Life & Times

Borderlands:

the difficulty of the liminal in primary care

THOSE IN TRANSITION

Mary Douglas, in her anthropological work *Purity and Danger*,[1] analyses the difficulty that many societies have in coping with the liminal, the person in transition, or development. She describes the many strategies used to cope with this, the segregation of those going through life changes such as puberty, childbirth, or bereavement in order to protect them while they are at their most vulnerable, neither one thing nor the other. She also describes the fear attached to liminal items that we lose during status transition (such as the placenta), and the magical properties that they bring, for example, in some societies the placenta must be buried in the grounds of the family house in order to prevent danger to the child or mother. Disorder symbolises both danger and power.

Understanding social role definitions even now underplays so much of how we think and act that it becomes hugely important in medical transactions. Dr Ann York, a consultant psychiatrist, has spoken of diagnostic labelling and how it influences our perceptions of social role.[2]

STAY IN YOUR LANE

Many doctors struggle with the liminal. Those patients who lay claim to our own role by appearing overly informed are often given short shrift or literally 'put back in their place'. Expressions of irritation are directed at those who dare to try to take ownership of their own illness or think in any depth about the consequences of procedures to come. Such patients are often given derogatory titles such as '*Guardian* readers' and actively avoided. This triggers the question as to why medics feel so negatively about those who are doing the best that they can to understand their own circumstances?

Similarly, those doctors who become patients often experience worse health care. There is awkwardness in approaching them, often a level of insensitivity towards their personal thoughts and fears. Other staff can be unwittingly uncaring: *'Now you know what it feels like to be on the other side!'* is a comment of little comfort to the doctor dealing with serious illness.

Studies of physicians' health behaviours have detailed the embarrassment felt on taking up the patient role.[3] Caroline Elton[4] also explores this, looking at the experiences of junior doctors who are trying to deal with being patients at the same time as completing their training. She looks at examples of an obstetrics registrar who is experiencing recurrent miscarriage and a junior doctor being treated for malignancy, and how their dual status impacts on the work and their treatment.

Mary Douglas explains how in these situations of displacement:

'this role is in practice difficult to play coolly. If anything goes wrong, if they feel resentment or grief, then their double loyalties and their ambiguous status in the structure where they are concerned makes them appear as a danger to those belonging fully in it.'[1]

NO NEAT BOXES

How about the issue of inexplicable ill health? The most difficult patient consultations are often with those who feel unwell but where we cannot categorise the diagnosis easily: the functional neurological disorder, fibromyalgia, non-specific abdominal pain. Is this made more difficult by a training that reinforces an ill/not ill, worthy/not worthy opposition? Are the social determinants of health, causing the 'unworthy patient consultation' about, for example, marital distress, less important than the genetic?

Or is it that we see our own skills increasingly through algorithms that determine optimal medical care through a yes/no sequence and we thus develop an impatience and lack of empathy towards those who are somewhere in-between?

This can lead to an unthinking 'one size fits all' approach and a dogmatism that prevents the patient's symptoms being heard. Ill health doesn't easily fit into neat boxes. Patients with undiagnosed illness or distress inhabit a liminal zone for much of their life, aware that their physicians are perplexed or impatient with their symptoms. It's no surprise that we often see maladaptive coping mechanisms in this group and find it difficult to consult effectively with them.

Life is rarely black and white. Have sympathy; there's an awful lot of grey out there.

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REFERENCES

1. Douglas M. *Purity and danger: an analysis of concepts of pollution and taboo.* London: Routledge, 2002 [first published 1966].
2. BBC Radio 4. D is for diagnosis. *Four Thought* 2018; **4 May:** https://www.bbc.co.uk/programmes/b06qkp8y (accessed 6 Apr 2020).
3. Thompson WT, Cupples ME, Sibbett CH, *et al.* Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study. *BMJ* 2001; **323(7315):** 728–731.
4. Elton C. *Also human: the inner lives of doctors.* London: William Heinemann, 2018.