PERSONAL EXPERIENCE

Communication in the doctor-patient relationship

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COMMUNICATION forms relationships: without communication there can be no relationship. However, a relationship sets the pattern of communication. Only rarely can two people communicate in depth immediately. Usually they first test each other's responses and if these are sincere and favourable, a degree of trust enters the relationship and encourages deeper communication.

We communicate in endless ways and this results in a great diversity of relationships. A baby for example, even before birth has a relationship with the mother. After birth he can be pacified by a tape-recording of his mother's resting heart beat. Within a few months, mother and baby have widened their range of communication and perception. Perhaps a placid, trusting relationship will have built up, or maybe we will find mother in tears, exasperated, angry, guilty; a strong relationship but a distressing one. It is not long before the baby recognises in his mother's communications or expresses in his own behaviour, happiness, love, anger, dependence, pain and a host of other emotions. Later still, mother and baby will express their feelings verbally, but by this time the relationship is already well developed, and may not be easy to change.

What I am trying to suggest is that relationships are built up not only with words but with all sorts of different displays and expectations of behaviour and that each relationship has its own special pattern of communication.

The same, I am sure, applies in our relationships with patients. We are communicating in a language of words and behaviour. Relationships may exist before a word has been spoken. If a pretty girl sits down and starts to cry, the relationship is surely already well on its way and the communication that follows will largely depend on how the doctor responds. One may feel irritated, another embarrassed, another protective and warm, and any of these feelings will affect the pattern of communication.

The child at school may be talkative and rational. He must control his emotions or risk being teased. Yet when he goes home he may revert to the crudest forms of behaviour becoming almost incoherent. Similarly, when the patient comes to the doctor his emotional problems are often kept beneath the surface and he presents a reasoned, well argued account of his illness. Certainly, by the time he reaches a consultant this is often so.

In general practice both patients and doctors are closer to their ground roots and less inhibited. Yet we are just detached enough for safety's sake. We will be exposed to anger but seldom to blows, to strongly affectionate feelings but feelings we can control and use therapeutically. We will meet riddles, dishonesty, deception, feelings of dependence and so on. These feelings will be expressed in words and behaviour.

We must not suppose that it is only the patients whose language takes this form. The doctor needs more than most professional people to monitor his own behaviour and see how it affects his relationships. This is termed "knowledge of self" and then lightly dismissed as if it is something that we all possess, but it is difficult because it resembles an emotional striptease.

Verbal communication

Firstly words communicate facts, straightforward, down-to-earth facts. Once I thought

my role was to educate and enlighten patients. After a year or so of laying down the law I began to realise that very little factual information could be communicated in this way. Patients appeared to understand at the time, only to return later quoting to me all manner of extraordinary advice I had given them. Sometimes this was due to language failure. One woman for instance insisted I said she had dry rot in her back.

Often patients are anxious and this prevents remembering. One article described patients with angina being put in a quiet room on their own, in comfort, and shown a film explaining to them all about their illness. These were compared with another group of patients who had been given a similar explanation by their doctor. After several months it was found that the patients who had seen the film in a relaxed atmosphere could recall far more of the information and advice given.

Often I suspect I am giving advice and enlightening patients on all sorts of things they haven't really come to seek enlightenment about. Besides, people choose to hear what suits them. Like my patients, I tend to listen only to what I want to hear. So, if words must be used to enlighten, keep them simple, clear and short. Some patients find it difficult to speak a language I can understand.

Recently I left a senior medical student with a patient. I commented cryptically that we had problems in communicating. After 15 minutes earnest interrogation, the student had a complex history mainly of belches, wind, burps and rheumatism. There was no mention of total incapacity for work resulting from two recent heart attacks, epileptic fits and a small stroke!

A patient often uses words to skate round problems which are embarrassing or painful. He skates around testing out the relationship to see if he dares to say what he came to say, to see what mood the doctor is in, to try him out with a few different symptoms first.

A girl of 17 came to see me when I was running late and my staff were wanting to get home. She said she had had terrible abdominal pains for at least three months. 'Terrible' is a favourite skater's word and is often an invitation for the symptoms to be dismissed or at best taken lightly. "Well, if you have had this terrible pain for three months why have you suddenly decided to come today?" She paused, "My periods have been very heavy." "Ah, and when was your last period?" "Oh, two weeks ago." "Is there anything else you would like to mention?" "Not really." 'Not really' by skaters usually means 'Yes, really'. I dutifully examined her abdomen and found nothing.

The pain was in her right side and she pointed from there down towards the groin, and while doing this reminded me that her periods had been heavy. "Well, perhaps you would like me to examine you down below?" "I don't mind" I took this to mean 'Yes please' and went ahead. She wasn't a virgin but everything seemed normal. Afterwards, when she came back into the room I said "How are you getting on with intercourse? Are there any problems?" I am sure if I had said 'Have you been having intercourse?' she would have started skating again. After a few more prods she said that during a petting session the previous night her boyfriend had scratched her down below and made her bleed. This alarmed him so much that he insisted she go to the doctor.

I asked her why she hadn't been able to come out with the problem right away. She said she had been too embarrassed, besides she was afraid I might be annoyed with her or tell her parents. I was able to reassure her and remind her that I now knew she was having intercourse so in future she wouldn't need to beat around the bush, and could feel free to discuss her problems. I implied that our relationship could now stand it. I enlightened her on my pet subject, contraception, and offered her the 'Pill.' She politely refused.

Months later she returned. My enlightening words had been a waste of time—she was pregnant. But the relationship had improved, as she was now able to tell me her problem and discuss her feelings and the difficult emotional climate at home. She used our relationship to gain valuable insight into the family dynamics at home and into her own motivation for needing a baby at that stage.

Like my patients I spend a lot of time skating. I use vague words such as "Well, there is a lot of it going about." I use words to skate around a painful situation, such as a patient who is dying, leaving him to follow up the conversation with more penetrating questions if he wishes.

The most exasperating use of words is when they are used to obscure. Patients may take shelter behind a barrier of words. This effectively prevents rational enquiry. We

are besieged with symptoms, questions, side-effects, anecdotes or enquiries into our health and so on. The patient dictates the relationship.

I find that when I am hardpressed and in a hurry, or anxious to postpone a problem I tend to do exactly the same thing. I talk more and more, leaving the patient no time to bring up any other problems, perhaps smothering him with reassuring words or exhorting him to come back in two weeks if he is no better, or writing out prescriptions, buzzing the receptionist to find out swab reports, or discussing doses of tablets at great length, certainly not allowing a word in edgeways. It takes a brave patient to say, "For heaven's sake sit down, shut up and listen."

I think I tend to confuse patients with questions. It puts them off their stride. Worse still, they may return a week later and offer the symptom—"You know, Doctor, you asked me if I was passing urine too often? Well, now I don't seem to be able to stop going."

Silence, on the other hand, can be really productive. After a few moments of silence patients may offer vital information, often unanticipated but maddeningly relevant, making me stop in my tracks and view the problem from a totally different point of view. Silence also helps me to grasp what is going on from a more detached point of view.

We use words to express emotions as well as facts. We know that emotional problems lurk behind almost every illness, sometimes causing the illness, sometimes magnifying it, adding the ingredients of terror, dread, apprehension, loneliness, or self disapproval. An illness may become much easier to bear and to manage if these emotional feelings can be talked over. A few simple questions or remarks may help to bring them out; there may be some skating perhaps or the truth may be hidden behind many words but it will find its way out—if only we listen.

Many of us find emotional matters distasteful, it not positively frightening. We start calling patients neurotic or saying we have no time for such things. We have long since learnt to deny many of our own emotional feelings but they continue to roam in our subconscious and may find expression in unexpected ways. Similarly, our patients may find it easier to deny emotional problems. How then can we help them to find expression? The clue may lie in their behaviour (or in our behaviour). The patient's behaviour is quite as important as the words he uses to express his feelings. Words and behaviour are often in accord and help us to make our diagnosis and to assess the severity of the complaint, for instance, the man limping painfully into surgery with gout in the foot expresses his pain by his behaviour as much as by his words. Sometimes however, the patient's behaviour seems inappropriate or exaggerated; then we know that he has more to express than he has been able to put into words. Emotional feelings are often easier to express in behaviour than in words, so we must learn to use the patient's behaviour to help him to express his emotions verbally. If he denies the emotion then we can confront him with the inconsistency of his behaviour. This will often win the day.

Crying

Crying is perhaps the most eloquent form of behaviour. We can learn so much from it if we can develop the technique of encouraging the patient to talk about his feelings while crying. Not only does crying release a flood of tears, but with a little help it will also release a flood of the patient's true feelings. We know, for instance, that the patient may be angry; we don't know who with, perhaps with himself, perhaps with someone else, perhaps with the doctor.

Of course we must make sure that the tears are genuine and not laid on, for instance, to soften us up for taking sides in a domestic argument. I find the handkerchief a useful guide. A patient who is caught unawares by tears often has no handkerchief at the ready; the tears come with obvious difficulty and are angrily wiped away only to be

replaced by more. Make-up may get smeared everywhere. Eventually, once feelings have been expressed, I delve into my supply of hankies—not before.

I am suspicious when the patient cries almost straight away, with handkerchief at the ready. One patient whose games I know pretty well by now said last week "Not even tears will move you these days" meaning 'Not even tears will get the response I want from you'.

Watching the patient

Behaviour then presents to us as an acting out of problems which may be difficult to express or not even consciously acknowledged. We cannot observe behaviour while making notes, or looking at records. Patients are irritated if you don't look at them, they feel they can't communicate properly. Equally, evasive patients often become increasingly irritated with me for looking at them so much. But if we are going to make use of behaviour we must see the blushes, the tremors of the chin, the sudden avoidance of gaze, a sharp movement of the hands.

These gestures sometimes flatly contradict what the patient has just said. An obvious example would be a girl denying that she is embarrassed while at the same time blushing, then I could say 'Yet, I can see you are blushing.' Once the patient realises that you have correctly interpreted her emotions, she will often capitulate with relief and talk realistically.

During physical examination, behaviour may present as the most important physical sign. What could be more eloquent than a recently-married woman's vaginismus?

A man of 18 complained of abdominal pain. He denied anxiety of any kind. I examined his abdomen, did a rectal examination and found nothing. Later, he returned and again I examined his abdomen, this time I also examined his testicles. He promptly had an erection. I tried to hide my embarrassment behind reassuring words like "Mmm, healthy abdomen, I can't feel anything wrong there. Good. Normal erection. Right, well put on your clothes and come over to my room." Then I fled. When he came into the room he looked a little flustered. He immediately took a wallet out of his pocket and opened it and asked me if I wanted to see his medical card. I noticed a photograph of his girlfriend and thought to myself 'Ha, he is trying to tell me he is heterosexual.' I took cover behind a smoke screen of words, reassuring him about his abdominal pain, showing him how colic caused pain and telling him how good 'Colofac' was. I firmly handed him the prescription but he did not want to go. I stood up and he slowly went towards the door but he did not open it, so I opened it for him. Then finally he said, "Do you get many patients who do that?" He was still skating but I wasn't having it. "Good Lord, yes. This sort of colic is very common in young men." Another pause and still he wouldn't go. "I mean, many people who have erections?" "Yes, of course, it's just a reflex." And at last he was gone.

I knew I had hopelessly mismanaged the whole thing, and discussed the case with a group of doctors at our weekly meeting. All agreed that he had sexual problems; various possibilities were discussed. I predicted that he would never come back to see me; the others all predicted that he definitely would. He did, that very afternoon. He said he had come back because his boss wanted confirmation of his illness with a certificate. This time I was determined not to let him out of the surgery. I skated, I asked direct questions only to be met by denial. I was at a loss, I could think of nothing more to say and there was silence. Then quite suddenly he said "Do you mean homosexuality?" He then related several homosexual experiences. Recently during showers his boyfriend had ejaculated bloody semen. This led my patient to wonder if he had swallowed some of the blood on other occasions, hence the tummyache. Later, he told me how he dressed up as a beautiful young girl and out came the wallet again. Underneath the photograph of his girlfriend were photographs of himself dressed up as a beautiful young girl. Then with a laugh he suggested that he might be pregnant, but behind the laugh there was a serious anxiety. On top of all this he was engaged to be married and his father was having regular intercourse with my patient's 11 year-old sister. He said he had wanted to talk things over with a doctor for some time but he hadn't known how.

This example illustrates several points. Firstly, the erection communicated his problems where words had failed. Secondly, my feelings of embarrassment prevented communication. Although I did not display my embarrassment, I used various tactics to get him out of the room. He was firmly handed a prescription, he was even shown to the door. I attempted to submerge him with words and reassurance. For his part, he communicated the urgency of the problem, not only through his erection, but in his

display of photographs, in his hesitancy, in his asking the most important questions as he was about to leave the room. He displayed his anxiety that he might be pregnant by laughing and laughter is often a sure sign of emotional tension and anxiety.

It displays how the group was able to see the truth far more clearly than I could. It also shows how their support bolstered my own determination. It was no longer me asking the questions, but the group behind me. Yet in the end silence succeeded.

There is a sequel to the story which shows that perhaps I had at least learnt something.

He returned one day unable to sit down on the chair and carrying on as if he was in agony. He said he thought that he must have piles. This time I wasted no time in asking him what he was afraid he had caught from his boyfriend. The answer was quicker to come back "gonorrhoea"—and he had.

So behaviour may both reveal an emotional problem, and also compel us to examine the body even if the patient's words scarcely make it seem necessary.

Touching

Touching plays an important part in our more intimate relationships. This is perhaps why we fight shy of the same form of communication in our relationships with patients. Yet, whether we like it or not we do communicate with patients by touching. It is a one-sided affair, the patient doesn't get much opportunity to touch the doctor, although some people like to shake hands.

We tell patients much by the way we examine them. The patient doesn't quickly forgive the doctor who hurts him. He can certainly tell whether he is being examined carefully or casually. She can tell if the doctor likes her or not. It is easy to examine a beautiful young woman gently and warmly, yet if we are honest with ourselves I think we would agree that we would not feel her breasts in the same way that we would feel a fat, 60-year old's. Nor, I hope would we feel her neck in the same way as we would feel a stevedore's. The cold clinical approach doesn't go down well in my practice. A body should be handled with the respect and warmth it deserves and there is something wrong in the patient's eyes with the doctor who cannot see that.

Patients can be very choosy about whom they allow to touch them. We must all know of patients who have saved their symptoms up until we return from holiday.

One girl attended me for various problems, mostly arising from her unfortunate childhood. She was repressed sexually, but eventually she got going and was married. She presented on my half-day with abdominal pain and was whisked off to Addenbrooke's where she had her appendix out. But the pain persisted so she went back and saw a senior surgeon who tested her urine and did an IVP.

Finally, I was asked to visit. With scarcely a moment's hesitation I enquired into her sex life and she promptly said that the pain was made worse by intercourse and readily agreed to my examining her. This would have been unthinkable a year before. She had a huge cervical erosion, which when palpated produced the pain in her abdomen. I asked her why she hadn't told anybody about the pain's connection with intercourse. She just smiled and said "You know I am a bit choosey who I tell about these things." Meaning, surely "I am a bit choosey about who touches my sexual organs."

Touching is a simple way of showing concern and giving encouragement in adversity.

I was standing at the end of a child's cot; he was badly burnt and lay there whimpering. He had poured a jug of boiling coffee down himself. Mother stood there with me and started to cry. She managed to say "I feel so bad and helpless." I put my arm round her shoulder for a moment or two and then said "Bless you." I remember thinking what an odd thing to say. I hoped the gesture said something like this: "I understand how you feel, it could have happened to my child. I am not angry with you because I know you try your best to be a good mother, and this is not always easy. I want you to feel my concern, you are not alone."

The trouble with making gestures such as this is that one can't tell what the patients make of them. What if she took the gesture to mean "Gosh, I want to cuddle you. How about it?" But there may come a stage in the doctor-patient relationship where the gesture can be used as a meaningful form of communication, more sincere perhaps than words.

The whole question of touching, how to touch and what is communicated by touching is highly complex and emotive. It is dangerous ground. In spite of this I am sure that touching has a most important place in forming relationships, in communication and in therapy. Even I draw the line at kissing. It is true I kiss little girls when they ask me to and I once kissed an old lady. The only patient who has kissed me took an overdose the next day.

Presents

Giving presents is another form of communication of relevance in the doctor-patient relationship. Most doctors are compulsive present givers and few patients can escape without a prescription or a free holiday off work. But that isn't enough. The doctor usually feels compelled to throw in a packet of advice for good measure. Of course, some presents are given because they are deserved or because it is traditional. It is the same with prescriptions, certificates and advice.

However, there are other reasons for giving presents. We may, for instance, give presents to keep a relationship sweet. However hard we deny it, presents do achieve their aim.

I was given a large swivel chair by a patient after delivering his wife's third child. It seemed quite out of proportion to the nature of service I had done for him. Sure enough, within a few weeks he asked me for a complete medical check up. A little later he said that his family were going to live in another part of Cambridge, an area where I seldom visited, would I please continue to look after the family. Had it been anybody else I would have said 'No' but the present won the day.

I give my patients a lot of presents to keep the relationship sweet. After all, 'placebo' means 'I will please' and much of what I prescribe is for this end. Here my needs and the patient's expectations are not necessarily in step. The patient may not want the placebos or the advice which I need to give him.

Surely sometimes presents are given to make up for something that is lacking in a relationship. Don't we often hear "He brings home presents but that's not what I want." Some of my prescribing is to make up for what is missing in a relationship. I may not want to go into the patient's irritating anxieties and problems but at least I can give her some diazepam or amitriptyline or sleeping tablets. If that seems to satisfy her then perhaps repeat prescriptions will keep her quiet and well clear of the surgery. A whole book has been written on repeat prescriptions and the uneasy doctor-patient relationships behind them (Balint *et al.* 1970).

Most of my presents at Christmas time come from Russians and Poles with whom I can scarcely communicate verbally. We use handshakes, smiles, tears and presents instead. I still feel uneasy and guilty when I am given a present. I have an old lady quite severely crippled with rheumatoid arthritis who never used to call me till Christmas time. She would then show me her poor joints and insist that I accept £5 for my children. This happened three years running.

Then I treated her sister there for a serious illness, and her nephew in the same house for lobar pneumonia, and during these visits a relationship gradually built up with the old lady. I began to realise what a difficult life she was leading and she began to confide some of her more depressed, lonely feelings, her fear of going out, her fear of dying. We approached her problems from various angles and her depression began to lift. She felt better than she had felt for years and even began to go out on her own and start shopping. I called in to see her shortly before last Christmas and found her happy and well in spite of her arthritis. I knew something had been achieved because this time she offered me no present. The relationship no longer needed one.

The patient in his home can widen the range of non-verbal communication until it becomes almost limitless. If I am not too rushed and feeling in the mood for receiving communication, home visiting can be very helpful. The state of chaos or tidiness, even the title of a book laid open at the bedside. Photographs too can throw light especially if they appear or disappear.

One elderly patient knew she was dying of cancer. One day a photograph of a young girl appeared on her bookshelf. The lady as usual was saying she wished she were dead. "Who's that?" "Oh, that's my first daughter, she died of pneumonia." "So you are looking forward to meeting her?" "Exactly". Then she went on to tell me how she was not allowed to put flowers in her child's memory in Church.

Since that time she had not been to Church, yet read her Bible daily. She was able to air her feelings of spiritual isolation and her need for reconciliation. She was so sure she would meet the child that at last I understood why for the past six years she had often asked me to give her something to polish her off. It had always annoyed me. This was the old lady I kissed. She had to go into a Marie Curie Home in London because she couldn't manage at home any longer. Just as I was leaving she said "You won't forget me, will you?" "No, of course not". It was quite biblical, she said it three times and each time I said "No, of course not", but when she said it yet again just as I was going out of the door, I turned back and kissed her on the cheek. Then I think she did understand.

Anger

Another important aspect of communication in the doctor-patient relationship is the way in which doctors and patients behave towards one another. Angrily, weakly, seductively, critically and so on. If we find emotions in patients difficult to deal with, we will find them all the more difficult when the emotions seem to be directed at us personally. Patients find it difficult to verbalise these feelings quickly. Most will find it difficult to say 'You're a useless doctor' or 'doctor, you make me mad'. If he cannot say it then he may write it. For example:

"To Dr Recordon.

I hope you put the right name on that spittin' tin. You put Mr Arthur Wright on the prescription. My husband's name is not Wright or Wrong, his name is Mr Albert W. That is how doctors make mistakes and that is how patients snuff it. By the way, my husband is a little better this morning.

Yours,
Mrs W . . ."

It is so easy to deal with this sort of anger. I simply apologised and explained that in fact Arthur Wright had died that day and that was why he was on my mind. Mrs W. had rightly sensed my lack of concentration and concern. If a patient cannot write his criticism he will use the language of behaviour to express it, and if he can't even behave angrily in my presence he will use even more indirect ways of communicating it.

Perhaps he will fail to keep appointments or cause difficulties with the receptionist. He may start asking for visits at awkward times or bring someone else into the room with him. If he is really angry with me he may take an overdose of the tablets I have just prescribed for him. Inevitably, the relationship becomes strained and untherapeutic. I find myself feeling frustrated, irritable, evasive and defensive. I may break out and blame the receptionist for letting him in and soon his pain in the neck is my pain in the neck. We all have such patients; our clinical judgement becomes impaired and we start making mistakes.

All this can be prevented if we can recognise early enough in the patient's behaviour his anger towards us. Once recognised it may not be difficult to coax him into expressing it verbally and once it is brought out into the open it will be much easier to deal with. Sometimes I will find it is not me he is angry with but someone else altogether. He has, as it were, transferred his feelings for someone else onto me and is working his spleen out on me.

Transference

Transference is perhaps the most subtle form of communication in our relationship. Once we are aware of it we can make very good use of it. Also, we will save ourselves from the fear of emotional entanglement with our patients. Through transference we learn to feel what effects the patient has on other people, or should have on other people by feeling the effects ourselves. Seductive young girls are not trying to seduce me but they may well be trying to seduce someone else, possibly successfully. Possibly they are having difficulty in relationships.

When a drab 15 year-old suddenly becomes a sizzling 16 year-old I start talking about the 'Pill' no matter what she has come about. Nowadays, when I find a married patient

has become unusually attractive I start ferretting around for marital problems and it is quite extraordinary how often they are there. Perhaps the husband is no longer responsive. What's the matter with him? Has he found a girlfriend? Or has he got a boyfriend? There are dozens of possibilities—but the clue is offered by the emotions she arouses within me.

Of course, I show my feelings for patients in my behaviour, often quite unconsciously, the way I listen, or talk, or look or doodle, the way I touch, the way I hand over a prescription or bang down my case on an irritating visit. The way I respond to a smile or look away. In fact, I think my patients are better at understanding my behaviour than I am at understanding theirs.

Anger and affection are the two most difficult emotions to deal with. Faced with affection and the loving feelings of a patient we become almost as evasive and difficult as when faced by angry feelings. Yet, if love and anger can be harnessed into the doctor-patient relationship and used, great therapeutic good can ensue. Firstly, an attempt at harnessing a patient's anger.

He was a young man of 19. I treated his mother for migraine for about a week until at last it became apparent, even to me, that she had had a subarachnoid haemorrhage. Eventually, she had an operation and the bleeding aneurysm was dealt with. But after a few months she had another subarachnoid haemorrhage and was admitted to hospital. Her husband went with her but left before the doctors could ask his permission to use her kidneys for transplantation. So they asked me to go round. The husband said he didn't mind but his daughter and the 19 year-old boy were adamantly opposed.

The mother died and I followed up the father. He began to strike me as a remarkably selfish man. One night the boy called my senior partner to visit his father. He couldn't find anything much wrong, but the boy was extremely abusive and rude. My partner commented angrily on this the next day and because he had been made angry I felt angry. Later, the boy came to see me complaining of backache. I could find no cause for it and told him so. I asked him how things were at home. "Oh, fine thank you". Later still while showing a distinguished visitor around the university centre I was greeted by the lad "Oh, you remember you said there was nothing wrong with my back? Well, I went to an osteopath and he found three weaknesses." "Really? I hope you are better now." and I passed on.

I hate being approached by patients in the street and I do not like being told I am wrong in front of distinguished visitors. I was annoyed but I remembered how hopelessly wrong I had been over his mother's diagnosis, and next time when he came to the surgery complaining of feeling tired I raised the matter. I said—"Look, I am delighted that you have come to see me. I will certainly do what I can to help you but you have already gone out of your way to show me that you are aware of my limitations. It must be very difficult for you to feel that doctors can help you when we failed to keep your mother alive." "Yes, it is true I felt that the doctors should not have let my mother die and it made me pretty disillusioned and angry." We discussed this a bit more and I even let him know some of the feelings I had had when I realised his mother had had a subarachnoid haemorrhage after treating her all that time for migraine. I tried to show him how much I had cared and how much I had learnt. I also conveyed to him how distressed I was at his mother's death and how it served to remind me of the limitations of modern medicine. In his turn, he went on to say that he was not angry with the doctors so much for allowing his mother to die, but for not seeming to care, just treating her as a patient whose kidneys they wanted to get as soon as she died. "They only seem to care for their own interests. My mother was there just to be used," and as he went on in this vein his description of the doctors became more and more like a description of his father.

It was easy to move the conversation to his feelings for his father and his anger at his utter selfishness both before and after the mother's death. The boy was then able to talk about his mother saying how much closer he was to her than his father had ever been. The door was unlocked to a very much better relationship. At first, I had taken his anger personally but I was only really able to help him when I realised that his anger towards me was a symptom of his anger in relationships elsewhere.

The next example is more involved because it shows transference working both ways, and I don't even know now if I have it properly sorted out in my own mind.

A girl of six, about the same age as my child, was found to have a malignant tumour in the chest and it slowly became a large, fungating mass. Nothing more could be done. I knew the mother well enough to feel she was unlikely to cope for long. Also I was very worried about the prospect of looking after a dying child at home for the first time. I did not know how much she wanted to know. From the outset I made it clear that I wanted to do all I could to keep the child happy and comfortable. We talked at some length about our feelings and I visited frequently. One day, when the mother opened the door she was in

tears. I put my arm round her shoulders. "What's the matter?" "Whatever I do for Leslie it's wrong and I am trying so hard." I don't know what putting my arm round her did but I am sure that things altered radically from that day. Her little girl had always struck me as being similar to my own boy, both were difficult and hard to please and yet both were capable of being extraordinarily lucid about their feelings. But now something had happened in the doctor-patient relationship. It was as though I was feeling the feelings of my own child dying and also perhaps for the first time realising what her mother was feeling. In some curious way I took some of the burden from the mother. Although I was more deeply distressed, the mother regained her confidence. Our conversations took on a new meaning; she no longer cried with me yet was able to express the most sophisticated feelings, even feelings of ambivalence about the child's dying. In the last few days before the child died, although I like to feel that I was the main support I think, in fact, she was supporting me. On those last two days after leaving the house and driving away I had to stop at the end of the road and cry.

Perhaps this is taking the whole thing far too far. But it does serve to demonstrate transference at work and give some idea of how a relationship built up as a result of communication at every level. I think I managed to remain just detached enough to see what was going on and to use my feelings, the parent's feelings and the child's feelings to form an extended doctor-patient relationship. Certainly, after the child died the mother was able to communicate her feelings of grief, relief and ambivalence about the child's dying with extraordinary freedom. I saw her at decreasing intervals and in the end I felt she was coming more for my sake than for hers. She now works and appears to have made a good recovery.

So, whether we like it or not, we do identify closely with our patients, yet we can remain objective (detached). Only by feeling the patient's feelings can we hope to understand them properly. Yet if we lose our objectivity and act on our feelings we are unlikely to help patients resolve their problems. Time and again my failures have occurred when I have lost my objectivity.

Transference then works both ways. It may lie at the bottom of the worst and most disturbed doctor-patient relationships as well as the best. In counter transference, I may identify my enemies as well as my friends in my patients. If I am lucky enough to be aware of my feelings I may be able to use them usefully. If I am blind to them, as is often the case when they are disagreeable or strongly affectionate, I may still act on them unwittingly, while consciously thinking I am acting in the patient's best interests. Husbands get forgotten or undermined. Patients' qualities become accentuated to the detriment of reality.

This partly explains why I can communicate with some patients easily and warmly and yet feel irritated and angry with others. Another part of the explanation surely, is that I select the patients I most need. The doctor who needs to dominate will find patients who need to be dominated. The doctor who needs closeness will seek warmth and close, almost sexual relationships, with his patients. The doctor who seeks to establish his image amongst his peers will find his peers and his upper-middle class patients the most challenging. The doctor who needs to be needed will surround himself with dependent patients who cannot do without him. The doctor with unsatisfied conflicts will seek patients or family situations where he can work them out.

There is something of all these needs in each one of us. Yet if we can recognise them, we will not only save ourselves work but we will also find that we can widen the range of patients with whom we are prepared to communicate.

A group of doctors

How then do we learn? Awareness and interest must first be aroused, possibly by reading, possibly by listening, but the real learning comes from day-to-day experience, scrutinised *not* so much by oneself as by other members of a group. I have already mentioned that I belong to a group of doctors who meet once a week. There, we learn to scrutinise what is going on in our relationships with patients. We can learn also from the scrutiny of our staff, our patients, our partners and not least of our family. Through others

I am slowly acquiring the skill to communicate and the knowledge of how to deal with the communications therapeutically. But this is useless without the motivation to put it into practice. I am basically idle, my own needs and my family's conflict with my patients'. My patients' needs appear to me to oppose my hobbies, my garden, my need for quietness, my need to be a father and a husband. These are some of the needs which make me rush headlong through the day in a mad drive to finish and which compete directly with my desire to communicate.

There are also doubts and fears which dampen my ardour. I am afraid I may uncover more than I can cope with. This feeling of incompetence waxes and wanes. I prefer not to undertake ventures which may end in failure; after all 'the worst pain in the world is the pain of failure'. Besides, I am afraid of doing more harm than good.

Yet if my ambivalence tempers my ardour I am still faced with an undeniable reality—which is that my patients are attempting to communicate their needs and problems. Learning with the patient to understand his problem in the setting of a personal yet professional relationship is not only most exhilarating, it is also the basis of therapy.

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I have also been influenced by articles and supplements in *The Journal of The Royal College of General Practitioners*—notably the three below.

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TEACHING CONTRACEPTION

The foundation has made a grant of £6,200 over two years to enable Professor M. C. Macnaughton in the department of obstetrics and gynaecology at the Royal Maternity Hospital in Glasgow, Dr Elizabeth Wilson of the Family Planning Association and Dr R. McG. Harden of the University Educational Technology Unit, to organise the production of information of audiotape, 35mm slides and filmstrip, to teach contraceptive techniques and some other aspects of family planning.

Professor Macnaughton is concerned to ensure that from now on all Glasgow medical students will be properly taught about family planning—which, despite the recommendation of the Royal Commission on Medical Education, has not yet been achieved in most medical schools. Dr Wilson's particular interest is in the contribution which programmed learning by tape and slides can make to instructional and refresher courses for general practitioners and other medical people, including postgraduate students from developing countries, who are responsible for community services into which family planning enters. Examples of the topics to be presented are hormonal, chemical, and mechanical contraception and the rhythm method, male and female sterilization, the conduct of an interview, and family planning as part of maternity care.

The Nuffield Foundation (1972). 26th Annual Report p.52.