Doctor-Patient Relationship

Essential C M E is a series involving a continuous self learning process in Family Practice for general practitioners, primary care physicians and generalist medical officers. With the introduction of the category "Family Physician" and the need for certification and recertification in the future, this series is aimed at the busy doctor to help him or her to update knowledge on broad issues in family practice by using different approaches. Some parts will be focused on helping the general practitioner to obtain certification as a "Family Physician" via postgraduate examinations.

There are five parts to the section.

Part One is called BENCHMARKS FOR THE BUSY GP. Instead of reading through a long article, a group of GPs will have extracted the important facts on the subject from a general practice perspective.

Part Two will be on SOUTH AFRICAN RURAL GENERAL PRACTICE. It will deal with the issues arising from practice in remote rural clinics. It will be context related to practising in poverty stricken communities and problem orientated to the specific conditions arising from this context.

Part Three is called TEACHING OLD DOCS NEW TRICKS and is a mock oral examination for a postgraduate degree in family medicine.

Part Four will be a self evaluation section by short MULTIPLE CHOICE QUESTIONS (MCQS).

Part Five is a selection of SOURCES OF INFORMATION and resources for further reading.

Throughout these sections family practice perspectives and theories will be integrated with the clinical aspects. Obviously this CME section cannot cover all that is "essential" in a prescriptive way but aims to help you revise, stimulate your interest and provide some guideposts.

This eighth one of the series is on PATIENT-CENTRED CARE.

Part I

CME Editor:
Dr Chris Ellis MD, MFGP

Benchmarks for Busy GPs

This section is not a comprehensive review but a short selection of abstracts to help you focus on important aspects of the subject partly in the form of reminders and memory joggers.

The doctor-patient relationship is central to the patient's satisfaction, compliance and to positive health outcomes.

Effective communication between the doctor and the patient is a central clinical function.

The doctor-patient relationship is an almost inexhaustible area of research with innumerable variations.

Michael Balint, in conjunction with a group of general practitioners and psychiatrists, explored, via continuous group discussions, the positive and negative effects of the doctor-patient relationship (Balint, 1964 in references).

They proposed that:

The most frequently used **"drug"** in general practice is the doctor himself.

There is an **"unorganised"** phase of an illness, which is the first phase

which is often seen in general practice before the patients settled down to a definite "**organised**" illness.

In some cases the patient **offers** or **proposes** various illnesses and goes on offering illnesses until an agreement is reached by both doctor and patient on a justified illness.

In this process are propositions, counter-propositions, offers, responses, acceptances, rejections and compromises.

Through this process, the doctor can allow and help the patient to realise and express his or her real problems. They found that the doctor-patient relationship can develop in a useful way if the doctor accepted the patient's offers **at face value** and kept an open mind.

In some of the patients, he proposed the quest for a **deeper, more comprehensive diagnosis** to enable the doctor to make a better assessment.

The doctor's **responses** may contribute to the ultimate form of the illness to which the patient may settle down. This partly depended on the characteristics of the doctor. No general practitioner is interested in every one of the branches of medicine. Some are "psychotherapeutically minded" whereas some are "obstetrically minded" etc etc. The doctor's personality and subjective interests, he said, may have a decisive influence on what he notices and records about his patients.

In all these different ways a unique relationship establishes itself between a general practitioner and those of his patients who stay with him. It is not love, or mutual respect, or mutual identification, or friendship, though elements of all these enter into it. The group called it "**a mutual investment company**".

Often the patient wants first **to know what he is suffering from** and only secondly for therapy for it. Not paying attention to this order of importance may be the cause of disappointment for the patient in the doctor.

Finding "nothing wrong" may not be a satisfactory answer to the patient's request for a name for his illness. The patient is left frustrated because his "offer" is rejected. The doctor is also frustrated because he may feel that giving a spurious name is insincere and might lead to unnecessary investigation and treatment.

The doctor must, at times, find out which is the more important between "**the act of complaining**" and "**the complaints themselves**".

There may follow what Balint called "**a dangerous confusion of tongues**" with each party talking in a language not understood by the other.

The doctor often erroneously expects too much from his intellectual explanations, even when they are backed up by undeniable facts.

Balint proposed that there may be two therapeutic atmospheres in the doctor-patient relationship. The doctor can be a "father" to the patient and perpetuate a "father figure" role or a teacher-pupil relationship. Or he can make the patient aware that he or she expects this role from the doctor and that he can fulfil this role to a certain extent but that it may not be appropriate. The real question, he said, is how much dependence constitutes a good starting point for successful therapy and when does it turn into an obstacle.

The old answer was that experience and common sense would help the doctor to acquire the necessary skills in dealing with these situations. Research in family medicine has shown that these skills can be taught and can partly avoid the "trial and error" knocks of experience.

Balint proposed that some patients go from doctor to doctor until they find one who is in a way congenial to them. He called this **"the self-selection of patients according to their doctors"**.

"How to start" was the phrase the group used when the doctor decided to change approaches and start something new in the doctor-patient relationship. This would involve booking the patient for a "long interview". But it was important not to go on indefinitely in a long interview. The experienced doctors had some idea of "when to stop". It required a sense of proportion. The drug "doctor" must be administered in the right dosage.

The group found with some difficult patients, that showing "more sympathy" and trying "to do more" was of no avail and only set up an endless circle.

Doctors, they found, used **"contact-maintainers"**. For instance, by sending a patient for an investigation, contact is maintained because the patient has to come back for the result. This may help postpone other more expensive or intensive interventions until the atmosphere is right. Prescribing a medicine that has to be checked or reviewed is also a method to "maintain contact" so that new avenues of approach can be tried till the problem is resolved.

One of the major factors that interfered with a constructive doctor-patient relationship was called the **apostolic function** of the doctor.

Apostolic function is the vague, but almost unshakeably firm, idea that the doctor holds of how a patient ought to behave when ill. It is almost as if each doctor has had revealed to him by divine authority what is right and wrong for his patients. It is then his sacred duty to convert his ignorant patients to his faith and commandments.

Apostolic zeal is not in itself wrong (most of it is common sense) but requires insight by the doctor into his own agendas and programming and an awareness of how it can block communication with the doctor.

The doctor-patient relationship is the core and "basic tool" of family medicine.

It can be examined in many ways.

Szasz and Hollender provide three models.

The **"activity-passivity"** model in which the doctor acts on a patient who remains passive (ie when in a coma, in emergencies etc).

The **"guidance-cooperation"** model is when a patient is ill and takes the initiative to go to a doctor for his guidance but the doctor is still in a position of power (mainly in acute disease).

The **"mutual participation"** model assumes equality between the doctor and patient with the patient taking ownership or part ownership in the process (mainly in chronic diseases such as diabetes etc).

Veatch divides the doctor-patient relationship into four models:

The **"Engineering model"** in which the doctor is viewed as an engineer or plumber or body mechanic hired by the patient.

The **"Priestly model"** is when the doctor is seen as a priest who has the authority to make moral decisions on behalf of the patient.

The **"Collegial model"** regards the doctor and patient as colleagues pursuing the common goal of eliminating the illness.

The **"Contractual model"** in which the patient and doctor share decision making based on mutual trust and confidence. Obligations are imposed on both parties and both parties may derive benefits.

There are several other models of the doctor-patient relationship such as the Sociological model, the Anthropological Model (Hellman), The Transactional model (Berne), the Psychological model (Rosenstock) etc.

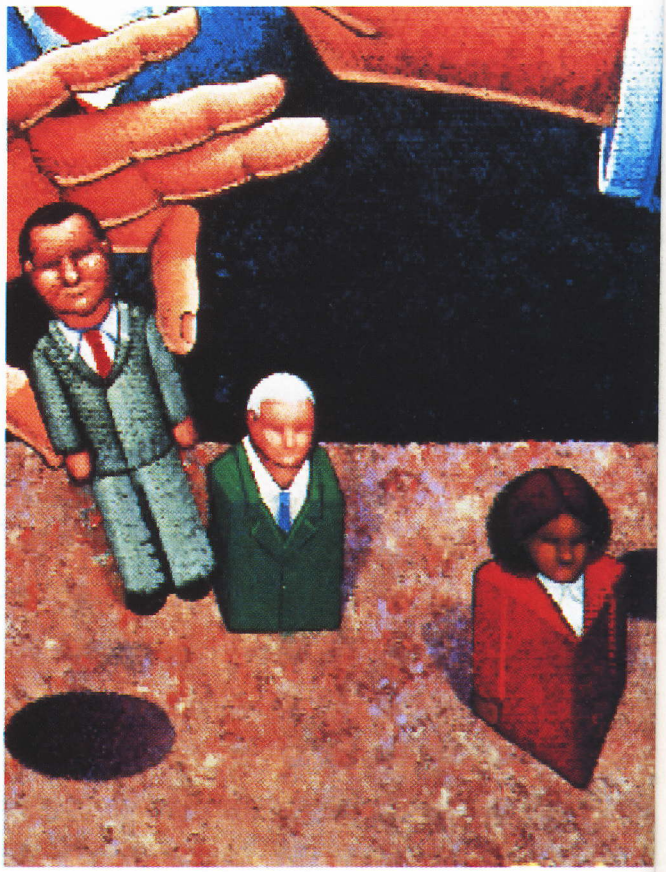
(See also for some other models: Six events occurring in a consultation (Byrne and Long, 1976) and Seven tasks of the Consultation (Pendleton, 1984)and The Inner Consultation (Neighbour, 1987) in Essential CME – The Consultation, July, 1994)

The Doctor's Feelings in the Doctor-Patient Relationship

Doctors often perceive that their feelings and reactions to patients are either inappropriate or irrelevant to the consultation. We have been trained to be objective, detached observers. These reactions can be used as a powerful diagnostic tool and as a barometer of the doctor-patient relationship and indicator of the stage to which it has developed.

These have been called "autogenic" feelings (lit arising from within).

These feelings can be of anxiety, irritation, anger, sexual arousal, compassion, etc etc. The degree and type of emotion varies according to the personalities involved, the context of the consultation and other variables such as fatigue etc.



The doctor may feel impatience, contempt, doubt, scorn, dislike through to hate. These feelings may be diagnostic of the patient, the doctor or their relationship.

Feelings in the doctor have been divided into those unconnected, indirectly connected or directly connected with the patient who is consulting the doctor.

Unconnected feelings are when the doctor's emotional state has nothing to do with the patient being consulted, eg he is overworked, his car has broken down etc etc and he is rushed and irritable.

Indirectly connected feelings occur when the doctor has a problem which resembles that of the patient who is consulting him.

Directly connected feelings is when the doctor is relaxed, has no personal problems and responds directly to something in or connected with the patient.

The feelings that the doctor experiences may, in fact, mirror those felt by the patient, eg anger, sadness etc.

Two more concepts that are used in these interactions are **transference** and **countertransference**.

Transference is when the patient endows the doctor with the qualities of a parental figure or figure of authority. The characteristics of one or both parents are often transferred to the doctor.

Countertransference, on the other hand, is when the doctor reacts to the patient in terms of his or her own earlier significant relationships. Countertransference phenomena are, in a sense, often part of a larger problem of doctors who are caught up in their own needs while treating patients, eg the need to be needed. It may involve the reasons for the choice of career as a doctor. Doctors may seek power over their patients or the love of their patients, leading them to sacrifice themselves excessively. They may desire the plaudits of their colleagues more than the well-being of their patients etc etc. (Lidz, 1983)

(Further reading on doctor's feelings and reactions to patients are Balint, 1964; Gorlin & Zucker, 1983; Freeling & Harris, 1984; Longhurst 1988; Herman, 1990; Ellis, 1992 in reference section.)

Several other aspects of the doctor-patient relationship have been covered in Essential CME "The Consultation" and "Patient-Centred Care".

Part 2

South African Rural General Practice

This section presents a problem orientated approach in the context of rural practice.

Problems in the doctor-patient relationship in this context may arise if the doctor is from a different culture to the patients being treated.

It is a basic tenet of Family Medicine that the doctor-patient relationship should be underpinned by the same features and principles no matter what context or persons are involved.

Nevertheless practising medicine in a transcultural context may need some special emphases in order to **"bridge the gap"**.

One can start to **"close the gap"** by calling a patient by his name and introducing oneself. Your name, it has been said, is your most important possession. Next is to enquire where the patient is coming from, both geographically and personally.

Interpreters and language differences may provide barriers or, somewhat paradoxically, help the doctor-patient relationship (see under Essential CME – The Consultation, July, 1994)

One of the foundations of the relationship in a cross-cultural situation is the ability of the doctor to convey to the patient, messages that make sense to the patient, and be able to receive messages from the patient. This is not just a language issue, as direct translations may not work. The metaphors and idioms of the community have to be used as bridges. A patient who feels his world is understood and taken seriously is more likely to respond to an intervention.

Body language and communication through facial expressions and gestures are valuable if the language link is weak.

Because of the large element of education required within the consultation, there is a teacher-pupil relationship in many consultations. Never assume this, as the patient may be, for instance, a well educated teacher or although not "educated" be more understanding of life situations, cultural interactions etc than the doctor himself.

In this clinic we tend to stick to the medical conditions that are presented to us because firstly we are on familiar ground and secondly because of the pressure of time and numbers of patients to be seen.

The Western doctor thus addresses himself largely (but not exclusively) to the diseases that the patient suffers from and to the rational, conscious part of the patient. The traditional healer, on the other hand, may be concerned primarily with the unconscious part. Jung felt that it was "extremely important to be able to enter the sphere of irrational experiences" but equally important not to get stuck in the irrational, and to grant the rational its indisputable value.

Problems in the doctor-patient relationship in a cross-cultural encounter may arise between the **"two worlds"** of: *The Western world* which is primarily **scientific, rational and ego-orientated** and the *Old African world* which is primarily **intuitive, non-rational** or orientated towards **the inner world of symbols and images.**

WE NEED YOUR HELP

Your comments on this CME Section are welcome:

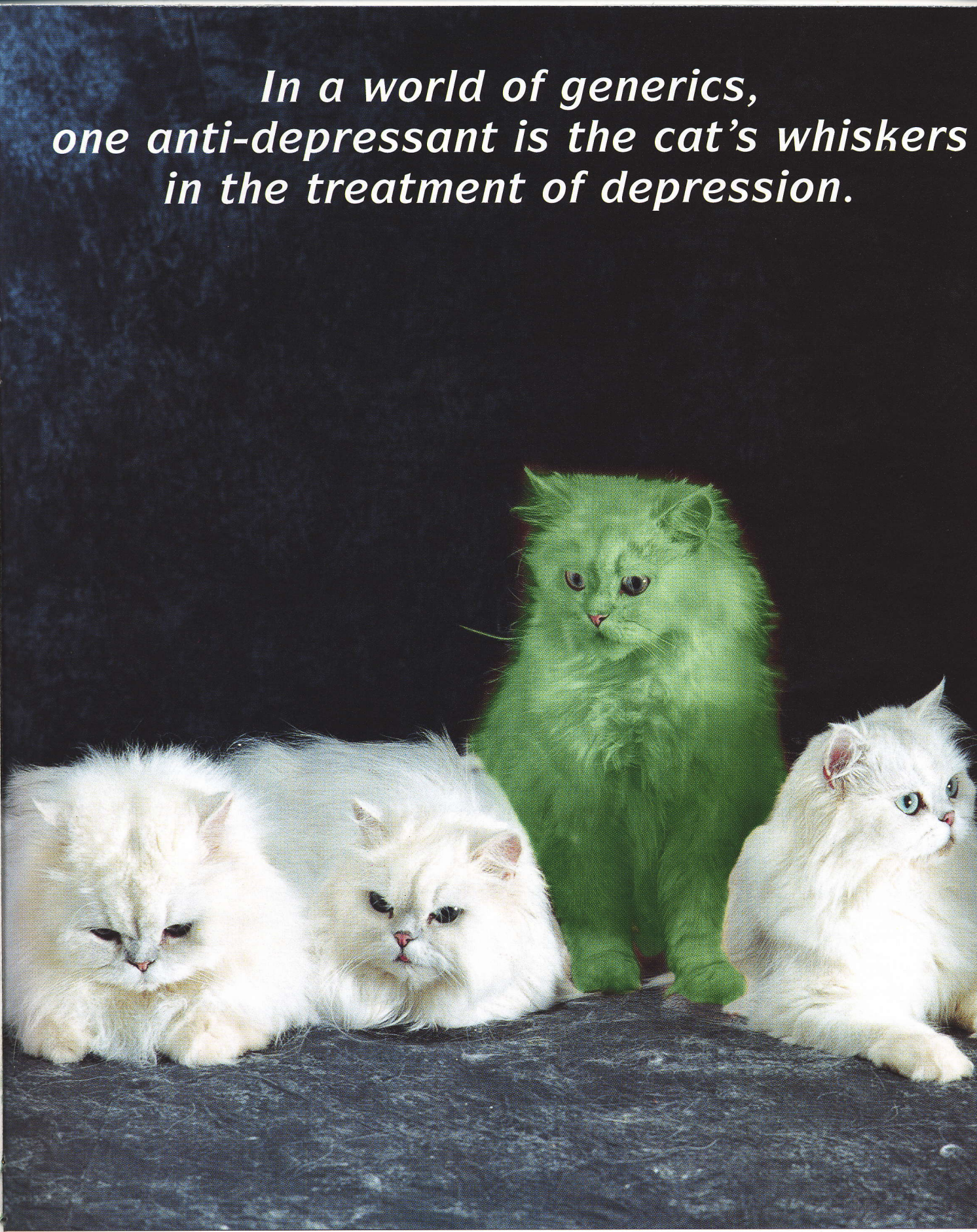
We need help to provide an ongoing education that is appropriate to practice. We invite you to make up MCQs or ideas on benchmarks, rural practice etc.

Please return to:

CME Editor.
SA Family Practice
Box 3172
Cramerview 2060

or Fax to 01213-92387

In a world of generics, one anti-depressant is the cat's whiskers in the treatment of depression.



NORISTAN GENERICA

No Compromise

Division of:
Noristan Limited,
326 Marks Street,
Waltloo, Pretoria.

ETHIPRAMINE

First among equals for quality and affordability.

S5 *Ethipramine 10 mg and 25 mg Tablets. Ref. No's. B695 and B694 (Act 101/1965). Each 10 mg tablet contains: Imipramine hydrochloride 10 mg and Tartrazine. Each 25 mg tablet contains Imipramine hydrochloride 25 mg.*

Imipramine hydrochloride 10 mg or 25 mg

4600

The challenge is "not to do violence to either world".

Working with other cultural groups in a shared country requires a willingness to understand the patient's belief systems and an **acceptance of the paradoxes they produce.**

In a society that is in the process of transition, aspects of our relationships with patients may provide challenges to the adaptability of both doctor and patient. Yet there are few, if any, societies world wide without crumbling beliefs, ethics and values. (Plutarch complained of the same thing in the 4th century BC so perhaps nothing really changes).

(References, see Ngubane, 1977; Vera Buhrmann, 1989; Hammond-Tooke, 1989; Deagle, 1989; Fehrsen,1989.)

Next Issues are:

April	1995	Prevention/Screening
May	1995	Backache
June	1995	Alcoholism
July	1995	Hypertension
August	1995	Urology

Contributors to this Section:

CME Editor: Dr Chris Ellis.

Editor: South African Family Practice. Professor Sam Fehrsen.

Editor: South African Family Practice Manual. Dr Manfred Teichler.

Dr Jannie Hugo, Deparment of Family Medicine, Medunsa

Teaching Old Docs New Tricks

This section takes the form of a mock oral examination for a postgraduate membership or masters degree in Family Practice.

Question One: *What are the most important things you know about doctor-patient communication?*

Answer: We know a lot about the results of poor communication.

For instance:

- In 50 % of visits the patient and the doctor do not agree on the nature of the main presenting problem.
- Patients are interrupted by the doctor on an average **within 18 seconds** and fail to disclose other significant concerns.
- Most complaints by patients deal, not with clinical competency problems but with communication problems.
- A high proportion of patients do not understand or remember what their doctors tell them about diagnosis or treatment.
- Patient anxiety and dissatisfaction is related to uncertainty and **lack of information, explanation, and feedback from the doctor.**

We know quite a bit about the results of positive communication.

For instance:

- Positive outcomes are improved when the patients are allowed to express their health concerns without interruptions.
- Agreement between the doctor and the patient in identifying the nature and seriousness of the clinical problem is related to improving or resolving the problem.
- Greater participation by the patient in the encounter improves patient satisfaction and compliance and outcome of treatment.
- Good clinical communication is feasible routinely in clinical practice provided that the clinician **has learned the relevant techniques.**

Question Two: *What do you think are the most important things that you could do to improve clinical communication between you and your patients?*

Answer: First encourage your patients to discuss their main concerns without interruption or premature closure. Contrary to expectation of many doctors, this need not take long: **a maximum of two and a half minutes or an average of ninety seconds!**

Elicit patients' perceptions of the illness and their feelings and expectations.

Use open ended questions, frequent summaries and clarification.

Important skills are giving clear explanations, checking the patient's understanding, negotiating a mutually agreed treatment plan, and checking patients' attention to compliance.

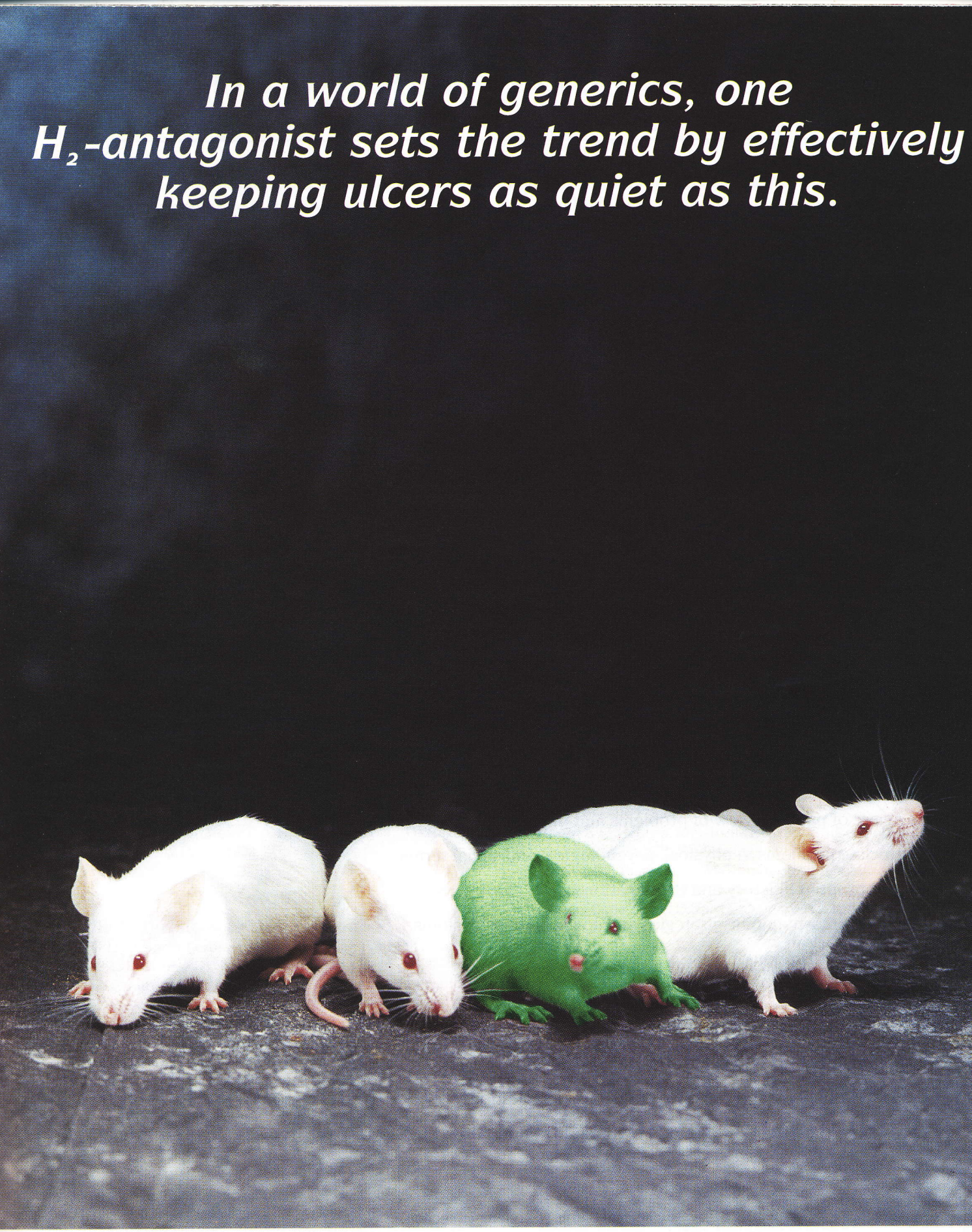
Factors with a negative impact include **inappropriate use of closed ended questions and premature advice and reassurance.**

(Answers from: Simpson M, Buckman R, Stewart M, Maguire P, Lipkin M, Novack D, Til J. Doctor-Patient communication: the Toronto consensus. BMJ 1991;303:1385-7.)

Question Three: *What use do you think all this study into the doctor-patient relationship is? Is it just to give academics something to do?*

Answer: One of the main reasons for studying the process of the doctor-patient relationship is to find out its effect on outcomes and what the patients (and doctors) learn and remember from the consultation. Also how the relationship effects compliance, patient satisfaction etc. The studies can thus help us to improve our consultation skills and clinical outcomes.

In a world of generics, one H_2-antagonist sets the trend by effectively keeping ulcers as quiet as this.



NORISTAN GENERICA

No Compromise

Division of:
Noristan Limited,
326 Marks Street,
Waltloo, Pretoria.

ULCIM

First among equals for quality and affordability.

S4 *Ulcim 200 mg and 400 mg Tablets. Reg. No's. Z/11.4.3/176, Z/11.4.3/177.*

Each tablet contains 200 mg or 400 mg Cimetidine.

4600

Part 4 Multiple Choice Section (MCQS)

Multiple choice questions are intended to cover the factual clinical areas of general practice. They also test reasoning ability and understanding of basic facts, principles and concepts. The questions are of the true/false type. In some examinations marks are deducted for incorrect answers or failure to answer while in others marks are not deducted for incorrect answers.

The doctor-patient relationship does not lend itself to examination by multiple choice questions.

It may be examined via "live" consultations with patients or videos of consultations.

Another method that brings in the doctor-patient relationship is the MEQ (modified essay question). While the MCQ is regarded as testing knowledge, the MEQ looks at problem-solving skills and behaviour.

The MEQ presents a situation that might be encountered in a typical day in general practice. The situation is described in a couple of lines. The answer should be in expanded note form.

As an example:

Your first patient is Linda Brown, a 38 year old typist who bursts into tears as soon as she sits down. She says she cannot cope with life any longer. What are your aims for this consultation?

Answer: A good candidate would be expected to:-

- Establish rapport and allow time for patient to express feelings eg guilt and anxiety.
- Develop trust to allow patient to state underlying concerns and worries.
- Be aware of patient's view of problems and their management.
- Appreciate problems in physical, psychological and social terms.
- Take appropriate history and examination.
- Establish present coping strategies and social support systems.
- Encourage utilisation of these.
- Appreciate underlying suicidal risk and take appropriate history.
- Consider referral to psychiatrist.
- Be aware of limited consultation time.
- Consider follow-up and sensitive ending to consultation.
- Appreciate the effect on doctor's own feelings and allow time to recover if necessary prior to next consultation.

(From Practice Exams for MRCGP by Sandars and Baron, see reference section)

Part 5

Sources and Resources

BOOKS THAT SOUTH AFRICAN GPs FIND MOST USEFUL TO KEEP IN THEIR ROOMS

The South African Family Practice Manual, published by South African Family Practice.

The Merk Manual of Diagnosis and Therapy. 16th ed. Rahway, New Jersey: Merk Research Laboratories. 1992.

Current Medical Diagnosis & Treatment. Lange Medical Publications/Prentice Hall. Published yearly.

The Paediatric Handbook. Edited by H de V Heese. Cape Town: Oxford University Press. 1992.

Frere Hospital Handbook by Mitchell, Morris and Meyers. Cape Town: Juta and Co. 1990.

The Diagnosis and Management of Sexually Transmitted Diseases. Ed. R Ballard. Available from STD Research Unit, SAIMR, Box 1038, Johannesburg 2000.

South African Medicines Formulary. 2nd ed. MASA Publications. 1991.

MIMS Desk Reference. Mims/Times Media Ltd, published yearly.

Pharmacotherapy by C P Venter 2nd ed. Pretoria: MC Publishers, 1993.

Antibiotic Guidelines by Koornhof H J, Liebowitz L D. Pretoria: J L van Schaik, 1991.

Oxford Handbook of Clinical Specialities by Collier J A B, Longmore J M, Harvey J H. 3rd ed. Oxford: Oxford University Press, 1991.

Oxford Handbook of Clinical Medicine (pocket size) by Hope R A, Longmore J M, Moss P A H, Warrens A N. Oxford: Oxford University Press, 1993

SOURCES AND RESOURCES

Specific References to this Section

Deagle G L. The art of cross-cultural care. Can Fam Physician 1986;32:1315-1318.

Ellis C G. An investigation into the phenomenon of chronic unhappiness as presented in Family Practice. Doctoral thesis in Family Medicine. Medunsa, 1992.

Fehrsen G S. Bridging the Cultural Gap. 1989: available Resource Centre, Department of Family Medicine, Medunsa.

Freeling P, Harris C M. The Doctor's Feelings-a sixth sense. In: Freeling P & Harris C M. The Doctor-Patient Relationship. 3rd ed. Edinburgh: Churchill Livingstone, 1984.

Gorlin R, Zucker H D. Physicians reactions to patients. The key to teaching humanistic medicine. New England Journal of Medicine 1983;308:1059-1063.

Herman J. Anger in the consultation. British Journal of General practice 1990 May;176-177.

Longhurst M. Physician self-awareness:the neglected insight. CMAJ 1988;139:121-24.

Neighbour R. The Inner Consultation. Lancaster: MTP Press Ltd, 1987.

Ngubane H. Body and Mind in Zulu Medicine. London: Academy Press, 1977.

Szasz T S, Hollender M H. The basic models of the doctor-patient relationship. A.M.A. Archives of Internal Medicine, 1956;97:585-591.

Vera Buhrmann M. Living in Two Worlds. Cape Town: Human & Rousseau, 1984.

Veatch R. Models for ethical medicine in a revolutionary age. Hastings Center Report, June, 1972:2-7.

Sources for CME and General Practice CME

Cambell GD, Seedat YK, Daynes G. Clinical Medicine & Health in Developing Africa. David Philip: Cape Town. 1982. (now needs updating).

CME/VMO South Africa's Continuing Medical Education Monthly. MASA Publications.

Essential Drugs. SAMJ. vol.64. 15 October 1983. p.648,685, 686.

Elliot PG. MRCGP MCQ Practice Papers. Knutsford: Pastest. 1993.

Gambrill E, Moulds A, Fry J, Brooks D. The MRCGP Study Book. 2nd ed. Oxford: Butterworth-Heinemann. 1988.

Hammond-Tooke D. Rituals and Medicines. Indigenous Healing in South Africa. Johannesburg: AD Donker Ltd, 1989.

Health Promotion at the Community Level. Bracht N. Ed. Sage Publications Inc,. 1990.

Martin P, Moulds A J, Kerrigan P J C. Towards better practice. Edinburgh: Churchill Livingstone, 1985.

Mc Daniel S, Campbell TL, Seaburn DB. Family-Orientated Primary Care. A Manual for Medical Providers. New York: Springer-Verlag, 1990.

Mitchell PJ, Morris CDW, Meyers OL. The Frere Hospital Handbook. A guide to Medical Management, Investigation and procedures. Cape Town: Juta & Co. 1990.

NHG Standards. Guidelines for General Practice. Dutch College of General Practitioners. The national guidelines of the Dutch College of General Practitioners (NHG) are called the NHG Standards.

Palmer KT. Notes for the MRCGP. 2nd ed. London: Blackwell Scientific Publications. 1992.

Pistorius GJ, Pistorius CWI. Family Practice Management. Pretoria: Haum.1990.The Paediatric Handbook. Ed. H.de V Heese. Cape Town: Oxford University Press. 1992.

Sanders J, Baron R. MRCGP Practice Exams. 2nd ed. Knutsford: Pastest. 1992.

South African Medicines Formulary. 2nd Ed. Cape Town: MASA Publications. 1991.

South African Family Practice Manual. SA Family Practice.

Update. The Journal of Continuing Education for General Practitioners, George Warman Publications.

Some of the "Bibles" of Family practice and Family Medicine

Balint M. The Doctor, His Patient and the Illness. 2nd ed. London: Pitman Books Ltd. 1964.

Christie R, Hoffmaster B. Ethical Issues in Family Medicine. Oxford University Press. 1986.

Crouch MA, Roberts L. The Family in Medical Practice. London: Springer-Verlag. 1987. (out of print).

McWhinney I.R. A Textbook of Family Medicine. New York: Oxford University Press. 1989.

Rakel RE. Textbook of Family Medicine. 4 th edition. Philadelphia: W B Saunders Company. 1990.

Stott NCH. Primary Health Care. Bridging the Gap between Theory and Practice. Berlin: Springer-Verlag. 1983. (out of print).