The needs and expectations of doctors and patients

H. M. Holden, MA, MRC.PSYCH, DPM, DRCOG
General Practitioner, Saltburn-by-the-Sea, Cleveland

DOCTORS need patients as much as patients need doctors. Most medical publications are ostensibly about the needs of patients, and although much paper and heat is expended over negotiations about pay and conditions of work, the needs of doctors as a species are seldom considered. I shall try to explore the mutual needs and expectations of doctors and patients as they are shown by their attitudes to one another. Ideally there should be a mesh between the expectations of patients and those of the doctors who serve them. I would like to compare and contrast these expectations.

The needs and expectations of patients

Some forms of suffering, especially those associated with pain, are considered to be 'medical'. The range of such suffering has greatly increased in recent years; there is a tendency to 'medicalize' social problems. Persons who consider that they have medical problems declare themselves as 'patients' and seek the help of a doctor, usually a general practitioner. They expect:

1. That the doctor will listen and try to understand their complaint even if they themselves do not.

2. That he will be discreet and keep their confidence.

3. That he will relieve them of some of their suffering (dis-ease) by writing out an incomprehensible prescription which will provide them with a magical medicine or tablet.

4. That he will exercise the authority vested in him by them as patients, and ratified by the State through the granting of degrees and licences, and that he may, if necessary, use this authority to relieve them of some, or all, of their social responsibilities (e.g., by granting a medical certificate).

5. That he will, if necessary, see them through to death, and that he will negotiate in the process of dying so as to relieve the patient and his/her relations of at least some of the pain and anxiety of death. This is very important since it determines much of the patient's awe, reverence, and distaste for the medical profession. Priests and undertakers are viewed in a similar light, and for the same reason.

6. That the doctor will *know* what is wrong. Doctors are invested with a special understanding of the workings of bodies. Most patients do not know, and do not want to know, about their insides. Any breach of the skin, however trivial, is a matter for medical skill.

The attitude with which patients approach doctors is determined largely by these expectations. Doctors have been invested by the public with special knowledge and power; they must therefore be approached with circumspection and with a certain reverence in the hope that they will live up to the patient's hopes. It is therefore assumed:

1. That doctors are noble and self-sacrificing, though they never advertise the fact. (But there are posters to be found in many waiting rooms, such as the one which admonishes patients "not to waste the doctor's precious time" and not to keep the doctor waiting by being late for appointments.) They must be treated with special care and must not be called out unnecessarily, especially at night.

2. Doctors are indispensable and must be rewarded more highly than any other night or shift worker ("What would we do without you doctors?"). They are not overpaid and should probably receive more.

3. Doctors must be treated with due respect. They must always be addressed as "doctor" and may need to be placated or manipulated so that they may use their authority to the patient's advantage (namely, the complicated negotiations that go on over the issuing of medical certificates).

4. Doctors are always busy and it will be difficult to get to see one. This view, which is boosted by appointment systems and by posters issued by pharmaceutical firms (who know what they are about), reinforces the doctor's authority (see 1).

5. Doctors like 'interesting cases' and are interested in medical symptoms. Thus it pays to present oneself as an interesting case rather than as a suffering person.

The needs and expectations of doctors

Doctors also have expectations both of their patients and of themselves. They expect of their patients:

1. That they should be 'ill', or at least simulate illness in order that the doctor may:
a) Exercise his medical skills.
b) Use his medical authority.
c) Be busy.

2. That patients should respect medical authority. They should not question their doctor's diagnosis or medical advice.

3. Patients must learn to recognize that doctors are busy and important people, they must therefore be prepared to use the proper channels to gain access (waiting rooms and appointment systems), and any breach of the rules must be firmly dealt with.

4. Doctors expect that patients need prescriptions and that these prescriptions will relieve the patients of their suffering (physical or mental). The writing of a prescription may actually serve a number of different functions. These include:
a) Rational chemotherapy.
b) Palliation and relief of pain.
c) Relief of anxiety (for both patient and doctor).
d) Termination of an interview.
e) Symbolic doctor/patient ritual.
f) The need to keep the patient at a distance (emotionally).
g) The need to be seen to do *something* in order to boost the doctor's image, both with the patient and with themselves.

5. Patients should be medically ignorant and doctors usually do little to dispel this. Explanations to patients about their illness are usually brief or non-existent. Programmes involving medical education of the lay public take a low priority with most doctors, and do-it-yourself medicine is positively discouraged. Doctors guard their privileges closely, and vigorously oppose any attempt to make drugs more freely available. Restrictions on the sale of aspirin have been proposed recently, while attempts to make contraceptive pills more freely available are strongly opposed by the medical profession on the ostensible grounds that these are potentially dangerous drugs. As yet, however, no-one has suggested that alcohol and tobacco, the most commonly used tranquillizers, should be available only on medical prescription.

Doctors have a complementary view of their own role and status, which largely corresponds to their patients' attitudes.

1. Doctors are busy people. They need to be since there is nothing so disconcerting and morale-destroying as an empty waiting room—doctors need to be needed. There can never be any possibility that increased medical efficiency will reduce the workload, and the idea that doctors might eventually work themselves out of a job is not to be thought of. (Parkinson will beat Illich every time.)

2. Doctors need to be able to use their skills and to demonstrate their effectiveness in diagnosis and treatment. Patients who defy diagnosis, or who obstinately refuse to get better tend to be regarded as 'awkward', 'attention-seeking', or 'neurotic'.

3. Doctors *are* noble and self-sacrificing and they fully qualify for the respect and admiration which is their proper due (except for those lazy doctors in the next practice who refuse to visit their patients at night).

4. Doctors are *always* kind and sympathetic towards their patients. When this is impossible (and there are some patients towards whom it is hard to feel friendly) doctors tend to feel disconcerted because of the threat to their own self-image. Often this discomfort turns to anger and a wish to remove the offender from their list.

5. Doctors must be protected from their patients' unruly and inconsiderate demands by a barricade of receptionists, one of whose tasks is to keep the patients under control and protect the doctors from being bothered. At home doctors' wives often serve the same purpose.

6. With all these virtues, doctors value their skills highly and should certainly be paid much more than the average wage.

Discussion

The practice of medicine has three major components:

1. Diagnostic and therapeutic skill.

2. Medical authority.

3. Medical art (by this I mean the traditional art of patient care and management whereby patients may feel understood and comforted).

In spite of some overlap, these components are, I think, distinct. Although many would consider that medical skill is the cornerstone of medicine, it can be argued that for much of the time real medical skill enters very little into our dealings with our patients. Thus it is very easy for impostors to pose as doctors and to practise undetected for years. Often these impostors are loved by their patients and respected by their medical colleagues. Real scientific medical skill is a very new phenomenon.

Until 300 years ago, knowledge of the anatomy of the body was rudimentary, since dissection was forbidden and physiology was based on the totally erroneous theory of humours. It is arguable that the efforts of doctors made only a negative contribution to their

patients' health. This, however, in no way detracted from their status and authority in the community, and the mutual needs and expectations of patients and their doctors have changed little over the centuries.

The development of modern scientific medicine has, of course, reinforced the power and status of our profession but it has also given a new slant to the doctor's view of himself and his craft. Doctors are now scientists with 'real' knowledge. Most younger doctors see this knowledge as being linked with hospital medicine rather than general practice, and many general practitioners nowadays see themselves as second-class doctors because of the lack of opportunity to be 'scientific'. 'Interesting cases' are rare and, because of lack of time and facilities, are usually passed on to the hospitals. This is where the action and the glamour of medicine now resides.

It must be admitted that for the general practitioner much of the knowledge vested in him by the patient is spurious. How often during the course of any day does the general practitioner reassure a patient who has a vague febrile illness and who is asking for a diagnosis, that he is suffering from influenza or a virus infection, when in truth he knows no more than the patient himself. He is nevertheless performing an important function. The patient cannot bear the uncertainty; the task of the doctor is to relieve him of the responsibility and bear it for him. He knows (usually) enough to determine whether the patient is acutely ill—but that is all. He is in the position of *The Physician* in the Victorian painting by Sir Luke Fildes which is still to be found in many hospital boardrooms. In this picture the doctor is sitting by the bedside of a sick child. It seems clear from his expression that he does not know what is wrong with the child and is powerless to affect the course of the disease. What he *can* do is to see it through and relieve some of the anxiety of the parents who can be seen in the background.

This aspect of medicine is still as important as ever. It may be argued that the growth of scientific medicine with all its computerized trappings has taken something away from the human art of medicine, even though lives have undoubtedly been saved as a result. Perhaps it is significant that the BBC should have chosen the 1920s, (the era before antibiotics, steroids, beta-blockers, antidepressants, health centres, disposable syringes, and emergency deputizing services) as a suitable period in which to stage a popular serial which focuses on the doctor-patient relationship.

Actually, I am proud of my profession, but I think that there is a real danger that we doctors may begin to believe that we are as potent and omniscient as our patients would like us to be, and unfortunately this illusion is fostered by all the scientific trappings of our art. We have been thrust into a position of great responsibility and authority and we tend, whether consciously or not, to invite our patients to approach us with all kinds of intractable social problems, disguised as illness. It is important that we should understand and accept the limits of our own potency. Perhaps diazepam is a safer tranquillizer than alcohol but do we necessarily help our patients by removing from them the responsibility of deciding when they need that kind of prop? Occasionally this is very necessary, but are we sometimes too reluctant to allow our patients to resume responsibility for this sort of decision?

Above all it is important that we should realize our own limits. We can do little to prevent our patients eating too much, smoking too much, and drinking too much. Nor can we do much, as doctors, to change by purely medical means intractable social evils. We cannot clear slums, provide supportive communities for the isolated, or work for the unemployed.

Unfortunately, the myth that social suffering can be put right by pharmacological means is subtly reinforced by the drug companies with advertisements which propose panaceas for all our miseries. Whether doctors should use their influence for political ends in order to change some of these social conditions is open to question. My own belief is that such political activity is justified but only so long as we declare our interests and are clear about our own limits.

Meanwhile, let us beware of medical arrogance. Doctors are already pompous enough.

References

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Accidental hypothermia and impaired temperature homoeostasis in the elderly

A longitudinal study of the age-related decline in thermoregulatory capacity was made in 47 elderly people to try to identify those at risk from spontaneous hypothermia. During the winters of 1971/72 and 1975/76 evironmental and body temperature profiles were obtained in the home, and thermoregulatory function was investigated by cooling and warming tests. Environmental temperature and socio-economic conditions had not changed but the body core-shell temperature gradients were smaller in 1976, indicating progressive thermoregulatory impairment. People at risk also seem to have low resting peripheral blood flows, a non-constictor pattern of vasomotor response to cold, and a higher incidence of orthostatic hypotension.

Reference

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