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DOCTORING AS A HUMAN EXPERIENCE - ON DEVELOPING A HEALING PARTNERSHIP: The Doctor-Patient Partnership

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Introduction

In *IJHC* Volume I, No. 1, "Patients' experiences," Ronald Banner explored the process (stages) of becoming a patient, how suffering is much more than pain, and the subjectivity of decision making by patients. All these point up the need for inputs from patients. These should be our advisors/counselors/teachers - these people who have experienced illness and who understand their experiences. These advisors are essential in understanding and improving patient care, as well as in medical education, policy development and research (Reiser 1993). I illustrate the notions presented in this article with the experiences I shared with a patient named Stanley, who had severe and complex illnesses.

The Doctor

Is the doctor just a disease detective, a storehouse of facts and techniques, a computer programmed to be a "provider" of cost effective treatment? Or is s/he, like his or her patient, a person affected by the experience of illness?

Let me share with you some highlights of Michael Balint's book, *The Doctor, His Patient and the Illness* (1957). Insights from this book have helped me over the years to better understand the doctor-patient-illness relationship.

When Michael Balint, M.D. started research seminars to study psychological implications in medical practice, the first topic chosen was drugs. They discovered that "the most frequently used drug in general practice. . . [is] the doctor himself." However, there was no study of this drug, its dosage, frequency, allergies, side effects, etc. (Stanley, the patient described in Part I of this article with ill-defined joint disease, blindness, and paraplegia due to collapsed vertebrae, needed and received plenty of me and plenty of others.)

To better understand this drug, general practitioners and psychiatrists met weekly to discuss actual cases, studying the difficulties and successes in working to have a more comprehensive understanding of their patients, while recognizing the personal responses of doctors to their patients' illnesses (counter-transference).

They discovered that the family care physicians usually viewed their consultants as mentors, perpetuating the pupil-teacher relationship. Since the role that consultants take on for patients usually differs from the primary care physicians' role, there was often no captain of the ship. This produced a "collusion of anonymity." The family care doctors relinquished their primary care role to a degree,

deferring to the consultants. The consultants provided diagnostic and therapeutic expertise. The patients ended up having less of the vital essence of personal doctor input.

My way of handling this with Stanley and with many other hospitalized and office patients is common to several practitioners I know. After rounding in the hospitals early in the morning, I come to my office and contact consultants who have seen or will be seeing my patients. I discuss with the consultants the nature of the patients' problems and establish a plan of action. These calls, which vary in number and length each day are a cause of chagrin both to the office patients who may have to wait and to the office staff. I persist with these calls because I feel they are absolutely essential to proper patient care.

The Balint seminars also found that doctors had an urge to prove they are good, kind, knowledgeable and helpful. Yet this backfired if the patient or the illness did not meet the doctors' expectations, leading to frustration and anxiety.

How did the doctors handle this frustration and anxiety? One response was to give patients reassurance. This had to be analyzed to see if it was given for the patients' sake or for the doctors'.

Another response of doctors to anxiety was the "Apostolic Function" Doctors have ideas of how patients should behave when ill, and what is right and wrong for them to expect and endure (for example, pain and anxiety). Even further, we doctors often find that we have a sacred duty to convert to our faith all the unbelieving and ignorant among our patients. We may have difficulties with patients who refuse, for instance, to accept our prescriptions for tranquilizers (in favor of healing or other complementary therapies), or our predictions that their diseases will be fatal within a given period (Roud 1990).

In contrast, imagine a "Mutual Investment Company" in which the doctor and patient invest in each other, not only to gather and provide information but also to enter a relationship of availability and duration. Their shared experiences lead to trust and respect, so that numerous threads bind the doctor and the patient. While this is more common in primary care, I should add that many consultants also form a "Mutual Investment Company" with their patients. A successful "mutual investment company" enables the doctor to be comfortable enough to take risks, to achieve "the courage of one's own stupidity," to feel free to be himself with the patient, and to use past experiences and present skills and intuitions without undue inhibition. I cannot think of a concept that has shaped and changed my approach to patients more than Balint's "Mutual Investment Company."

This process also acknowledges that every illness may also be a vehicle or a plea for love and attention.

Finally, the Balint process teaches that when in doubt, do not hurry, but listen and never advise a patient before you have found out what the real problem is - often a psychological one which is underlying the physical symptoms or disease. This is a new skill, requiring a considerable change in a doctor's personality and work style. Wise and aware doctors continue to meet in "Balint groups" to explore and work out these and related issues for themselves.

Foundations of a Healing Partnership

Having briefly explored some experiences of being patients and doctors, let us explore some foundations needed in developing a healing partnership. Since Hippocrates and Osler wrote about dehumanization, it is neither new nor exclusively the fault of high tech science. (Reiser and Rosen 1985).

Can dehumanization be prevented? To understand medicine and practice it as a human experience, Reiser and Rosen (1985) suggest four essential principles: competence, conceptualization of illness, acceptance and empathy (my order). Let us consider each of these in detail:

1. *Competence* in disease diagnosis and treatment means: factual knowledge, technical expertise and skills. Nobody would disagree that competence is important. I would like to include four additional meanings of competence which are less accepted and practiced:

a. We should seek reasons and stresses which may underlie illnesses. When someone becomes ill, it is important to ask "Why now?" "What new things are happening in the patient's life?" M.D. can mean Medical Detective.

b. We should not forget clinical judgement - how to decide with incomplete information. Think of an iceberg, in which only one-tenth is visible above the ocean surface. This requires imagination. As Albert Einstein said, imagination is often more important than knowledge.

c. Leo Galland, M.D. (1994) suggests another approach. He feels that we should individualize treatment based on identifying characteristics of the individual patient that are relevant (rather than plan treatment based on making a diagnosis of a specific disease entity and treating that). Such characteristics may include: What are the biochemical and/or emotional mediators of the patient's illness? Can we identify triggers that activate the mediators? What factors (biological and psychological, congenital or acquired) predispose the patient to develop the illness? What events precipitate the onset of illness?

d. Competence in medical treatment should include awareness of complementary and alternative medicine (CAM) modalities.

> *In Stanley's case, optic neuritis was a disease where I depended on neurological, rheumatological and ophthalmological consultants. Since none of us had a crystal ball, walking the tightrope between tapering steroids too quickly or too low and facing more blindness vs. facing the severe side effects of high doses and long duration of steroid treatment was a struggle. Stanley, his wife and I, with the help of consultants, all faced and dealt with this together. As to "Why now? identifying triggers and the like, I searched but came up short.*

2. *Conceptualization of Illness* Here lies some of the most theoretical material of this presentation, helping to understand the plights of today's patients, their doctors and the entire medical establishment.

George Engel (1985a) feels that the way physicians think about, and act with patients is based on a paradigm deeply imbedded in medical education – yet one that is neither examined consciously nor critically. What is this model?

The current biomedical model, which has produced miraculous technological advances, resulted from the marriage of 17th century Newtonian mechanistic physics and the Church's permission to dissect human *bodies* - with the mind, soul, behavior and morals left to the church. This led to Cartesian dualism of mind and body, with the focus on diseases rather than patients. It produced the reliance on reductionism, which teaches that the understanding of a complex entity is best achieved by studying its component parts from which the whole can be reconstructed. We went from studying the heart, to studying the heart muscle cell, to studying its bioelectrical activity the biochemical reactions inside the heart muscle cell.

As doctors focused on finding the lesion, they began to view patients as simple machines and to look at themselves as repairmen. Although disease diagnosis and types of treatment may have improved, overall patient care has frequently suffered. While the biomedical model, reductionism, and "smaller is better" has not always led to better patient care, the biopsychosocial model usually has.

What is the biopsychosocial model? Engel (1985a) wrote that psychological and social factors operate as well as biological ones in patients' illness. This relies on systems theory.

What is systems theory? "Nature is ordered as a hierarchically arranged continuum of systems, with its more complex, larger units superordinate to the less complex, smaller ones."(Engel 1985) Since each system is also a component of a higher system, a person may be, for instance, the highest level of an organismic hierarchy while also the lowest level of social hierarchy. Each level or system has a distinctive organization and methodology for study.

What constitutes health? Health is based on achieving harmony in each system/level and *between* the systems/levels. Disharmony may arise in any system/level and spread to other systems/levels, depending on the ability of that system/level to adapt to change.

Norman Cousins made an observation, and I have also seen this in my fellow physicians. Because of the explosion of information, doctors often draw a box around the area of their expertise, learning as much information inside the box and withdrawing into it. By ignoring any information or inconsistencies outside the box, they also develop a distorted concept of illness. To develop a healing partnership, physicians must learn to live with ambiguity, uncertainty and not knowing all of the facts. (Reiser and Rosen 1985) They must also understand that their particular area of expert focus may only be one hierarchical component of the illness picture.

> *In Stanley's case, the reductionistic/biomedical model fell short of treating his diseases. This model was even more wanting in dealing with the effects on all involved of such a combination of devastating illnesses.*

3. *Acceptance* is not an action but an attitude/ receptivity: the patient is not an object you do something to but a fellow person (like the doctor) that you embrace in your mind, heart, conscience.

Stephen Ray (1985), a sensitive plastic surgeon expressed his feelings about working with the severely deformed: "Before I enter the room to see such a person, I clear my mind of prejudices and preconceptions. I remind myself that all of nature is part of some universal order and is therefore harmonious and beautiful. Then, if I walk in the room and see a man or woman whose face has been scarred beyond recognition, I do not see the grotesqueness but find myself thinking of spiritual things - ancient craggy rock faces, gnarled old trees. It's odd - but with this attitude, where others find ugliness, I can discern beauty."

Reiser and Rosen (1985) present two models of acceptance:

a. Maternal acceptance - Picture a mother fondling a three month old infant. The mother holds the infant to her breast, often with her left hand, with the baby's head near her heart. One gazes at the other. The mother may stroke the baby and the baby may touch the mother's breast. There is little motor activity. The baby's tone is relaxed. Things are quiet and serene. But what if the baby is held awkwardly by a tense, disturbed or indifferent mother? A vicious circle may result. The baby may cry and tense its body with its back and neck arched. This agitates the mother, who may become even less available to give caring attention to the baby. . . who may then cry more. . . etc.

b. Illness often makes adults feel helpless and dependent like a baby. Enter the doctor, who may be afraid of disorganization and helplessness in him/herself and then, in an effort to reduce his or her

uncertainty, probes the patient with questions and instructions. What the doctor really needs to do is to help the patient relax, feel protected, begin to trust - by opening up to, and resonating with, the patient; by listening; and allowing the patient's feelings to emerge (Reiser and Rosen 1985). The patient, sensing the doctor's discomforts, will hesitate to be open about his or her feelings. This leaves the doctor "protected" but uninformed about some of the "whys" underlying the disease.

4. *Empathy* is "The ability to fully understand and share in another's feelings, coupled with the ability to know that these feelings are not identical with one's own." (Reiser and Rosen 1985) If it is hard to define, it is harder to achieve. I am reminded of the Native American expression, "You can't judge someone until you walk in their moccasins."

Harry Wilmer (1987) distinguishes between pity, sympathy and empathy in the doctor-patient relationship, based on the identification of the self with the other.

a. Pity is, at the best, compassion, at the worst, contempt. It can be a defense against identification with the sufferer. *(It is possible to feel pity yet have no clue as to what Stanley is really going through.)*

b. Sympathy (Syn = together; Pathos = suffering) includes a merging of identities. It is the sharing of the suffering and pain as if it belonged to both participants. (*How would I feel if I were in Stanley's place?*)

c. Empathy means keeping one's own identity separate while entering imaginatively into the other's life experiences and emotions. (*What does Stanley feel?*)

Communication

Norman Cousins felt that all healing partnerships depend on effective communication. What power do words have? Nothing is more inevitable in serious illness than the anxiety or even panic that accompanies it. The words a physician uses can have a profound effect on the patient's wellbeing. A doctor's words can be gate openers - opening the way to awareness, growth, recovery, mobilizing the will to live and setting the stage for heroic responses. A doctor's words can be gate slammers - producing despair and defeat, impairing the usefulness of whatever treatment is prescribed and compromizing the healing environment which is central to the care of the patient.

What the scalpel is to the surgeon, words are to the clinician. When he uses them effectively, his patients do well. If not, the results may be disastrous. (Tumulty 1973)

It is a challenge to health caregivers to communicate negative information without crippling. We must present negative information to the patient as a challenge rather than as a death sentence.

Since patients are not equally adept at handling the truth, how do we deliver the truth? Does a doctor know enough about a human being to predict the outcome when bad news must be conveyed? Do we unload a truckload of informational bricks on a patient? Must we not abide by principles of informed consent? If doctors feel that they must mention every possible complication to a patient in order to protect themselves, don't we now have a conflict of interest between the patient's needs for humanistic treatment and the physician's need for legal protection? (Cousins 1985)

Norman Cousins illustrates the power of words to achieve goals other than complete cures. Cousins was asked by a hospital physician to see one of their patients, a judge who was very ill. Although he had always been a fighter, the judge was now willing himself to die and his character had changed drastically. The doctor felt that if the judge's family could be given just a week with him the way they used to know him - not in health but in the spirit as they had known him, this would be a most

meaningful gift which they would treasure for the rest of their lives. Since Cousins was leaving for China the next day, he went to the hospital that night.

The judge, who was over six feet tall, was down to about 90 pounds, wasting away and barely able to speak. Cousins introduced himself, indicating that he was there because of the doctor's recommendation, in consideration of the familyWhat about the family?" asked the judge in a whisperWell, you know, cancer is the most contagious of diseases," Cousins saidNo, it's not," said the judge. Cousins clarified, "Well, it is contagious in the sense that grief is a virus, and sometimes the way we die helps to determine what happens to others; and when you look at the records, you will find that wives follow husbands within a few months and husbands follow wives - and the inability to handle grief is really a virus. You know, your family has always seen you as a fighter, and now you're going out of character." The judge said, "I gotcha."

The next day when they tried to hook him up to the intravenous he insisted that they feed him in the normal manner. Two hours later, he asked his wife to come over to play a game of bridge. When Cousins returned three weeks later, he discovered that the judge had died just two days before his return. He had not only lived out one week but lived out three and did so with spirit. He found his victory, and the family found its victory, in an altered context that was real (Cousins 1985).

Reiser and Rosen (1985) give us additional insights.

> Healing is an intrinsic activity in all natural systems. Utilizing a general systems approach, we know that it takes place on all levels of the hierarchy, and that every level or part influences the whole and vice-versa.

This is not the view that is held today in medicine.

> Just look at the language, at the metaphors we so often choose. . . . We speak of combating infection. We attack the problem of heart disease. We try to conquer cancer. In short, medicine is a battle. It is a war. Disease is an evil invader that has landed on the patient's shors from remote and barbarous regions. When the patient begins to lose the battle against the invader, he calls the doctor in. Like a hired gunslinger or Samurai warrior, the doctor takes up the fray, . . . Viewing medicine as a battle too often reduces the patient to an object - a fragile boat, a rudderless frigate, a hapless barge of statistical misfortune tossed upon the story seas of illness. . . . The family of the patient is also relegated to the role of hapless bystander - worried figures huddling outside the patient's room, clutching hats and purses, waiting, hoping, praying for the doctor to perform his miracle.
>
> This view is troubling for many reasons, especially because it produces discouragement in the physicians and causes many missed opportunities for healing of the patients, their families and friends. Even if a cure is not possible, by paying attention to the patients' goals and needs, doctors can Facilitate a healing process. Acceptance. Listening. Support. Keeping hope alive. Truly knowing what it means to walk in the patient's shoes and being able to communicate that knowledge.

Specific Techniques

Let me share with you a few examples of how a healing partnership may be developed.

William Branch and Tariq Malik (1993) note that while most studies of doctor-patient communication focus on training young physicians and emphasize making empathic statements and using open ended interviewing techniques, experienced clinicians may function differently. They videotaped five seasoned clinicians, all with different styles but in whom all the patients had developed trust. In some interviews they found instances, lasting from one to seven minutes, where the patients discussed their

concerns about personal, emotional and/or family issues. These interactions stood out from the rest of the interview and were termed "windows of opportunities."

Thomas Delbanco (1992) developed a Patient's Review questionnaire, intended as an added part of the complete history taken on admission and/or to be used prior to discharge from the hospital. This enriches the doctor-patient relationship by inviting the patients' perspectives. (See Table 1)

Dale Matthews, Anthony Suchman and William Branch (1993) describe ways of creating a favorable climate for "connexional experiences". These are moments of particular closeness during the medical interview when the meaning of illness and/or life is shared, opening up physiological, psychological and spiritual feelings in the doctor and patient, with a therapeutic value to both of them.

Kathryn Barnet (1972) suggests that touch may satisfy many levels of needs.

> The greater the patient's sense of isolation and sensory deprivation, the greater his need for relatedness to others through touch.
>
> The greater the patient's altered body image, the greater his need for acceptance through touch.
>
> The greater the patient's feeling of depersonalization, the greater his need for identity through touch.
>
> The greater the patient's regression, the greater his need for communication through touch.The greater the patient's anxiety, the greater the nurse's responsibility regarding the appropriateness of the use of touch.
>
> The greater the patient's dependency, the greater the nurse's responsibility regarding the appropriateness of the use of touch.
>
> The greater the patient's self-concealment, the greater his need for communication through touch. The greater the patient's need for privacy, the lesser his need for touch.
>
> The greater the patient's need for territorial imperative, the lesser his need for touch.
>
> The lesser the patient's self-esteem, the greater his need for confirmation through touch.
>
> The greater the patient's sense of rejection, the greater his need for acceptance through touch.
>
> The greater the patient's fear of death, the greater his need for relatedness to others through touch.

Finally, there is Dennis Novack's (1987) "Therapeutic aspects of the clinical encounter." This helps to understand the therapeutic efficacy of the physician-patient relationship and then to develop therapeutic strategies. He suggests that therapeutic aspects of the clinical encounter may include cognitive strategies (e.g. negotiating priorities, educating), affective strategies (e.g. empathizing, encouraging emotional expression), behavioral strategies (e.g. rewarding desired behaviors), and social strategies (involving family and social agencies

Art Or Science?

Are the care of the patient and the development of a healing partnership art or science or both? Anyone who reads George Engel (1985b) or anyone familiar with specific techniques of interviewing or of the scientific analysis of patients' behavior would recognise the scientific basis involved. Yet, let us also consider these quotes, many of which served as "teachers" in helping me to help Stanley:

. . . knowledge without compassion within our profession is an obscenity just as compassion without knowledge within our profession is quackery. Alvin Ureles (1972)

It is probably fortunate that systems of education are constantly under the fire of general criticism, for if education were left solely in the hands of teachers the chances are good that it would soon deteriorate. Medical education, however, is less likely to suffer from such stagnation, for whenever the lay public stops criticizing the type of modern doctor, the medical profession itself may be counted on to stir up the stagnant pool and cleanse it of its sedentary deposit. The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine - or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients. . .

The primary difficulty is that instruction has to be carried out largely in the wards and dispensaries of hospitals rather than in the patient's home and the physician's office. Now the essence of the practice of medicine is that it is an intensely personal matter, and one of the chief differences between private practice and hospital practice is that the latter always tends to become impersonal. At first sight this may not appear to be a very vital point, but it is, as a matter of fact the crux of the whole situation. The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it, and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients. . .

But if teachers and students are liable to take a limited point of view even toward interesting cases of organic disease, they fall into much more serious error in their attitude toward a large group of patients who do not show objective, organic pathologic conditions, and who are generally spoken of as having "nothing the matter with them". Up to a certain point, as long as they are regarded as diagnostic problems, they command attention; but as soon as a physician has assured himself that they do not have organic disease, he passes them over lightly. . .

Thus, the physician who attempts to take care of a patient while he neglects this factor [the patient's character and personal life] is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. The good physician knows his patient through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in the personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient. Francis Peabody (1927)

Confidence is the best tranquilizer; hope is the best antidepressant. Jerrold Bonn (1989)

> It is more important to know what kind of patient has the disease than what kind of disease the patient has.
>
> Sir William Osler (1985)

> One can know a hell of a lot of science, read every article in every journal, take continuing medical education to the point of stupor, and still lack clinical judgement. We have all met people who are licensed, learned and loved by patients, and who have absolutely none [clinical judgement]. . .
>
> It is, in fact, attitude, not stupidity or ignorance, which is the main barrier to clinical judgement. Good judgement involves doing that which will make the patient feel better, not that which

makes us feel better.

If we accept this - and we had better, if we really want to heal rather than treat - we have to be advised that "insight" is not, like immunization, a one shot charisma. The next hurdle is wisdom. . . All that I mean by "wisdom" is a sensitive attention to ordinary, shallow realities, to the components of human experience, and an awareness of the fact that their diversity and multiplicity are patterned. The best way to get it, if we want to be doctors, is not to study philosophy, unless it interests us to read other men's systems, but to cultivate a consuming interest in human natural history; as an ornithologist lives birds, we need to live and study people.

Alex Comfort (1980)

It is our duty to remember that medicine is not only a science, but also the art of letting our own individuality interact with the individuality of the patient.

Albert Schweitzer

If a doctor would be a physician and not merely a body technician, he must also be a knower of souls, those of his patients and, not least, his own.

Leon Kass (1980)

Table 1. Elements of the patient's review (Delbanco 1992)

Dimensions of Care	Focus of Patient's Review
Respect for patients' values, preferences, and expressed needs	What are the patient's short-term and long-term goals? What level of involvement does the patient want in decision making? What does he need, want, or expect from the health care system? What are his feelings about an advance directive?
Coordination and integration of care	Is care delivered by the range of providers effectively coordinated? Does the patient get consistent information from different clinicians?
Communication and education	Does the patient have the information he wants about his clinical status, diagnostic tests, and treatment options? Do the patient and his family know what they need to know to manage on their own to the extent that they are able to do so?
Physical comfort	Is pain alleviated as much as possible? Does the patient have the help he needs with bathing, eating, household chores, or other activities of daily living? Have remediable deficits in functional status been adequately addressed?
Emotional support and alleviation of fears and anxieties	Is the patient worried about his or her illness or its effect on the ability to care for her/himself or dependents? What are the principal stresses in the patient's life? Is he or she worried about paying medical bills or about lost income due to illness? Does the patient have access to appropriate support networks to help with these worries?
Involvement of family and friends	Are family and friends appropriately included in planning and providing care? Do they have the support they need?
Continuity and transition	Do the patient and family understand medications to take, treatment regimens to follow, activities to pursue or avoid, and danger signals to look out for? Are there clear plans for continuing care and treatment?

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Ronald Banner will continue in the next two issues of the *International Journal of Healing and Caring*with further observations on:

Caring for the Human Spirit, the Patient's Soul

The Doctor's Soul

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