Original article

Personal responses in medicine: adding to the three stage assessment

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S Afr Fam Pract
1995;16:446-452

KEYWORDS
Physicians, Family;
Consultation;
Physician-Patient Relationship;
Emotions;
Records.

Curriculum Vitae

Chris Butler *grew up in the eastern Cape and did a Bachelor of Arts degree at Rhodes University before qualifying in medicine at the University of Cape Town in 1986. Since his internship at Groote Schuur, he has worked at Somerset and Red Cross Hospitals and was a medical registrar at Cecilia Makiwane Hospital in the Ciskei for a time. His itchy feet have taken him as far afield as Saskatchewan, and after stints in psychiatry in the UK, he trained in general practice near Cambridge. He is now a principle in general practice and a lecturer in the Department of General Practice of the University of Wales College of Medicine in Cardiff. Chris enjoys teaching and his special academic interests include the organisation of primary care for people with diabetes and negotiating behaviour changes, especially with smokers. He is married to Judith van der Voort and they are expecting their first baby in July. Boerewors connoisseurs will be pleased to hear that Chris' legendary braaing skills have not been too badly damaged by the Welsh weather.*

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Abstract

Personal responses to clinical encounters are inevitable in both clinicians and patients, and handling them sub-optimally means that consultations can become the routine processing of 'cases' by clinicians who are alienated from the patient's story, emotional responses and their own, potentially useful subjective reactions. Using subjective responses more constructively requires that changes are made to both clinical practice and teaching. Regarding clinical method and record keeping, two suggestions are explored which may enhance patient-centred assessment. Firstly, the call to include aspects of the patient's story in their own words is reaffirmed. Secondly, it is suggested that relevant personal responses of both clinician and patient can usefully be incorporated into the three stage (clinical, personal and contextual) formulation. A simple model is then offered which may be of practical help in teaching students about the constructive use of personal responses in the consultation.

Introduction

The consultation is a common human experience and it is neither possible nor desirable for clinical encounters to be 'affectively neutral'.[1] Inevitably, personal responses in medicine can have important consequences for all concerned, so at the very least, they should be recognised and handled in ways which minimise their chances of causing harm. Furthermore, our desire to practice the best possible medicine should make us attempt to harness and maximise their positive potential.

Emotional responses of both clinicians and patients are often handled sub-optimally in western medicine. The

personal reactions of clinicians to patients are frequently viewed with suspicion in general medical settings, and undergraduate medical curricula that pay detailed attention to emotions within the consultation are the exception rather than the rule.[2-4]

This discussion focuses on the effects that such neglect by default and example has for patients, clinicians and the diagnostic process. In order to contribute to a changing culture which maximises the constructive potential of subjective responses, practical suggestions are explored to enhance clinical method and record keeping. Finally, a simple model to aid the teaching of students in this area is offered.

Personal responses and patient satisfaction

Despite medicine's roller-coasting technical advancement and ever-improving measures of 'hard' health outcomes, patients are reporting a growing sense of dissatisfaction with their health care, and this apparent incongruity has been called the 'health paradox'.[5] One factor which may help explain this puzzle must surely be the mounting sense that the health system fails to acknowledge and address the uniqueness of each individual's experiences. Preoccupation with technological excellence, consumerism and 'standard setting' often comes at the expense of nurturing individual relationships and a holistic approach to each person's complex physical and psychosocial situation.

It is well known that failure at the level of doctor patient communication results in most litigation and that patients will forgive their doctors a great deal if they feel they have been respected, listened to and their problems acknowledged.[6]

Paying attention to the affective component of the consultation will at least ensure that patients feel that some sort of emotional exchange has occurred and they have been treated as individuals rather than recipients of standardised packages of care.

Emotions in the clinical encounter and the psychological health of clinicians

There are many good reasons why the giants on whose shoulders we now stand discouraged the emotional expressiveness of doctors in training. At one time, it seemed that patients would be content with competent clinical care, courtesy and adequate information, and that they seldom expected explanations, understanding and emotional support from their doctors.[7] Over involvement, over anxiousness, sexual attraction, creating dependency and so on are all obviously counterproductive to the clear judgement and therapeutic effectiveness of clinicians. Distinguishing between ethical conflicts, value judgements and emotional responses can be very difficult, especially if one is not in the habit of talking about such things.

Thus, most undergraduate medical students are taught predominantly in a biomedical paradigm to perform a thorough 'objective' history, a systematic examination, order rational special investigations and then to formulate a diagnosis and a plan of management. Ironically, emotions have been seen as unwelcome intruders which pollute the objectivity of the consultation. (A truly scientific approach would have acknowledged and assessed them.) Once qualified, young doctors are suddenly confronted by the responsibilities of influencing and officiating over the great dramas of life and death and they are frequently ill prepared for dealing with the inevitable emotional responses. Their feeling, creative selves may become overwhelmed, suppressed and then atrophied.

While Balint groups exist in a few centres, there is still little place for the recognition and expression of the emotional responses of clinicians in the prevailing medical culture. Although treating the patient as a 'whole person' is now a favoured slogan, talk of treating clinicians as 'whole people' is not often heard. The expression of emotions in the clinical trenches may be

Healing and story telling have ancient and deep connections

Use patient's own words in medical records

Patients are reporting a growing sense of dissatisfaction with their health care

seen as a sign of weakness and a pointer to a lack of availability to stand by patients in their crises.

'Professional burnout' is a well recognised and increasingly common syndrome among doctors and the suppression of emotions and their associated creative potential may contribute to it. Loss of a sense of humour and creative problem solving, irritability, a cynical attitude towards patients, diminished sense of satisfaction, emotional exhaustion, depersonalisation, and low productivity are some of the symptoms.[8]

The diagnostic and therapeutic value of emotions in the consultation

Many writers have given examples where attention to emotions in the clinician have constituted a breakthrough in the healing process.[1, 9-11] Some psychiatrists have long since recognised that depression is an 'infectious disease',[12] and a plummeting mood in the clinician may be an important clue to a diagnosis of depression in a patient. Equally, emerging hatred or frustration in the clinician may be associated with a personality disordered patient,[13] and Asher has spoken about the tightening of a clinician's fist as a sign of the hysteric![10] All psychodynamic methods of psychological treatment acknowledge the transference, counter-transference phenomena and may construct the healing process around the scrutiny of these emotions.[14] The potential benefits to patients of addressing transference and counter-transference in training doctors for general medical settings has been well documented.[15, 16] The constructive use of personal responses can therefore lead to important diagnoses which may make it possible to avoid putting patients through cruel, dangerous and expensive investigations. It enhances clinicians' ability to engage patients at the true source of their problems and avoids the entrenchment of emotional stress as physical 'illnesses'.[9]

As long ago as 1967, Freeling and Browne stressed the importance of using all the data that is available to the general practitioner for the diagnosis: "...These include the behaviour and emotional state of the patient and his family, the effects produced on others, including the doctor himself, and the general environmental situation. Since many of these facts require skill both to elicit them from the patient and to interpret them when obtained, a study of this aspect of patient care must be included in the doctor's training."[10]

Adding to The Three Stage Assessment by incorporating 'story'

It has been argued that traditional medical records reflect medicine's imbalance in favour of the 'objective' and that the way we keep our notes usually ignores the importance of individuals' interpretation of their experiences.[17]

Drawing on literary theory, Donnelly has highlighted the distinction between two forms of narrative. A 'chronical' is a medically sanitised selection of events perceived by clinicians to be relevant to the diagnosis and management of the patient; it usually restricts itself to the physical world and omits what the patient knows, feels and experiences.[17]

This is the style of discourse generated by the biomedical clinical method.

A patient's 'story', on the other hand, not only constructs a 'landscape of the events' that have occurred, it also reveals a 'landscape of consciousness' and thus records emotions as well as events.[17]

For the patient, the advantages of the recording of 'stories' instead of 'chronicles' include a recognition of their unique experience and their feelings. Healing and story telling have ancient and deep connections, and as the psychotherapist, priest and poet knows well, telling one's own story and having its importance recognised can mark the beginning of a journey of insight and self healing. Since the patient-centred clinical method seeks to address

Acknowledge the uniqueness of each individual's experiences

Telling one's own story can mark the beginning of a journey of insight and self-healing

patients' concerns in an empowering and respectful way, the discourse of 'story' seems more congruent with this philosophy of care, and recording extracts from patients' stories in their actual words can be profitably included in patient-centred clinical method.

Adding to The Three Stage Assessment by incorporating personal responses

The three stage, assessment includes personal and contextual evaluations, and the rationale for each of these components has been eloquently justified elsewhere.[18, 19] Although certain personal responses may be included at the 'personal level', this usually relates to patients' subjective account and their interpretation of their symptoms. It does not tell us much about the patient's responses to the clinical encounter, their treatment and the information they are receiving. Also, there is no requirement in this assessment to routinely record the potentially useful information about the clinician's response to patients and their story. Formally recording clinicians' responses and reactions would encourage an holistic view where the clinician is seen as influencing and influenced by all other components of the system.

Thus, a place could be made in the medical record for personal responses; it could have two components.

Firstly, a record can be made on how the patient appears to be responding emotionally to illness, information sharing, and treatment experience (including relationships with health care workers). One obvious benefit would be the avoidance of burdening patients with inappropriate information and procedures who are, for example, in a state of 'anger' or 'denial' after having just received bad news. Interaction can be tailored to the patient's knowledge, emotional state and receptivity. Clinicians on the receiving end of 'anger' are less likely to feel individually blamed and see it as part of a normal grieving process. This will enable them to feel less defensive and more equipped to respond appropriately. Such a record could be crucial to communication between the patient and other members of the care team who appear on the scene.

Secondly, clinicians may note aspects of their own emotional responses which have diagnostic and management relevance. Under their management plan, they might record how they intend to act on their emotional responses and how these might effect future management. For example, after consulting with a woman with terminal breast cancer who feels that "had the doctors picked this up earlier, my disabled son would have someone to look after him come Christmas," the clinician may record, "I felt blamed and inadequate". The clinician may then make a note of a plan for dealing with the emotion, for example: "Acknowledge anger. Offer to discuss plans and investigate options for son's future care."

Adding to The Three Stage Assessment; illustrative patients

Patient One

A woman in her late thirties called out a doctor because of perineal bleeding. The consultation focused on the presented problem until a few routine gynaecological questions were asked. The patient then suddenly lost her sunny affect, burst into tears, and told the doctor how unhappy she had been ever since she had had a termination of pregnancy at the age of 19. Her parents had exerted a great deal of pressure on her to have a termination. She reluctantly agreed, and had regretted it ever since. This visit was the first time she had told anyone apart from her present partner about her suffering. She remains angry with her parents but has never fallen pregnant again.

The usual Three Stage Assessment of this patient may be enhanced by incorporating some of the patient's own words which give more informa-

Record stories instead of chronicles

Doctors tend to be pre-occupied with technological excellence

Patients forgive their doctors a great deal if they feel respected and listened to

tion about the problem than many pages of medical 'chronical' ever could. Incorporating a category for personal responses also illustrates how this can add to assessment and management.

Patient Two

Parents brought an 11-month old baby to a doctor for the problem of an upper respiratory tract infection. This was the first time that this family had consulted at this practice. Several months before, the child had been involved in a motor vehicle accident and an arm and a leg had been amputated. The clinician was initially taken aback by the unexpected sight of a disfigured baby. She decided to share this with the parents, and asked them if other people also reacted in a similar way. They confirmed that this frequently happened and that they found it very upsetting. The father had been driving the car at the time of the accident and although the accident was not his fault, he still felt responsible. The clinician was able to hasten the fitting of artificial limbs to the child, which improved people's reactions to the baby. She also made a follow-up appointment to allow the parents to talk more about their feelings. The clinician informed other members of the primary health care team of the baby's injuries so that they would know what to expect if they met this child.

A tool for teaching the constructive use of personal responses to clinical situations

Most students will be unfamiliar with this style of assessment and tutors may therefore find a simple schema useful to illustrate ways of handling their reactions to clinical situations.

The tutor could go through the following steps with the students:

1. Stress that personal reactions to patients are a normal part of being human. Dealing properly with them is essential to their own psychological integration and individual responses can be helpful to the diagnostic and therapeutic process.

2. Reactions to patients are not all the same. Distinguishing between emotional reactions, value judgements and ethical conflicts is important.

3. Sometimes it may be useful to share

Recipients of standardised packages of care!

Patient One

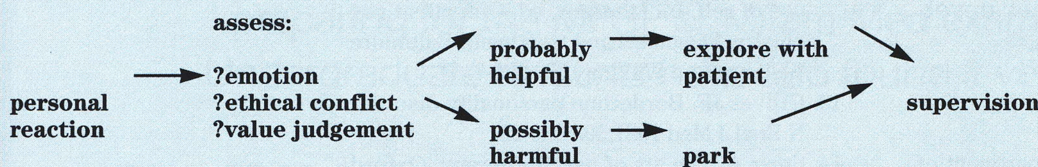
Assessment	Plan
Clinical	
PR. Bleeding, haemorrhoids	Supps
Prolonged grief reaction	?counselling
Personal	
Regrets decision to terminate pregnancy	
"I lost my son when I was 19"	?Grief
Angry with self and parents	counselling
Regrets about losing first relationship	
Contextual	
Childless	Explore ideas about
"James and I are friends rather than lovers"	future pregnancy
Spends most of her time helping others	?'atonement'
Responses	
Patient	
Feels better for having spoken to someone about it at last.	
Found it painful to talk, would rather initiate future contact.	
Clinician	
Moved by a sense of great sadness	Be especially available
Felt privileged to listen	for future discussion
Listening felt most therapeutic	(active listening emphasis)

Patient Two

Assessment	Plan
Clinical	
URTI	Paracetamol and advice
Amputations	OT and prostheses
Personal	
Parents upset by others' reactions	Discuss with appliance centre
Contextual	
Father driving when accident happened	Follow-up appointment for
"Not a night passes without me waking up crying; I re-live it even in my sleep."	parents to ventilate feelings
Responses	
Patient	
Appreciates clinician's openness.	
"You are the first person to talk about how you react to him. Most people recoil in horror and then try and make as if nothing has happened. It makes my heart bleed for him."	
Clinician	
Initial shock at seeing disfigured child	Prepare colleagues

and explain emotional responses and ethical conflicts with the patient. All possible value judgements and other potentially unhelpful responses should be parked and not mentioned to the patient. A useful question to ask oneself is: "Will raising this with the patient be therapeutic for the patient or predominantly self serving for the clinician?"

4. Supervision should take place at a later point in which responses to patients form part of the discussion. This may be with senior colleagues, contemporaries or other members of the health care team. This will hopefully contribute to a changing medical culture where personal responses and emotions become less of a taboo and their value more appreciated. It should be stressed that this style of approach does not mean that every consultation for a sore throat be transformed into a high drama of mutual catharsis or that clinicians should ever burden their patients with their own unhappiness and sadness.



Two controversial issues arise. Firstly, it may be argued that subjective comments in the notes may cause prejudice about patients to become entrenched. Secondly, clinicians may fear upsetting patients and making themselves vulnerable to litigation through this style of record keeping, especially where patients have access to their medical records. However, clinicians should be trained to see a patient's story as a never-ending account which is likely to be full of surprises, and that their own responses should also be flexible and dynamic. They will hopefully record the growth in their affective resonance with the patient as well as the positive results of endeavours to foster progress in the doctor-patient relationship, thus minimising prejudice and patient offence. Dealing honestly and formally with such matters is preferable to the clinician maintaining an 'objective', inoffensive medical record while 'unloading' their emotions in the tearoom in ways which are often uncomplimentary and break confidence.

Conclusion

Since subjective responses are at the heart of the human condition and therefore clinical medicine, in order to practice medicine of the highest quality, we need to be sure that we are recognising and effectively using them in our encounters with patients. Addressing the emotional matter of the consultation and formalising it in teaching and in this expanded patient-centred assessment, has many advantages.

Recording patients' actual words and their emotional responses makes it a discipline and then a habit to see things also through their words and eyes. It encourages complimenting the 'objective' clinical narrative with a form of discourse which is more congruent with the patient-centred clinical method. Paying proper attention to patients' 'stories' will make patients feel acknowledged and respected. For the clinician, psychological balance is enhanced through greater usage of their unique creativity which is likely to improve professional and personal life. This approach also ensures that potentially useful diagnostic information is harnessed and used constructively in the clinical encounter. The formal recording of useful subjective responses combats a sense of alienation from patients and of somehow being separated from t he patient's systems; it sharpens our sensitivity to how

Emotions are seen as unwelcome intruders

The doctor's emotions have caused a breakthrough in the healing process

we influence the story and how it influences us. Art and life cease their mimicking, separate dances; they become inextricably integrated and both clinician and patient enhance their health and humanity.

Formal evaluation of the application of these ideas has not yet been undertaken. However, the proposed additions to the three stage assessment and the model to aid teaching has been explored with experienced clinicians and teachers in a workshop at regional conferences of academic departments of general practices as well as in workshops within one department of general practice. Initial work with undergraduate students and general practice registrars has yielded exciting responses. It is hoped that this discussion will stimulate their further development and formal evaluation.

Acknowledgement

I am grateful to members of the Department of General Practice of the University of Wales College of medicine for their debate and constructive criticism of earlier versions of this paper.

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