, when prognosis emerges as a focus of interest in a clinical encounter, there typically are also other elements of the encounter that are anxiety provoking. That is, prognosis often emerges in medical care in a setting in which other potentially noxious and worrisome stimuli are present—such as death or uncertainty. Such co-occurrence strongly suggests that we are dealing with a social pattern of the type that sociologist Renée Fox has so frequently identified in medicine. Moreover, the stylized responses to prognosis in medicine, and the cathexis of prognosis with these other concerns, suggest that the anxiety regarding prognosis (and regarding the other issues we will be considering) is *sociological* rather than *personal* in nature. Psychiatrist Rollo May draws a distinction between fear and anxiety by arguing that “anxiety is a *diffuse* apprehension, and...the central difference between fear and anxiety is that fear is a reaction to a specific danger while anxiety is unspecific, ‘vague,’ ‘objectless.’ The special characteristics of anxiety are the feelings of *uncertainty* and *helplessness* in the face of danger. The nature of anxiety

can be understood when we ask *what* is threatened in the experience that produces anxiety" (May 1977:205).<sup>2</sup> And he proceeds to define anxiety as "the apprehension cued off by a threat to some value that the individual holds essential to his existence as a personality [and to his security]." In normal, non-pathological anxiety, the threat arises from an attack upon the foundation of one's security, and the threatened individual cannot "stand outside the threat" and objectify it, and therefore cannot marginalize or trivialize or compartmentalize or demarcate the threat. The threat is fundamental and somehow transcendent or thoroughgoing. One is afraid, one knows it is serious, but one may not be aware of exactly what one is afraid of. Most generally, it seems that anxiety can arise from a realization of human contingency, that is, a realization of human vulnerability to the powers of Nature, for example, to illness or to death. These initial—basically psychological—ideas, expressed about fifty years ago, take us a certain distance, but only so far, in understanding physician anxiety—for reasons I will touch on shortly.

A case drawn from my book on prognosis, *Death Foretold*, can serve to illustrate some of the various reasons that doctors might be anxious, and the kind of threat to their sociological existence and security we are considering here. One young pulmonologist described his intense experience caring for a critically ill patient as follows:

\* \* \*

One of the hardest cases I ever took care of was when I was an intern in the CCU [Cardiac Care Unit]. There was this guy who came in because he had some mid-epigastric burning. Turned out he had a gastric carcinoma. This was all as an outpatient. And they wanted to bring him in for a resection for his carcinoma. But he was an elderly guy, and there was a concern that he had angina, so they wanted to perform a cardiac catheterization to make sure that he could survive his gastric resection. So they catheterized his heart. On the cardiac cath table, he had a ventricular tachycardia. He then had a heart attack. They brought him to the CCU. He eventually went to open heart surgery. He had a heart attack after his surgery. He was on a ventilator. Had pneumonia, lung failure, and renal failure. And actually, they had given him a medicine he was allergic to, and so he had bone marrow failure as well!

So here was a very healthy—healthy, really—functional man in his middle seventies who—it's unbelievable isn't it?—who had the most minimal of symptoms which brought him to immediate attention as having a small, even curable, gastric carcinoma. And he goes through these amazing machinations of

our medical facility, and ends up with multi-system failure. Now, his gastric carcinoma is the *least* of his worries. He's on a ventilator and has a heart that doesn't work, kidneys that don't work, and he's in bone marrow failure, and his lungs are shot. It's incredible!

So he's got four-system failure. He's going to die. There is no way he can live. And yet, I took care of him really from the first day I came to the CCU to the day I left about a month later. I think he died on the second-to-last day before I left the unit. So the entire time I took care of him, I began to...I began to hate him. This is the only patient I've ever had that I've ever truly hated. And it was because he wanted to live so badly. Every day I had to take blood from him...new arterial lines, new central lines, feverish all the time, everything had to always be changed... He was blowing up like a balloon from poor nutrition. Edema everywhere. I would have to go in with a needle more than an inch just to hit a vein or an artery. You know, he would weep from his wound every time I would do it. I was clearly hurting him with everything I did. And it showed on his face. But he was *alive*. And, despite all these problems, which should have killed anyone else in just a few days, he lived an entire month. And I had to really hurt him day after day after day after day. And I wanted to quit weeks before he died.

But my superiors—who didn't have to go in with him every day and work with him—would not let me. Basically they told me that I “had to go culture him for infection,” or “he needs a new [intra-vascular] line.” They're not the ones that have to do it. I'm the one that has to do it. And even despite my discussions with the family—and I think I was as capable of telling them his prognosis, even as a beginning physician, as anyone else—clearly he was not going to live. But the family was always optimistic because the attending physician always said every day that he was still alive. And the family hung on to that, like that was it. That was all they knew: that every day he was alive. And “when was he going to be able to come home?” Not “*could* he ever” but “*when*.” And I couldn't understand: they couldn't see it. And so I had to hurt this guy every day.

Finally, they all saw that he wasn't getting any better. And they agreed to make him DNR and not to resuscitate him if he should have a final event. And the day they decided that, that very night he died! And the next day, the family came in to see him. He had died early in the morning. And they came in that morning to see him, and they saw me there, and I told them how very sorry I was. And they were furious...with me! And his daughter told me that she hated physicians, that she hated me, and that she had a young boy who wanted to be a physician, and she would *never* let him. Never let him be a doctor—because of what we did to her father.

I think that was the hardest case...you know, I predicted...I knew he would die. It was remarkable that he...I never expected that he would die the day that they decided to make him DNR. And the patient didn't even know that we had made him DNR.

I can't believe that he carried on like this for a whole month. And yet he died the day his family and we made him a DNR. Even though he did not know that they had done that. Here he is, in this very controlled environment, and the attending is telling them, the family, every day that the patient is alive another day. And all of a sudden we decide that it is hopeless, that he's not getting any better, let's just not push on any further—not *withdraw* life support, mind you, just not push any further—and that day he dies. The day that I don't have to put the defibrillator on him and resuscitate him if necessary, he dies. (Christakis 1999:147-148)

\* \* \*

This case offers a number of insights about several aspects of medical practice. It is clearly relevant to the role of prognosis and it involves a considerable amount of iatrogenesis. Moreover, in a self-fulfilling-prophecy-like fashion, there is the feeling at the end of this case that when the physicians ultimately predicted that the patient would die—when they decided that the case was “hopeless”—they somehow contributed to the patient's death. In other words, just as the physicians' therapeutic interventions iatrogenically hastened the patient's death in this case, there is the sense that the physicians' prognostic pronouncements iatrogenically did the same. This case illustrates the frightening and awesome power of medical care to both keep the otherwise dead patient from dying and to make the otherwise well patient nearly dead. In the face of this power of medical care, it is not surprising that the physician is anxious about, and troubled by, the possibility that his prognostic assessments might have similarly untoward and powerful effects, might run amok just like the diagnostic and therapeutic interventions. Moreover, the experience of caring for this patient—including the foreknowledge that he would die (acquired early in the patient's care), the prognostic estimate that the care was “hopeless” (stated late in the patient's care), and the evocation of “hatred” in several parties (a rather strong word and sentiment)—was very profound for this physician. The physician was anxious and troubled by his painful and ineffective therapeutic interventions, by his ominous foreknowledge, by the proximity of death, and by his and the family's feelings.

The objects (in May's sense of the word) that I think make doctors anxious are: 1) death, 2) uncertainty, 3) helplessness, 4) the future (and its prediction), 5) emotions (such as affection for or ha-

tred of patients or by patients), and 6) iatrogenesis (including medical error).

However, when I say that physicians are anxious about these things, I do not mean merely in a *personal* way, the way any human being might be anxious about some of these occurrences or issues, such as death or uncertainty or helplessness. I mean something more, in that the anxiety here is not merely personal, but also social—much in the way that Renée Fox has characterized other aspects of the predicament of health professionals (Fox 1988,b,d,e). That is, when I state that the doctor is anxious about death, I do not so much mean death as it might affect them personally, but rather about death as an object that impinges on their patients or their practice, an event that affects their professional or social role as a physician and to which this role is unavoidably or inescapably oriented.<sup>3</sup>

Technical advances and discoveries in medicine, especially since the turn of the century, have held such promise that society has endowed physicians with the privilege and the duty to eradicate disease.<sup>4</sup> From this perspective, death or uncertainty or iatrogenesis connote failure—not just of the therapeutic armamentarium to achieve its objective, but also of the physician to fulfill his or her social role. Indeed, when physicians speak of the death of their patients, they often use expressions which suggest rectifiability—such as “we lost the patient”—or which suggest a failing on the part of the patient—such as “that patient died on me.” Physicians’ dispositions and behaviors (such as ritualized prognostic optimism) and institutional practices (such as rapid sequestration of dead bodies in hospitals) serve to protect them from being identified with the failure to fulfill their role.<sup>5</sup>

Beyond the compunction to fulfill one’s social role, powerful emotional and intellectual strands within the professional culture of medicine also lie at the core of the anxiety regarding death. Optimism, activism, meliorism, and a hubris-ridden, “against-the-odds,” “we-shall-overcome” attitude is endemic in physicians. Describing physicians’ attitudes towards death, Fox has observed:

The Judeo-Christian tradition [in America] emphasizes that, because human life is divinely given, it is inherently sacred and important, has absolute, inestimable worth and meaning, and should be protected and sustained.... [But] in recent years, the unqualified commandment to support and sustain life has become increasingly problematic in American society, particularly in the medical sector. The sanctity of life ethic has helped to push physicians, nurses, and other medical professionals into a pugilistic

tendency to combat death at any cost, and to define its occurrence as a personal and professional defeat. This heroically aggressive "courage to fail" stance has been reinforced by the development of more powerfully effective forms of medical technology that increase the medical team's ability to save and maintain life. (Fox 1988a:429-430)

In the face of such rising expectations, it seems only natural that the profession would be anxious.

Similarly, the role of physician requires the confrontation not only with death, but also with other possibly anxiety-provoking phenomena, such as uncertainty. Indeed, in the foregoing case as more generally, prognostication instantiates a particularly acute kind of uncertainty that transcends the classic types described by Fox (1988e).<sup>6</sup> A fundamental uncertainty arises in prognostication from the mere fact that knowledge of the future is *irremediably* provisional. Uncertainty about the future results both from a personal ignorance that is unavoidable and from a limitation in medical knowledge that can never be fully remedied. The limitations in ability to predict future events and their timing is a particularly thorny form of uncertainty, especially since, paradoxically, situations in medicine with high unpredictability both demand and subvert efforts by physicians to render prognoses.<sup>7</sup> However, the key observation for present purposes is that uncertainty, whether arising from prognostication or the more customary sources, is an inherent part of medical care that physicians cannot avoid much as they might want to.

In short, physicians have sociological anxiety because they are structurally confronted with danger and threats to their social duty. They cannot escape some of the problems we have discussed since these problems (death, uncertainty, emotions, prediction, etc.) are inherent in their social roles. Yet, these dangers threaten physicians' social roles, and this is what I mean by sociological anxiety. Doctors are supposed to like their patients and be liked by them, they are supposed to know things, be certain, be effective, see into the future, cure disease, and forestall death. Doctors' failure to meet these objectives, or even the risk of failure involved in facing these challenges, threatens to make their practice *meaningless*, by rendering actions harmful, therapy ineffective, the future inscrutable, patients rageful, or experience amoral. To paraphrase sociologist Robert Merton in his discussion of sociological ambivalence: unlike a psychological perspective on anxiety, a sociological one focuses on the ways in which the anxiety comes to be built into the structure of

social roles. A sociological perspective draws attention to the processes in the social structure that foster anxiety in particular kinds of role-relations. And a sociological perspective also draws attention to the social consequences of anxiety for the workings of social structures (Merton and Barber 1976:5).

All of these observations, of course, borrow heavily from Renée Fox's path-finding work in medical sociology. She has examined in numerous places the distinctive and socially structured experiences of patients and doctors in the context of illness, as well as the stresses, anxieties, and coping responses that these experiences have engendered. Whether we are thinking of patients on Ward F-2, or medical students in the dissecting room, or physicians being socialized to cope with uncertainty or to manifest "detached concern," or transplant surgeons demonstrating a "courage to fail" ethos, in all of these cases we are confronted with how such socially-situated actors are responding to stressful, anxiety-provoking situations in which they must confront death and attempt something that might well both be impossible and absolutely imperative. Moreover, her work has called attention to the melding of the personal and social and moral experience of such actors, and it sets the framework for finding analogous processes at work at both individual and social levels. The sources of physicians' anxiety have moral overtones because they are connected to a possible failure to fulfill their social role, which, consequently, suggests a possible delict or culpability on the part of the physician and of the profession.

Fox has thus been profoundly concerned with not only the determinants of social processes, but also with their personal, social, and moral consequences. This begs the question of what the beneficial and harmful consequences of this sociological anxiety in physicians might be. But she has had something to say about this too, in her work on how physicians confront death, uncertainty, and the potentially dehumanizing threat of illness.

At an individual level, anxiety can certainly be useful. For example, the anxiety medical students feel about their training and competence can motivate them to study and work harder. The confrontation of their mixed feelings about examining the human body can serve to bolster their ability to deal with its decrepitude, which is such a necessary part of their profession. Like its individual counterpart, sociological anxiety, in moderation, can enhance perfor-

mance. That is, a certain amount of sociological anxiety may help to keep the medical profession in balance, fulfilling its role adequately. For example, the "courage to fail" ethos that Fox and Judith Swazey identified in the area of organ transplantation can be seen as productive (Fox and Swazey 1978). Similarly, the argument that Fox makes in her classic work on "training for detached concern" is also an institutionalized way that members of the profession are systematically socialized to cope with the structural, anxiety-provoking aspects of their profession. These responses attempt to balance the personal and professional risks and benefits of avoiding anxiety-provoking objects. On the other hand, if the challenges of the circumstances become overwhelming, physicians may avoid the object. This is one of the reasons that physicians avoid prognosis: high expectations for prognosis, coupled with the manifest difficulty in meeting them, make physicians structurally anxious and, consequently, lead away from engagement with this domain. Similar arguments can be made about the other sources of anxiety. In excess, therefore, anxiety can lead to blind spots in a profession and a kind of institutionalized denial that, in the long run, is not merely counterproductive but also intrinsically unstable. A profession that inescapably faces death and so many other threats cannot avoid them completely.

### Notes

1. I attempt to get to the root of this anxiety and to understand the thoughts and behaviors that the necessity of prognostication engenders in Christakis 1999. This book grew from a dissertation I did under Renée Fox's supervision at the University of Pennsylvania from 1991 to 1995.
2. Emphasis in original. By "objectless," May does not mean that the anxiety lacks a stimulus or trigger. Similarly, when I argue that physicians are anxious about something, I do not mean that the cue to the anxiety is unknown (e.g., it might be death), but rather that there is an additional aspect to the anxiety-provoking object that threatens the social nature of physicians' existence and that is often, at least initially, not manifest.
3. This is analogous to the difference that sociologist Robert Merton has drawn between a personal, psychological ambivalence on the one hand, and a sociological ambivalence on the other (Merton and Barber 1976, Merton 1976).
4. For more on the status gradually assumed by the medical profession, see Starr 1982.
5. It reflects both irony and arrogance that physicians feel guilt when their patients die—irony because they are not (ordinarily) truly responsible for the patient's death and arrogance because they believe that they are so powerful that they might have prevented it (see Christakis 1996). Regarding the "ritualization of optimism" in prognosis, see Christakis 1999.



6. Uncertainty in medicine has been classically described by Fox as having three principal sources: "The first results from incomplete or imperfect mastery of available knowledge. No one can have at his command all skills and all knowledge of the lore of medicine. The second depends on limitations in current medical knowledge. There are innumerable questions to which no physician, however well trained, can as yet provide answers. A third source...derives from the first two. This consists of difficulty in distinguishing between personal ignorance or ineptitude and the limitations of present medical knowledge" (Fox 1988e:20; see also Fox 1988c).
7. The situation is not so simple, of course, because, as I discuss in *Death Foretold*, formulating a prognosis may be a way for physicians to cope with the uncertainty in medicine. Making a prediction can make physicians feel as if they have some rational understanding, and therefore control, over a patient's disease. The uncertainty associated with serious, life-threatening diseases is both unsettling and threatening to physicians, and they thus welcome situations where they can cope with it through prognostication. The ability to prognosticate can provide reassurance. Similarly, prognostic *certainty* can, paradoxically, also be problematic for physicians. Certain knowledge of an unfavorable future can be perceived as a burden. See also Fox 2000.

### References

- Christakis, Nicholas A. 1999. *Death Foretold: Prophecy and Prognosis in Medical Care*. Chicago: University of Chicago Press.
- Christakis, Nicholas A. 1996. "Managing Death: The Growing Acceptance of Euthanasia in Contemporary American Society," pp. 15-44 in *Must We Suffer Our Way to Death? Cultural and Theological Perspectives on Death by Choice*, edited by R. P. Hamel and E. R. DuBose. Dallas, TX: Southern Methodist University Press.
- Fox, Renée C. 1988a. "Advanced Medical Technology—Social and Ethical Implications," pp. 413-461 in *Essays in Medical Sociology*, edited by R. C. Fox. New Brunswick, NJ: Transaction Publishers.
- Fox, Renée C. 1988b. "The Autopsy: Its Place in the Attitude-Learning of Second-Year Medical Students," pp. 51-77 in *Essays in Medical Sociology: Journeys into the Field*, edited by R. C. Fox. New Brunswick, N.J.: Transaction Publishers.
- Fox, Renée C. 1988c. "The Evolution of Medical Uncertainty," pp. 533-571 in *Essays in Medical Sociology: Journeys into the Field*, edited by R. C. Fox. New Brunswick, N.J.: Transaction Publishers.
- Fox, Renée C. 1988d. "The Human Condition of Health Professionals," pp. 572-587 in *Essays in Medical Sociology: Journeys into the Field*, edited by R. C. Fox. New Brunswick, N.J.: Transaction Publishers.
- Fox, Renée C. 2000. "Medical Uncertainty Revisited," pp. 409-425 in *Handbook of Social Studies in Health and Medicine*, edited by G. L. Albrecht, R. Fitzpatrick, and S. C. Scrimshaw. London: Sage.
- Fox, Renée C. 1988e. "Training for Uncertainty," pp. 19-50 in *Essays in Medical Sociology: Journeys into the Field*, edited by R. C. Fox. New Brunswick, N.J.: Transaction Publishers.
- Fox, Renée C., and Judith P. Swazey. 1978. *The Courage to Fail. A Social View of Organ Transplants and Dialysis*. 2d ed., rev. Chicago: University of Chicago Press.
- May, Rollo. 1977. *The Meaning of Anxiety*. Rev. ed., New York: Norton.
- Merton, Robert. K. 1976. "The Ambivalence of Physicians," pp. 65-72 in *Sociological Ambivalence and Other Essays*, edited by R. K. Merton. New York: The Free Press.

Merton, Robert K., and Elinor Barber. 1976. "Sociological Ambivalence," pp. 3-31 in *Sociological Ambivalence and Other Essays*, edited by R. K. Merton. New York: The Free Press.

Starr, Paul. 1982. *The Social Transformation of American Medicine*, New York: Basic Books.