How personal is personal care in general practice ?*

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MANY doctors and almost all patients regard personal care as fundamental in general practice. Yet the general practitioner may also be concerned with the care of groups of people and may have to intervene at the level of community care.

A girl drug addict was resident at one of the halfway hostels between psychiatric hospitals and the open world. She had been purchasing drugs in the black market and had given some of these to other residents. None of the members of the staff of that hostel knew of this for a fortnight. In the end complaints by other residents reached the staff and the medical and social workers of the hostel discussed what to do about the girl's misdemeanour. The discussion disclosed that there had been a considerable amount of trouble in the hostel. Communication between residents and staff had been poor and relationships tenuous because of numerous recent staff changes. It became quite clear that the girl's misdemeanour was not so much a symptom of the girl's illness as of the illness of the hostel community. It was the community, not the girl, who needed and received treatment.

The concept of personal care implies a kind of human relationship that is easier to describe than to define and that means different things at different levels of human relationships. One might ask whether and in what way the doctor's concept of personal care differs qualitatively from the personal care that, for example, a hairdresser gives to his client, a valet to his master, a nursing mother to her baby. There is indeed a difference. It is determined by the level of the response of each partner to the other. In the case of the doctor the response to the elemental need of the sick person to feel that his physician cares for him (Galen wrote: " Confidence and hope do more good than physic ") is on a professional level.

Our professional care differs from the everyday involvements of people, in that it is *therapeutic*, in other words, that its sole aim is to assist the patient to regain his health. This implies that our professional care is not given to satisfy our own emotional needs or to be a substitute for unattainable emotional targets of our own. Equally, our professional care is not given to fulfil the fantasies of our patients who may dream of and hope for a different kind of care, when they may wish that their doctor were their lover, their father, their friend, or their brother.

Although the everyday involvements between people and the doctor-patient relationship differ profoundly in quality, they have a common psychological basis, namely *identification*, a mental mechanism used unconsciously by every human being from the early days of childhood as a means of developing the self on the pattern of others so as to increase inner stability.

Significance of compassion

The identification in the doctor-patient relationship is based on two sets of emotions. The first consists of the patient striking a chord within the doctor, so that by the very fact of the patient's suffering, a feeling of *compassion or sympathy* is aroused within the doctor. Without this feeling of compassion there can be no real interpersonal relationship on the medical level.

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I remember treating a man suffering from malignant melanoma. He and his family were very anxious and excitable and became somewhat of a thorn in my flesh, because they called often for home visits, although I had already prescribed all the drugs that I thought he needed. One day his daughter, then aged 12, telephoned me in the evening and said: " Doctor, could you come to visit father, he is worse again ". I had seen him that very morning and somewhat angrily said to the little girl: " Look, I cannot come so often to see your father; he has got all the medicines he needs ", whereupon the little girl said: " But, doctor, he is suffering."

I felt rather ashamed then that a little girl should have to point out to me that I needed more compassion. I went and visited the patient and for the first time felt that the man did not really need or want the analgesics and sedatives I had given him, but that he needed someone with whom he could share the burden of his suffering and of his fear of impending death.

We do not always respond to suffering with compassion. Some doctors find it more difficult than others to feel compassion, and some patients may not arouse compassion, but other emotions, such as disgust, or anger. But in the professional relationship between doctor and patient, the doctor should always ask himself whether and how the arousal of responses other than compassion is diagnostic for a particular patient or for a particular doctor-patient relationship.

Empathy

The feeling of compassion or sympathy and the ensuing desire to help and care for the patient are by themselves not enough to establish a professional relationship that may be useful therapeutically. A second set of emotive forces is needed that puts the relationship beyond and above the ' tea and sympathy ' level. This is the ability of the doctor to take part in or to feel himself into the patient's emotions and ideas, to assume the inner frame of reference of the patient, an emotional process called *empathy*. In everyday language empathy is putting oneself in another's place. On the professional plane, empathy, in contrast to the identifications of everyday relationships, should no longer be an unconscious understanding of others, but should be brought into the doctor's awareness.

The physician in his professional relationship should also be aware that the patient's frame of reference is, in fact, not the physician's, although in a sense the physician has assumed it as his own. And, the physician's empathic identification should be temporary only, so that he may identify with the patient for a given time, while maintaining his own identity. This is in contrast to more permanent identifications, say, of a wife with her husband, or of two friends with each other, identifications that will permanently modify to some extent the personalities of the participants, a process that would not be desirable in the doctor-patient relationship.

Both sets of emotions are needed in personal care. Compassion is the basis of all interactions between doctor and patient; if it is lacking, the doctor will become a mere machine, easily replaceable by a computer. Without empathy it is impossible to understand the patient's suffering, to appreciate his problems, and to deal with them on a level acceptable to the patient. Sir George Pickering, no mean physician, wrote in 1963 in the *British Medical Journals* " Unless the doctor is utterly devoted to his patients and prepared to take immense trouble to understand their problems he is inferior to a machine."

No doubt then, up to the level of the empathetic process the relationship between doctor and patient will have to be one of highly personal care. Both compassion and empathy are interlinked and cannot be separated in the process of professional identification. Empathy is not possible unless compassion is felt, and compassion is wasted, or at least is not therapeutic, if not followed by empathy.

Up to this level then, *one* doctor, *one* person only, will have to remain involved with the patient.

Continuing care

From that point onwards, however, after the doctor has felt *with* the patient and has felt himself *into* the patient and thus obtained some glimpse of the patient's inner world and problems, it becomes possible to break the continuity of personal care and to refer the patient to others, be it a nurse for a dressing, a social worker for practical solutions, to a psychiatric social worker or a psychiatrist for the discussion of emotional problems, to other specialists for specific diagnostic or therapeutic tasks, or even to let an emergency doctor or locum deal with the patient.

When personal care is continued beyond the stage of empathetic identification, how personal or how intensive should it remain? This will depend, firstly, on the problem presented, secondly, on the doctor, and, thirdly, on the patient.

There are some illnesses or problems that require high degrees of personal care.

I had a woman patient, who had had psychiatric treatment for many years. She was married, and she was a very disturbed, cold person, who was quite unable to show or give affection to people. She had a dog in whose care she was immersed and who meant more to her than any other being. The dog died, and she fell into a deep depression with gross withdrawal into herself. She claimed to be a zombie, that life was not worth living, although she could not be bothered to commit suicide. When I saw her first, I decided that only the most intense personal care could lift this woman out of her state of intense withdrawal and depression. By my open interest in her, in her thoughts, her feelings, by frequent though brief interviews, she was brought to feel a great deal for me, and she began to recognise that she was indeed able to have feelings. This led eventually, after a stormy period of resolving the bonds of transference, to a considerable improvement in her condition and in her ability to form and maintain human relationships.

The intensity and need for continuity of personal care will also depend on the doctor. We doctors are trained to look at people mainly from the physical point of view, and when we are confronted, as we are in general practice, by illness that reaches from the somatic over the emotional to the social, we may not be able or willing to deal with this global problem. Professor Walton, of the Department of Psychiatry, University of Edinburgh, published a study of the willingness of doctors to recognise and treat the social and emotional aspects of illness. He found that there were quite a number of doctors who were neither equipped nor willing to deal with those aspects.

An acquaintance of mine who had some acute, rather serious emotional problems, had pains in his chest and consulted a cardiologist. The cardiologist, after having examined the patient, said: " There is nothing wrong with your heart. I know you have problems, but do not tell me about them; this is not my sphere; go and solve them ".

This is advice as good (or as bad) as telling our patients: " Pull yourself together " or " forget about it." Some doctors may be reluctant to deal with their patients on a level of very personal exchanges, because the patients' problems may be too similar to the doctor's unsolved own emotional problems, or because the problems may arouse within the doctor strong feelings of embarrassment, shame, disgust, or similar negative affects.

Are some problems presented by patients, such as marital difficulties, psychosexual disturbances, a child's unwillingness to go to school, being a social drop-out, really medical problems and do they concern the doctor? Some doctors might well consider that the personal care they are willing to give to their patients would not include those personal elements. There are also doctors who feel that some social problems of their patients, housing difficulties, lack of money, difficulties in adaptation to work, criminality, are completely outside their realm, and that the patients should call for social assistance from other sources.

What should these doctors do, when they are confronted with problems with which they feel they will not or cannot cope? One answer would be that they should at least show compassion and try to understand as much as possible, convey some of his understanding to the patient, and then refer him.

There are some patients, too, who cannot accept strong emotional bonds with others and would rather have tenuous and loose personal involvements, including with their doctors. They may change from partner to partner in a partnership practice, or they may call out emergency doctors rather than their own doctor, or they may be quite happy if they have an impersonal contact, as so many repeat prescription patients have. Highly personal care may become too much for some patients. We all know of patients on whom we have lavished a high degree of personal care and who, apparently ungratefully and incomprehensibly, have left us to sign on with another doctor in the district.

The quality and degree of personal care have important implications for treatment. Our traditional diagnoses do not take this into account at all, although in our true assessments of our patients clues of the impact the patient has made on us and thus on others and the disturbances of relationships brought about by this may be provided by our feelings towards the patient, typified by such expressions (which may at times remain unspoken and only felt) as: " this awful woman "; " oh, not Mr X again."

If such feelings are understood by the doctor as diagnostic pointers to the patient's emotional illness and not as signs of personal involvements between patient and doctor, personal care will then take a truly professional character and will indeed become therapeutic.