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 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
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, alcoholism, drug abuse, or antisocial behaviour. Acceptance attitudes are non-judgmental in that the doctor is impartial to the values held by the patient. When the patient 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 non-judgmental acceptance
3. The doctor needs to understand the patient, not judge him.
4. The doctor needs to be empathetic towards the patient.
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 creates 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 says 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 & 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 lifetime, in a variety of situations, which enables him to make interventions which would be impossible for any specialist including a psychiatrist.

As Balint4,5 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 inadmissible, 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 grandchild.'

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 have 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 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 disinclined 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 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 upon 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 'contrarywise' 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 understands 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'.