Resistance and rebound

'He heard the deep before him, and a cry
Before. His own thought drove him like a goad.'[1]

'Resistance' and 'rebound' are two words that can describe phenomena that will be familiar to all GPs. They relate to internal feelings and states of mind that arise in the doctor as a result of certain kinds of interactions with patients, or possibly for other reasons that are peculiar to the doctors themselves, but which affect the way they relate to patients. They can result in inappropriate behaviour towards patients and lead doctors to make mistakes, not because they are ignorant or careless, but because their attitudes are temporarily 'out of order,' and their own thoughts are driving them 'like a goad'.

Resistance is the frame of mind that doctors get into when, for reasons that are not actually based on clinical judgement, they decide not to agree with a patient's request for something. A patient who has had a cough for a couple of weeks, for example, might begin a consultation with a firm demand for a chest x-ray. It would be an unusual GP whose automatic reaction was not to think immediately, 'Well the last thing I'm going to do is send you for a chest x-ray!' The GP would think this before considering the patient's history and doing a physical examination, to determine whether in fact there were reasonable grounds for requesting an x-ray. If they were not careful the doctor's attitude of resistance could override their judgement, even if on clinical grounds alone an x-ray would be a reasonable option.

Another example (from the past!), might be refusing to do a night visit. The doctor may be tired from previous visits or simply disinclined to get out of bed, and while talking to the patient on the telephone they may decide that they will not visit whether or not the information they've given indicates that the patient needs to be seen. The doctor may not be consciously aware of their attitude of resistance, and may misinterpret (or mis-hear) what the patient says, in order to fulfil the strong desire to stay in bed.

Rebound is, in some ways, the opposite of resistance and is what happens when a doctor realises they have not taken a patient's problem seriously enough, and then suddenly becomes aware that the patient is actually quite ill. The doctor may overreact to this realisation, and do more for the patient than is really appropriate in order to allay the guilt that they feel for not initiating correct management sooner. This sometimes follows a period of resistance, when the doctor becomes aware that they have allowed their attitude to colour their clinical judgement, and then goes to the opposite extreme. An example might be when, for various reasons, a doctor is delayed in visiting a patient whom on arrival they find to be in a considerable pain and distress. The doctor may give them parenteral drugs and several tablets from their bag, whereas if they had got there a few hours earlier they may have just left a prescription. Fear of a complaint can also lead to rebound behaviour in the doctor. If a doctor hears that the patient or a relative were very unhappy about their actions (or lack of them) in a previous consultation, they may go to inappropriate lengths to satisfy the patient in the immediate future.

Resistance and rebound can contribute to the value of the consultation if doctors take time to reflect on their behaviour, and become more aware of what is going on within themselves, and how that has affected their interactions with patients. Hopefully, this will decrease the likelihood of resistance or rebound to affecting judgement and behaviour on future occasions.

Long ago, when I was a registrar, (called a trainee in those days), I was called once at 4.30 in the morning by a young woman who was 16 weeks pregnant. She had been woken by a 'pain in her womb'. She was registered with a neighbouring practice that my training practice shared a night rota with. In a half awake state I scribbled her name, address and telephone number on the pad by the phone, and started asking questions about the pain, mainly to give myself time to wake up. As she talked, I reflected that I couldn't think of any serious conditions that would cause pain at 16 weeks (I'd established that she wasn't having dysuria, frequency, contractions or bleeding), and I advised her to take paracetamol, apply a hot water bottle, and see her own doctor in the morning if the pain hadn't gone. When she'd rung off, I found that I was now properly awake and my mind started to function more clearly. I realised that I'd decided not to visit simply because I couldn't think of any possible serious pathology (and it was 4.30 a.m.). This was resistance. Actually, I thought, she might be having an abruption, or could have a twisted ovarian cyst, and so on (a textbook of early pregnancy pathology suddenly seemed to open in my head). There was no going back to sleep after about 10 minutes of reflection on these possibilities, so I ventured out in search of the address I'd written down.

I didn't know the region where she lived very well, as my practice had few patients there, and I drove fruitlessly around the streets for a while before stopping at a telephone box and ringing to ask for directions. I got the 'number unobtainable' signal. I tried two or three times, and then rang the operator, who confirmed that the number didn't exist. In my sleepy state I'd obviously recorded it wrongly. It was here that I went into rebound with a vengeance. I went to the local police station to ask for directions, but the duty policeman (who'd lived in the area all his life) said that the address I'd got didn't exist either! Furthermore, it bore no relation to any possible real alternative that he could think of. As a last resort, I rang directory enquiries, but they had no listing under the name the patient had given me anywhere within 20 miles of the

area. Feeling thoroughly vexed and not a little guilty, I had to return home defeated.

In the morning, I rang her practice (as was routine), to tell them about the call, and, because of the problem I'd had, I asked the receptionist taking the message to check the patient's address for me there and then. She returned from the files to say that they didn't have a patient by that name registered with them. Thinking that perhaps the patient had made a mistake, I checked the records of the practice I was in also, but again they proved a blank. By now my trainer had become aware of me fiddling around with the records and asked what the problem was, so I told him the whole story. He listened sympathetically and suggested that my telephone advice was probably quite appropriate, and that I had been acting out of unnecessary guilt, and that anyway there was nothing more that could be done given the mystery of the patient's whereabouts. I was grateful for this, but couldn't resist a phone call to the gynaecological senior house officer in the local hospital to see if anyone fitting the name or symptoms had been admitted there in the night. To my relief, they hadn't, and I was finally able to let the matter go. I never did learn anymore about who she was or what had been causing her pain, but the episode sticks in my mind because it was my first (but by no means last) experience within myself of what I am now calling resistance and rebound.

More recently, I saw a child of 11 months in evening surgery whose parents had asked for a visit 2 days previously because he had a cough. One of my partners had asked them to bring the child to the surgery, but they had not done so until now. They opened the consultation complaining about my partner's failure to visit, and I started defending the decision and asking them why they hadn't brought the child sooner, when I noticed that the baby was actually looking quite ill. A more thorough examination revealed an increased respiratory rate and creps at the left base. My attention was now totally focused on sorting out the sick child, and for a moment I thought of admitting him, but felt that that wasn't actually essential and would encourage their grievance with my partner. So, I prescribed a broad-spectrum antibiotic and instructed them to call me if the child worsened. An hour and a half later I was still not at ease about the child, and realised that in not admitting him I was simply protecting my partner and not necessarily responding to clinical need, so I decided the only option was to visit and review him. The parents were surprised but very pleased to see me, and to my relief the child was already much better; his respiratory rate had returned to normal and his temperature was down. However, the father was suspicious about my motives for visiting (I'd told them I was passing and wanted to see how he was). 'You must have been worried about him,' he said, 'it shows that other doctor should have come when we called.' This was not the outcome I desired so I tried to deflect his concern back to the baby, giving instructions (again) about keeping his temperature down, before proceeding on my way.

This whole episode shows a mixture of resistance and rebound. I was initially resistant to their complaint about my partner because his request to get them to attend with the child was perfectly reasonable, and they'd delayed in complying. As a result of that their baby had become quite unwell, so I started to shift into rebound mode when I realised this, but again felt resistance within myself to the idea of admitting the child, for entirely non-clinical reasons. Further rebound then occurred, and I visited the child, probably unnecessarily (it is hard to tell in retrospect how anxious I would have been purely on clinical grounds, had they not been complaining about my partner's behaviour). In any case my concern was not really logical in that they had been offered an earlier consultation which they refused, and if they wished to complain it would be my partner's problem rather than mine.

The day-to-day decision making of GP's is frequently influenced by factors such as those I've described. Being aware of this is important, as is being honest about them. Only if awareness and honesty prevail can the doctor grow in self-awareness and continue to learn about helping his patients in ways that are not negatively influenced by agendas of his own. This is spiritually challenging and demanding, but adds considerably to the rewards of medical practice.

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REFERENCE

1. Lord Tennyson A, *Morte D'Arthur.* 1835.