Home visiting: the part played by the 'intermediary'

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SUMMARY. Home visits are usually initiated by someone other than the patient, whom we have called the 'intermediary'. It is seldom an objective decision on the part of the intermediary that a home visit is needed and is usually the result of his or her own anxieties. It is therefore important for the doctor consciously to aim at a diagnosis or formulation of the problems of the intermediary, and it may then become possible deliberately to help him or her with his needs and anxieties. If these are not considered, the strains or dissatisfaction of the intermediary which initiated the visit are likely to remain, and to influence both the way the doctor treats the patient and the doctor's sense of competence.

Introduction

IT has been noted that when anxieties become too much for the patient or the patient group to contain, they overflow and outside help is called in (Clyne, 1961). The general practitioner is one source of help and is called upon when the major factor of distress is, or can be made to appear to be, medical. One person is required to be 'sick' and in need of medical help—the 'nominated patient'; but it is often someone other than the nominated patient who makes the request to the surgery. This person we have called the 'intermediary'. The person in the household who was held to be in most need of the doctor's help we called the 'principal patient'. The nominated patient is sometimes only mildly unwell, not personally distressed, and may not have sought or even needed treatment. In these cases it is often the intermediary who is the principal patient, although he does not usually recognize himself as such.

The presence of the intermediary sometimes makes the visit easier for the doctor, as in the case of a sick child, but at other times the worried third person's communication may blur the issues and make accurate assessment of the nominated patient's problems more difficult.

Aim

This paper is an enquiry into the part played by, and the influence of, the intermediary in home visits made by general practitioners.

Method

The observations are derived from a research-cum-training seminar consisting of 12 general practitioners and two associates, based on the principles laid down by Balint (1968). The group met weekly for two hours and had been working together for two years before this particular project began.

Fifty home visits were chosen at random from those which had been undertaken on the two days before each seminar. This restriction was made so that the doctor who was reporting the home visit was more likely to remember the incident in detail. Cases were presented by members of the group in turn and discussion followed the usual lines of Balint seminar groups. That is to say, not only the illness, but the clinical transactions of each case were given in full and then discussed and further explored by the group with emphasis on dynamic shifts in the doctor/patient relationship.

As these cases are a random selection of home visits a full range of situations will not have been covered and the observations in this paper are therefore necessarily anecdotal. They are not an attempt to cover all the possibilities or a classification of situations in which the intermediary plays a significant part.

Of the 50 home visits chosen, an intermediary had called the doctor in 35, and the patients themselves had called the doctor in the other 15.

Results

During the pilot study for this series it was noted that the part played by the intermediary was often of great importance, and in the main study it became one of the aspects of home visiting which was particularly studied. Once discovered this seemed obvious, but it is a fact that all of the general practitioners had hitherto felt that the intermediary was only an interference to be disregarded or kept out of the way as much as possible in the interests of 'proper medicine'. As the study proceeded the intermediary was often found to be a source, even a key source, of important information which could throw light on the whole event.

Before the consultation

Whatever the cause of his feelings (usually anxiety) the intermediary may express them by calling the doctor. These anxieties may or may not be based on reality, but of course will be an outcome of the situation as he sees it. In his opinion extra resources are needed to handle the nominated patient, and perhaps others involved. He tends to select from the problems as he sees them, and consciously or unconsciously label them 'medical' in order to ensure that the doctor will visit the patient. The effect of some visits is clearly to allay the anxieties of those involved and the treatment of the patient is essentially only the means to this end; in other words, the visit is primarily for the intermediary. The way that the request is made will set the tone of the visit.

The intermediary demands a visit

1. The angry intermediary

If the intermediary demands that the patient is visited the doctor usually goes feeling angry, and time and energy are wasted in a competition over who is going to be in control of the decisions about the nominated patient. Until the plight of the intermediary is recognized and resolved, there is little hope of the doctor assessing the problems of the household objectively, only of his treating the nominated patient more or less inappropriately.

Patient 1

The message was passed to Dr O. via his receptionist: "My father has very serious back trouble and shouldn't be left lying at home. Why isn't the doctor doing anything?". Dr O. had seen the patient at his surgery five days before. He was then complaining of backache, but there were no physical signs and the doctor had sent him home to rest with some analgesics and had given him an appointment for one week's time. Some years previously, the patient had had a laminectomy for a prolapsed disc, and he was very disgruntled because he thought that that should have been the end of his backache for ever.

The doctor had previously decided to visit him at home if he did not come in for his appointment, but that morning the daughter spoke to the receptionist: "If the doctor doesn't come, something else will happen"—a definite threat, and she put the telephone down before she spoke to Dr O.

The doctor knocked on the door knowing he was in for a fight. A woman in her thirties shaking with anger greeted him with "I'm glad you've come at last". Dr O. replied, "I only got the call a few minutes ago; where's the patient?". That is, he tried to brush aside the one who sought his help (the intermediary), and looked for a 'patient'.

As she began to follow him upstairs he dismissively said "Well, I'll see him alone", and she reluctantly turned away still obviously in a flaming temper.

The patient by contrast was apologetic to the doctor but did have pain despite the analgesics. Dr O. again found no physical abnormalities but spent half an hour with him explaining how he viewed the problem, discussed some of the patient's fears, and drew up a plan for his treatment. The patient, shaking his hand with gratitude, said "I am sorry about my daughter, but she's got a lot of problems". However, he did not want to talk about them, because they were 'very personal'. She was waiting at the bottom of the stairs and launched into a tirade against the doctor for "not caring", "leaving him to rot", "bad treatment", "malpractice", and threatening "to report him to everybody". Dr O., after trying to answer these accusations and not getting a word in, lost his temper and jabbing his finger at her shouted, "I'm a doctor, and I know exactly what is wrong with your father and you know nothing", and stormed out leaving the woman in tears.

Who had needed the doctor? Why? Who was anxious? Why? This had neither been thought of nor examined. The doctor thought it was merely a battle of wills over the treatment of the nominated patient, and he was not in a frame of mind to listen to the 'interference' of the daughter. But for what purpose was he called in? And did the visit fulfill that purpose? Who had the problems? And who had shown the doctor these? Was she helped?

2. The intermediary as messenger

The intermediary may be a child or a neighbour sent as a messenger by the patient or by an anxious relative. The result is that little information can be obtained about the urgency of the situation and the doctor may have to treat as an emergency a situation which turns out to be a relatively trivial illness, although the surrounding anxieties may be far from trivial. Not many of us have the self-control in these circumstances to be able to enquire unhurriedly into the anxieties which brought about the request.

Patient 2

A rather breathless, frightened-looking 14-year-old arrived as the doctor was beginning his Monday morning surgery, saying, "My mum's collapsed and she says will you come and see her?" Not wanting to leave a waiting room rapidly filling with patients, the doctor found himself saying, "Do you think she is seriously ill?" before realizing the lad was quite unable to give any further useful information. Then, without waiting for a reply, he said, "All right, I'll come and see her now, but I shall be very cross if there's nothing wrong with her".

The doctor was ushered in by the boy's grandmother to the bedroom where the patient lay sprawled face down on the bed, apparently unconscious. She did not move when the doctor asked the grandmother what had happened. He was told, "She collapsed about 20 minutes ago", and he went to turn the patient over, only to find she was fully conscious. He found no physical abnormalities and said he did not think there was anything seriously wrong. Putting a hand on the boy's shoulder, he said, "She's going to be all right".

The doctor asked the nominated patient to make an appointment to see him and hurried back to his surgery, while the grandmother got ready to go to work and the children to get off to school. Everyone was by now late and angry.

It appeared an overdramatic call for help, but the doctor had no idea what it was about. An anxiety attack which frightened the grandmother? Hysteria following a row? In the hurried circumstances he may be excused for not attempting to find out, and he hoped to be able to do so at a later consultation. But did the 'patient' want him at all? Or was he simply to be a pawn in an unexamined family battle or tragedy?

It was our experience that observation and enquiry about what leads to the call is seldom made during a home visit. The circumstances are generally not conducive to this. One commonly forbidding factor is the presence of others in the room who hold various undeclared stakes in the visit. The doctor does not know where to begin—even if he wished to. Because of this, and of course his own predilection, he gets confined to 'body-doctoring' by somebody who has decided to use him only in that way.

The intermediary during the home visit

1. The complaining intermediary and the uncomplaining patient

We were surprised to find how often (50 per cent of the cases where an intermediary was involved) the intermediary was noted to be anxious and complaining on behalf of a patient who was relatively unworried.

Patient 3

Mr T. was a 67-year-old man whose wife telephoned on Monday morning saying that her husband had 'collapsed' the previous day with a crushing pain in his chest while they were out for a walk. He was taken to hospital but sent home after investigations as no abnormalities were found. Mrs T. is a caring woman looking after not only a husband who has been restricted by angina for seven years and has Parkinson's disease, but also two sisters, one totally deaf and the other with angina and hypertension. She clutches at the doctor and holds on to his arm, and the doctor feels she has totally unreal expectations of him.

When the doctor arrived the husband was asleep and quite unperturbed. She, however, was complaining, "I do have so much to put up with, don't I?" The doctor ignored this complaint but treated the non-complaining husband by stopping his 'Sinemet' and keeping him in bed for 24 hours before mobilizing him. The wife followed the doctor out to his car and asked him what the trouble was, and how it would affect him, although he had already explained to the apparently relaxed patient in her presence. She said how marvellous the doctor was, and the doctor, knowing there was little he could do for the nominated patient, felt burdened by this 'messianic' role. She seemed to feel that the doctor could prevent death just by being there—"He'll be all right now". Clearly she wanted the doctor for herself, because of her undisclosed anxieties, but the doctor was embarrassed by her unreal expectations of him and tried to ignore her anxieties and treat only the unperturbed patient.

The seminar group was not surprised to hear that this couple gave the doctor presents at Christmas, and it was pointed out that she (the intermediary) copes for and controls the husband, her two sisters, and the doctor, and that the doctor uncomfortably plays the part allocated to him by her. The patient was uncomplaining and the intermediary was perhaps relieved at least temporarily, but the doctor feels uneasy because his relationship with the intermediary is insincere and her anxieties are acted out rather than discussed. He knows that he is incapable of fulfilling her expectations of omnipotence, and yet he ignores her—the very cause of his work. He left saying, "I'll come back again on Thursday". The intermediary's use of the doctor is clearly driven by undiscussed anxieties, and by Thursday she will be needing another dose of the doctor to contain them. It is likely that he will then again collude with her, but not discuss her worries.

This case also illustrates the way that the complaining of the intermediary is done as if it were on behalf of, and about, the patient. The doctor, who is looking for a patient claiming to be ill, may then feel justifiably irritated when he finds the patient neither sick nor distressed. As a response, this irritation is a poor substitute for enquiry into the intermediary's worries, which were the reason for the visit in the first place.

2. The principal patient

There are times when the nominated patient is not unwell, or only mildly unwell, and it is the intermediary who is the person in trouble, or in other words, the principal patient.

Patient 4

Dr E. parked in the high street to visit a nine-year-old boy with stomach pains. He had not been there before, and he had to go into several shops before finding the way into the flat above. He was met by the mother, who was clearly very anxious. She said he had been vomiting and having diarrhoea since the early hours of the morning, but the doctor was greeted by a cheerful-looking child who said he was "fine". Apart from a slight raised temperature there were no abnormal physical signs and he seemed a happy boy. They went on to talk about what he had had to eat. Apparently he had been fishing in the river the day before, and his mother was afraid he might have caught "some germ from the fish". The doctor rather dismissed this, and did not prescribe any treatment because the boy was really quite well. His mother was by then apologising for asking the doctor to call, but she had been "so worried".

The doctor knew that the boy's mother had left her alcoholic husband a year before to live with a man in this dismal flat. She had discussed this with him when she had been to see him with menorrhagia and headaches. He looked upon her as being a sad, anxious woman, and realized that she was the principal patient. He was not sure what the present trouble was, and with her son present did not feel that he could discuss it further, so he asked her to come and see him at his surgery.

If the doctor is observant he may decide that the intermediary is the principal patient, but as with this woman, further difficulties often arise when attempting any 'treatment'. This woman's attitude was "There's

nothing wrong with me, I am worried about my son", and it was this displacement of trouble that made it difficult to turn the focus of the consultation on to her. The covert nature of the intermediary's needs and the associated difficulties in asking for help add to the problems. These may be intractable when the principal patient is registered with another doctor. Typically this happens when a visiting relative calls in the doctor to see an elderly but not seriously ill parent. The general practitioner may then feel that he has no right to identify major personal needs in someone who is not 'his' patient.

When the doctor is uncertain who the principal patient is in a disturbed family it has been suggested that he should ask himself "who labelled what behaviour a symptom?" (Royal College of General Practitioners, 1972). However, the doctor should not let himself be blinkered by shifting the label of being the patient from one person (the nominated patient) to another (the principal patient) and thereby miss an opportunity of enquiring into the problems of the whole family or patient group.

3. The intermediary and dependant patients

When the nominated patient is a child, or an adult who is so ill that he has become dependant, the doctor may divide his attentions so that he questions and examines the one who is sick, but his instructions are given to the intermediary. Discussing an adult's illness with the intermediary occurs increasingly as the nominated patient becomes more ill.

Patient 5

Dr A. was called in to see an 88-year-old unmarried woman who had had an operation for cataract removal two weeks before and had had two visits since the operation—the first because of a sore throat and the second because of giddiness.

She lives alone and is usually very independent, calling in the doctor herself when she thinks it is necessary. On this occasion she had her SRN grand-niece from Australia staying with her and it was she who had initiated the visit and telephoned because the old lady was coughing and unwell.

The old lady, brusque as ever, and in full command of her fears, greeted the doctor with bluff cheerfulness: "I'm not going to die you know, doctor". However, she was clearly unwell and racked by coughing. The grand-niece helped the old lady to sit up and pull up her nightie for the doctor to examine her chest. He found that she had basal pneumonia and noticed that he was talking more to the grand-niece and less to the patient, partly because she was deaf, but also because she was ill and weary. Aware of the concern of the intermediary and her readiness to look after the patient, he realized that for the first time he had talked not to, but across, this vigorous old spinster, and that uncharacteristically, she had accepted this.

Here the patient's loss of self-care and the intermediary's assumption of care was clear. The previous week the patient had asked for the visit, but now she had become more unwell and had become passive and dependant on others. The intermediary had responded by taking over the decisions and at least temporarily any instructions would be given to, and carried out, by her. It was as if the patient had given up responsibility for her own body and handed this over to the intermediary who, at the same time, became the doctor's assistant in the management of this illness.

The doctor also had responded to the change, and he discussed the problems not with the patient but with the intermediary. Now it was the intermediary's turn to bear the anxieties and to call on the doctor when these became too burdensome. As people become less able to look after themselves, they come to depend upon others and sometimes evolve an extensive support system from relatives, neighbours, friends, or voluntary organizations. The intermediary is the spokesman for this group of people who call on the doctor's resources when their own are overstrained. This is especially clear when the patient has a terminal illness. The doctor turns his advice slowly away from the patient and towards the relatives, the future survivors. This, however, often involves a less than truthful relationship with the patient.

Patient 6

Mr C., aged 69, had known he had a carcinoma of the bronchus following investigations earlier in the year, after he had coughed up blood. Radiotherapy and chemotherapy had helped, but now he had developed hoarseness and an ENT appointment was arranged. Mrs C. then telephoned saying that her husband had cancelled the appointment. "He is making out that he is getting better and I don't know what to do now." The distress of the intermediary and her initiation of the visit was clear, but the doctor would have none of this and dutifully saw his nominated patient. Dr O. called and Mr C. greeted him in a very hoarse voice: "You shouldn't have come, I am better". The doctor told him (insincerely) that he wanted another chest x-ray to see how the primary was doing, and Mr C. agreed to this, although protesting, "It is all clearing up" and "I am not coughing now". Downstairs, Mrs C. said "What do you think, doctor?", and Dr O. said he thought the cancer was spreading. He told her that he would discuss possible treatment with the chest surgeon and would let her know.

This was the first time that the patient had been left out of the management of his own case. Mrs C., now clearly the manager, said she and her two sons did not want Mr C. to be told the cause of his hoarseness. The doctor would have preferred not to withhold information from the patient, but he acquiesced with the wife. Later he realized that he did so only because the patient was dying, written off as it were, and that he was in fact caring for the intermediary and not primarily now for the patient.

4. The absent intermediary

In six of the 50 cases the intermediaries were not present when the doctor saw the patient, and there were problems resulting directly from this. In one the intermediary was at work, but the other five were excluded by the doctor.

Patient 7

A neighbour of Mrs D's telephoned asking Dr J. to call because "She is short of breath and talking to her husband, and he has been dead for 14 years". The doctor first called on this neighbour who held the key. She let him in, and called out, "The doctor's here, Edith", and then disappeared. Mrs D., who was sitting wrapped in blankets and clearly well cared for, said she "couldn't get her breath like in the past". Apart from this she was "fine", and had walked half a mile daily to a lunch club until the week before. Asked if her feet swelled, she said "Yes, a little", but in fact they were enormous and she also had moist sounds at her lung bases. Dr J. prescribed a diuretic and asked about her family. She was quite coherent about missing her dead husband and how her son and daughter each wanted her to live with them, but she wanted to "stay in my own home—I've been here 43 years".

The seminar speculated about her fear that the doctor would try to move her out of her home. She had hidden her swollen legs and played down her incapacity. The doctor left without seeing the intermediary again.

The intermediary had been ignored. For the doctor the nominated patient was the extent of his concern. But was this wise? The seminar was in difficulties understanding the intermediary. Like the doctor, they felt that if the intermediary were absent, so much the better. It was then realized that supporters tended to be ignored unless they were close relatives. The seminar members took refuge from self-criticism by reminding themselves of ethical and possible legal difficulties over maintaining confidentiality, but it was eventually decided that this was a rationalization and that these problems would have been overcome if the doctor had really wanted to share the anxieties of the intermediary about the prognosis. The significance of the intermediary had not at this time been recognized, but we may speculate that the doctor had identified with the patient's system of denial—"Hear no evil, see no evil, speak no evil".

Mrs D., assisted by many friends, was able to maintain a pretence of 'independence'. The intermediary was not, however, just a messenger. The anxieties she expressed about Mrs D. were almost certainly those of the other helpers in the support system. We found that the helpers tend to be ignored unless the doctor needs them, for example to collect a prescription, whereas they actually need the doctor to help them with their distress. They may need support, encouragement, or opportunities to discuss their anxieties. If, as in this case, the doctor avoids the intermediary, the needs of the support system are not catered for. The seminar became confident that if they made it a deliberate task to observe, diagnose, and treat the anxieties of the support system, there would be fewer demands for hospital admissions.

5. *The supportive intermediary*

The doctor may feel that there is little he can do in the way of organic medicine for many patients with chronic illness. He may visit them and adjust or change their treatment, feeling that it is all rather pointless, yet the patient and his supporters seem to feel that his visit is important to them. If the doctor becomes aware that his main therapeutic effect is the encouragement and support of the patient, his relatives, and perhaps the neighbours, usually through the intermediary, he can set about achieving this deliberately. This gives him a sense of being useful.

Patient 8

Mr M. telephoned and asked their doctor to call in to see his 68-year-old wife, because "She's being sick after she eats". This had been going on for four days. She had pulmonary tuberculosis as a young woman and was in a sanatorium for many years. She was also being treated for congestive cardiac failure, myxoedema, Parkinson's disease, and she had had a ring fitted because of prolapse.

The doctor was let in by the husband, a cheerful retired bus driver with "Hello, doctor, glad to see you". Mrs M. was sitting, wrapped in innumerable woollies, looking miserable. There was no change in her condition and the doctor reduced the dosage of digoxin ('Lanoxin') and prescribed metoclopramide ('Maxolon') tablets three times a day. He wondered whether it would not be better to stop all the tablets and to see what would happen. Without support through polypharmacy would they be able to face the tragic situation? And could the doctor?

As the doctor left the house, Mr M. was in the front garden arranging to go out with his neighbour in the evening. He is a cheerful, easy-going man to whom the doctor turns with relief. The doctor sympathises with Mr M. and temporarily shares his burden and sense of hopelessness about his wife, but he feels safer resorting to drugs than having an open discussion. Undoubtedly Mr M. finds support and encouragement from the doctor's visits, but the patient remains isolated in her misery.

The main relationship for the doctor was with the intermediary, and there was little pressure on him to do anything positive. The consultation stayed at the level of a social chat and the doctor and the intermediary avoided getting involved in the patient's more distressing problems.

6. *The intermediary acting on behalf of a child*

Doctors automatically accept that it is appropriate to discuss illnesses with intermediaries (parents) when the nominated patients are children. Although the doctors attending the seminar were interested in emotional problems and often knew a great deal about the families, in every case the doctor fought shy of serious enquiry into emotional situations during a home visit to a child. They were aware that a child might be used as a 'visiting card' for one or both of the parents to hint at troubles to the doctor (Balint, 1968), but at most they showed polite interest and seemed deliberately to keep the conversation at the level of a social chat. The presence of the ill child, and the unfamiliar setting seemed to be inhibiting. It has been noted that trainees feel insecure in a patient's home because the consultation is taking place on foreign (the patient's) territory (Gray, 1978) and this is probably a major factor in experienced general practitioners also failing to make enquiries.

Patient 9

Dr K. was asked by Luke's mother to visit him because of headaches and high temperature. He agreed to visit, and knew that she had had emotional problems and had just married for the second time. Luke was in bed reading a comic and not looking unwell, but the doctor found that he had tonsillitis with an exudate. The doctor told the mother the diagnosis and gave her a prescription for pencillin.

The doctor knew that Luke's mother and step-father had serious emotional problems, but he did not want the difficulty of enquiring into the family situation at that time, and opted to accept the easier and safer local diagnosis of 'tonsillitis'.

This is an obvious example of 'part body doctoring'.

Patient 10

Justin's mother telephoned on Friday and said she thought that Justin, aged four, had measles. The doctor gave advice and said, "If he gets a rash, ring me up". She did so on Sunday morning. The doctor visited, confirmed the measles, and had a chat with the parents about what to expect. The next day brought another request to visit. The doctor spoke on the telephone to Justin's mother who said that he had had "awful diarrhoea through the night, and red runny eyes". When the doctor arrived Justin was fully dressed on the sofa in a darkened room. The doctor turned on the lights and examined a chirpy Justin, finding nothing except 'ordinary measles'. He told the mother so, but she remained anxious and he asked about this. She continued to centre all anxiety on the child's condition: "It is so out of character for him". The doctor told her it was to be expected, that she was doing everything necessary, and that she could telephone him on the following day if she were worried. Justin was the couple's first child. During the second pregnancy the mother had dreams about producing a mongol and insisted on an amniocentesis. This confirmed her fears, and led to an abdominal hysterectomy. They still have only one child.

Here the nominated patient copes well, but it is the intermediary (mother) who needs help. Practical advice, medical reassurance, a doctor prepared to call daily if need be, and a husband's support have not relieved her worries. But her worries have not actually been explored or diagnosed. The doctor noted that she lacks confidence about her ability as a mother to this child, and proposes to discuss this at a more suitable time. He is aware of family problems, but felt that during a home visit for an actual physical illness he was not sanctioned by the intermediary (the principal patient) to be other than a body doctor to the nominated patient.

Conclusion

The doctors taking part in the seminar all recognized that they often had feelings of irritation during home visits because of the apparent lack of medical need in the patient they had come to see. This lack of satisfaction was reflected in several suggestions from members of the seminar to end this study early in the series.

As the study progressed, much of this irritation disappeared because more was understood about the needs of the intermediary and the support system. More enquiry was made which resulted in an increased feeling of usefulness on the part of the doctors. It should therefore be stressed that it is important for the general practitioner to consider the anxieties of the intermediary and the support system in every home visit.

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Decreased bioavailability of digoxin due to antacids and kaolin-pectin

Employing a Latin-square design and single-dose studies of bioavailability in 10 normal human volunteers, we tested the hypothesis that antacids and kaolin-pectin might interfere with the bioavailability of orally administered digoxin. Cumulative six-day urinary digoxin excretion (expressed as the percentage of a 0·75 mg dose recovered) was as follows: control, 40·1± 3·0 (SE); aluminium hydroxide, 30·7±2·9; magnesium hydroxide, 27·1±2·4; magnesium trisilicate, 29·1±1·7; and kaolin-pectin 23·4±2·0. The differences in means were highly significant ($F = 10·47$, $p<0·005$). Further analysis (multiple comparison test) revealed that control differed significantly from each of the other treatments ($a=0·05$), but there was no such difference between any of the other treatment groups. The decreased cumulative excretion produced by antacids and kaolin-pectin reflected a striking reduction in digoxin absorption associated with these compounds that was not related to alteration of gut transit time or to adsorption of digoxin to these gastrointestinal medications.

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