First encounters

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SUMMARY. Some conclusions are reported from a series of seminars involving several experienced general practitioners over a period of three years. The aim was to examine first consultations in general practice.

We found that these were often handled superficially and that both doctors and patients seemed hesitant in their new relationship. We believe that the loss of a trusted family doctor can create a bereavement reaction in patients, especially where the relationship has been long and when the doctor leaves or dies suddenly.

We are investigating the possibility that the death rate is increased among patients who have recently lost their general practitioner suddenly.

Introduction

In October 1973 the members of a group of eight general practitioners who had met weekly during the previous two years at the Tavistock Institute of Human Relations were asked to participate in a study, through their case presentations, of patients attending their surgery for the first time. With some hesitation the group agreed to keep aside records of all their first encounters with patients each week; one case, decided by chance, was then presented and discussed in depth weekly throughout the following year.

Although the group had been accustomed to presenting cases for discussion for some time, these had been self-selected, so criticism was to some extent anticipated. In this study, however, we found ourselves more exposed and vulnerable as we could not predict which case would be chosen; furthermore it rapidly turned out that we were dealing with consultations which were particularly badly handled by all of us. This provoked a certain amount of antipathy to the project which recurred throughout the year as we glimpsed our inadequacy at dealing with new patients.

As the seminar progressed, we began to recognise that we continually ignored and avoided the effects of several highly relevant factors which separated this type of patient from the usual surgery attender. In particular, we came to believe in the disturbance created in the individual by the social upheaval of moving house and of losing a doctor, usually the general practitioner, who may have been a long-standing family friend. Even though our leader, Dr Lewis, often brought our attention back to bear on these factors, after a year we were still failing to allow our new patients to ventilate them. The possible reasons for this are discussed below.

Object loss

It is interesting to compare the effect of the loss of doctor and old home with that of the ultimate loss, bereavement itself. Several well-documented surveys have shown that the grief reaction which follows bereavement may be the cause of greatly increased figures for both mortality and morbidity occurring in widowers and widows respectively in the first six months after bereavement. Parkes (1973) has postulated that the type and

intensity of relationship and the mode of death are important factors in the severity of the grief reaction, a dependence relationship with sudden and unprepared loss carrying the greatest risk. A grief reaction may furthermore be created by loss of any love object, whether it be husband or wife, parent or child, pet, home, money, or limb.

Under the British National Health Service nearly all residents of the United Kingdom have been registered since 1948 (or longer) with a general practitioner, who usually cares for the family unit while resident in his area. Thus, under stable conditions a family doctor may be expected to develop an intimate and lasting relationship with his patients over many years. The role he plays and in which he may be placed varies considerably according to his own personality and that of his patient, from the purely professional occasional consultation to the tenuous relationship of the " repeat prescription " situation and the enormously powerful dependence relationship in which the doctor may be placed in parental/filial/lover role by his patient.

It therefore seems feasible that a family doctor who has cared for several generations of patients may have developed an intense relationship with some members of the family, perhaps even more intense than that within the family itself, where the stress of such a close relationship may not be tolerated. The " loss " of such a person whether by death, illness, retirement, or moving to another area, might be expected to create the anger, insecurity and anxiety of grief in susceptible patients in much the same way it does in bereavement. Furthermore, the degree of reaction might be expected to relate to the degree of dependence, mode of leaving, and length of the relationship.

The relationship established with a new doctor under such circumstances is likely therefore to be deformed to some extent by the separation-anxiety provoked by the loss of the previous doctor. To this should be added the problems of loss of a home, described by Fried (1962) as " a highly disruptive and disturbing experience," of which he says " it seems quite precise to refer to reactions of the majority as grief." Despite the presence of these two factors, loss of doctor and loss of home, in our series the new doctor rarely encouraged his new patient to discuss either topic at the first encounter; this despite repeated reinforcement of these factors in previous case presentations to the group.

At first we wondered whether this defect in our initial consultations was because we felt threatened in some way by the previous doctor; new patients frequently will have their previous medication completely changed at first encounter as if to brush away all evidence of the previous general practitioner, and we tended to avoid any discussion as to whether the patient missed his old doctor, almost as though his acknowledgement might reduce our own potency.

Example (1)

A middle-aged man from the practice of two general practitioners who had moved away came to see one of us, asking for a repeat prescription for medazepam 'Nobrium' mentioning that he had had hypertension treated with pills which had been stopped. The doctor had previously seen his wife, who was about 20 years younger, and their seven-year-old educationally subnormal daughter. The doctor, quite out of character, not only without question repeated the prescription, but also added hypotensive drugs in view of his raised blood pressure and said he ought to do some investigations " some time " of the hypertension. The other members of the seminar took the doctor to task for this, not only for ignoring the psychological aspect of the case, but also for ignoring the side-effects of his treatment (he had prescribed ganglion-blockers), particularly impotence. It was felt that the singular lack of curiosity by both parties which transpired during the relating of the case may have been in part due to the joint annoyance with the former husband and wife practice, who had left without much warning and seemingly without any thoughts of placing their patients.

In this case the joint anger with the previous doctors seems to have affected the management of the patient by the new doctor.

A potent cause of separation-anxiety also appeared to be the loss of home with its attendant neighbours, friends, or family, " Attachment behaviour," as described by

Bowlby (1969) deals with the need for people to maintain closeness to people likely to protect them. Derived from the child/mother relationship, it extends later to objects such as the home, whose absence activates a separation anxiety. This may be characterised by a " sense of loss, pining, symptoms of distress, a sense of hopelessness, the occasional expressions of both direct and displaced anger, and tendencies to idealise the lost place." We failed just as much to ventilate this disruption with our new patients, yet how could the topic have been threatening to us? Possibly the answer lies in the distorted relationship with the new doctor as a result of these separation-anxieties. Under these stresses it seems likely that some patients may tend to resist early development of a close relationship, fearful of a repetition of the anxiety and insecurity of a further separation.

Example (2)

A 40-year old single man, who had recently moved, came to see one of the members of the seminar for the first time, complaining of indigestion. He looked anxious and mentioned that his job, which was driving a security truck, was becoming an increasing worry to him. The doctor did not appear to have taken this up, yet carefully examined him and thought that he might have an ulcer. Although the doctor asked him to come back, he did not give him a definite appointment, and gave him a certificate for a few days off work, which was so worded as not to require attendance for a final certificate. During discussion it was felt that the seeming reluctance to go into the reasons for his move and any other difficulties in his life must have been disappointing for a patient who came with a worry and was treated only physically. It may well be that the doctor reflected the patient's own unwillingness to develop the relationship further at that time.

First consultations treated superficially

In retrospect, before starting this study, such patients tended to be treated briefly and superficially "in order to give time for the relationship to develop". Even with the study in mind and a conscious effort to cull information to present to the group later on, our initial interviews were surprisingly superficial. Follow-up did not appear to show many patients in whom the relationship developed further. Temporary residents seemed to create even greater frustration in this respect: in a one-off situation no possibility of a developing relationship existed. The consultation tended to be brief and taken at face value, exposing the presenting doctor to attack from the group. Nevertheless, it is difficult to envisage any better way of dealing with the problem, which in itself would provide excellent material for study.

The reason for the anxiety created in the group by examining these relationships seemed to be that it was felt on many occasions " instant rapport " was not applicable to their first consultation, as in most first encounters in the Western culture, and thus a sense of failure resulted. Initially the members of the group felt that a new case was handled " inadequately " if a relationship was not successfully established, and " adequately " if rapport was achieved. This view, however, was revised to some extent by our realisation of the way a patient's own feelings dictated the outcome of an interview, and that we so seldom perceived those feelings.

Example (3)

A cultural attaché from the embassy of an African country was seen as a new patient. He had been living in the area for five months and had just been joined by his family. An anxious and subdued man, he said he had been investigated in Geneva for palpitations, and otherwise had some anxiety about lumps which appeared in his testicles for about an hour and then went down again. The interview never seemed to get going, and the doctor remained uncertain why he had come. In discussion it seemed to us that he probably had some anxiety about potency or coping with his family. His own subdued and depressed mood seemed to have been caught by the doctor.

On the other hand, there may be occasions when a superficial interview may be appropriate.

Example (4)

A 20-year old man came to the surgery for the first time, having been sent by his employers as he had fainted at work. The reason appeared to be that he had stayed up until the early hours studying to take an examination which was on the following day. His parents had spent many years abroad and he had been sent away to school for most of this time; he was now working in his father's firm and gave the impression of being rather lost and uncared for. Full examination was normal and he was reassured. The doctor did not take up his probable psychological problems in view of his impending examination, but then seemed to have caught some of the patient's own diffidence, as he did not ask the patient to return.

Effect on the patient of sudden loss of the doctor

During the course of the study of first encounters, seven patients were discussed whose move to a new doctor was because of a sudden move or illness by the previous doctor. There appeared to have been little preparation of the patient for this, and in five cases there was anxiety expressed which the new doctor was reluctant to discuss. The anxiety was on occasions expressed as anger.

Example (5)

A 22-year old postman complained at first attendance of a sore throat. He abruptly rejected the doctor's first choice antibiotic and requested another, which his old doctor had usually prescribed and received it. He and his wife lived with grandparents and had changed from a doctor who was dying of cancer. The grandparents had remained on his list and the couple were angry with the dying doctor because he would not visit their grandfather. The group felt also that the new doctor helped to compound a rather poor interview because of her own feelings of guilt in not contacting the sick doctor before taking his patients.

In one seminar member's practice there have been seven such " losses " of doctor in the past ten years, five by death, one by retirement, and one by emigration. Furthermore, in the past five years there have been five vocational trainees working in the practice, who have been encouraged to develop warm and sound relationships with the patient; the trainees, however, have been taught to discuss and emphasise the limit of their stay in the practice, particularly with patients whom they may have taken on for long interviews. Some partners have prepared their patients well for their departure, others have not. It has been noticeable the degree of resentment and disturbance created by the loss of these doctors, some of whom had cared for their patients for over 30 years.

Example (6)

Mrs A, aged 30, a rather childlike housewife with two daughters and an ineffectual husband, presented in 1969 with a complex mixture of a bereavement depression following her idealised father's death, panic attacks, phobias about illness and death, and marital problems. During the ensuing five years she consulted the doctor many times, initially with several long interviews and later with short follow-up consultations. She was able to discuss her dependence needs from him and improved to the point where she was able to deal effectively with her problems and lead a normal life. During his association with her, she remained on his partner's list, with whom the whole family were registered, and saw him on numerous occasions with various psychosomatic illnesses, all of which he dealt with in a purely physical way by investigation and reassurance.

She reappeared in February 1975 with the complaint that she had become increasingly depressed over the past three months with a return of all her old symptoms, sleep disturbance, thought block, and tearfulness. There appeared to be no precipitating factor until the doctor wondered aloud if she missed her other doctor, his partner, who had emigrated to Australia in September 1974. At this she burst into tears, and expressed her grief at his loss (" as though part of me is gone "). At this session and later, her dependence needs were discussed and the possible effect of the loss of her doctor, and she improved thereafter, returning to her usual, albeit not entirely normal psychological state.

Death of patients after doctors leave practice

When the topic of departing doctors was raised with the staff of the Family Practitioner Committee, comment was made of the apparent increase in deaths notified to them in the departed doctors' lists. This factor is now being investigated and so far appears to be upheld in cases where the doctor died or left suddenly. The mortality rate in cases where the doctor was able to prepare the practice for the " loss " is more complex and no such assertion can be made.

Continuing the parallel with bereavement loss, one series showed that bereavement depression after sudden death of a spouse was more prolonged and severe than among those who had a longer preparation for bereavement. Likewise it became apparent to the group during this survey that there were several occasions when the precipitous departure of a family doctor created marked anxiety and anger amongst his patients; this was manifested by mood disturbance or even somatic symptoms.

It therefore appears that it behoves the departing doctor to be aware of this possibility and to prepare for it with sensitivity and care; similarly the new doctor would do well to remind himself of the possible implications of the change, and teach himself to overcome his prejudices against the old doctor, allowing the patient the chance if needed to ventilate his feelings about the loss. He would do well to remember that the annual turnover of patients in his practice, if that of the members of the group reflects a true average, could be up to ten per cent of the list size—about 250 patients a year or more.

It seems likely that our first and last encounters in general practice are badly handled by us; we have to learn to say " hello " and " goodbye ".

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FAILURES OF COMMUNICATION

" A different kind of failure of communication sometimes brought to me consists of failure by a hospital to inform a family practitioner about a patient's discharge, or to inform him soon enough, or to give him enough information. I have upheld a number of complaints of that kind ".

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