

The influence of a third party on a medical consultation

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SUMMARY. As doctors solicitous in the need for privacy, we may find it difficult to accept the presence of a third party; as teachers of medicine we must encourage their presence. We must also recognise that their presence may alter the nature of our practices. The tradition of the bipartite consultation, even if it has its origins in ecclesiastical history, cannot be sacrificed completely in the interests of teaching. Careful thought must be given to how much modification of the medical consultation can be allowed. At the same time recognition of the attitude of other professions to the use of pupillage in teaching might save some time and thought. Lawyers have been using this technique for generations, and they like ourselves are concerned with the same kind of human confidence.

Introduction

The privacy of the medical consultation may have originated in the church confessional, but it has become traditional for the doctor to try to conserve the confidentiality of the occasion. Not long ago the therapeutic tools which the doctor could use were few and blunt; only the subtle variations in their use made one doctor different from the next. Confidentiality protected the individualism of each doctor, so confidentiality had to be preserved.

With the growing potency and number of modern drugs the secrecy of the medical interview has relaxed (at the same time as the use of Latin and the apothecary's connotation has been jettisoned) and medical experience now tends to be shared. Before this dissolution of medical privacy is allowed to go too far, it is necessary to re-appraise the importance of the private consultation. The presence of a third party is the first step toward the erosion of confidence, yet it is an essential part of English medical teaching.

Absolute privacy is scarcely conceivable in these days, and absolute confidence is a legal concept which has been eroded in the medical world by the increasing availability of doctors' records. Complete dissolution of the mores of the doctor-patient relationship is to be avoided. This may be a question of feeling and not of reason, so we must try to define the need for this person-to-person confrontation divested as far as possible of all its traditional mystery. Only then can we put the third party's presence into perspective. If that can be done, it may be possible to define the ways and means of introducing the third party to the consultation without making the patient feel threatened. For it must be the absence of threat which allows the growth of mutual confidence between the doctor and his patient.

The content of the medical consultation

The patient seeks the help of a doctor. The patient needs help; the doctor must be able and willing to give it. For the patient the consultation may be a unique event; to the doctor it is part of a sequence in which the variable factor is the patient. He is individual and therefore infinitely variable; his total problem is compounded of ethnic, hereditary, and social factors; he presents himself to the doctor with a clinical condition which varies

with the widely variable pathology. For reasons compounded of all these variables, he presents with his own concern for survival.

The doctor must be able to gauge and share that concern. Disproportionate concern, too little or too much, may represent a psychopathological response to normal pressures, but more usually the pressures are too great on an otherwise normal person. In either case, the patient's sensibility can be so stretched that he can no longer respond to the disciplines of society. The last resort left for him may be the doctor's interview. That approach may require all the moral energy the patient can muster, and it must not be destroyed by the third party's presence. The patient who feels that his shame is too great to divulge, will need all his will to seek the aid of the doctor. He will need to devote all his attention to the doctor (and not as we too often suppose making a reciprocal demand of the doctor's attention). In this situation, the patient has an absolute right to a bipartite consultation.

If we are right in assuming that privacy is the patient's privilege, not the doctor's, then we must be sure that privacy and the bipartite consultation are synonymous. I believe that they need not be. Privacy, confidentiality, and even intimacy, can be preserved in a larger group. We come therefore to the relevance of a third party being present.

The presence of a third party

The patient has the privilege of privacy. The clinician has a privilege, not exclusively his, to invite or allow the presence of a third party. He may exclude that presence to protect himself or the patient. In a teaching situation that adjustment must already have been made.

We cannot engender circumstances which we know to be destructive of the patient's confidence. He may have been waiting in a state of vacillation for weeks before making an appointment, itself a deterrent to easy approach to the doctor. There may be a further delay, an interval between making and keeping the appointment. Such circumstances make a fragile foundation for a medical consultation; it is essential that it is not destroyed by the unwanted intrusion of a third party.

The presence of the third party may ruin the matrix upon which the patient's story and the doctor's interpretation may interact. The more dramatic the confrontation, the less this may be true. The patient shattered by major blood loss, by disintegration of his nervous system, or by myocardial infarction, is not likely to be concerned by the nature or the number or those who offer him aid. He may not even ask for evidence of competence.

At the other end of the scale, there is the patient whose self-concern has blunted his judgment, and for whom the choice of medical opinion is delicate and even critical. The general practitioner may find it difficult to support such a patient. Committed to a state of despair, there must be a sense of taking the plunge when a patient eventually decides to seek the help of a particular doctor; the competent but repetitive support which the doctor can offer to that patient will be a poor substitute for the salvation which the patient had hoped was within his grasp.

It is not an easy position for the doctor. He must decide when the critical moment has arrived when he must guide the patient towards the consultant psychiatrist. This step takes the patient to a widening situation in a psychiatric unit; the pockets of his psyche are turned out and the cosy, bipartite consultation with the general practitioner is traded for group activities in which the third party may be multiplied to the *n*th degree. Too delicate an approach on the general practitioner's part to the referral of his patient to seek another opinion, can waste time and even life. And the delicacy of feeling, which prevented the doctor from seeking a second opinion on behalf of his patient,

might have been saved by a readiness to share the clinical responsibility. I believe that I might have altered the fatal career of a 35-year old spinster whom I had not been able to help with regular but repetitive support. I later read that she had destroyed herself publicly with burning petrol, a fate which could have been avoided if any accident could have introduced into the situation a third party with the perception which, on this occasion at least, I lacked.

We assume that such confrontations have failed because of the severity of the patient's disorder, or because the patient and the appropriate doctor have never been put together. We gloomily reflect upon the patients who have made such progress soon after, if not as a direct result of, coming under a colleague's care. We blame ourselves for not having done better, but we do not ponder on how the successful confrontation could have been made sooner. The choice of doctor is a lottery; the access to further opinion is too rigidly structured. The fault may not be wholly with ourselves but with the system.

The presence of the third party may be a reforming step in the right direction, a compromise between the serial bipartite consultations of conventional medical practice and the broader intercourse of group therapy (or of course of normal life). The third party alters the matrix of communication if he offers little more than atmosphere to the occasion. He helps to release repressed ideas and dissolve phobias, and he may even elicit items of the patient's history which had previously remained obscure. There will always be the patient who demands privacy, fearing that the deceit which he can maintain with one doctor (the one of his choice), may be uncovered if he is confronted simultaneously by more than one.

Perhaps the better understanding of the traditional role of the third party in medical consultations will help us to evaluate his presence in more novel circumstances.

Situations where the presence of a third party is usual

I recall being taught, and with lurid illustrations, how essential it is to have a chaperone present or near at hand when examining some female patients. I have come to recognise that the presence of the chaperone is a necessity only after the need has passed; the practice nurse is usually more fully employed than the calls for chaperoning could justify.

I remember an occasion when I feared for my professional image, simply for the lack of the chaperone. There was in fact more than one such occasion, but they all involved one strange woman. In retrospect, I believe she was designing that I should examine her pelvis, but I did not suspect this at the time. When I made this examination she had an orgasm and I saw her no more. It was then that my fears mounted, and for some weeks I dreaded possible legal repercussions. But I came to assume that the patient was seeking this unsatisfactory solace elsewhere, and I had in no way helped to solve her psychoneurotic problem.

There are other ways in which the third party may assist at a consultation. A nurse or another doctor will often assist in some technical procedure in which the technical help is of less importance to the patient than is the presence which sustains the patient. The patient's fear, or reaction to fear, could invalidate the technical procedure; by dissipating the fear, comforting and reassuring, the third party plays an added role. The held hand may be more important than the passing of an instrument from hand to hand.

Again there may be present a third person representing another discipline. It may be a social worker, a nurse, or an educationalist. And the doctor in such circumstances may find that he has to take a back seat, while the patient and the other party make the prime moves. The well-tutored psychoneurotic may recognise this and turn to the social worker as a better source for the help he needs than the doctor.

Another doctor being present is usually a convention designed with the patient's knowledge and consent. For this reason the patient often produces gems of information which had previously remained buried. The patient benefits from the tripartite confrontation; he has the advantage of the further opinion. The consultant has a peep into the patient's natural environment, aiding him in his evaluation and the general practitioner has the edification of looking at the case from an altered viewpoint. The successful tripartite consultation has more rapid success than any other method of referral. No outpatient consultation can be modified from its rigid and conventional structure; even the presence of the general practitioner cannot easily bend the inflexible, overstressed, outpatient interview.

Sometimes the third party is the patient's relative or friend. Their presence may be easy to explain: one patient may require to be helped in his wheelchair, while another, a young unmarried girl prefers a mouthpiece to explain her predicament. When it is not easy to discern the function of this third party, his presence makes for difficulties, and, if after the introductions the third party remains, the clinician will have difficulties with his history-taking. The more difficult it is to detach the third party from the scene, the more likely it is he or she that is in need of medical care and not the nominal patient.

Finally, the extra person may be an interested observer or a pupil, whose interest is likely to have a beneficial influence on the interview. The patient's reaction to that presence is certain to be informative, even if he requires the third person to retire from the room. The patient's wish must be respected. Usually that presence aids rather than hinders the progress of the consultation; communication between doctor and patient is improved. The third party acts as a baffle, an alternative focus for the patient's communications, both spoken and unspoken: the pressure on the patient is reduced; he articulates his feelings and thoughts all the better.

The presence of the third party is not always an advantage. I remember an occasion when I was visited by a foreign orthopaedic surgeon; I was glad to have him "sit in" on my practice, my natural peer on surgical and orthopaedic matters. It did not take long to discover that he was also my peer, or was at least ready to pre-empt my opinion, in all branches of medicine.

That was a disastrous day for me, but it served to emphasise the true advantages of the acceptable third party. My orthopaedic surgeon was the antithesis of the interested pupil; the latter's academic expertise, recent learning, fresh approach and sharp cerebration help and stimulate the thoughts of the patient's general practitioner, whose deep concern with the patient may usefully be reactivated by the patient's reaction to that other presence. And the subsequent discussion between doctor and pupil may realign the facts of the case to the ultimate advantage of the patient.

Effect of the third party on the patient

Finally one must consider the effect on the patient of this new situation. The third party, who is placed by design and not by accident, has a function to fulfil. Connivance of the patient is the first step towards success; as we have seen, the second clinical opinion or the collaborative assistant can help the patient much more than the simple creation of the tripartite situation would suggest. The understanding nurse can do so much to help the patient ignore his suffering that her function is extended far beyond that of an extra pair of hands.

Many who have been patients will have sensed the discomfort of being in the simultaneous care of too many anonymous assistants. It is always difficult for the patient to gauge the size of the medical entourage particularly if he is already supine, prone, or in the lateral position. He may know the doctor, but it is difficult for him to guess the size of the attendant cast, the *dramatis personae*, and the order of their appearance. Unless he can feel secure in these circumstances, it can be impossible for him to

accept the manipulations to which, unsighted and perhaps in pain, he has to be subjected. It is a good feature of general practice that the patient is acquainted with the cast; if a new character appears he or she is introduced to the patient personally.

The most comfortable medical collusion is often created between the midwife and the parturient mother. The normality of the situation or its very naturalness makes the appearance of the doctor on the scene almost an intrusion. He comes with his skills because the normality is slipping out of the situation, sometimes so dramatically and hurriedly that the patient is shocked and her attendants are dry mouthed and anxious. So the doctor, well-known to the patient and competent though he may be, may be a most unwelcome intruder on the maternity scene, representing as he does the complications of labour and the intrinsic dangers of childbirth.

The barriers which this emergency can create will be the more difficult to surmount if the doctor has never seen the patient before. I have been called to the patient of a colleague on such occasions and have always noted that sense of estrangement. My ignorance of the patient makes the task intellectually easier; I know nothing of her fears and the solution of her obstetric problem slots more easily into textbook classifications which I learned as a student. Yet it emphasises the closeness of the liaison between the midwife and the patient. I feel the need to suborn the confidence of the patient so that she may allow my clumsy manoeuvres about her pudenda. In no other circumstances can one be so aware of the patient's agony. The familiar roles are reversed and one is glad of the presence of the midwife as a third party through whom an approach to the patient may be made. It is significant that domiciliary midwifery has always respected the advantage of having that third party present.

DRUG TREATMENT FOR PSYCHIATRIC PATIENTS

The drug treatment recommended in the discharge letters of 359 psychiatric patients was compared with the records of the supply of drugs given on leaving the hospital, and differences were found in 20·6 per cent of the sample. A comparison of the patients' treatment sheets, and the records of drugs given on leaving the hospital showed that drugs had been stopped on the day of discharge in 26·4 per cent of the total. It is suggested that the communication of information about drug treatment to general practitioners requires further attention, and that drugs should not be stopped on the day of discharge.

The drug treatment of the same group of patients was reviewed 18 months later, at which time 49·1 per cent were still receiving psychotropic drugs. Only 35·3 per cent of these prescriptions were for drugs of the same group as those given at the time of discharge from hospital.

REFERENCE

Ballinger, B. R. (1973). *British Journal of Psychiatry*, **121**, 63.