

# More than medicine: The therapeutic relationship in general practice

Patrick Bolton and Allan Shafer

Socio-Analysis 5: 2003 ()

## *Introduction*

My (PB) daughter has a story in which a pet cat is taken to the vet for a check-up at the same time as the family car is taken to the mechanic for a repair. The simile is obvious: cats are machines and vets are their mechanics. Public policy, driven by the economic rationalist desire for tangible outputs, is driving the same simile for general practitioners (GPs): GPs are supposed to be mechanics for humans. This is seen in attempts to reinvent GPs as providers of population health (Towler, 1999) and coordinators of care for people with complex care needs (Helliwell et al. 1997). When asked, GPs appear to concur with this biomechanical view of general practice: Australian GPs recorded that 95 per cent of patients came to see them for a 'physical' problem (Bridges-Webb et al. 1992).

In contrast to this, our anecdotal and actual experience has been that many GPs are uncomfortable with an exclusive emphasis on their biotechnical role. There is evidence that the GP's role has another at least equally important, but poorly recognised, aspect (Wiener J and Sher 1998). It is widely reported that many, and perhaps a majority, of patients attend GPs for primarily psychosocial reasons (Chrisman and Baker, 1978; Ingham and Miller, 1986). There is an inconsistency between the stated predominance of the biomechanical model and the evidence that GPs frequently work in a psychosocial paradigm. Despite this inconsistency, patients are generally very satisfied with the services that they receive from GPs (Bolton, 1999), although they also report that GP communication skills need to improve (Stewart-Weeks et al. 1996).

We suggest that this apparent tension between biotechnical and psychosocial views of general practice can be addressed by a model of the encounter between a GP and a patient that contains two parts. The first is a visible and explicit interaction based in a biotechnical domain. The content of this interaction manifests as 'general practice' in the public sphere. The second, a subtler and more fluid interaction, addresses psychosocial concerns, which are often implicit.

1

In a successful encounter these two interactions occur concurrently and are closely interrelated. Patients' high levels of satisfaction with general practice suggest that GPs are expert at this synthesis.

If it is true that the psychosocial role is integral to general practice, then it is surprising that this aspect of general practice is so absent from descriptions of, and policy discussions about, general practice. If the psychosocial role of general practice is important, then there is a need to better understand how it is integrated into practice, so it can be supported and improved. It is not possible to do something well unless one is clear about what it is that one is trying to do, and unless one makes deliberate attempts to improve. The very neglect of these issues may of itself be significant. Why are the psychosocial aspects of general practice ignored when they are identified as one of the key distinguishing features of general practice? (RACGP, 1996). The purpose of this paper is to describe a preliminary exploration of the scope, nature and practice of the psychosocial role of general practice using a socio-analytic framework. Socioanalysis is the activity of exploration, consultancy and action research which combines and synthesizes methodologies and theories derived from psychoanalysis, group relations, social systems thinking, organisational behaviour and social dreaming (Bain, 1999). The framework is founded in the tradition pioneered by social scientists and psychoanalysts at the Tavistock Institute of Human Relations in London, particularly that of Wilfred Bion and A K Rice (Bion, 1961; Rice, 1965). The paper begins with a description of the socio-analytic approach and the method by which it was applied to a group of GPs. The results of this approach are then described, before concluding with some suggestions about how to take this work forward.

## ***Background***

The aim of the project was to clarify our understanding of the doctor-patient relationship in light of the paradox between an overt focus on the biotechnical role of general practice, and the evident emphasis on the broader psycho-social role of this relationship. We referred to this part of the relationship of interest as 'the non-medical factors which contribute to health'. This formulation was chosen to make it clear that our task belonged within general practice, although it might be informed by disciplines such as psychology and sociology.

Our objective was informed by a belief that the non-medical factors which contribute to health are important to both health outcomes in general practice and the wellbeing of general practitioners. A better understanding of these factors is therefore a prerequisite both to improving the relationship between individual GPs and patients, and to providing insights that may enhance the value of general practice to both GPs and the community.

A socio-analytic action research approach was chosen to explore the dynamics of the doctor-patient relationship because of its capacity to elucidate unconscious processes which contribute to group outcomes, and because this seemed relevant to the paradox observed around the biotechnical and non-medical roles of the GP.

2

More than Medicine

3

socio-analysis 5

Action research (Long, 1999) involves a research group developing hypotheses in an experiential context, and testing them by making interventions and evaluating outcomes in the work context, reviewing them in the research group and then framing new hypotheses for further testing, in an iterative process (Bain, 1982). There is a variety of approaches to action learning, but the socio-analytic approach includes an exploration of the dynamics of the action research group. This is accompanied by significant learning-from-experience on the part of participants. This emerges from two contexts: the actual application in the workplace, and from the processes that occur in the research group itself, whose own parallel processes are examined. Parallel process is a phenomenon that has been well documented: in this process a group unconsciously mirrors in its own dynamics, the dynamics of the relationships which it is studying (McNeill and Worthen, 1989). Exploration of the dynamics of the group added value through enhancing the participants' learning, especially with respect to the aims of this project.

## ***Method***

Seven GPs were approached to participate, and five of these agreed to do so. GPs were invited to participate on the basis that they were known to one of us (PB) and thought likely to be open to the underlying question and the socio-analytic approach used. Participants were provided with a briefing similar to the material in the introduction.

A half-day introductory session was held four weeks before the project began. One GP who was unable to attend was interviewed by teleconference with the same agenda. The group then met for three two-day weekend sessions. These sessions were separated by periods of four weeks and two weeks in order to enable interventions to occur in their workplaces. Participants were paid an honorarium in acknowledgment of the time taken to participate in the study.

A GP-facilitator and a socio-analyst jointly facilitated the groups. The role of the facilitator was to facilitate interaction within the group around the subject area and to manage the administrative boundaries. The role of the socio-analytic consultant was to assist the group to explore the conscious and unconscious aspects of the group's work in depth: there were two components – exploration of the case material which was presented and offering insights into the way in which the group's behaviour reflected the issues under consideration. The socioanalyst was chosen on the basis of extensive experience in psychoanalysis and group dynamics. This project was jointly authorised by the Australian Institute of Socio-Analysis and the Division of General Practice, Central Sydney Area Health Service.

## ***Case studies***

Participants were requested to prepare and present to the group detailed process notes on

either a specific patient or an issue on which they wished to work, and which they thought illustrated a problem or concern which they associated with the non-medical factors which contributed to health. The notes were to describe the background to the patient/issue and to provide a detailed description of an interaction that captured the dynamics of the doctor/patient relationship. Examples of issues which could be worked with included particular subsets of patients (eg geriatric patients, patients with HIV/AIDS) which were challenging to the GP's role.

The method for working with the material was an applied version of the socio-analytic model called 'Consultancy Skills Groups' (Bain, 2001). Consultancy Skills Groups are composed of five to seven members, together with a consultant. They provide opportunities for members to take up consultancy, enquirer and observational roles using members' own consultancy and organisational experience. Roles are rotated at each Consultancy Skills Group Session. The Consultancy Skills model was originally pioneered at the Tavistock Institute by Harold Bridger, and has been used and developed by AISA in consultancy training programs since 1985. In the application used for this project, each participant takes up one of five roles, which are rotated across the three weekends, so that each person experiences each role. The roles are designed to assist the researchers to develop and use micro-observational skills to gather data. The roles are:

Presenter (P) - the presenter of the clinical material

Inquirer (I) - who interviews the presenter

Three further roles are designed to facilitate observation of the dynamic of the interview and also enable a further process which will shortly be described:

Observer A - primarily observes the Presenter (P)

Observer B - primarily observes the inquirer (I)

Observer C - primarily observes the interaction or relationship between P and I.

Following a short interview, A B & C discussed their observations while P and I listened. The interview continued with P and I attending to what they learnt from the discussion. A group discussion followed with the tasks of: exploring the presenting problem; developing hypotheses about the dynamic processes; and developing interventions based thereon. The facilitator and consultant offered hypotheses about the group processes and the dynamics of the interview, (which provided further immediate and dynamic data about the 'consulting relationship' of the particular inquirer and presenter), the presenting issues and parallel processes in the group. Hypotheses were jointly developed by all participants and interventions designed for P to apply in the intervening weeks. An iterative cycle of hypotheses and hypothesis testing was set up over the three weekend sessions.

Material presented by the participants covered the following areas:

A depressed and agitated patient

An aggressive patient with HIV

Geriatric patients in nursing homes / Administrative pressures on the GP

4

More than Medicine

5

socio-analysis 5

Coeliac disease and nutritional therapies

Taking on a directive role with a patient, or the tension between what the patient wants and what the GP wants to provide.

### **Results**

All participants reported that changes occurred in the way they related to patients that brought about demonstrable changes in the health of the patients and themselves as a result of their learning. The specifics of these changes are not presented here because the focus of this study is on the general factors that emerged surrounding the GP-patient relationship.

Themes arose and were explored in regard to the non-medical factors in the doctor-patient

relationship that contribute to health. These have been loosely grouped into topics. In some cases the themes address more than one topic. The themes are as follows:

### ***1. The task of general practice***

As GPs, participants discovered that they all had a commitment to the caring relationship. This factor was regarded as a central feature of the doctor-patient relationship that contributed to health. Accurate language to describe the quality of the caring relationship was difficult to locate. The doctors felt that this took the form of a particular quality of 'love' for the patients. Participants recognised that a conviction about the value of general practice was common to them all. Participants felt that a belief in the value of the work was necessary to sustain the GP when work satisfaction is otherwise limited. It was believed to be important to have a clear sense of what one is trying to achieve against which progress can be assessed and management strategies adjusted. Through this, relationships with patients were experienced as high quality. The doctor-patient relationship itself was then therapeutic.

Participants identified that good general practice demonstrates a capacity for containment (17). A psychoanalytic definition of containment has been provided by Hannah Segal: When an infant has an intolerable anxiety, he deals with it by projecting it into the mother. The mother's response is to acknowledge the anxiety and do whatever is necessary to relieve the infant's distress. The infant's perception is that he has projected something intolerable into his object, but the object was capable of containing it and dealing with it. He can then re-introject not only his original anxiety but an anxiety modified by having been contained. He also introjects an object capable of containing and dealing with anxiety. The containment of anxiety by an external object capable of understanding is a beginning of mental stability.... in this model the analytic situation provides a container. (Segal in Bick, 1986, pp134-5).

6

More than Medicine

Esther Bick sees containment as the opposite of falling to pieces or annihilation. Containment has increasingly been recognised as a crucial component of caring relationships. In the research group containment became known as the 'holding pattern'. The patient communicates verbally, nonverbally, and emotionally to the GP. The GP takes the patient's communication into his or her mind, processes it, and reflects it back in a manner which, if successful, better permits the patient to digest or manage the problem for themselves. The experience of feeling deeply understood in this way is a core component of healthy human emotional development generally (Shafer, 2001).

### ***2. Courage and personal authority, and appropriate authority for the task.***

This is the capacity to exercise judgment about the use of authority or status. The need for the doctor to delicately assess the appropriate level of authority (and sometimes of authoritarianism) was significant. Managing oneself in relation to the mythologies of medical practice - being able to work in one's own way, to be able to be oneself, and negotiate differences was a crucial aspect of this.

***3. Engaging with the patient's distortions of,*** or projections onto or into the doctor, and the doctor's distortions of the patients: the two sets of distortions operate and interact and were felt to play an important role in the relationship.

### ***4. Relationship and tension***

GPs need to manage boundaries with care and sensitivity to the specific relationship and context. Boundaries are the points of connection and separation in relationships, roles, processes, tasks and locations. There are the obvious external boundaries (like the professional/social one or time boundaries) and there are the internal ones (e.g. between different roles the doctor identifies with: e.g. as healer and as 'manager' or as 'mechanic; or the boundary between thoughts and feelings).

There is also a relationship between the internal and external boundaries. Factors in the management of external boundaries **interact with** factors in the management of internal boundaries.

Whenever such a boundary is breached it alerts one to a dynamic process. GPs need to attend to the meaning and implications of boundary breaches and respond to them thoughtfully. The management of diverse boundaries is a central issue.

An example that emerged from the group was a GP who **out of kindness** had an overdeveloped 'carer' role (internal role boundary violation) and who initially overlooked a patient's lateness (time or lateness being an external boundary violation). The GP's internal boundary between the 'caring' and 'management' roles had been breached, and this interfered with understanding the meaning for the patient of the breach of the time boundary. This has implications for the GP, the patient, and their relationship. This is further elucidated in the next point.

7

socio-analysis 5

GPs need to manage the internal relationship (i.e. in the doctor's mind) between the desire to be a 'healer' (who loves, heals, makes well, holds) and the 'manager' (or perhaps 'bureaucrat') who is experienced by the GPs themselves as an unfeeling, 'managing' and/or uncaring function. This emerged as a central issue. However both roles need to be mobilised in the service of the patient.

Managing the tension between the desire to control (the patient and/or the disease) and the capacity to accompany the patient (i.e. be in the same mental and emotional space as, and empathise with, the patient, without acting on these feelings) **is a further critical instance**. Pressure on doctors to be omnipotent is well known and mobilizes their own desires for omnipotence. "Being with" the patient, in contrast with curing them, is a more painful position to be in touch with and to sustain because it can be felt as impotence. The next point develops this from an additional angle.

Managing the tension between the various sources of pressure **to be omnipotent or to 'know the answers'** (from the patient, from the professions, and from oneself - Jureidini and Shafer, 2002) and the need for, and the capacity to, 'not know' or to tolerate uncertainty **is important**. The capacities to inform the patient appropriately about a condition, and **to tolerate not knowing the answer** (in reaction to both the patient's anxiety for answers and the pressure from the doctor to be wise) were felt to be relevant. This involves the valuing of, and capacity for, long-term relationships with patients. It includes managing appropriate role relationships (e.g. warm carer/professional attendant) and personal hopes for the patient. **An example of this would be** managing ambivalence about helplessness and chronic illness. Conversely, tension develops from managing feelings of frustration or rejection which arise when a patient wants a 'quick-fix' and the doctor desires a longer working relationship.

### ***5. Capacity to hold a meta-view of the doctor-patient relationship while it is happening.***

This involves recognition of one's emotional valencies (i.e. what emotions in patients or types of relationships one attracts to oneself). Attending to the implications or consequences of these when necessary, and exercising adequate judgment about how to deal with this where significant. Managing the nexus of the doctor's style and the patient's capacity and need was also important.

Examination and recognition of what exactly it is one attends to in the relationship with the patient (e.g. presentation, symptoms, dynamics, one's own feelings, facts etc.) was a notable factor.

Certainty, an apparently unshakeable or unassailable stance, may clash with and contrast with the pain and uncertainty of the way of working encompassed by this project.

8

More than Medicine

### ***6 Rewards of general practice***

The 'camaraderie of like-minds' - sharing one's experience of the work with others emerged as an important dimension present through the group and in general practice. General practice - like many confidential professional relations - is often an isolating experience. Managing the isolation of the role, or the isolating aspects, of being a general practitioner (whether in solo or group practice) was significant for the health of the GP. The gaining of support and likemindedness was felt to be a sustaining and nourishing variable.

### ***7. Commitment to the task of general practice.***

Questions arose about what the core task of general practice might be. Might general practice be more about a process of care more than an outcome? This appears to be a central issue embedded in our opening comments regarding General Practice as a technical and/or psychosocial process. **Accurately defining the (primary) task of general practice is critically important, since it underpins many other dimensions of general practice that contribute to health: the role of the GP, the definition and management of various internal and external boundaries; the level of authority of the GP, and the way the doctor-patient relationship is organised."**

**8. Gaining replenishment from the work** - feeling satisfied, appreciated and adequately rewarded were valued highly. The work of general practice is known to be very demanding and pressurized. Balint ( ) has described the intensive projections into the GP and the impact of this on the capacity of the GP. The particular need for and the sources of replenishment from this work require more thorough explication which is beyond the scope of this paper.

### ***Discussion***

The themes described are affirming for general practice and indicate that the GPs in the sample are aware of, and at an important level operate through, a therapeutic psychosocial relationship which is concerned with the process of care giving as well as the outcomes of care as more usually conceived. We believe that greater attention to this aspect of general practice is required in order to ensure that GPs are satisfied by their work, and that the process by which this satisfaction is generated will necessarily result in better, richer patient care and by implication health benefits for both.

More needs to be done if this kind of process is to be made more widely available, not just in material terms, but also in the sense of making GPs comfortable to explore this aspect of their work. Not all GPs may feel so. Change will be facilitated if educational activities directed towards GPs and those wishing to become GPs are supportive of this model of general practice. The 'culture of general practice' as inherited during training requires attention. There is a serious tension between the increasing demand for even more cost-effective medical practice that limits the quantity and the quality of GP-patient contact and the health benefits of the more encompassing approach we are describing. By implication, medical education may be under even more pressure to focus on the biotechnical dimension.

We believe that the themes described above are in fact closely related to the 'core business' of general practice. They relate to what patients as individuals and society as a whole value in general practice. They also make general practice distinct from other medical specialties and bring different kinds of value. To the extent that we are right in this, these issues need broad discussion so as to support general practice. Wider research is implicated.

Importantly, the themes raised are not ones easily empirically verified. They occur in the space between the GP and the patient. This makes it difficult for them to be externally viewed and validated. This in turn makes it difficult and costly for them to be valued in the existing economic rationalist framework. More attention needs to be given to these areas if they are to be supported under funding models within a rationalist framework.

Finally, we do not believe we have adequately addressed why these issues are so neglected. Our experience has been that it has been difficult for us, and others to think about, and act on these themes. Apart from the difficulty that this creates for people working in this area, more work is required to understand what the significance of this resistance might be in a socioanalytic sense.

### ***Conclusion***

This action research program used a methodology that addresses the subjectively experienced dimensions of professional relationships. The themes that emerged were supported by the strong concurrence of the participants as they developed hypotheses about their relationships and interventions with their patients, sought evidence in their ongoing interventions and found consensus in their peers' evaluation of their evidence. In addition similar factors emerged in the group dynamics and the parallel processes in the relationship between the consultants and the participants, thus providing multiple sources of the same

evidence. These two sources of evidence provide strong support for the primary objective of this study: to elucidate the non-medical factors in general practice that contribute to health.

### **Acknowledgement**

The assistance of the GPs who participated in this study is gratefully acknowledged.

9

socio-analysis 5

### **References**

- Bain A. (1982) *The Baric Experiment*, Occasional Papers, London: Tavistock Institute.
- Bain A. (1999) 'On Socio-Analysis' in *Socio-Analysis*, Vol 1, No1.
- Bain A. (2001) Available online: <http://www.aisa.org.au/events/ocgdws.htm>
- Bick E. (1986) *The Work of Hannah Segal*. London, Free Associations.
- Bion W R. (1961) *Experiences in Groups*, London: Tavistock.
- Bolton, P. (1999) An Evaluation of the Balmain Hospital General Practice Casualty, Sydney: Thesis for the degree of Doctor of Philosophy, University of Sydney.
- Bridges-Webb, C., Britt, H., Miles, D.A., Neary, S., Charles, J. and Traynor, V. (1992) Morbidity and Treatment in general practice in Australia 1990-1991. *Med.J.Aust.* 157, s1-s56
- Chrisman, N.J. and Baker, R.M. (1978) Exploring the doctor-patient relationship: a sociocultural pilot study in a family practice residency. *J. Family Pract* 7, 713-719.
- Helliwell, C.D., Carney, T.A. and Hart, J.T. (1997) General practitioners' workload in primary care led NHS. *BMJ* 315, 546-546.
- Ingham, J.G. and Miller, P.M. (1986) Self-referral to primary care: symptoms and social factors. *J.Psychosom.Res.* 30, 49-56.
- Jureidini J. and Shafer A.T. (2002). Concealing and Revealing: Munchhausen-by-Proxy Syndrome in the Medical System. Presented at the *3rd Scientific Conference of the Australian Institute of Socio-Analysis*, Launceston, February 2001.
- Long SD. (1999) Action research, Participative Action research and Action learning in Organisations in Gabriel, Y. *Organizations in Depth*, Sage, London.
- McNeill BW and Worthen V. (1989) The Parallel Process In Psychotherapy Supervision. *Professional Psychology*, 20, 329-333.
- RACGP (1996) RACGP presidential task force 1996. Definition: General Practice and General Practitioner. Sydney: RACGP.
- Rice AK. (1965) *Learning for Leadership*. London: Tavistock Publications.
- Shafer AT. (2001) Common psychological defenses in people who work with loss and grief. Invited paper presented to the national conference of the *National Association for Grief and Loss*, Perth, October 2001.
- Stewart-Weeks, M., Cameron, I., Brooks, M., Patterson, K., Robson, J. and Monroe, L. Albany Consulting Group, (Ed.) (1996) *Integrating Consumer Views About Quality in General Practice*. Australian Government Publishing Service.

10

More than Medicine

Towler, B. (1999) *Enhancing the population role of general practitioners*, Canberra: GP Financing, Medicare Benefits Branch, Health Access and Financing Division, Department of Health and Aged Care.

Wiener J and Sher M (1998). *Counseling and Psychotherapy in Primary Health Care: A psychodynamic approach*. Palgrave, London.

### **Biographical note**

Associate Professor Patrick Bolton, MBBS PhD, is a general practitioner and health service administrator with a conjoint appointment at the University of NSW. At the time of this research he was Director of Acute Primary Care with Central Sydney Area Health Service and Director of Canterbury Division of General Practice. He is presently Medical Administrator, Northern Illawarra Hospitals Group.

Allan Shafer MA (Clinical Psychology), D Litt et Phil, is a Clinical Psychologist and Socio-Analyst in private practice. He works as an adult psychoanalytic psychotherapist and an organisation consultant. He is a Fellow of the Australian Institute of Socio-Analysis and is the Director of Group Relations Programmes. He is the past Director of Training for the Association for Psychodynamic Psychotherapy of Western Australia.

Australia.

11

socio-analysis 5