Behavioural studies on patient communication

L. E. WEAR, M.B., Ch.B., D.C.H., M.R.C.G.P.
Crewkerne

MY aim is primarily a re-classification of many of the common disorders seen in general practice into terms relating to forms of behaviour, forms of communication and their abnormalities. I am not concerned with treatment by the formation of analytical groups, either natural or artificial, because at the moment this is not really practical, although I am very interested in developing this as a possible alternative to the more traditional formal surgeries. The patients for this must be carefully selected, either within their own family group, or amongst other practice patients. Behavioural studies seem to me to be in their infancy and those engaged in this are feeling their way in the dark and we are bound to make mistakes.

The Concise Oxford Dictionary defines diagnosis as the identification of the nature of a disease by means of the patients' symptoms. On this definition how true are our diagnoses? Here I use the word 'true' advisedly as the aim we have in view, not least for our own satisfaction. It is instructive and I hope not a too metaphysical exercise, to examine this impartially on a succession of patients seen at the surgery. Thus, if we divide the degree of truth in diagnosis into absolute, established and partial, then we can see that all diseases fall into the latter two categories. The only absolute truth in diagnosis is death, with which we are not concerned at the moment. If we then take, as an established truth, a disease with either a pathological basis or a known cause, such as congenital or degenerative disease, or new growths, or infections, or injuries, then the remainder can be classified as partial truths only. In my own practice of 182 consecutive patients seen in the surgery, 79 (or 44 per cent) could be said to have an established diagnosis and the remainder (or 56 per cent) were diagnosed but with partial truth only. Of 43 consecutive patients visited at their homes, however, 31 (or 72 per cent) were considered to have an established diagnosis, and the remainder (or 28 per cent) only a partial one. So that there is here a difference in diagnostic emphasis which one would expect between home and surgery visits.

In the old days these partial diagnoses were called disorders of function rather than structure, and they included a tremendous amount of trivial disease. If one excludes the trivia, one is left with a fair amount of disabling disease which is still under the heading of partial diagnosis. When exploring new territory, I believe the correct procedure is to start on the coast-line and delve into the unknown interior at various points until one finds a way in which is reasonably unobstructed, not hesitating to leave the other paths which have proved unrewarding. In the same way, we can make behavioural observations in the field and interpret them wrongly, thus I try to retain an open mind and to jettison any interpretation that does not fit the facts.

What are the basic facts from which we can start? May I state what I believe to be three: First, it must be clear to most general physicians that many diseases with this partial diagnosis are not only diseases but also forms of behaviour. For example, the depressions are a disorganized state of melancholy, the scratching diseases are a disorganized state of irritation, the asthmas are a disorganized state of breathing. Secondly, what do the behavioural studies mean? Do they mean observing how a man walks

upstairs or drinks his beer, or do they mean how a man behaves in community with others, particularly in his family group. Both these are facets of behaviour, but completely isolated man is meaningless and cannot be studied at all. Behavioural studies thus must depend on interpersonal reactions in the group and this is my second basic premise. Thirdly, there is now a great deal of observational evidence to show that abnormal modes of behaviour result from a communicational abnormality, and that this is a concrete factor in the early causation of this type of disease. It may trigger off the trouble, but it is the type of person involved, their heredity, culture and environment, that predicates the type of disease response we eventually see in our patients. The disease itself masquerades under a variety of partial diagnoses, but what proportion of my 56 per cent is difficult to say—at a guess less than a quarter of this figure.

May I give an example of the difficulties of classifying behavioural disorders, by quoting acroparesthesia, with which you are familiar. When this was designated carpal tunnel syndrome, it appeared to be an established diagnosis due to a compressed median nerve in a swollen and oedematous carpal tunnel. However, I then discovered that 95 per cent of these patients gripped twice as hard for simple household tasks as a control group of similar age and sex. So it was straightaway thrown back into the behavioural group, because the cause lay in the patient's behaviour. Why should they act in this manner? Were they clutching at a straw? Was it lack of grip in human relations that made them grip material objects so firmly? Is there a communicational basis in its etiology?

At this point I wish to discuss my main case, which is a patient with chronic eczema. This patient attended my surgery regularly for some 12 years, starting in the mid-1950's, and she had recurrent eczema. She was a woman of about 38 years of age then, slightly histrionic, and impervious to any approach to her personal life. She became worse, and then better, and then worse again, until she developed a generalized eczematous dermatitis and required admission to hospital. This cleared her skin but she soon relapsed after returning home. Shortly after this, her husband died at the age of 40 with a heart attack, having previously been well. After attending for a tonic, I did not see my patient for six years. She then came and asked for sleeping tablets and returned two or three times with minor complaints, and it transpired (what I had already begun to suspect) that she was to get married again. My attitude to this was ambivalent. After the marriage, with the inevitability of a Greek tragedy, the patient returned to illness but not with the same pattern. No irritating skin this time, but more of a depressive mood, lassitude, sadness, poor sleeping and lack of energy. They moved to Yorkshire within a year and with the problem still unsolved. What does this case history tell us? First, from the behavioural angle, this was an objective behavioural experiment into (1) withdrawal of an interpersonal factor and improvement in the patient's symptoms and (2) re-introduction of an inter-personal factor with relapse of symptoms, although not of the same kind. All this occurred in an 'at risk' subject. This should dispel any doubts as to the validity of our hypothesis. Secondly, can we now say that here was a woman with a partial diagnosis of eczema, a partial diagnosis of psychoneurosis, or anxiety depression, but with an established diagnosis of a disorganized behavioural display? Now display and communication are synonymous, but in this case the behaviour and the display were also synonymous, and this is not always the case. Thirdly, I conclude that this was not a case where there was an unhappy and unfortunate first marriage. I concluded this because the symptoms reappeared (although not identical) after her second marriage. The only other interpretation is that she was unfortunate to contract another unhappy marriage: I think this is unlikely. This patient, I believe, had a disorganized behavioural reaction, which took this form of display. In a different age she would have found solace and considerable reintegration of her behaviour through the church and the confessional. Today she may be helped by group therapy, but only if it is always there in the same sense

that the church was always there. Fourthly, there was the other patient, the one I never saw, the first husband who died suddenly from a heart attack. This is the absent patient of Balint M. Of these two patients, who was the more sick—the present or the absent patient? How often one sees the multi-illness family. I have a collection of families where both husband and wife have hypertension. The close relations of cases of Parkinson's disease are particularly liable to stress illness, and one can only guess and speculate about the meaning of these observations. Fifthly, having arrived at an established diagnosis, we are faced with a nihilistic therapeutic approach. Our treatment remains largely symptomatic for various reasons, but occasionally (although not in this case) one can help. Here again, this is usually due to this rather mysterious process whereby the doctor and this particular patient establish a special relationship or form of communication, which is what we are trying to analyze. Although we have been dealing with abnormal communication, here we must, by definition, have normal communication, because it results in the patient's improvement. What then is the difference? I do not know this, but I think that abnormal communication is a negative force, as may be seen in the withdrawn patients with Parkinson's disease. Neurotic display in practice produces negative communication and environmental manipulation, although how this works I do not know. It may lie in what Canetti describes as the sting of power and authority, and others have simply called the power structure in the natural or family group. I try to use patient communication as a means of assessing the psychoneurotic in practice, and if they have a very marked neurotic display I decide against going any further. This problem of communication is very complex. If we are to believe George Steiner, there is a progressive retreat from words to non-verbal means for the more important messages, because in effect words have failed at this level, by becoming debased.

What makes treatment so difficult is that you are trying to teach your patients to regard their illness in a fundamentally different way to their own idea of it. This can be very difficult. It is certainly a help to find out if they are able to talk to anyone in their circle about their problems. In this connection I would like to mention a patient who came to see me complaining of a wheezy chest. There were no obvious physical signs and there was no sign of a wheeze. Just as she was going, she said "Of course, I worry a bit, I suppose." I said "Yes, what about?" "Well, if I go in the hairdressers I feel all hot, as if I am going to pass out, or standing in a queue." "Does this always happen?" "Oh yes, of course I keep things to myself. I don't tell anyone about how I feel." "What about your husband, do you tell him?" "Well, I have been married 25 years and of course he is in the fire-service." There is a pause while I work this out. "So you don't see much of him?" "Well no, and then we are both too tired to talk." I write a prescription. There is silence. I say "You had better get a bit closer to him, don't you think?" There is a pause. She says, "Yes, I think I see what you mean." This must seem very simple and superficial, and so it is. We have little time for any more. Does this help? I do not know, but I have the feeling that this was not neurotic communication and that I could help this patient. Sometimes one is up against poor intelligence and at other times against this problem of upsetting the power structure. This was brought home to me by two children, aged five and seven, who lived with their granny and suffered from recurrent colds and sore throats. Mother had divorced her husband and was living with another man whom she eventually intended to marry. After many months of surgery attendances by granny and the children I suggested to the grandmother that their symptoms might be an occult form of weeping due to missing their mother. This acted like a time-bomb, for within two days I was having a very unpleasant interview with a very aggressive and articulate young couple. However, I stuck to my guns and now they are all under one roof.

What of the way ahead, what are the possible lines of research? Firstly, reclassification. I have no neat form of classification of communicational diseases tied up,

but I think this should be directed towards evaluating a prognosis. For example, what type of patient can we treat with some faint hope of success? And I think a start could be made by finding a quick way of evaluating which patient is manipulating his environment and which is being manipulated. We do not want instant psychiatry in general practice, but we do want some general behavioural criterion by which we can quickly decide how far we can go with some hope of success. As soon as you accept the view that your patient is presenting not only with disease but with a form of abnormal behaviour, then your migraines, depressions and fibrositic patients present as if seen from another window in the mind's eye. In general practice we have an advantage here. The practitioner knows by experience that Mr X always reacts to stress by becoming depressed, or the farm worker by developing back pain, or the housewife by eczema. This is his pattern of behaviour and the observant practitioner can prevent an enormous amount of morbidity by early recognition. What is more difficult is to recognize the nature of the causative stress, and this is often quite impossible. It may be infective or traumatic, or it may be communicational. If it is the latter we must recognize neurotic display when we meet it, and be able to distinguish this from normal communication. It seems to me important to distinguish between these two as the prognosis is so different. I think it is largely a waste of my time and the patient's if I try to treat neurotic display symptoms other than by palliatives. Secondly, epidemiology. The epidemiological triad of soil, seed and environment, can be applied to patient communication and the behavioural response. Under the first, I would put a high sensitivity and awareness to other people as the most important characteristic in any 'at risk' group. I have one intelligent female patient with eczema and gastric symptoms who tells me she can sense immediately she enters a room the prevailing mood of the people in it, whatever may be spoken. I think one must accept this as authentic, although it is difficult to prove. There are certain things that do not require proof, and I think this is one. These people lead unenviable lives for half their time, but this is compensated for by a greater range of sensory awareness. Under the seed, I would only say this. If the environment is being manipulated for good or ill, then there must be some sort of communicational seed or black spell, or white spell, as Day would have it, to produce an effect. This is the sting which produces its effect by verbal or non-verbal means, at what I have called conversational or sub-conversational levels. When words are used in the family group, they are used for different ends and in a different form than, say, in the classroom or the shop. I have compared patient communication in the hospital, the general practitioner's surgery and in the home objectively by using the same patient in the different environments. I have found a gradual change from, at one extreme, a high informational content and a low emotional content, changing to the other extreme of high emotional content and low informational content at the other end of the scale. When the emotional content becomes distorted, the use of words for mandatory and mystifying and double-binding purposes, increases. Speech becomes oblique and intended to leave you guessing. I like Hoggart's statement that "It is going to rain", changed into the neurotic "hard luck, you'll need a mac, chum".

Finally, it is becoming more clear now to many people that the way ahead for general practice lies in behavioural studies, allied to clinical medicine. Hodgkin in the MacKenzie lecture for 1969 made the point that behavioural studies provide the general practitioner with a unique opportunity for research and the development of an academic discipline. He stressed that we must learn from animal studies, but never forgetting that animals are animals and humans are humans. As Lorenz has said, the main difference here is the human capacity for conceptual thought. In his Rock Carling monograph on the mental health services, Hill emphasizes the shift in psychiatric treatment from custodial care to counselling and community support, if only because of the holy writ of economics. The *Lancet* has commented on this to the effect that the wheel may come full cycle and the idea of mental illness, with its medical over-tones will be replaced by a

wider picture emphasizing social and genetic aspects. The family doctor does not want to be only a counsellor, he wants to be primarily a clinician, but he is also disenchanted with the psychotropic-drug era and would welcome the renewed impetus that behavioural studies would give to his speciality. Time is on our side, medicine is moving into the community and I think this trend will accelerate. The general practitioner holds the key to community medicine, and he must recognize this, and seize his opportunity. We must co-operate in behavioural studies, particularly in psychological medicine, and we must learn from one and another. If we do this together the opportunities are great indeed.

REFERENCES

Balint, M., and Balint, E. (1961). *Psychotherapeutic techniques in medicine.* London. Tavistock Publications.
Canetti, E. (1962). *Crowds and power.* London. P. 82.
Hill, D. (1969). *Psychiatry in medicine.* London. Nuffield Provincial Hospital Trust.
Hoggart, R. (1957). *The uses of literacy.* London. Penguin.

Maternity Unit. An experiment in very early discharge at the North Tees Hospital. R. J. Donaldson, Medical Officer of Health, Teesside.

The Medical Officer of Health, Teesside, describes an experiment in very early discharge of maternity patients undertaken at the North Tees General Hospital Maternity Unit from January 1969 to February 1970 and still continuing. In an annexe to the general-practitioner floor of the hospital two delivery beds were provided to which midwives, some of whom were attached to general practices, could admit cases for delivery under their own care. The patients returned home soon after delivery, or if delivered in the night, early next morning.

The objects of the scheme were to deliver the patient in a safe place, i.e. near a consultant obstetric unit; to preserve the skills of district midwives despite lack of home confinements; to foster integration between hospital and district midwives; and to avoid disruption of patients' family life consequent upon long stays in hospital.

Although at the time of the report only 82 patients had been delivered in the unit, it had proved so satisfactory that bookings for 1970 were being accepted at the rate of over 300 per annum. Almost all the patients, midwives and general practitioners who used the unit were well satisfied, but there are still some doctors who do not use it. Midwives, who accompanied the patient on her way home after delivery, complained that much time was lost in waiting until an ambulance was available.

Inevitably a few patients booked for the unit were delivered at home (seven per cent) and a few mothers (five per cent) and babies (four per cent) were transferred to hospital. General practitioners were called to three cases in addition to these.

Experience of domiciliary delivery and home nursing is incorporated in the training of pupil midwives. The difficulties of providing this experience would have been increased by transfer of some of the few remaining domiciliary cases to the very early discharge unit for delivery. Fortunately the Central Midwives Board chose Teesside as an experimental area for an integrated training scheme. Instead of the previous requirement of 10 home deliveries for each pupil, only six domiciliary cases were needed, of which three could be delivered in the very early discharge unit.

One of the comments of general practitioners on the very early discharge unit was that its facilities ought to be as good as those on the general-practitioner floor. Except for their proximity to the hospital, it is evident that the delivery rooms offered little more than a good class home. They were considered inadequate for forceps delivery for which patients were removed to the "appropriate part of the hospital" and indeed inadequate for suturing for which a treatment room was made available.

Comment

Provision in hospital of a very early discharge unit where district midwives can deliver their patients is an admirable start towards integration of general-practitioner-unit and domiciliary midwives. It should lead on to the admission of district midwives to the full facilities of the general-practitioner floor, to even less rigid rules for pupil-midwife training, and to the adoption of either very early or 48-hour discharge for all patients for whom it is appropriate.