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.

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 unconscious. 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 offending item, the child performed appallingly.

The extraction was stopped almost before it had begun. To my utter amazement, the mother then 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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<table>
<thead>
<tr>
<th>Important constituents</th>
<th>Lactogen reconstituted at 12.8% w/w</th>
<th>Codex Standard*</th>
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*for formulas enriched with iron.

Just one good reason to recommend Lactogen.

Lactogen is a complete formula enriched with minerals, vitamins, copper, zinc and iron according to the latest recommendations of the American Academy of Pediatrics and Codex Alimentarius Commission. This ensures adequate quantities of these nutrients for normal healthy growth. Because of its special characteristics, Lactogen can be used during the whole first year of life and even after.

For healthy contented infants recommending Lactogen where a breast milk substitute or supplement is required, makes a lot of sense.

Breastfeeding is the first choice when advising a mother on how to feed her infant. In its biochemical and immunological properties breastmilk is unique and whenever possible breastfeeding must be encouraged.

Family Practice — October/November 1982
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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One cannot hastily assume that an adverse reaction is due to allergy because other disorders give rise to the same assortment of symptoms. Digestive disturbances may be due to gastric hypoacidity as a result of:

- immaturity of the digestive system;
- climate;
- 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.


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The doctor/patient relationship

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 in-
consequential 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" 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 tact-
fully about the wife-husband relation-
ship and/or any extra-marital affairs
etc.

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Patients with psychological pro-
blems which manifest with chronic
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As Balint put it: "The use of em-
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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

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 open 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).