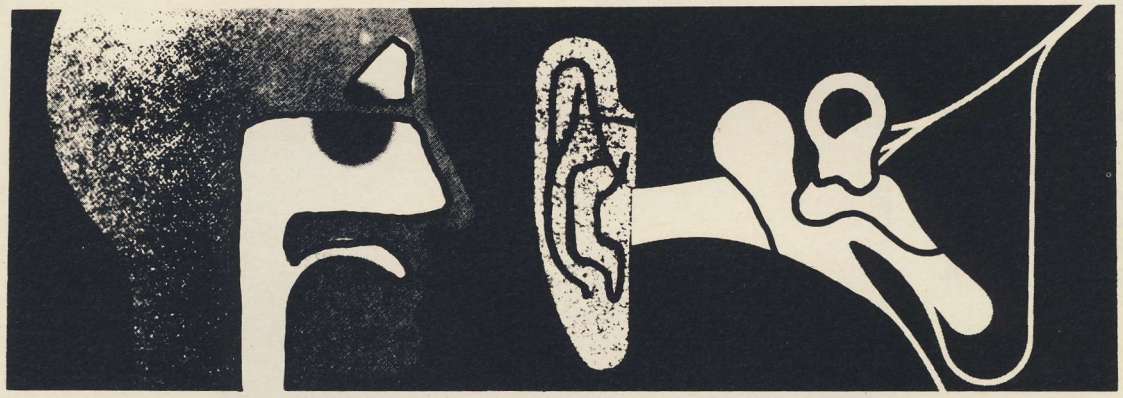


The doctor-patient relationship in general practice

Dr Stanley Levenstein

It may be asked why we as general practitioners should attach much importance to the doctor/patient relationship. Is it not sufficient to be able to diagnose and treat the problems which present to us?

To answer the question, it should be borne in mind that studies have shown that the most important single factor determining a patient's compliance with doctors instructions for treatment is the quality of the doctor/patient/relationship. That is to say, the most important factor determining whether a particular patient, for example, a hypertensive, will succumb to the complications of his condition, eg. a cerebro-vascular incident or a coronary thrombosis will be the quality of his relationship with his doctor.

In the sphere of emotional disorders too, there is abundant evidence to support the view that the relationship between doctor and patient is not only an important, but **the** the most important determinant of the outcome of therapy, irrespective of the technique or school of thought which the therapist applies.

The question which then arises is: what are the special features of the doctor/patient relationship which will determine whether treatment, whether for an organic or for an emotional disorder, is successful or not? Research by Rogers,[1] and Truax [2]and Carkhuff, has isolated a few characteristics of the counsellor or doctor which are most likely to result in a favourable outcome. These are:- (i) Empathy; (ii) Non-Judgemental acceptance; (iii) Genuineness or congruence.

These attributes are by no means as easy to acquire as they may appear, and there are numerous ways in which they may be negated without the doctor even being aware that he is doing so. I will discuss each of these characteristics briefly.

EMPATHY

This is an attitude of therapeutic understanding which emphasizes seeing the patient as he sees himself. It means the attempt to think **with**, rather than for or about the patient. An example of an empathetic attitude would be a doctor who when faced with a patient who says 'I don't like taking antibiotics' tries to understand the patient's feelings from within the patient's frame of reference, instead of saying something like 'listen, who's the doctor over here, you or me!?' **Please note:** empathy is **not** sympathy. A sympathetic attitude, while intended as a supportive device, says in effect 'you poor person, I feel so sorry for you since you cannot help yourself'. The patient is then made to feel incapable of handling his feelings himself, and this encourages inappropriately dependent and evasive behaviour.

NON-JUDGEMENTAL ACCEPTANCE

The doctor tries to say in effect 'I neither approve nor disapprove of your behaviour and attitudes, but I deeply respect your right to feel as you please and your right to act or feel differently from me.' The doctor makes the patient feel that no matter how he feels towards the doctor, it doesn't matter, and that he won't judge the patient for seeking help for whatever reason, be it for a venereal infection, alcholism, drug abuse, or anti-social behaviour. Acceptance attitudes are non-judgmental in that the doctor is impartial to the values held by the patient. When the patient is is accepted by his doctor, he experiences this acceptance as a feeling of being **unconditionally** understood, loved and respected.

There are **four** basic assumptions underlying acceptance:

1. The idea that the individual has infinite worth and dignity.
2. It is the person's **right to**

make his own decisions and lead his own life.
3. The patient has the capacity or potential to live a full, self-actualised, socially useful life.
4. Each person must accept responsibility for his own life.

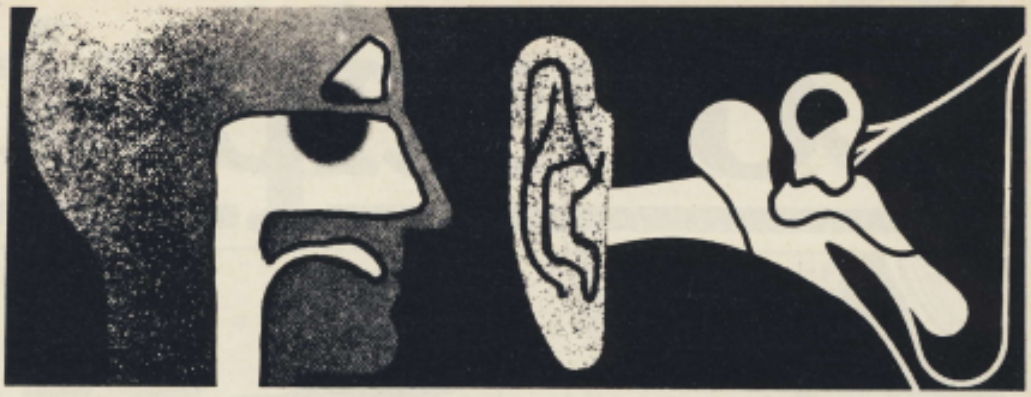
The doctor's responsibility is to enhance the sense of self-respect and self-responsibility in his patients.

The **value** of acceptance to patients is:
1. The patient gets **involved** in the consultation process when he senses that the doctor really cares about what he thinks and feels.
2. It creates a warm psychological climate, which is most favourable for the learning of new responses and the extinguishing of old non-adaptive behaviour.,
3. A reduction of defensive attitudes eg. rationalisation, denial etc. This is because acceptance creats in the patient a feeling of being so comfortable in the doctor's presence that he need no longer keep his guard or defences up.

It should be noted that there are certain attitudes which should **not** be confused with acceptance, ie.:
1. Approval or agreement is not acceptance. Accepting a person means neither approving nor disapproving of what he say or feels. For example, if an unmarried woman asks for a prescription for the pill, and the doctor approves (or disapproves) of her request, it will make it very difficult for her to express any reservations that she may have about it or to change her decision at a subsequent time.
2. Acceptance is not tolerance. In consultation situation, tolerance implies 'putting up with'. It therefore implies a negative acceptance rather than a positive one, and only a superficial kind of respect for personality. The tolerance attitude implies that there is a characteristic, such as race difference, of which the doctor is aware, and which the patient senses he is trying to be tolerant (and not accepting) of.
3. Acceptance is not an attitude of emotional neutrality. It is a **positive** active attitude towards the patient, ie. 'I see, appreciate and value these ideas and feelings along with you'. That is to say, while the doctor does not impose his own value system on the patient, he does not adopt an aloof or indifferent attitude towards his feelings either.

GENUINENESS (CONGRUENCE)

The doctor must present himself as a real person in the interview encounter. A common behaviour running counter to this idea in doctors is the facade of professionalism — a kind of protective personal distance.



If a doctor tries to be accepting without truly feeling this way inside, the patient does not take long to find it out, eg. if a doctor says 'I'm not angry', while sitting with clenched fists and jaw, this will have a negative effect on the doctor/patient relationship.

It seems that when the patient experiences a relationship in which this deceit is not present, and when he feels that the doctor is serious and 'on the level' with him, he realises that he can drop his own facade and can accomplish little by being deceitful himself, eg. if a doctor adopts an intellectually pretentious manner this would make it less likely that the patient will avoid this style of dealing with his problems himself.

According to Brammer[3] & Shostrom, if the doctor has an element of genuineness or 'openness' of personality, this permits the patient to 'use' the doctor's ego for building his own.

With regard to the situation in general practice, there are some distinctive features which make his relationship with his patients a special one. He sees his patients over a long period of time, possibly for a life-time, in a variety of situations, which enables him to make interventions which would be impossible for any specialist including a psychiatrist.

As Balint[4,5] puts it: 'The general practitioner, of all types of doctor, has the most strings to his bow. He occupies the safest position and may take considered risks with his patients — risks which would be inadvisable, or even rash, for any of his specialist colleagues. If he is a good doctor, true to his calling, his relationship to his patient is strong and many-sided enough to overcome a host of difficulties. Let us suppose he (the GP) makes a mistake. The patient may perhaps stay away for some time, but sooner or later he will probably come back either because his supply of medicine has run out, or because he has got some slight malaise, eg. a cold, or in order to consult the doctor about his child, his wife, or even his grandfather.

'Even if the patient himself refuses to see him for some time, the doctor may continue the treatment, for instance, when seeing the wife for antenatal examinations or while inoculating one of the children. If need be, the doctor may a subsequent casually at the patient's house after visiting one of the neighbours in the same street. No such possibilities exist for the specialist, or for the psychoanalyst. If their relationship with the patient has been broken off, whether by the patient or through their own mistakes, they can hardly do anything but wait and hope'.

Balint also makes the point that the GP examines the various parts of the patient's body and is even allowed to inspect and to touch the parts not usually exposed for inspection. Balint maintains that this intimate contact has highly important psychological implications and therapeutic potentialities, but psychiatrists and analysts have practically no experience with these dynamic factors.

Another distinctive feature of general practice is the GP's relationship not only with individuals, but with whole families. This provides the GP with the opportunity to get information about family members he may not see from their nearest relatives and to provide to help for them through these indirect channels.

Having listed some of the advantages which the GP has in his relationship with his patients, it should be noted that his position as a GP also places him at a disadvantage in some respects. For one thing, his relationship with members of families can result in his becoming over-identified with certain family members at the expense of others, eg. a woman may repeatedly present to the GP with her child, she may later present herself, with psychosomatic symptoms or depression due to marital problems. The GP may have become so identified with the wife that he may find it extremely difficult to empathise with the husband, whom he may never have met. A useful way of trying to circumvent this kind of problem is for the GP to ask to see the husband as soon as he suspects that the wife has emotional difficulties, and for him then to try to arrange for a combined consultation(s) with the husband and wife as soon as possible.

Another difficulty facing the GP is that patients who speak to him about their emotional problems sometimes find it difficult to consult their GP at a subsequent time for a physical ailment, because of their fear that they may again be expected to discuss their emotional problems at a time when they feel dis-inclined to do so. As one patient put it to me recently: 'I was glad to be able to talk to you about my marital problems, but now that's behind me, and I was scared you would ask me about it when I came to see you about my sore throat'.

The GP needs to point out explicitly to his patients that they should always feel welcome to come and discuss their problems with him, but should never feel under any pressure to do so.

Finally, it must be remembered that the doctor patient relationship in general practice is a professional relationship and not a social one. As far as possible, the GP should avoid engaging in social relationships with patients, and should discourage friends and relatives from becoming patients.

The relationship between doctor and patient, in order to be effective, should have well-defined **limits,** such as the adherence of the patient to the prescribed consulting hours (except in

cases of emergency), keeping appointments, payment of fees, etc. It is also highly in advisable for a GP to accept favours or presents from patients however tempted he may feel to do so at certain times. For example, a GP who takes up the offer of a patient who owns a clothing shop to sell him clothes at a cheaper price than that offered to the general public, is inviting this patient to expect special favours from him too, such as calling him out at night for inappropriate reasons, expecting him to do house visits when he is quite well enough to come to the rooms, etc. The GP may then feel resentful towards his patient, but be unable to take the matter up with him because of his sense of indebtedness to him.

The resentful GP will then be unable to empathise properly with his patients problems, because of his (unexpressed) anger towards him.

Similarly, a social relationship with a patient will necessarily mean that the GP will have needs of and feelings towards the patient which will interfere with his capacity to help him in the professional situation. The patient for his part may well be reluctant to expose problems in his personal life for fear that this may jeopardise the social relationship and put pressure on the GP to help the relationship on a chatty, social, level. The GP in trying to resist this pressure, may well be perceived as being 'contrariwise' by the patient, to the detriment of the professional relationship (and probably the social relationship as well).

In advocating a clear separation of professional and social roles, it is not, as mentioned earlier, being suggested that the GP adopt an aloof or distant manner in his relationship with his patients. On the contrary, it is important that he be as real and as open with them as possible and avoid all obstacles which put distance between him and his patients, such as sitting behind a desk, writing copious notes while his patient is talking to him, etc. At the same time, the GP is going to make far better use of his self as a therapeutic tool, or as Balint put it, as the 'drug doctor' if he understands clearly his role as a doctor and does not confuse it with the other roles in his life.

I can think of no better way to conclude than by quoting Michael Balint: 'It happens so rarely in life that you have a person who unerstands what you are up to and openly faces it with you. That is what we can do for our patients, and it is an enormous thing'.

REFERENCES

1. Rogers, C, (1974): On Becoming a Person — A Therapist's View of Psychotherapy. London: Constable
2. Truax, CB and Carkhuff, RR (1975): Toward Effective Counseling and Psychotherapy. Chicago: Aldine
3. Brammer, LM and Shostrom, EL (1968): Therapeutic Psychology, 2nd ed. New York: Prentice-Hall
4. Balint, M (1971): The Doctor, His Patient and the Illness, 2nd ed. Surrey: Pitman Paperbacks
5. Balint, M and Balint E, (1972): Psychotherapeutic Techniques in Medicine, London: Tavistock Publications

ABOUT THE AUTHOR

Dr Stanley Levenstein qualified at Pretoria in 1970 and has been in active general practice since 1972, acquiring the MFGP (SA) in 1974. He is secretary of the Cape Region of the Faculty of the General Practice and Chairman of the Human Behaviour Sub-committee.

He has been actively involved in under and post-graduate education for several years, and has taken special interest in the psychological aspects of general practice.

He was one of the founders of the original Balint Group in Cape Town and was elected founder President of the South African Balint Society in July 1979.

He has authored numerous publications, one of which, entitled 'Anxiety and the General Practitioner — a Psychotherapeutic approach' was awarded the Louis Leipoldt Memorial Medal in 1977 for the best article by a general practitioner in the South African Medical Journal.

Practice Briefs

Forensics symposium

The 'Kennedy Assassination', 'Shotgun Wounds' and 'Death in Joggers' will be among the international topics if interest to be discussed at the Sixth South African International Symposium on Forensic Medicine to take place at the College of Medicine in Johannesburg from 17th to 20th March, 1981.

These three papers will be presented by Dr Werner U. Spitz, Chief Medical Examiner for Wayne Country, Detroit (USA).

Also included in the programme will be papers on the medical treatment of prisoners and detainees; traumatic neuropathology; abortion; medico-legal problems in the practice of district surgeons; medico-legal problems of alcoholic intoxication; the relationship between medical and legal practitioners in regard to litigation; the psychiatrist and the evaluation of criminal responsibility; and medical miscellany.

Further information is available from either Dr H. Bukofzer or Dr V.D. Kemp, Honorary Organising Secretary, P.O. Box 3796, Johannesburg 2000.

For further information circle **No 201**

UCT clinical trials post-graduate programme

Following the highly successful Clinical Trials Programme — one of the first of its kind in South Africa — which was presented last year by the Post-Graduate Medical Education Centre of the University of Cape Town, the conveners of the programme have further developed the course to include an understanding of the students t-test and other important statistical methods used in drug testing.

The Clinical Statistics Programme has been mounted by the UCT's Post-Graduate Medical Education Centre in association with the Department of Pharmacology and the Graduate School of Business from 2 - 5 February 1981, and will be of interest to leaders in the pharmaceutical industry and to clinicians in academic, hospital and private practice who are interested in the statistical basis for the construction, performance and evaluation of drug and therapeutic trails.

The design and administration of the course reflects the pooling of a wide range of knowledge and skills. Teaching skills and experience in the field will come from the highly regarded overseas group, Clinical Research Services, who will run a manual 'Instant Experience in Clinical Trials' game. This novel teaching and well-known expert on clinical trials. The Faculty of Medicine at UCT will provide local medical expertise and the administration and the venue for the course have been provided by UCT's Graduate School of Business which specialises in running professional executive programmes of a high calibre.

The programme is residential in Cape Town and full details can be obtained from the Director, Graduate School of Business, University of Cape Town, Private Bag, Rondebosch, Cape, 7700, South Africa.

For further information circle **No 202**

Local GPs invited to Austrian congress

South African general practitioners have been invited to consider attending the International Society of General Practice's 29th congress in Klagenfurt, Austria, from 14 to 19 September, 1981.

Topics to be covered will be:

- Social and medical rehabilitation
- Atherosclerosis as a problem for the general practitioner
- Prevention in every day practice
- Results of research in general practice
- The general practitioner as a teacher
- Family planning

The congress is being organised by Dr Gottfried Heller.

Further information and registration details are available from the Secretary, SIMG, Mrs Sigrid Taupe, A-9020 Klagenfurt, Banhofstrasse 22, Austria.

For further information circle **No 203**