THE DOCTOR-PATIENT RELATIONSHIP IN THE SURGERY*

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IN GENERAL PRACTICE the patient usually meets the doctor either in the home or in the surgery. The doctor-patient relationship in the surgery will be dealt with here.

The patient comes to the doctor because he has, or thinks he has, some ailment. Though it may appear trivial to anyone else, this ailment is important to him because it concerns his own person. For this reason he is tense and part of this tension is transmitted to the doctor. Such tension, if allowed to persist, will upset the patient's reasoning and descriptive powers. Therefore, to get a coherent, accurate history, the first thing the doctor has to do is to put the patient at his ease. There are many ways he can do this. Though they may be learnt by experience as part of the art of medicine —and some of them can only be learnt in this way—the following suggestions may help the beginner:

1. Take the history in a room that is homely. The more the consulting room is like an ordinary living room, the more will be its soothing effect on the patient.
2. The doctor's attire should be conservative, lest it divert the patient's attention, even to a slight extent, from his illness. The use of a white coat should be avoided.
3. The doctor should greet the patient by name and shake hands with him. Incidentally, shaking hands with the patient is a valuable means of gauging his degree of anxiety. If he is over-anxious, often he will grasp the doctor's hand in a convulsive fashion with one that is cold and clammy due to excessive sweating of the palm.
4. Have the patient comfortably seated.
5. The doctor should not only be relaxed but should appear so, for the benefit of the patient.
6. He should refer briefly to the patient's previous illnesses and their dates (from the record). This gives the patient the feeling that quite a lot is known about him already and tends to put him at his ease.

*Lecture delivered to fourth and final-year students at University College, Cork.

J. COLL. GEN. PRACTIT., 1966, 11, 21

7. The use of courtesy and consideration will show the patient that the doctor is there specially to help him; that he is not rushed; that he recognizes the patient's human dignity and does not regard him as a mere unit.
8. The patient should be listened to and not interrupted in the middle of his story. By his actions and demeanour, the doctor should show him that he is listening with cool interest, neither shocked nor baffled.
9. Small-talk should be cut completely in most cases. In some it has a limited use in breaking the ice. Usually the patient likes to get on with what he came for.
10. If the patient gets mixed-up in his story, he should be guided through it with a few apt suggestions.
11. If the patient is garrulous, it is better to let him finish his story unless it is going on for too long. The primary object of his visit may be to get somebody to listen to what he has to say.

History

What the patient tells the doctor is confidential. The doctor's or the patient's voice should not be heard by anyone else while the consultation is taking place. For this the consulting-room should be sound-proof; if there is a separate examination-room, this should also be sound-proof. There is nothing more embarrassing for the patient than to overhear the conversation from the consulting-room when he knows that he himself will be entering the consulting-room shortly.

The patient's record should be in front of the doctor when the former enters the consulting-room. While he is giving the history, particular notice should be taken of the way in which he presents it. The hypochondriac will be verbose and irrelevant; he will keep talking until interrupted. The nervous patient will sit bolt upright, clenching his fists or fiddling with some object in his hands; his sentences will come in quick bursts. When the symptoms described are vague, the patient may be afraid, ashamed or unaware consciously of his true symptoms. Again the symptoms may be hidden to see if the doctor will find the cause of the trouble in his examination. This often happens when the patient has already been told that he has a certain complaint. In the case of a child, the over-anxious parent will not only tell the doctor of what the child complains but will forestall it in answering simple questions such as: "Are you going to school?" asked by the doctor to put the child at its ease. The over-anxious father will answer the questions directed to the mother.

When a patient is difficult or aggressive without apparent reason it may be that he is in a constant state of nervous tension from the circumstances in which he is placed. Example: A woman of 28 has a family of nine; she has no domestic help; she never has a holiday. She is irritable with everybody. When she visits the doctor she has

a multitude of complaints, none of which respond to the treatment given. On her next visit she is almost accusing in her attitude when she says the treatment has done her no good.

There is the patronizing patient who addresses the doctor as 'Doc'. Often he has the diagnosis made and will say what it is. He may resent probing into his past history or his family history. Such a person may have little respect for the doctor or for the medical profession as a whole. Extra care should be taken with him as it will be harder to get an accurate history. He is not to be mistaken for the ignorant patient who lacks good manners. This person is often below average intelligence. His history will often be inaccurate and reliance should be placed on getting a supplementary history from a relative and laying more emphasis on the physical signs.

The patient who is partially deaf can be irritating. Shouting at him is an effort and one has the feeling, which is probably true, that everybody in the building and even outside, can overhear what is being discussed. This patient is often annoyed because he cannot hear what is being said and may be insulted if it is written down for him. Again it is well to get the help of a relative in answering most of the questions and confining those directed to him to what cannot be gleaned from the relative. Remember to lower the voice to normal when the next patient is seen!

It is hard to get a good history from the patient known well socially. One does not feel like delving into his life to the extent which is required in history-taking. He will resent questions as being too personal, though before coming to the surgery, he may have fully intended telling everything. One solution here is to direct him discreetly to another practitioner.

Beware of the patient who is obviously distressed and tries to minimize his symptoms. He may suggest that the diagnosis is something simple and harmless but is, in fact, afraid he has something serious and wants the doctor to say he has not. Extra care should be taken with the history and examination in this case.

The patient appreciates a screen in the consulting-room behind which he can undress; this applies even more so the female patient. It is better still if the patient can undress in an examination-room where he may take his time dressing and undressing and avoid that sensation of being rushed which he will often have if the doctor is present. Also, if there is an examination-room, the history of the next patient may be taken while the first is undressing.

To an onlooker the history taken by the general practitioner may often seem skimped. The reason is that the doctor's previous

knowledge of the patient makes many questions unnecessary.

Examination

The examination of the patient in general practice has wide limits. It may be the quick look, as in the case of a repeat attendance for Bell's palsy, to the exhaustive examination as in the case of a person with early suspected disseminated sclerosis on his first attendance.

The time spent on examination is left to the doctor. Patients do not object to the length of the examination, as such. They are impressed by the lengthy examination even though an examination which is just as efficient might be carried out in a quarter of the time. What they do not like is being exposed to cold for a long period; it is well to have a good heating system in the surgery.

The patient will tend to expose as little as possible. He should be told exactly what garments to take off for an adequate examination. Here again an examination-room is an asset. One might feel like examining without proper exposure in order to save time if one has to wait while the clothes are taken off. Again, to save embarrassment, especially in the case of the female, one may limit the exposed area unduly. If an examination-room is available, such embarrassment is less likely to occur.

For one's own protection, it is better to avoid examining female patients vaginally without a chaperon. At least, one should not do this examination while alone in the building with the patient.

The suspected neurotic should always be examined for two reasons: (1) Because it is right to examine every patient—unexpected findings often result; (2) It will make him feel better and he will more readily accept advice and treatment.

When examining patients for insurance companies, or in any examination which needs a report to a solicitor, it is well to have a system which is as full as possible though it might appear that such a routine examination is unnecessary and not requested. If an incomplete examination is done in the first place, a major condition might be missed which could prove embarrassing in court of law.

It often happens that the patient says that he is not ready for examination. This usually means that he did not expect to be examined and has not got clean underwear on. It is better in this case to examine him at a later date, making it quite clear that a diagnosis cannot be made until he is fully examined.

When examining a child, leave the throat until last. This examination will usually upset him and if done at the beginning will mean an unco-operative, crying patient for the rest of the examination. In

examining the throat, have the child's head and arms immobilized either with one's own hands, which is difficult, or by a third person; then get it over as quickly as possible. If the child is unco-operative from the start, avoid the couch and use the mother's lap. Tell her to let it sit upright. If one does not do this, her immediate reaction is to lay the child flat on her lap and this is likely to cause crying. This is especially important in palpating the abdomen. It is better to do it with the child sitting upright and not crying than lying flat with tense abdominal musculature from crying. In the infant the bottle will usually prove effective.

When small children and infants are being examined, use deliberately slow movements. Any quick movement will alarm them and lead to crying. However, in the examinations of the throat and lungs crying is an advantage, in the former because the mouth is already open and in the latter because deep inspirations are taken. Older children respond amazingly well to the sharp command. It must not, however, be harsh.

Difficulty is often caused by the well-meaning relative (usually the grannie) who keeps fussing the child. It is well to get such a person to leave the management of the child to the doctor, if it can be done discreetly. Unfortunately, it often happens that she is convinced that she is the only person who can manage the child properly. Toys and sweets have their uses in gaining the co-operation of children. Sweets may be temptation for the doctor as well as the child!

Shyness or false modesty can cause difficulty in examination. Sometimes it can be overcome by ordering the patient sharply without being rude to expose the required part. In other cases, one may succeed by asking the parents or any other person accompanying the patient to leave the room while one examines him. Another way is to assure the patient that doctors are used to doing these examinations. It is better to refrain from saying that he is wasting time as this will add antagonism to shyness.

The quickest way to warm the hands for examination is to put them in warm water. A warm chest-piece to the stethoscope and a warm sphygmomanometer cuff will be appreciated by the patient and in the child will often prevent crying. A rubber cuff fitted over the bell of the stethoscope is less cold than metal or bakelite.

It is easier to examine the relaxed patient than one who is tense; examine him gently, perhaps with a little light conversation to take his mind off the examination.

In the consulting-room use a chair that is easy to get out of. This will make the occupant feel more inclined to do examinations than

if he uses one that imprisons him.

If there is a secretary, she can help in the examination by testing urines and weighing patients. This can save a lot of time in general practice.

To the patient the examination is by far more important than the history, the latter being looked on as a sort of preliminary chat before getting down to business.

Investigation

Many patients are frightened by investigation when it means being handed over to another doctor. If it consists of the general practitioner's ordering the tests which are carried out in the hospital, then the process is not so frightening. Where it is felt that the interpretation of the result of a special test is beyond the scope of the general practitioner, it is better to refer the patient to the specialist concerned.

Sometimes the patient will ask for a certain investigation such as an x-ray. Usually, there is no need for it but he imagines that it will give a definite answer to his complaint. Often, he attributes a cure to it. It should be explained what may be expected from the investigation and he will usually accept such an explanation.

Expense is saved in having special investigations done by the general practitioner because it avoids either specialist or hospital inpatient fees or both. It will mean extra trouble for the general practitioner in collecting specimens, blood, sputa, etc., but gives him more satisfaction in his work.

Where there is a possibility of legal action one should err on the side of over-investigation even though one is morally sure that the results of many of the tests will be negative and wasteful from the medical point of view. This is because one's management of the case will be open to non-medical scrutiny and omission of a certain test or tests may appear as negligence in the lay mind. This form of investigation is for self-protection and should be resorted to only when necessary.

If the general practitioner does an investigation himself, it will be appreciated by the patient. People have an inherent dislike of hospitals because of the impersonal atmosphere there, the trouble of making appointments and the queuing. Though these occur also in the surgery, they occur on a smaller scale; the patient has to summon up his courage even to go to the surgery—he does not want to go through an even greater ordeal in braving the hospital. The general practitioner is somebody he knows and the more that can be done for him in the surgery, the better he likes it. The disadvantage to the doctor is that laboratory tests are time-consuming and if he has a big practice, it usually means that he will not have time except

for the simplest of tests.

There is the patient who does not want a special test because he is afraid of what it might reveal. This applies especially to an x-ray of the chest—he is afraid that he will be sent away to a sanatorium for a long period. Such a patient can often be persuaded by explaining that as long as he defers investigation the longer he will be worried about the result and in the meantime, if the worst is true, the sooner he begins treatment the better.

General practice is the ideal field for routine investigations. These are usually accepted well by the patient; it shows him that the doctor is doing more than the minimum. The ones commonly done by the general practitioner are: urine testing, haemoglobin estimation, ESR, RBC counts, differential counts and simple bacteriology. It is worth one's while doing them for the occasional pathology which is found and which might otherwise be missed.

Diagnosis

While being dogmatic with the patient it is well to have a personal mental humility about the diagnosis. To do this one has to say one thing and think another. If all doubts are displayed to the patient, not only will it make him nervous but he will be inclined to lose confidence in the doctor. When telling him the diagnosis one is taking the calculated risk that one is right. If the risk is big it may be better to come out and say one does not know. This is seldom necessary. One can often tell him that special investigations are necessary to diagnose his condition. One might tell him he will have to return to see the effect of treatment. On the other hand, one should try not to commit oneself to something which may eventually turn out to be wrong.

The patient wants to have confidence in his doctor and every effort should be made to foster this desire. If one gives him the impression that one is mystified, it will often make him panic. He may seek the advice of other doctors. He may ask to be admitted to hospital again looking for a definite diagnosis. If he does neither of these things, he will probably give a distorted account of his symptoms on subsequent visits, because his imagination will magnify the various possibilities in his mind.

If a serious condition is suspected, it is better to tell either the patient or his relatives about it. If not, then, should the suspicion prove correct, and should this diagnosis be made by a colleague, the patient and his relatives lose confidence in the doctor and he loses them as patients.

When the original diagnosis is wrong, it is better to be candid about it to the patient. It is difficult for the doctor to admit that he

is wrong and it will lessen the patient's confidence in him, but in the long run he will lose the confidence of the patient less than if he tries to fool him about the diagnosis. There is nothing that will undermine the patient's confidence more than if he discovers the doctor is not truthful. When it is kinder to withhold the diagnosis from the patient, as when he has cancer, it is better to omit saying it than to deceive him and say he has some condition which he has not. Even if the patient asks a direct question, the doctor can often stall him by talking round it. If he insists on an answer to his question, then it should be given to him. The position about telling the relatives is altogether different. Where the diagnosis is withheld from the patient, the relatives should always be told. Otherwise they will accuse the doctor later of not knowing what it was.

The diagnosis of a serious condition should not be withheld from every patient. One will have to judge his temperament before deciding. He may be the type of person who will be happier in his mind if he knows the worst straight away than to have it withheld when he knows perfectly well that he has a serious condition. Again, circumstances may alter the decision; should sudden death be likely from the diagnosis, one may consider the patient would want to prepare for his death in either a spiritual or in a temporal way.

If the family decides that he should be told and asks the doctor to tell him, it may be well to suggest to them that the information would come better from some close friend of the family, remembering that non-medical people can often put it in a less frightening way than can the doctor. The doctor in his explanation may unknowingly use terms which may not be understood clearly, thus adding confusion to the plight of the unfortunate patient.

There is one time when a serious condition should always be told to the patient, i.e. when a major congenital abnormality, such as anencephaly, has been discovered in the foetus. Though it will come as an acute shock to her, the pregnant mother can withstand the psychological trauma better than the puerperal mother. It is of secondary importance that it frees the doctor from the blame of not knowing beforehand. When a condition like this occurs, for which no cause is known, it is a fact that the patient will often invent her own cause and the doctor is as good a scapegoat as any other and will be maligned unless he has taken steps to cover himself. However, this is a secondary consideration because it is the patient who is of primary importance. But there is no harm in covering oneself provided the patient does not suffer by it.

The doctor should be sure the patient understands what he is told. It is so easy to slip into a technical way of speaking quite uncon-

sciously. If the patient does not understand fully what the doctor says to him, he may not ask him to explain either because he does not want to display his apparent ignorance or because he is already too upset by the part of it he does understand. The diagnosis should be stated clearly and emphatically. Qualifications such as: 'A touch of . . .', 'A bit of . . .' should be avoided; one should not say: 'I think you have . . .' but instead: 'You have . . .'. The patient's mind should not be clouded in doubt after seeing his doctor; he should be satified that his condition has been diagnosed accurately. If not, another condition has been added to what he already has—namely, worry. A sign of success in this direction is when the patient says: " You've eased my mind, doctor."

In the whole interview with the patient, it is the diagnosis which makes the greatest impact on his mind. It should never be treated jokingly, remembering that of all things that bring him to see his doctor, it is never for amusement and he will resent it bitterly if fun is made of what he considers important.

Before giving the diagnosis, the doctor should see that the patient is fully dressed, seated comfortably in front of him giving him his whole attention. He should be comfortably seated himself, leaning forward slightly and looking directly at the patient. He should resist the temptation to save time by giving the diagnosis while the patient is occupied with dressing, or while he (the doctor) is occupied by the examination or washing his hands or writing a prescription.

The temptation to make the spot diagnosis is often great. A conscious effort should be made to keep the diagnosis for the proper time. Otherwise, one may be forced to go back on what one has already said, causing confusion to both doctor and patient.

Prognosis

In giving the prognosis one should try to be as accurate as possible. At the same time emphasis should be laid on the brighter side. For instance, should a patient complain of a pain in his chest which is probably fibrositis, but where angina must be ruled out, the doctor might tell him there is nothing seriously the matter but for the sake of completeness he would like an electrical recording of his heart and to try out his response to certain tablets when he gets the pain.

Peace of mind to the patient should always be aimed at, whether it be at the present meeting or a future one. This will not be achieved when he is told there is definitely nothing the matter when it turns out eventually that his complaint is serious. The anticlimax of finding out the worst after being assured he is all right is devastating to the patient. The doctor's judgment of what to say to the patient varies from one to another, as in the case of the diagnosis. But whereas the diagnosis should be specific, the prognosis should not

be limited to definite times or definite degrees of severity because every patient's response to disease is different.

Where the prognosis is hopeless it is usually better to give it to the relatives rather than the patient himself. They may or may not tell it to the patient. The doctor's role has now changed from that of medical adviser to that of comforter and anything that will help to keep the patient's spirits up is to be recommended. The fact that he is seen regularly is a comfort to him. If he has pain the doctor sees to it that it is relieved. Often one gets the impression that he knows his disease is fatal but does not want to be told it is.

There are times (e.g. in alopecia areata) when extra emphasis should be laid on the good prognosis because though the condition may eventually have a favourable outcome, it will take a long time during which period the patient is worried that it will never get better. It is well if the doctor can forestall such worry. He will then remember the doctor's advice when otherwise he would despair of cure. One should see such a patient regularly, to encourage him by repeating that he will eventually get better.

A guarded prognosis should be given where the cure depends partly or wholly on the patient's will-power, e.g. the alcoholic. Though at the time he may fully intend to abide by the doctor's advice, he may break down under the sustained effort of keeping to it. Here again one should prepare him for such an occurrence by telling him that there is a possibility that he will lapse unless he is firm.

Patients with neurotic symptoms will often like to be told that their organic symptoms are serious and that they will last a long time or even be incurable. If it is pointed out to them that the prognosis depends on the way they face up to reality, they may be satisfied for the time being. Eventually, they tend to relapse until it would appear that they would prefer to have some organic disease than face the circumstances in which they are placed.

The prognosis should be rounded off by saying that if things do not turn out as predicted the patient should return. So many diseases turn out differently from what was originally thought, that it is hardly ever safe to tell the patient definitively that he will need no more treatment. Always leave the door open to further attendances no matter how sure the prognosis is.

In giving the prognosis the patient's social background is taken into account. Knowledge of his environment plays an important part here. The doctor knows the type of person he is and if he will stick to his treatment; he knows his family circumstances; his type of work; his neighbourhood and the difficulties with which he is faced in day-to-day life. Most of all he knows his attitude towards

life and can anticipate his way of thinking. Take the case of the businessman with a duodenal ulcer. The doctor knows the prognosis is largely dependent on his freedom from worry. The patient may or may not be the type who will take advice. His means of livelihood may be such that he cannot have freedom from worry. The doctor may know that family strife may hinder it. All these things are important in giving the prognosis. It is only by practising in an area for a time and getting to know the community thoroughly that these circumstances may be known and recognized. The more one is part of the community in which one practises, the better can this be done. This cannot be done simply by practising medicine—one must take part in the life of the community to such an extent that one knows the people's likes and dislikes, the types of work done in the area, their pastimes, their difficulties, their virtues and their vices, their habits and their customs. At the same time it is wise to maintain a certain reserve with patients met socially as they may be shy when seen professionally at a later date.

A knowledge of the hospital and specialist services open to the patient is important in giving the prognosis, especially in serious diseases. The doctor should know what these services are. He should keep up to date in them because from time to time new services are brought in and old ones rescinded. A good way to keep abreast of these changes is to attend clinical meetings, where one meets colleagues and discusses these matters with them before and after the main meeting. Much valuable information is gleaned in this way over a cup of coffee. Another way is to keep in touch with the local health authority and a third is by visiting the hospitals and meeting the specialists. The more one knows of the quality and facilities of the specialists, the more accurate will one's prognosis be.

Extreme vagueness in the prognosis can lead to confusion and worry in the patient's mind. It is well to give him something definite to hold on to and then explain what else he might expect. Let there be one or two points in what is said which will override all the others in his mind, e.g. " You will be better in four to five days " or " The condition is not serious but may take several months to clear up completely ".

Treatment

Because treatment in general practice is usually put into operation by the patient himself and because he has little knowledge of medicine, every detail should be explained in full and phrased in such a way that he understands it completely. For example where saline fomentations are required, he should be told to bathe the part in water which has plenty of salt dissolved in it; that the water should

be *comfortably* hot because if it is too hot he will have to be treated for burns as well.

The doctor should tell him that while he is under his care he should take no other form of treatment except what he orders for him. Unless he does this he may find that the patient is taking pills or medicine which were formerly prescribed for him.

The doctor should get to know the prices of the various drugs. One way he can become unpopular is to prescribe expensive drugs without warning the patient beforehand.

Appliances used in treatment can often be improvized from common household equipment, e.g. a chair laid on its side can serve as a bed-rest; an orange-box with two sides knocked out can serve as a bed-cage; the effect of a steam tent may be achieved by having a kettle boiling in a small room.

There are some ideas so ingrained in people's minds that it is impossible to uproot them. One is that a patient needs a tonic in the form of medicine after an illness. It is wise to give them some mixture such as Syr. Glycerophos. Co. which is inexpensive and harmless. They will invariably say they feel much better after it. Another idea which is prevalent is that the service is valueless unless a prescription is given. Again it is wise to acquiesce and, if advice only should meet the case, give something inexpensive as a placebo. The beneficial effect in both cases is psychological. Refusing to prescribe in these cases is futile until the public accept that tonics are of no more benefit than coloured water.

The patient will usually take advice on how long he is to stay in bed. When he will go back to work is a different matter. If he works for himself, he will go back sooner than he is advised; if he works for someone else he will want to go back later than he is advised. Of course, once the doctor has given his advice, his duty is done and it is up to the patient to carry it out.

In treating, the impression that should be given to the patient is that he is being offered advice. The term ' under doctor's orders ' is a bad one. Patients resent being forced to do something but if the doctor gives his advice and leaves it at that, then it is up to the patient to avail himself of it or not. If he objects strongly to the treatment advised, e.g. going to a sanatorium for pulmonary tuberculosis, one cannot force him. However, if the doctor says to him that he would do it himself if he had the patient's condition, then the latter realizes that it is purely for his own good and he will usually agree to it.

The general practitioner may often have to fall short of the ideal treatment where circumstances are against it. If a mother of a large family has influenza, she may not be in a position to spend five days in bed and, if so, there is no use in advising it. She should be told

what the best treatment is, and helped to work out how near she can come to it.

There are so many new preparations now on the market and so many new ones coming out that it is impossible to keep track of them all. It is better to become familiar with one drug in each group and to use this exclusively. Pick out one for a particular disease, study the literature carefully; know its price, its dangers, its limitations, its advantages. Then note its effect on your patients. If satisfied with the results, stick to it until a better one turns up. However, keep up to date, if possible, with every new drug which comes out. Though not prescribing it, one is using something equally good, and one is less likely to be embarrassed when a patient asks about a new drug he read of in the *Digest*.

In general practice, reassurance forms a large part of the treatment. In this the doctor's own personality means much. If he can instil confidence into a patient, the latter will believe him when told that there is no cause for worry.

Student Opinion on General Practice Attachment. I. M. RICHARDSON. *Brit. med. J.* 1965. **2**, 101.

This paper analyses the reports of 69 senior medical students at Aberdeen University who took part in a voluntary two-week attachment to general practice. Eighty per cent of the students found their attachment " very interesting " and most wrote a detailed account of their observations. Thirty (43 per cent) students felt that their choice of future career had been influenced by their experience—21 of these towards general practice. Voluntary general practice attachment schemes such as this, despite their limitations, are useful sources of guidance in the planning of new medical curricula, and their vocational value is also of great importance in recruitment for general practice.

A Greenock Family Doctor Looks Back Seven Years. J. HERD HENDERSON. *Brit. med. J.* 1965. **2**, 416.

Dr Henderson ' put his plate up ' in Greenock in 1957. He gives detailed figures showing the growth of the practice, its income and expenses over the first seven years. He describes the doctor-patient relationship in the practice as good. There are about 2,400 patients in the practice but " seldom are there more than two calls in a week-end or more than one in the half day off ".