MPS Balint Essay Competition — winning entry

GENERAL PRACTICE

The doctor/patient relationship

by Dr Stuart Philips BSc (Hons), MBChB

The General Practitioner is more often than not, the "first contact" that the patient has in the medical field. Therefore he is the one who must accept the presentation of illness made by the patient.

The type of presentation depends on three factors which exist in a dynamic equilibrium consisting of the patient, the doctor and the relationship. When considering any particular consultation, all three factors are of importance.

The patient arrives along with a host of unseen factors trailing in his wake. Firstly, his personality, an entity determined by his birth, family background, schooling and experiences of interactions with other individuals.

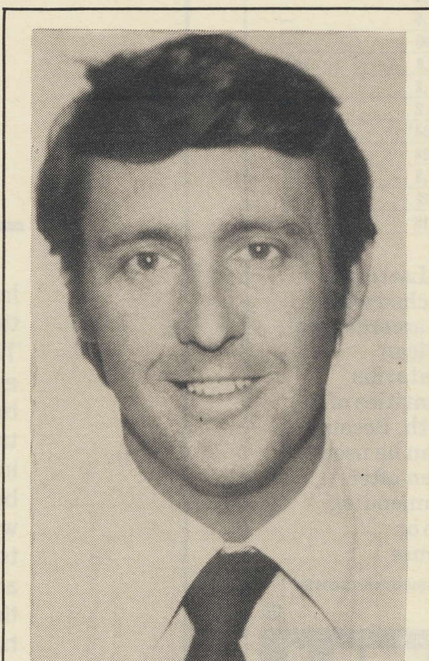
Consequently, he is unique and his motive and means of consulting with the first contact doctor are determined by both his collective (ie genetic) experiences and his environmental experiences.

Next, the patient also has his family "waiting in the wings" as well as his type of work, his financial situation, his religious concepts and his cultural or social values.

To consider such a vast array of inter-related factors is daunting but does make one aware of the very unique nature of each patient. The doctor, being human alas, is equally unique. Consequently, so is their relationship.

The GP, by the nature of his role, should be aware of all these factors and yet should not allow his own persona to be harmful to the patient. He should accept the patient in his entirety without imposing values or moral judgements on the patient. He should not allow himself to be directive towards his patient nor burden his patient with his (the GP's) own emotions or problems.

At the time of first contact the patient is probing the environment of the consulting room, assessing all the time the reactions and receptiveness of the doctor. Any response from the doctor, be it verbal or nonverbal, may change immediate as well as future presentations.



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Slowly, there is a bridge built between patient and doctor. Across this bridge there is a free to-and-fro flow of traffic, most of it unseen or unconcious. The doctor's role here is to demonstrate to the patient that there is a bridge which is open. He should also be as aware as possible of all traffic crossing the bridge, much hidden to the patient but not so submerged to the doctor. Slowly, he can assess input and build up an understanding of the whole patient.

Emotions evoked in the doctor are of vital importance and need rapid review in order to reveal new aspects about the patient that are not directly obvious, as well as new aspects about the GP of which he may himself have been unaware.

I remember one experience during which a patient evoked an energy reaction in me. The patient was a six year old boy who presented with his elder brother and mother. The patient was querulous and demanding. The mother was overly concerned about the patient and acquiesced to his demands constantly. The problem was that the patient had a splinter in his finger which he received while fiddling with an article he was warned to avoid. When I proceeded to extract the offinding item, the child performed appallingly.

The extraction was stopped almost before it had begun. To my utter amazement, the mother than asked for a sweet for her poor child. My colleague, under whom I was working at the time, gave out sweets immediately, smiling. I was furious. If the child did not allow the splinter to be removed I saw no reason why he should have a reward.

Afterwards I communicated my feelings to the other doctor who prompted a self-analysis. On reflection, I concluded that I was angry because the child had demonstrated my ineffectiveness. I had been trained to cure many things, not least of all splinters. The child had demonstrated very effectively that I was not the all curing, all effective doctor. There were some things that I could not do.

Quickly and successfully he had humiliated me and placed me back on earth. In addition, the child had demonstrated my ineffectiveness to his mother and how powerful he was in foiling the masterful doctor. He had divided the mother and me and was then proceeding to rule. If I had not been given the insight into these subtle events, my relationship with

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Pantothenic acid (mg)	0,25	0,20	—
Vitamin K (µg)	5,2	2,6	—
Folic acid (µg)	5,8	2,6	—
Biotin (µg)	1,4	0,96	—
Sodium (mg)	31	12,8	38,4
Potassium (mg)	92	51,2	128
Chloride (mg)	69	35,2	96
Iron (mg)	0,8	0,64*	—
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[1]Codex Alimentarius Commission – Recommended international standards for foods for infants and children CAC/RS 72174 – 1976.

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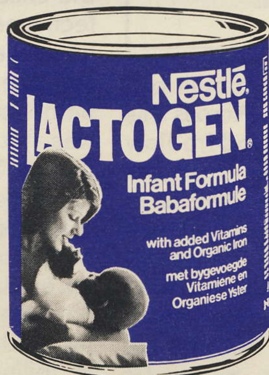

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the mother would have been damaged.

Ideally, the doctor receives, untainted, the full communication of the patient and then considers the effects of any intervention in the illness upon the whole patient and his life.

Being aware of the facts he may decide that certain procedures, either diagnostic or therapeutic, may not be worth the disruption in the patient's life. He may realise, if he is aware, that referral to a dermatologist for eczema may represent a rejection to the patient.

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The patient has offered an illness. Irrespective, it is the first "span" of the bridge and must be accepted. This allows for further building until eventually the traffic across the bridge may reveal to the doctor the true motive for the consultation, the initial "span", the eczema, being buried and forgotten below the weight of the real problem. If the doctor had accepted the "span" and acted immediately by referral, the patient's tentative plea for help would have refected and the bridge would have collapsed.

Having pointed out the dynamics of the "first contact" consultation one turns to the function of such dynamics.

The patient has needs and expectations as does the doctor. These will be either fulfilled, denied or frustrated by the quality of the doctor-patient relationship.

The doctor is attempting to fulfil these needs and expectations but requires information to do so. Straight question and answer sessions may very rapidly result in the patient leaving the surgery with a bag of pills for an illness he may not have or is at least inconsequential to him and thus with no intention of complying with the therapy. The doctor has not allowed the patient sufficient lee-way in which to provide all the facts. The problem is therefore how to discover what is troubling the patient with the

patient's wholehearted commitment.

Very often the doctor is confronted with minimal signs and seemingly irrelevant symptoms. Special investigations often lead up a blind ending alley and may indeed "organise" an illness in a "neurotic" patient. An empathetic approach can often avoid this.

I recall an elderly lady of Lithuanian extraction, who was a chronic attender at a busy out-patients department. She presented with hypertension, which was poorly controlled. On my first contact, I was demoralised by the thickness of her "folder". Skimming through it, I saw repeated notes on various ill-defined symptoms such as headaches, arthralgia, insomnia, abdominal pains and so forth.

On seeing the lady walk in my first impression was one of sadness which evoked a feeling of sorrow in me. The patient began by pouring out all the aforementioned ailments. I listened and quietly asked a few questions, one of which was how her husband related to all these ailments. "Oh doctor", she said, "I lost him in the camps!" I started asking questions about the camps. She immediately perked up as if, at last, someone was interested in her past. She talked for a while and shed a few tears. When I felt that I had established rapport with her, I turned to the hypertension.

On subsequent visits, her ill-defined ailments decreased and so, surprisingly enough, did her blood pressure, despite no change in drug therapy. Similarly by saying to a patient with poor peak flows, "using your inhaler as frequently as I advise seems to frighten you . . . . would you like to explain to me how you feel about it?" is often more valuable than saying, "If you don't use your inhaler as I advised, you'll keep having attacks and it'll be your fault".

In the latter case the patient will probably continue to be non-compliant, whereas in the former approach, the possibility of further effective therapeutic intervention remains open.

My failure to empathise adequately with a patient is illustrated by the following example:

A young girl was admitted to an ICU in coma, the latter having been precipitated by medical investigations. The mother and father had a poor relationship and the father used

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Digestive disturbances in infants – not always due to a cow's milk allergy

	Breast milk	Pelargon	Cow's milk
Presence of bifidus factor	Yes	No	No
Main bacteria present	Lactobacilli	Streptococcus lactis	Other gram+ bacteria
pH in stomach 2½ hours after ingestion	3,75	3,71	5,10
Enzymatic activation	optimal	optimal	partial

Breast milk, Pelargon → Good digestion and assimilation of nutrients.
Cow's milk → Gastrointestinal disturbances

One cannot hastily assume that an adverse reaction is due to allergy because other disorders give rise to the same assortment of symptoms.[1] Digestive disturbances may be due to gastric hypoacidity as a result of:
- immaturity of the digestive system.[2]
- climate.[3]
- type of diet.

Gastric hypoacidity may lead to: decreased gastric, pancreatic, biliary and intestinal secretions. Pre-acidification of milk compensates for this decreased output.

So, when baby suffers from a mild digestive disturbance, it makes sense to prescribe Pelargon to achieve a physiological environment in the stomach similar to that obtained with breast milk and to help overcome the tendency to partial digestion of milk.

1 Fomon, S. J., Infant Nutrition, second edition (W. B. Saunders Company, Philidalphia) ppp. 436.
2 Agunod A., Correlative study of hydrochloric acid, pepsin and intrinsic factor secretion in newborns and infants. A. M. J. Dis. 1969; 14(6): 400–413.
3 Bezkorovainly A. Human milk and colostrum proteins A. Review. J. Dairy Science 1977, 60, 1030.

Pelargon is a scientifically adapted and balanced food, intended for routine feeding of healthy infants from birth onwards.

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the unnecessary initial admission to batter his wife with guilt. I realised that both parents were intensely angry but could not elicit an outright expression of such feelings.

As the patient's condition deteriorated, I began to avoid the father. It was only when I presented this case to a Balint group that I realised that this was because I was protecting myself from a possible barrage of aggression from him. Unfortunately the child died and the family left having received no satisfactory psychological support from me. A while later I met the mother again and we discussed inconsequential matters.

On saying goodbye, she thanked me for being "too kind!" It then dawned on me that by being so "kind" I had blocked any therapeutic catharsis that may have occurred, because the parent felt that she could not be angry with someone who had been so kind.

Even if a consultation is mainly "organic" in nature "there is a psychological aspect to every patient-doctor transaction"[1] and if the GP has a sufficiently free-flowing relationship with say a patient with pelvic inflammatory disease he may use the consultation to enquire tactfully about the wife-husband relationship and/or any extra-marital affairs etc.

> . . . by being "so kind", I had blocked any catharsis that may have occurred . . .

Patients with psychological problems which manifest with chronic attendance are refractive to most (all?) pharmacological intervention and are frequently the bane of the doctor's life, yet so little is taught of how to manage these patients in undergraduate medical training. The doctor is supposed to handle them "instinctively".

As Balint put it: "The use of empirical methods picked up from everyday life or established during everyday medical practice would be

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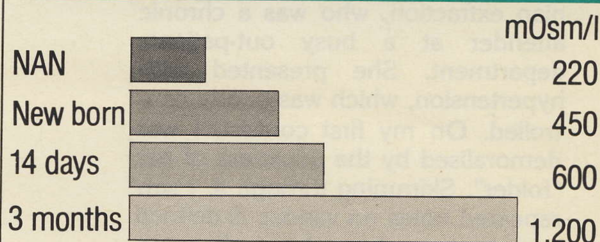
Nan's mineral salt content suits infant renal capacity.



Development of renal concentrating ability in newborn etc., compared with NAN potential urinary load.[1,2]

NAN's mineral salt content is reduced so that the levels of mineral salts are at levels comparable to those in breastmilk. The infant fed on NAN gets a proper amount of sodium and an appropriate sodium/potassium balance. The mineral content ensures a renal solute load that suits the infant's limited renal concentrating capacity especially during the first few months of life and guarantees the maintenance of normal water balance.

NAN is scientifically formulated. Its nutritional elements are close to breast milk so that when a mother cannot breast feed, it makes sense to recommend NAN.

1. Royer, P.: 18 lessons on biology of human development, P. 108 – 187, Fayard ed., Paris, 1975.
2. Polacek, E.et al: The osmotic concentrating ability in healthy infants and children, Arch. Dis. child. 1965, 40.291.

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looked on with suspicion in any other sphere of medicine and they should be accorded no higher status in psychotherapy".[2]

In a country such as ours, the doctor is frequently confronted with a patient who hails from an entirely different cultural background. This is especially so in rural practice.

Thus a GP should have a working knowledge of such cultural dynamics so that when he places himself in the patient's "shoes" he can relate to the world as the patient sees it. The concept of "causation" in certain rural societies is very different from traditional Western concepts and unless the GP can comprehend this and use this knowledge effectively, therapeutic change may be thwarted.

I recall one young 19-year old woman from the "homelands" who had had four children with a fifth on the way. Two of the four had died of gastro-enteritis and the fourth was presenting with diarrhoea. I explained about the concept of gastro-enteritis being related to poor social circumstances, overcrowding and too many mouths to feed in an unhygienic environment.

The woman looked at me with disbelief and when the child died it simply confirmed her opinion that I did not know what the "real" cause of the diarrhoea was. To make matters worse I then raised the question of contraception.

She left, clearly not feeling understood by me and determined to continue having children to present to her husband and to prove herself as a woman in her society. My feeling of helplessness and confusion was profound.

By trying to see the world as the patient sees it and by assisting the patient toward developing insight into himself and his problems the doctor may be able to bring about meaningful therapeutic changes as well as meet the needs and expectations of the patient.

A pre-requisite for this aim is trust. The patient feels that the doctor understands him and can help and also that confidences divulged to the doctor will go no further without his permission.

By building bridges between himself and his patient, the doctor will over the years develop a meaningful, fulfilling role in society and promote those positive changes in his patients of which they are in need.

References

1 *Greco, RS: "One man's Practice": Tavistock Publ. London: 1966.*

2 *Balint, M and Balint, E: "Psychotherapeutic Techniques in Medicine: Tavistock Publ. London: 1972.*

Entries called for next MPS Balint essay competition

The South African Balint Society is offering a prize of R400 for the best essay on the topic **"Difficult patients"**. The competition is being kindly sponsored by MPS Pharmaceuticals (Pty) Limited.

Essays should be ± 2 500 words in length, type-written in double spacing and in triplicate, and should not have been previously published. They should be illustrated by examples from the author's own experience, with the identity of patients being suitably concealed.

Entries must be submitted under a nom de plume and be accompanied by a sealed envelope containing the author's name and address. The competition is opent to all doctors except the committee of the SA Balint Society.

Entries must be addressed to the Honorary Secretary (Dr S Furman), SA Balint Society, c/o The SA Academy of Family Practice/Primary Care, Rooms 24/25, Medical House, Central Square, Pinelands, 7405 and should reach him **not later than 31 March 1983.**

The Balint Society Committee will act as judges of the competition and their decision is final. The committee reserves the right to publish the winning and any other entries. The winner will be announced on the occasion of the Balint workshop to be held in Cape Town in April 1983.

Symposium to focus on Diabetes Mellitus

Developments in the treatment and management of the diabetic patient, as well as the many aspects of the disease itself, will be discussed by several prominent international and local authorities, at a symposium to be convened by the Medical Research Council, in Cape Town, from 18th to 20th November, 1982.

Convened under the aegis of the Society for Endocrinology, Metabolism and Diabetes of Southern Africa, and part sponsorship of Novo Industries (Pharmaceuticals) (Pty) Ltd, the symposium has attracted speakers from the United States of America, Denmark, England and Wales.

Among the topics to be discussed will be diabetic neuropathy, diabetes in pregnancy, genetic interrelationships, epidemiology of vascular disease in diabetes, and practical aspects of metabolic control in diabetes.

Further symposium information and registration details are available from Novo Industries (Pharmaceuticals) (Pty) Ltd, PO Box 783155, Sandton, 2146. Telephone: (011) 783-7275.

Critical care congress

Main themes of the Congress include Adult and Paediatric Intensive Care, Pharmacology and Toxicology. It is to be held on the 25 - 27th November, 1982, in the Robert Leslie Building, University of Cape Town. Enquiries should be directed to: Mrs Sally Elliott, Postgraduate Medical Centre, UCT Medical School, Observatory 7925. Tel: 47-1250 ext 348.

Forensic Psychiatry Congress

A Forensic Psychiatry Congress will be held at the UCT Postgraduate Medical Centre in Cape Town from the 16th - 18th February, 1983.

Speakers will include three Forensic Psychiatrists from the UK and one from Canada, together with speakers from the Forensic Psychiatry Unit, Valkenberg Hospital.

Please direct enquiries to Postgraduate Medical Centre, Medical School, Observatory 7925, telephone 55-8969 (Cape Town).