

Put the search down

A short book about looking up symptoms online and
reading until you find the frightening answer

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First edition

Written by AI with human guidance. It can
contain mistakes, which later editions correct.

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Before you start

This is a short book and you can read it in two or three sittings. It's about one habit. You notice something in your body, such as a twitch, a headache or a mole you hadn't seen before. You pick up your phone to find out what it is. An hour later you're still reading, and you're more frightened than when you started. You put the phone down at last, and you've settled on the worst explanation you found.

I'm going to argue three things. The first is that searching makes sense from the inside. It's quick and private, and it feels like the responsible thing to do. The second is that a search can't do what you're asking of it. It can't examine you, so it can't tell you what you have, and it can't rule anything out. It does calm you, briefly, and then the worry comes back stronger. Left to itself, a search tends to end at the frightening answer, for reasons that have little to do with your body. The third is practical. When a symptom worries you, you look once, at one trusted page, to find out what to do. Then you do it, and you put the search down. Chapters 15 to 17 cover how.

This book contains no medical advice of its own. It can't tell you whether your symptom matters, and it won't try. Every statement about health in it comes from the NHS or from a paper named in the notes.

Four cautions.

If you think you or someone else may be seriously ill or in danger right now, don't read this book and don't search. Call 999. If you need help urgently and it isn't an emergency, call 111 or use 111 online.

Nothing in this book is a reason to stay away from a doctor. The argument runs the other way. Most of what you're trying to get from a search can only come from a person who can examine you. If a symptom is worrying you, a GP, a pharmacist or 111 is the right place to take it, and searching often delays that.

If worries about your health have started to take over your life, that has a name, and it can be treated. The NHS describes health anxiety as spending so much time worrying that you're ill, or going to get ill, that it starts to take over your life. Its advice is to see a GP if your worries are preventing you from leading a normal life or if self-help isn't working. Chapter 18 says more.

And if you live with a diagnosed condition, some of your looking up is part of managing it. This book isn't about that. It's about searching a new symptom, late, alone, until you're frightened.

The notes at the back give my sources and their limits. Where I'm giving my own reasoning and not a finding, I'll say so.

Ten to eleven

It's a Tuesday night, ten to eleven. You're in bed with the light off, and the muscle in your left calf is twitching. It's a small flutter under the skin, a few seconds at a time, and it's been doing it on and off since the weekend.

You pick up the phone from the bedside table and type "calf muscle twitching". The first result is from the NHS. It says twitches are common and very rarely a sign of anything serious. It says they're often linked to stress, tiredness and caffeine. You had three coffees today, and you've been sleeping badly for a fortnight.

It's a full explanation, and you don't take it. You scroll down to the section headed "Conditions that can cause a twitch", and then you go back to the results and open the next one, and the one after. By twenty past eleven you've learned the name of a rare disease of the nerves. By midnight you're on a forum for people who have it, reading a post by a man whose first sign was a twitch in his calf.

At twenty to one you go to the bathroom, shut the door quietly, and stand on tiptoe on your left leg to see whether it's weaker than your right. You can't tell. You try again, and it might be. You go back to bed and lie awake, and the calf twitches, and each time it does your stomach turns over.

In the morning you're exhausted. The fear has shrunk to a manageable size in daylight, and you feel slightly foolish. By Thursday night you're searching again.

I'll use a few terms throughout. **The search** is a whole session, from the first query to the moment you put the phone down. **The first answer** is the ordinary explanation that usually turns up early on, which you read and pass over. **The frightening answer** is where the search ends. **Checking** means testing or examining your own body for signs, like the tiptoe in the bathroom. **The dip** is the short spell of relief you sometimes get from a reassuring page or a reassuring person. And **the one look** is what I'll suggest in place of the search.

The search has some regular features. This list is my own observation and not a research finding.

It starts with a real sensation. You aren't imagining the twitch.

It happens late and alone, and nearly always on a phone.

It passes over the first answer. The ordinary explanation is read, understood and not accepted, and the reading goes on.

It moves in one direction. Searches go from common to rare and from mild to grave, and almost never the other way.

It ends at the frightening answer. The search usually stops at the worst thing found, or when you're too tired to go on.

And it changes how you behave afterwards. You check your body, you sleep badly, and the next search starts sooner.

Try one thing before reading on. Open your browser history and look at the last month. Count the searches about symptoms, and roughly how long each went on. Next to each, write how you felt afterwards, in a word. If most of them say "fine" or "relieved",

searching may be working well for you, and you may not need this book. If most of them say "worse", read on. You can adopt chapter 15's way of handling a symptom today if you like. There's no need to finish the argument first.

Why searching seems sensible

I don't want to start by telling you the searching is silly. It isn't. People who look up their symptoms are mostly trying to be sensible about their health, and there's a lot to be said for it.

It's immediate. The twitch is happening now, at ten to eleven, and the surgery opens at eight. The phone is eighteen inches away. Anything that offers an answer in ten seconds to a question that's bothering you is going to get used.

It's private. You don't have to say the fear aloud to anybody, or sit in a waiting room, or describe your calf to a receptionist.

It spares other people. Many people who search are trying not to waste a doctor's time. You want to find out for yourself whether the thing is worth an appointment before you take a slot that someone else might need.

It fits an idea of being a responsible patient. We're encouraged to know about our health, to notice changes and to act on them. Looking things up seems to be part of that.

And sometimes it works. The psychiatrists Vladan Starcevic and David Berle, who have written a good deal about this habit, begin by saying that looking for health information online is common and often useful. A study led by Emily Doherty-Torstrick asked 731 people who searched their symptoms how they felt afterwards. Those with low levels of anxiety about illness recalled feeling

relief. For them, the search did what it was meant to do. The people with high levels of anxiety about illness recalled feeling worse, during the search and after it. Chapter 5 comes back to them.

So the same act gives different results for different people, and perhaps for the same person on different nights. That's worth keeping in mind through the rest of the book. I'm not arguing that the internet is bad for health or that patients should stay ignorant. My argument is narrower. For some of us, a particular way of searching reliably leaves us frightened. It's done late and alone, it goes past the first answer, and it carries on until something alarming turns up.

I think the search is trying to meet four needs, and this list is mine. You want to know what the thing is. You want to feel calm enough to sleep. You want to work out whether you need to see someone. And you don't want to be a nuisance.

All four are reasonable. The third is the one a search can help with, if you use it a certain way, and chapter 15 builds on that. The first can't be met by reading. The second is met for a few minutes and then undone. The fourth usually comes out backwards, because people who search a lot tend to end up needing more reassurance from others.

"I'll look it up, and then I'll know"

The search starts from a simple idea. You have a symptom, somewhere there's a page that says what causes it, and once you've read that page you'll know what you have.

A search can't deliver that, and the reason is simple. It has one piece of information about you, which is the words you typed. It doesn't know your age or your family history. It can't tell how much coffee you drank, and it can't look at your calf, test your reflexes, or watch you walk. It doesn't know that you've slept badly for two weeks. It doesn't know the twitch started the day after you moved a wardrobe. All it can give you is a list of every condition in which those words appear.

That list is long for almost any symptom, because bodies have a limited number of ways to signal trouble. Tiredness, headache, twitching, dizziness and a change in bowel habit each appear on the symptom lists of dozens of conditions, from trivial to grave. The search gives you the list. It can't tell you where on the list you are, and that was what you wanted to know.

There's a study that shows the size of the gap. Hannah Semigran and colleagues at Harvard tested twenty-three online symptom checkers. These are tools designed for this exact job, which ask you questions in the way a search engine doesn't. The researchers fed them forty-five standard patient cases with known diagnoses. The checkers put the correct diagnosis first about a third of the time, in 34 per cent of attempts. They listed it anywhere in their top twenty in 58 per cent. So tools purpose-built to narrow things down still

fail to name the right condition, even among twenty guesses, for roughly four cases in ten. An open search followed by an hour of reading isn't likely to do better.

Compare what happens in a consulting room. The doctor asks when it started, what makes it better or worse, and what else you've noticed. They look at the leg. They may test its strength and reflexes, which takes a minute and tells them more than you could get from a month of reading. They know how common each possibility is in people like you. And they have a tool that reading doesn't offer, which is time. "Come back if it's still there in two weeks" sounds like being fobbed off. It's a real test, because most harmless things will have gone by then.

I'm not claiming doctors are always right. But what settles the question is an examination, some history and the passage of time, and a search has none of those. What you get from an hour of searching is a longer list than you had after ten minutes. You don't know more about your own body. You know more about diseases, and that usually leaves you more worried.

"I need to rule out the worst"

You knew by five to eleven that twitches are common and very rarely serious. You kept reading because "very rarely" isn't "never", and you wanted to get from one to the other. The plan was to read about the serious causes, find that they didn't fit, and sleep.

That isn't how it usually goes. Ryen White and Eric Horvitz, two researchers at Microsoft, studied how it does go, using a large set of search logs together with a survey of 515 people. They were interested in what they called escalation. That's a search that begins with a common, probably harmless symptom and moves to reading about a rare and serious condition.

They found that search engines have the potential to escalate medical concerns. Whether a given search escalated depended partly on what people saw. It depended on how much medical content they viewed, and on whether the pages used alarming terms. It also depended on the person, since some people were more inclined than others to go for the grave explanation. And the worry didn't end when the search did. It persisted afterwards and interrupted what people were doing, across later sessions and other days.

Why would a search lean towards the serious? Here's my own reasoning, and I've three suggestions. The first is about what gets written. A serious disease has whole websites devoted to it, run by charities, hospitals and patient groups, and each one lists every early sign, including the common ones. A twitch caused by coffee has nothing of the kind. Nobody founds a charity for it. So the

volume of text linking "twitch" to the rare disease is far greater than the volume linking it to caffeine, though caffeine is a far more likely cause.

The second is about who writes about their own symptoms. The man on the forum whose illness began with a twitching calf wrote a long post, because it's the most important thing that ever happened to him. The thousands of people whose calves twitched for a week in a stressful month wrote nothing, because nothing happened. You can't read their posts. If you could, there would be too many of them to get through.

The third is about memory. Amos Tversky and Daniel Kahneman showed in the 1970s that people judge how likely something is partly by how easily examples come to mind. A vivid story about one man comes to mind very easily. "Very rarely a sign of anything serious" is a statistic, and it doesn't stay in the memory the same way. After an hour on the forum the rare disease feels likely, because it's now the most vivid thing you know about twitches.

There's also a flaw in the plan itself. You wanted to rule the worst out, and that can't be done by reading. It takes evidence about your own body, such as strength that's normal on examination, a test that comes back clear, or a twitch that has gone within two weeks. A page can only tell you what the disease looks like, and almost any early symptom list looks a bit like almost anyone. So when you read in order to rule something out, you usually find something that seems to fit.

"It calms me down"

Sometimes it does. You search, and you find a page that says it's nothing, and you feel your shoulders drop. That relief is real, and it's the reward that keeps the habit going. I've called it the dip. It lasts a short time, and the worry that follows it is often worse than before.

There's a careful study of the same thing happening in a hospital. Lucock and colleagues followed sixty patients who'd had a camera examination of the stomach and been told by the consultant that there was nothing seriously wrong. Everyone's worry fell sharply straight afterwards. The researchers then checked back after a day, a week, a month and a year. The patients who'd scored low on a measure of health anxiety hadn't been very worried to begin with, and stayed that way. Those in the middle were reassured and mostly remained so. In the patients who'd scored high, the worry and the belief that they were ill had come back significantly within twenty-four hours, and it stayed back for the whole year. That was after a specialist had looked inside their stomachs and found nothing, and the relief lasted them about a day.

If that kind of evidence only calms someone for a day, a web page won't do better. Starcevic and Berle describe repeated symptom searching as a form of reassurance seeking. The Doherty-Torstrick study in chapter 2 found that the more anxious a person was about illness, the worse they recalled feeling after a search, where less anxious people recalled relief.

Here's how I understand what's happening. What follows is interpretation, though it's close to how clinicians who treat health anxiety describe it. When you find a reassuring page, your anxiety drops. Your mind notes what made it drop, which was searching. The next time anxiety rises, the urge to search is a little stronger, because last time it worked.

But the relief doesn't last, because the reassuring page can't examine you either, and you know that. Within hours a doubt arrives. The page might have been about a different kind of twitch, or yours might be the exception. So the anxiety comes back, and what your mind now reaches for is another search.

Over weeks, each dip gets shorter, and it takes more reading to get one. There's evidence that the two things feed each other. Fam te Poel and colleagues in Amsterdam surveyed more than five thousand people four times over. People who were more anxious about their health searched more, which you'd expect. But among people who started out with ordinary levels of health anxiety, there were also signs of the reverse. More searching was followed by more health anxiety, which was followed by more searching. The authors call this initial evidence, and I'd treat it the same way.

None of this means you should never feel reassured about your health. When a doctor examines your leg and says it's fine, that's information about you. The dip you get from a web page at midnight isn't information about you, and it wears off, and you go looking for it again.

"One more page and I'll be sure"

At half past eleven you nearly stopped. You'd read enough to see that the odds were heavily in your favour. But heavily isn't entirely, and the thought came that the next page might settle it. So you opened it.

What you're after at that point is certainty, and it's worth asking whether any page could hold it. Doctors themselves don't deal in certainty about a twitching calf. They deal in likelihoods, in watching, and in ruling things out step by step if they need to. "Very rarely a sign of anything serious" is as close to certain as an honest medical writer can get in a sentence. If no page can promise you that you personally are fine, then the search has no finishing line, and you could read all night.

This matters more for some people than for others. Thomas Fergus surveyed 512 healthy adults in the United States about how often they searched for medical information, how anxious they were about their health, and how well they tolerated uncertainty. Intolerance of uncertainty means finding it hard to bear not knowing. For people who tolerated uncertainty well, searching had little connection to health anxiety. As intolerance rose, the connection grew stronger. The people who most needed the search to give them a definite answer were the ones for whom searching and anxiety went together.

A survey taken at one moment can't show which causes which. But it fits the experience of the search. If you go in needing to be sure, you come out more worried than you went in.

The search does end, though, so it's worth looking at how. You might expect someone in search of certainty to stop at the most convincing page. In my observation it stops at the frightening answer or at exhaustion, whichever comes first. I think that's because fear is the only thing in the search strong enough to interrupt it. The reassuring pages leave room for doubt, so you read on. The frightening page doesn't leave you wanting another page, because you're too scared by then to go on looking.

This is how a person can spend an hour finding out that a symptom is nearly always harmless and go to sleep convinced that they have the exception. They did read the evidence. The search happened to stop at the single page that pointed the other way.

The practical lesson is that the stopping point has to be decided before you start. If you wait to feel sure before you stop, you won't get there, and the search will stop at the frightening page. Chapter 15 suggests stopping when you've read what the page tells you to do.

"Better safe than sorry"

This is the argument that defends the habit when everything else has been conceded. The searching may frighten you and cost you sleep, but you'd rather be frightened than miss something. Searching feels to you like a kind of vigilance.

I agree with the principle, and I don't think searching satisfies it. Being safe, with a symptom, means getting it in front of someone who can assess it, at the right speed. Searching isn't a step towards that. It comes before that step or takes its place, and it can lead you wrong in two ways.

The first is the one this book has mostly described. You end up terrified of something unlikely. You may then go to the doctor in a panic, or you may be too scared to go at all. While you stay away you only suspect it, and the doctor might confirm it.

The second is the opposite, and it gets less attention. Sometimes people search in order to talk themselves out of going. They read until they find a harmless explanation that fits, and then they decide that's what it is, and the lump or the bleeding or the cough goes unexamined for months. A search can't rule the worst in or out, as chapter 4 said. If you use one to reassure yourself about a symptom the NHS says to get looked at, that isn't safe either.

So whichever way the search goes, fear or false comfort, it hasn't made you safer. Only the assessment does that.

And the assessment is closer than the search makes it feel. For a worrying symptom you have a pharmacist, who can be asked without an appointment. There's 111, by phone or online, which exists to tell you how quickly something needs seeing and by whom. And there's your GP surgery. Each of them can do what you wanted from the search in the first place. They take your particular symptom, in your particular body, and tell you whether it needs attention.

One finding from the symptom checker study is useful here. Semigran's team found that the checkers' advice about what to do was generally cautious. They tended to send people for care when looking after themselves would have been reasonable. That's a fault in a symptom checker. It's also a reminder that the careful, cautious route is already there and doesn't require an hour on a forum. If you want to be safe rather than sorry, ask someone qualified, early, and do what they say.

"But the symptom is real"

It is. I said so in chapter 1 and I'll say it again, because people with this habit are often told, or tell themselves, that it's all in their head. The calf is twitching. Anyone could see it.

A real symptom can still be an ordinary one. Anne McAteer and colleagues at the University of Aberdeen posted a questionnaire to adults registered with twenty general practices around the UK. It asked about twenty-five symptoms and whether people had had them in the previous two weeks. The average person had had between three and four. Some reported as many as twenty-two. The commonest were feeling tired or run down, headaches and joint pain. These were people living their normal lives, and most of those symptoms never reached a doctor.

So a healthy body has symptoms most of the time. It produces aches, flutters, twinges, rumbles, patches of numbness from sitting badly, and spots that come and go. Most are never explained, because they leave before anyone thinks to ask. If every one of them were searched, every one of them would appear on the symptom list of something dreadful, because those lists are built from the same ordinary signals.

Then there's what worry itself does. The NHS page on health anxiety says that anxiety can cause symptoms like headaches or a racing heartbeat, and that you may mistake these for signs of illness. Its page on twitching lists stress and anxiety first among the things twitches are often linked to, along with tiredness and caffeine. It adds that worrying can make a twitch worse. So the

sequence on Tuesday night may have run like this. A stressful fortnight, poor sleep and three coffees produced a twitch. The search produced fear. The fear, and the bad night that followed, produced more twitching on Wednesday, which looked like the disease progressing.

Checking works in a similar way. When you stood on tiptoe at twenty to one, you were running a test that you've no training to interpret, on a leg you'd never tested before, while frightened and tired. Of course you couldn't tell whether it was weaker. Any result would have worried you, because you had nothing to compare it with. If you press a sore spot every day to see whether it still hurts, you can keep it sore. If you take your pulse when you're anxious, you'll find it fast. I think checking, like searching, is a search for certainty by a method that can't supply it, and it gives you more sensations to worry about.

A symptom can be real and harmless, and it can also be real and partly kept going by the worry and the checking. A search can't tell you which of those you have. Often time will, and if it doesn't, an examination will.

"It's always at night"

Look back at the history you checked in chapter 1 and you'll probably find that most of the long searches began after ten at night. There are some plain reasons for that, and they say something about how far to trust what you conclude at that hour.

The first is that night is when you notice your body. All day there's been something else to attend to. In bed, in the dark, lying still, there's nothing to compete with a twitch or a heartbeat or an ache. The sensation is probably no stronger than it was at three in the afternoon, when you were too busy to notice it. It gets your attention at night because there's nothing else to notice. This is my reasoning, though I doubt many people would dispute it.

The second is that night is when nobody can be asked. The surgery's closed, the pharmacist has gone home, and your partner's asleep. You might ring 111 for something that alarmed you, but for a fluttering calf you wouldn't think of it. So the phone seems like the only thing open. In the daytime the same worry has other places to go, and it often gets mentioned to someone or dealt with, or else forgotten.

The third is that you're at your worst at that hour. A group of sleep researchers led by Tubbs has put forward what they call the mind after midnight hypothesis. They brought together evidence that positive mood is at its lowest in the small hours and negative mood peaks then. The kind of thinking you need for weighing evidence and stopping yourself is also impaired when you're awake at a time your body expects to be asleep. They offer it as a hypothesis for

further testing. Separately, Palmer and colleagues pooled 154 studies of sleep loss and found that people who were short of sleep felt less positive and more anxious. If you've had a bad fortnight of sleep, as you had in chapter 1, you start the search already more anxious than usual.

Put those together and the night-time search looks like this. You do it when sensations seem strongest and your mood is lowest. Your judgement is at its weakest, and the only source open to you is the one that leans towards alarm. Then you decide what the twitch means. The hour affects that decision at least as much as your calf does.

It's worth comparing how the same worry looks at different times. In chapter 1, by morning the fear had shrunk to a manageable size and you felt slightly foolish. Nothing about the twitch had changed overnight, but you were a different reader of it.

One rule follows from this, and it will come back in chapter 17. A new sensation noticed at night waits until morning, unless it could be an emergency. If it really does need a look, a four-minute look over breakfast will be calmer and more accurate than an hour at midnight. And a good share of what you notice at night won't be there in the morning to look up.

"The forums are where the real stories are"

Official pages are cautious and general. They say "usually" and "rarely", and they tell you to see your GP. A forum has people on it. They describe what it felt like and how it started, and what the doctors got wrong. When you're frightened, that feels like the truth that the official pages are too careful to tell you.

The stories are mostly true. I've no reason to think the man with the twitching calf invented anything. What's wrong is what you take from them. His story tells you what happened to him and to nobody else. You're reading it to find out your own chances, and a single case can't tell you anything about chances. To know what a twitching calf usually means, you'd need to know about everyone who's ever had one. That's what the dull official sentence gives you. "Very rarely a sign of anything serious" is a summary of all of those people.

Chapter 4 mentioned who posts. People whose symptom came to nothing don't join forums, and if they do, they leave when it clears up. People whose symptom turned out to be serious stay for years, because the forum has become part of how they cope. So everyone you meet on a forum for a disease has that disease, and a fair number of their stories begin the way yours does. The same would be true of any disease whose early signs are common ones.

Forums have a second effect, which I've noticed and can't source. They teach you new symptoms to look for. You arrive with a twitch. You leave knowing that others also had cramps, or a change in

their handwriting, or trouble with buttons. For the next week you watch your hands. Anyone who watches their hands closely for a week will catch a fumble or two.

Much the same applies to a few other sources. Symptom checkers were covered in chapter 3. They're built with care and they still name the right condition first only about a third of the time. Videos and social media posts about someone's diagnosis are forum stories with better production. Chat assistants powered by artificial intelligence are new enough that I've no good evidence to offer you on them either way. I'd say only that they share the search engine's basic limit, because they can't examine you, and they'll answer your follow-up questions for as long as you keep asking. For someone with this habit, that means the search never has to end.

None of this is an argument against forums for people who have a diagnosis. A person living with a condition can get a great deal from others who share it, and that's what those communities are for. They aren't meant for someone with a new symptom trying to work out at midnight whether they belong there.

"What if the doctor missed something?"

Suppose you do what this book keeps recommending. You see the GP about the calf. She asks her questions, tests the strength in both legs, taps your knees and ankles, and tells you it's a benign twitch, very common, likely to settle. You walk out feeling light. By the following evening you're searching again. This time you're searching for how often doctors miss the disease, and what tests she should have ordered.

If you recognise this, you're in well-charted territory. The NHS list of signs of health anxiety includes worrying that a doctor or medical tests may have missed something. And Lucock's gastroscopy patients in chapter 5 are the same case. The ones with high health anxiety were reassured by a specialist with a camera, and a day later their worry was back.

Doctors do sometimes miss things, and I won't pretend otherwise. If a symptom changes, gets worse, or goes on past the point the doctor said it would, going back is sensible, and good doctors want you to.

But look at what the evening-after search is doing. You had an examination, which is the evidence chapter 4 said you needed, and it was clear. The search has no new evidence to set against it. All it can do is raise the general possibility of error, which applies to every consultation anyone has ever had and can never be removed. So the worry the search is feeding now is about certainty, as in chapter 6, and it isn't really about your leg any more.

There's something practical you can do about this, and it happens in the consulting room. Before you leave, ask two questions. "What should I look out for?" and "When should I come back if it hasn't settled?" Doctors call this safety netting, and many will do it without being asked. Write the answers down, there and then, in your phone or on paper. You now have a rule that came from someone who examined you. If the twitch spreads or the leg feels weak, go back. If it's still there in a month, go back. Otherwise, leave it.

You can use what you wrote down the next evening. When the thought comes that she might have missed something, there's a specific answer to it. You can ask whether any of the things she told you to watch for has happened. If it has, ring the surgery in the morning. If it hasn't, the search has nothing to add, and you can tell yourself so.

If you find that no examination reassures you for longer than a day or two, whatever the result and whoever gives it, I'd take that seriously. It suggests that reassurance doesn't last for you, and that more of it, from pages or from people, won't fix that. Chapter 18 covers what does help.

"It happened to someone I know"

For many people the habit has a starting point. A colleague went to the doctor with backache and was dead within the year. Your father ignored a cough. A friend of a friend was told it was nothing, twice, and it wasn't. After something like that, the official sentence about symptoms being rarely serious stops working on you. For that person it was serious, and you were close enough to see it.

I wouldn't try to argue anyone out of that experience, and I won't try here. It's worth being precise about what it teaches, though, because I think the habit takes the wrong lesson from it.

What went wrong in those stories was nearly always delay. Someone had a symptom and didn't take it to a doctor, or took it and didn't go back when it carried on. The lesson is to get persistent symptoms seen, promptly, and to return if they don't settle. I'd defend that lesson to anyone. It's also the lesson of the one look in chapter 15, where the whole point is to find the instruction and follow it.

None of those stories teaches that reading about diseases at midnight protects you. Your colleague's outcome wouldn't have been changed by an hour on a forum. If it could have been changed at all, that would have taken an appointment made sooner. So vigilance, in the useful sense, means noticing a change, giving it a sensible length of time, and then acting. Searching isn't part of that, and chapter 7 described how it can get in the way.

There's a second thing the experience does, which the memory research in chapter 4 helps to explain. One death that you witnessed weighs more in your mind than any number of people you never heard about whose backache was backache. That's how memory works, and it isn't a fault in you. But it means that your sense of the odds has been reset by a single case. Your colleague's story is one of the rare ones, and because you knew them, it has come to feel like what usually happens.

If a loss like this sits behind your searching, two things may help. One is to say so to your GP when you next go. "My father died of lung cancer and I get very frightened about coughs" is useful information, and a good doctor will take it into account in how they examine and explain. The other is to consider whether the fear is really about your calf at all. Grief and shock can come out as worry about your own body, sometimes years later. If that might be you, it deserves proper help, and chapter 18 says where to find it.

"I'm only being an informed patient"

You might object that doctors want patients who take an interest. They do. A patient who understands their condition is easier to help, and nobody wants to go back to the days when patients were told nothing.

I think the phrase covers two different activities, and only one of them is what you've been doing at midnight.

An informed patient, in the useful sense, is usually informed about something they've been told they have. They've been diagnosed with asthma or an underactive thyroid, and they read about how the inhaler works, what the blood test measures, and what to ask at the review. They read this from sources the clinic recommends. It's bounded by a real diagnosis and it leads to better questions. In my observation it leaves people calmer, too. If that's what you do, carry on.

The midnight search is a different thing. It starts from a symptom without a diagnosis, and it tries to do the doctor's part of the job with none of the doctor's tools. You can see the difference in what it leaves you with. After reading about your own asthma, you know what to do on a bad day. After the midnight search, you have a list of frightening words and no instruction at all.

There's a version of being informed that does help with a new symptom, and that's arriving at the appointment well prepared. A doctor can do more in ten minutes with a patient who can give a clear account. It's worth writing a few lines beforehand. Say what

you've noticed, in plain words, and when it started. Say what makes it better or worse, and what else has changed lately, including sleep, stress, caffeine, new medicines and new exercise. Note anything in your family that's relevant.

Then add one more line, which people often leave out from embarrassment. Say what you're afraid it might be. "I read that twitching can be a sign of a nerve disease, and I've frightened myself" isn't a foolish thing to tell a GP. It tells them what you need from the consultation. They can examine for that in particular and tell you what they found. If you hide the fear, you may leave with your real question unasked, and chapter 11 described what tends to happen the following evening.

What a doctor finds less helpful is a patient who arrives with the diagnosis already made and a list of tests to order. That's the midnight search brought into the surgery. You'll get more out of the appointment if you describe what's happening and say what worries you, and leave the diagnosis to the doctor.

What the searching costs

You may think of the habit as costing the odd bad night. Add it up more carefully. Most of this chapter is my own reckoning, and I'll say where a study comes in.

Sleep. The search happens late, in bed, on a screen, and ends in fear. It would be hard to design a worse hour before sleep. Then the tiredness produces symptoms of its own the next day.

Fear that outlasts the search. White and Horvitz found that the anxiety from an escalated search persisted after the session ended and broke into people's activities on later occasions. You'll know this from the Wednesday after. The forum post comes back to you in a meeting and again at your child's football match, and your stomach turns each time.

More symptoms. Chapter 8 described the loop. Worry and poor sleep produce sensations, checking makes them worse, and each new sensation starts another search.

A bent relationship with your doctor. It can bend in either direction. Some people book repeated appointments for reassurance that doesn't hold. Others, as chapter 7 said, are too frightened to go, or have talked themselves out of going. Neither gets the benefit of a calm consultation in which the doctor hears a plain account of the symptom.

The people around you. A partner gets asked whether the mole looks bigger, or whether the leg seems weaker, or whether they think it's serious. They say no, it helps for an hour, and the

question comes again. The NHS lists always asking people for reassurance among the signs of health anxiety. Over months a partner will tire of answering, or will answer without looking, and you'll notice when they do.

Money. Some people pay for private scans, tests and supplements bought at one in the morning. They don't settle anything. A clear result reassures you about as long as a reassuring page does, and the supplements you bought on a forum's advice do nothing for a twitch that coffee caused.

Attention. Hours of each week go into reading about diseases you don't have. The habit also takes up part of your attention during the day. While you work and talk you're also monitoring your body for the next thing.

Trust in your own body. I think this is the largest cost. Someone without the habit who notices a twitch thinks "that's odd" and forgets it. You can't do that any more. Every sensation has become a question, and the only tool you have for answering it is the one that makes things worse. You've ended up afraid of a body that, on the evidence so far, has been working well.

It's worth putting a number on some of this. Go back to the history you looked at in chapter 1, add up the hours for the month, and multiply by twelve. Write the figure down. It's the time you spent last year reading about illnesses.

Against that, count what the searches have found. Over the past year, how many of them turned up a real illness that needed treating? If any did, you'd have got there sooner and more calmly

by ringing the surgery on the first day.

What to do with a symptom

You'll still get symptoms, and some of them will need attention. So stopping the search can't mean ignoring your body. You need something to do with a symptom that's quick and safe, and that has an end. I'll call it the one look. It's my own arrangement of NHS advice, and nobody has tested it as a method.

If it might be an emergency, don't look anything up. The NHS says 999 is for life-threatening emergencies like strokes and heart attacks. If you're not sure whether you need 999, it says to get help from NHS 111, which can check your symptoms and tell you what to do. Don't search first in either case.

Otherwise, look once, at one trusted page. In the UK that means the NHS website. Search the symptom with "NHS" after it and open that page only. The NHS pages are written for this purpose and they're reviewed on a schedule. Nearly all of them have the same useful section, under a heading like "See a GP if".

Read for what to do. You can't read your way to a diagnosis, as chapter 3 showed. The page can tell you which of three things applies. It may say this needs urgent help. It may say see a GP, with a list of the circumstances. Or it may say this usually settles, and give a time after which you should see someone if it hasn't. Find which of those is yours. For the calf, the page says to see a GP if the twitch lasts more than two weeks, or is in more than one place, or the area feels weak or stiff.

Write down the instruction and the date. "Calf twitch. Started Saturday the 4th. See GP if still there on the 18th, or if it spreads, or if the leg feels weak." Put it in your calendar. You've now handed the watching to a date, so you don't have to carry it in your head.

Then close the page. Don't read the list of rare causes at the bottom. Don't go back to the results. The one look takes about four minutes. If the page says to see someone, make the appointment at the next opportunity and tell the doctor plainly what you've noticed and for how long. If it says wait, wait.

If you're unsure which applies, ask a person. A pharmacist can be asked without an appointment. 111 online will take you through questions and tell you where to go and how soon. Either is better than a second page, because both of them end with an instruction.

If the page seems too general, that's by design. You'll be tempted to think the page doesn't cover your case. Your twitch is in the calf and sometimes the eyelid, or it's worse after exercise, or it's been eleven days and not fourteen. A general page can't speak to those details, and no page can. The details of your case are what an examination is for. So if your situation doesn't clearly fall under "wait", treat it as falling under "ask a person". You might feel that one page is too little to go on. If so, the answer is to talk to someone qualified, and more pages won't help.

If you're not in the UK, choose your page in advance. Most countries have a national health service site, a health ministry site, or patient pages run by a large teaching hospital. Pick one now,

while you're calm, and bookmark it. It should be written for the public and reviewed by clinicians, and it should tell you when to seek care. It shouldn't have a forum attached.

One look per symptom. If the same symptom is still bothering you tomorrow night, you already have your instruction and your date, and nothing has changed. Looking again won't give you anything new. If the symptom itself changes, that's new, and you can take one more look or ring the surgery.

You might object that this leaves you not knowing what the twitch is. It does. You'll know what to do about it and when, and that's all the search could ever have given you. Most of the time the symptom will go before the date arrives, and you won't ever find out what it was.

When the urge comes

You can agree with every chapter so far and still find your thumb typing the symptom at ten to eleven. The urge to search is strong, and it's had a lot of practice. This chapter is about the minutes when it arrives. Most of it follows the NHS's self-help advice for health anxiety, and I'll say which parts are mine.

Start by knowing what the urge is. It's a spike of anxiety with an action attached. The action promises to bring the anxiety down, and chapter 5 explained why the promise is only half kept. What the urge doesn't tell you is that the anxiety will come down anyway. Left alone, a spike of worry rises, levels off and falls. How long that takes varies, and I've no measured figure to give you. You can find out by timing it once. Searching brings the worry down sooner, but it means you never find out that it would have come down without the search.

Delay. This one is mine. When the urge comes, tell yourself you can search in twenty minutes if you still want to. You aren't forbidding it. Then do something else for those twenty minutes that uses your hands or your attention. The NHS advice is similar. When you get the urge to check, it says, distract yourself by going for a walk or calling a friend. At ten to eleven that might mean getting up, making a drink without caffeine in it, and reading a chapter of a novel in another room. Often the twenty minutes pass and you find the urge has dropped enough to go to sleep.

The diary. It's the NHS's first suggestion. Note how often you check your body, ask people for reassurance, or look at health information. Then try to reduce how often you do these things gradually, over a week. The note can be a tally on a card, with a mark for each search, each body check and each time you ask someone whether it looks all right. Counting makes you notice the habit while it's happening. It also lets you see yourself improving, because a week with nine marks is followed by a week with six.

The two-column table. This is also from the NHS. In the first column you write the health worry. In the second you write a more balanced thought. Their example has "I'm worried about these headaches" on one side and "Headaches can often be a sign of stress" on the other. The second column isn't there to convince you that you're well. It reminds you that the ordinary explanation exists, which is the one the search passes over.

Where the phone sleeps. This one is mine. Most searches happen in bed. If the phone charges in the kitchen, a search at ten to eleven requires getting up, walking through a cold house and standing at the worktop, and you'll do that far less often. An alarm clock costs a few pounds.

The people you ask. If your partner has become part of the pattern, tell them what you're doing and ask for a specific change. When you ask whether the mole looks bigger, they shouldn't answer the question. They can say, "What did the page say to do, and have you done it?" It will feel unhelpful to both of you at first. But they've had months of answering the question, and you both know it didn't help.

Checking. If you've been testing the leg or pressing the spot or looking at the mole every day, treat it as you treat the searching. Count it and cut it down. If the NHS page says to keep an eye on something, decide how often is sensible. Once a week at a set time is plenty for nearly anything a page tells you to watch. Do that and no more.

The decision

This chapter asks you to decide something. It comes late because at the start it would have sounded like being told to stop worrying about your health, which nobody can do on instruction. By now you've seen that a search can't tell you what you have or rule anything out, and that the calm it gives lasts hours at most. You've seen that it tends to end at the frightening answer because of how searching works, whatever the state of your body. And you've seen that the safe thing to do with a symptom is quicker than the search ever was.

Here's the rule I'd suggest. Put it in your own words if you like.

When a symptom worries me, I look once, at one trusted page, to find out what to do. Then I do it, and I put the search down.

It has five parts, and each answers a chapter.

Emergencies go to a person. If it might be life-threatening, I call 999. If I'm not sure, I call 111 or use 111 online. I don't search first.

One page, read for the instruction. I open the NHS page and nothing else. I find out whether to get help now, see a GP, or wait until a date. I don't read the list of rare causes.

The instruction gets written down with a date. I put it in my calendar. If the page says see someone, I book it at the next opportunity.

One look per symptom. I look again only if the symptom itself changes. I stay off forums, I don't open a second page, and I don't search in bed.

After an appointment, I follow what the doctor said to watch for. I ask what to look out for and when to come back, I write it down, and I use it to answer the thought that something was missed.

It helps to plan for the moments when the habit will try to restart. Peter Gollwitzer and Paschal Sheeran pooled ninety-four tests of plans in the form "when X happens, I'll do Y" and found that they make people more likely to follow through. A plan like this works because you've decided what to do before the difficult moment comes. Three are worth writing down.

When I notice a new sensation, I'll wait until the next morning before I do anything about it, unless it could be an emergency.

When I get the urge to search a symptom I've already looked up, I'll read what I wrote in my calendar. Then I'll wait twenty minutes in another room.

When I catch myself on a second page, I'll close the browser, put a mark on the card, and put the phone in the kitchen.

I'll be honest about what to expect, and this is my expectation and not a finding. The first week or two will probably be harder than searching was. You'll be doing without the dip, and the anxiety will have nowhere quick to go. You'll lie there at eleven with the twitch and a date in the calendar, and it won't feel like enough. The urge generally weakens over a few weeks if you don't act on it, though I can't promise you how fast.

You'll still notice symptoms, because that's how you're made, and some will still alarm you. What should change is what happens next. The noticing should lead to a four-minute look and an instruction. It shouldn't lead to a lost night. If it doesn't change after an honest few weeks, that's no failure on your part. It means the habit needs more help than a book can give, and the next chapter says where to get it.

Long-term conditions, children and bad nights

When you have a diagnosed condition. People living with a long-term illness have real reasons to look things up, and real symptoms to interpret. The one look still works. Your trusted source may be your clinic's own material, a specialist nurse's phone line, or the charity for your condition. Ask your team the safety-net question in a general form. Which changes should I ring you about, and which can wait for my next review? Their answer is the instruction you follow.

When you're searching for someone else. Parents search their children's symptoms, and adult children search their parents'. It frightens them the way searching their own symptoms would, and they feel more responsible. The rule is the same, and it's firmer for young children. The NHS says to call 111 if you need advice for a child under five. A parent's sense that a child isn't right counts as information, and it should go to a person who can assess the child. Reading forums doesn't do that.

When you're pregnant. New sensations arrive weekly in pregnancy and the stakes feel doubled. You also have something most people don't, which is a midwife and a maternity unit with a phone number, whose job includes answering exactly these questions. Use that number. I'd keep off pregnancy forums late at night.

When the news is full of a disease. During an outbreak, or after a celebrity's diagnosis, many people's searching rises. The same points apply. Pick one official source, read what it says to do, and

don't follow the rolling coverage.

When someone you live with has this habit. You'll have been asked, many times, whether it looks all right. Telling them not to be silly doesn't help, and neither does answering the question for the fortieth time. What helps is to ask what the page said to do, and whether they've done it. If the answer is to see someone, offer to sit with them while they book. If they've been frightened for weeks, show them the NHS page on health anxiety and let them read the list themselves.

When you slip. You'll have a bad night. Something will scare you, and an hour later you'll be on a forum with your heart pounding. It doesn't undo the weeks before it, and it doesn't prove the approach has failed. Close the browser and put a mark on the card. In the morning, do the one look properly, in daylight, and write down the instruction. Then work out what led to the slip. It's usually tiredness, stress, or a phone that had found its way back to the bedside.

When a search did once find something. Some readers will say that they searched, went to the doctor because of it, and it turned out to matter. I believe you, and I'm glad you went. What helped was that you went. One look at the NHS page would have sent you just as surely, days sooner and with less fear.

When it's more than a habit. Go back to the NHS's list. It includes constantly worrying about your health, frequently checking your body, always asking for reassurance, worrying that doctors or tests have missed something, and obsessively looking at health information. It also includes avoiding anything to do with serious

illness, and acting as if you were ill. If several of those fit and they're affecting your life, the NHS advice is to see a GP. You can also refer yourself directly to an NHS talking therapies service without going through a GP. The usual treatment is cognitive behavioural therapy, often called CBT, and sometimes medicine for anxiety.

There's decent evidence that it helps. In a trial led by Peter Tyrer, 444 hospital outpatients with high health anxiety were given either five to ten sessions of CBT adapted for health anxiety or the clinics' standard care. A year later the therapy group had improved more, and about twice as many of them had reached normal levels of health anxiety. The proportions were small in both groups, at 14 per cent against 7, so this wasn't a cure for most. It did make a real difference, and the difference lasted two years. A smaller trial reported by Jill Newby and Eoin McElroy looked at searching in particular. People with severe health anxiety who did an online CBT course reduced their compulsive, distressing searching much more than a comparison group did.

Needing that kind of help says nothing bad about you. The NHS describes health anxiety as related to obsessive compulsive disorder, and explaining it to yourself doesn't make it stop.

When the fear is of dying, or you feel hopeless. If the worry about your health has tipped into despair, or you have thoughts of harming yourself, ask for an urgent GP appointment or call 111. Treat that as an emergency for a person to deal with, and don't search it.

Ten to eleven again

It's a Tuesday night in early summer, ten to eleven. You're in bed with the light off, and there's a dull ache behind your right eye. It's been there since mid-afternoon.

The phone is in the kitchen, where it's been charging overnight since March. You lie still for a minute and notice the old pull. It says you could just go and look. You notice too that your jaw is tight, that you spent nine hours at a screen today, and that you've had about a pint of water since breakfast. You get up, drink a glass of water at the sink without touching the phone, and go back to bed. The ache is still there when you fall asleep.

It's there in the morning too, fainter. Over breakfast you take your one look. The NHS page says most headaches go away on their own and aren't a sign of something more serious. It says to see a GP if a headache isn't getting better or you regularly get headaches, and it lists the things that need urgent help. You read the list once. None of them applies.

You write in the calendar, "Headache since Tues 3rd. See GP if still there Friday, or if it keeps coming back." You close the page. It took about four minutes. By Wednesday evening the ache has gone, and on Friday the calendar reminder comes up and you delete it.

The calf stopped twitching in March, a few days before the date you'd written down. You never found out what caused it, and you've stopped wondering.

It hasn't all been smooth. In April a mole on your shoulder sent you to a forum for forty minutes before you caught yourself. The next morning you looked at the NHS page. One of the items on its list for seeing a GP seemed to fit, so you booked it. The doctor looked at it under a lens, said it was fine, and told you what changes to watch for. You wrote them down. The thought that she might have missed something came the next night, as you'd expected it would. You read what you'd written, saw that nothing on it had happened, and watched television.

The card on the fridge has four marks on it for last month. In February it had thirty-one.

You still notice every flutter and twinge, and you probably always will. Now when you notice one, you know what to do about it, and then you get on with the evening.

If you've read this far and changed nothing yet, do one thing tonight. Put the charger in the kitchen before you go to bed.

Notes

This book gives general information. It isn't medical advice, and it can't tell you whether any symptom of yours matters. If you're worried about a symptom, speak to a GP, a pharmacist or NHS 111. In an emergency call 999. The NHS services I describe are those for England as I found them in September 2026. Arrangements differ elsewhere in the UK and abroad, and they change.

I've kept sources out of the chapters where I could so they read easily. Here they are by chapter, with the limits I'm aware of. Unless I say otherwise, I read the published summary of each paper and not the full text. I checked each paper for a retraction or correction notice in September 2026. One has a published correction, which I mention below. Where a chapter isn't listed, it rests on my own reasoning. That includes chapters 1, 10 apart from one reference, 12, 13 and 19. The person in the examples is invented, along with the twitch, the forum post, the headache, the mole and the marks on the card. I've left the rare disease unnamed on purpose.

Before you start. The description of health anxiety and the advice on when to see a GP are from the NHS page "Health anxiety", last reviewed in November 2023. Advice on 999 and 111 is from the NHS pages "When to call 999" and "When to use NHS 111 online or call 111".

Chapter 1. What the NHS says about twitches is from its page "Twitching eyes and muscles". The list of features is mine.

Chapter 2. Starcevic and Berle, "Cyberchondria: towards a better understanding of excessive health-related Internet use", Expert Review of Neurotherapeutics 13, 2013, pages 205 to 213.

Researchers call the habit cyberchondria, a word I've kept out of the chapters. Doherty-Torstrick, Walton and Fallon, "Cyberchondria: parsing health anxiety from online behavior", Psychosomatics 57, 2016, pages 390 to 400. The 731 participants were volunteers recalling how past searches had made them feel, so the study can't show that searching caused the feelings. The authors say their finding needs repeating in controlled experiments. The list of four needs is mine.

Chapter 3. Semigran, Linder, Gidengil and Mehrotra, "Evaluation of symptom checkers for self diagnosis and triage: audit study", BMJ 351, 2015, h3480. The study is ten years old and the tools will have changed. I haven't found a comparable test of open web searching. The account of what a doctor does is general knowledge.

Chapter 4. White and Horvitz, "Cyberchondria: studies of the escalation of medical concerns in Web search", ACM Transactions on Information Systems 27, 2009, article 23. That the authors worked at Microsoft is general knowledge and isn't in the summary I read. Search engines have changed a good deal since 2009, and some now put official health information first. Tversky and Kahneman, "Availability: a heuristic for judging frequency and probability", Cognitive Psychology 5, 1973, pages 207 to 232. My three suggestions about why searches lean towards serious conditions are reasoning and haven't been tested.

Chapter 5. Lucock, Morley, White and Peake, "Responses of consecutive patients to reassurance after gastroscopy", *BMJ* 315, 1997, pages 572 to 575. It was a small study with one consultant and sixty patients. Te Poel, Baumgartner, Hartmann and Tanis, "The curious case of cyberchondria: a longitudinal study on the reciprocal relationship between health anxiety and online health information seeking", *Journal of Anxiety Disorders* 43, 2016, pages 32 to 40. There were 5,322 respondents. The two-way relationship didn't appear in the subgroup whose health anxiety was already at a clinical level, though the authors think searching may still help to keep it going. The idea that reassurance brings short relief and strengthens the urge comes from the cognitive behavioural account of health anxiety associated with Paul Salkovskis and Hilary Warwick. I've described it in my own words from general knowledge and haven't read their 1986 paper.

Chapter 6. Fergus, "Cyberchondria and intolerance of uncertainty", *Cyberpsychology, Behavior, and Social Networking* 16, 2013, pages 735 to 739. My account of why the search stops at the frightening answer is an observation with no study behind it.

Chapter 7. Semigran and colleagues as above. Across the twenty-three checkers, appropriate advice was given in 80 per cent of emergency cases and in 33 per cent of cases where self-care would have been reasonable. That people search to talk themselves out of going is my observation.

Chapter 8. McAteer, Elliott and Hannaford, "Ascertaining the size of the symptom iceberg in a UK-wide community-based survey", *British Journal of General Practice* 61, 2011, pages e1 to e11. The survey went to 2,474 adults aged 18 to 60, and the mean was 3.66

symptoms in two weeks. The NHS statements are from its pages on health anxiety and on twitching. What I say about checking is reasoning, apart from the point about pulse, which follows from the NHS statement that anxiety can cause a racing heartbeat.

Chapter 9. Tubbs, Fernandez, Grandner, Perlis and Klerman, "The mind after midnight: nocturnal wakefulness, behavioral dysregulation, and psychopathology", *Frontiers in Network Physiology* 1, 2022, article 830338. It's a hypothesis paper. Palmer and colleagues, "Sleep loss and emotion: a systematic review and meta-analysis of over 50 years of experimental research", *Psychological Bulletin* 150, 2024, pages 440 to 463. The first two reasons in the chapter are mine.

Chapter 10. Semigran as above. I know of no good evidence yet on artificial intelligence chat assistants and health worry, and the chapter says so.

Chapter 11. The NHS list is from its health anxiety page. Lucock as above. "Safety netting" is a standard term in general practice, which I state from general knowledge.

Chapter 14. White and Horvitz as above. Everything else is my own reckoning.

Chapter 15. The one look is my arrangement of NHS advice and hasn't been tested. The wording about 999 and 111 is the NHS's. The instructions for a twitch are from the NHS page on twitching. That pharmacists can be consulted without an appointment is general knowledge.

Chapter 16. The diary, the gradual reduction, the two-column table, the headache example and the advice to distract yourself are from the self-help section of the NHS page on health anxiety. The twenty-minute delay, moving the phone, and the request to a partner are mine. They resemble what therapists recommend, and I haven't sourced them.

Chapter 17. Gollwitzer and Sheeran, "Implementation intentions and goal achievement: a meta-analysis of effects and processes", *Advances in Experimental Social Psychology* 38, 2006, pages 69 to 119. The rule and its parts haven't been tested together, and what I say to expect is my expectation and not a finding.

Chapter 18. Tyrer and colleagues, "Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients: a multicentre randomised controlled trial", *Lancet* 383, 2014, pages 219 to 225. The journal published a correction to this paper in the same issue, and I haven't seen what it changed. The figures I give are from the summary, 13.9 per cent against 7.3 per cent reaching normal levels at one year. Newby and McElroy, "The impact of internet-delivered cognitive behavioural therapy for health anxiety on cyberchondria", *Journal of Anxiety Disorders* 69, 2020, article 102150. There were 41 people in each group, and the comparison group received information, monitoring and clinical support. Treatment options and self-referral are from the NHS health anxiety page. The advice for a child under five is from the NHS pages on 111. What I say about pregnancy and maternity units is general knowledge.

Chapter 19. What the NHS says about headaches is from its page "Headaches".