The harmful consequences of elevating the doctor–patient relationship to be a primary goal of the general practice consultation

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Introduction

In the UK, it has been estimated that an ‘average’ GP will undertake ~8000 face to face clinical interactions annually.\textsuperscript{1} The consultation has come to be identified as the cornerstone of general practice,\textsuperscript{2} and to be seen more than an occasion for the medical work of diagnosis and treatment.\textsuperscript{3} Beginning with the work of Balint,\textsuperscript{4} it has also come to be seen as a ‘meeting’ of individuals in which (often undifferentiated) symptoms are expected to be understood and accommodated in relation to their social and psychological contexts. Much effort in education and research has been invested in giving the consultation this deeper meaning and wider range of potential practice.\textsuperscript{5} Thus, whilst the doctor–patient relationship is a given in today’s primary care, achieving a satisfactory doctor–patient relationship has also been elevated to be an outcome or goal of every consultation. In many ways, exploring that relationship and the skills that may improve the outcome of the consultation have been welcome developments in primary care. It is well understood that a reductionist biomedical model of practice is unhelpful in understanding undifferentiated symptoms in primary care,\textsuperscript{6} and both doctors and patients evince a desire for humane interactions, marked by civility and an interest in the patient as a person. Recognition of the patient-as-person and the application of good communications skills play an important part in understanding the nature of symptoms and apprehending underlying pathologies, as well as securing adherence to treatment regimens.\textsuperscript{7–9}

More recently, the need for GPs to reflect on their work has been recognized: Fairhurst\textsuperscript{10} describes the cognitive and affective evaluations made by doctors about their patients, and how recognition of these both positive and negative evaluations is vital for GPs in reflecting upon the consultation.

The work of the GP has steadily shifted towards the management of chronic illness and incapacity in the community.\textsuperscript{11} In this editorial, we suggest that the historic emphasis on the development of ongoing relationships with patients presenting complex health problems in which psychological and social factors are implicated is confounded by doctors themselves feeling increasingly ill equipped to deal with them. Moreover, we argue that in the current context of general practice, GPs may feel increasingly powerless to resolve such problems and that they view themselves as colluding with patterns of illness behaviour that maintain, rather than resolve, chronic incapacity.

Collusion and its contexts

In a series of qualitative studies\textsuperscript{12–15} on the management of patients with chronic symptoms in primary care, we interviewed 101 GPs in North West England between 1994 and 2001. In these studies, GPs reflected upon the difficulties of developing effective therapeutic relationships with patients who presented intractable symptoms of chronic incapacity. They felt that their relationships with these groups of patients were marked by a similar kind of intractability: they were powerless to effect positive change for their patients—either because patients were either unable or unwilling to evince the motivation to recover, or because the GPs themselves felt they had little of therapeutic value to offer the
patients; thus they entered into long-standing relationships that had no possibility of a rational and successful conclusion. In the conduct of these relationships, GPs felt that they were forced to relate to their patients in ways that sustained and amplified incapacity; for the most part, they did not feel able to challenge patients they construed as unwilling to recover, or to motivate those who could not. The root of this collusion was their own powerlessness in the face of complex and intractable symptoms in which organic or psychogenic pathology was deeply embedded in a much wider array of problems.

GPs were pessimistic about their ability to impact on patients with chronic problems that were presented to them. Some blamed patients for these problems, but most did not. They recognized that the ongoing relationship with the patient may well be beneficial for that patient, but caused frustration for themselves. They recognized that they were expected to solve patients’ problems but that they had no authoritative position from which to do so. The tools and ‘power’ that medicine gave them are not those that can realistically impact on patients’ lives. In such circumstances, they had to make the best of being able to achieve little, a prospect which they found demoralizing and for which they felt that their training had left them unprepared. The respondents’ language suggested that they were distracted by the situation in which they found themselves trapped.

This is not just a feeling of ‘heartsink’ being expressed by the GPs. GPs were able to articulate clear explanations for the difficulties they experienced in the relationships with the groups of patients we interviewed them about: they felt their training had forced them to concentrate on maintaining the doctor–patient relationship, and to do this they felt they had to collude with patients and their symptoms, at the expense of their own concerns or judgements on appropriate management. They felt, however, that they had limited management options and resources, so had to manage the patient in primary care, because they have lost the capacity to intervene medically in a meaningful way with these patients. Their descriptions of powerlessness were run through with an unwillingness to challenge those behaviours that they found most difficult, and a recognition that they could not dispose of patients exhibiting them. This is not simply a matter of heartsink patients undermining the doctor’s clinical practice. While wider social and political features of the landscape of general practice play a part here, there is an alternative explanation. This lies in the ideology of patient-centred holism espoused by British general practice in the period since the Second World War, and its stress on the doctor–patient relationship as being in some way intrinsically therapeutic. The kind of position taken up by Balint, and espoused by his followers, laid great emphasis on this and exercised a powerful influence on the embryo Royal College of General Practitioners. This view informed subsequent ideas about the consultation and what clinicians should expect of themselves within it. The assumption that underpinned these intellectual moves was that knowing the patient, in the context of a continuing relationship, would empower the doctor to make appropriate clinical decisions. What is also important, however, is how GPs regard the legitimacy of patients’ presentations, the disposal options they see for each condition and the broader (and increasingly neglected) constraints within which doctors and patients operate in their negotiations around chronic illness.

In our studies, respondents worked to maintain relationships with patients, even though they felt powerless to achieve useful clinical outcomes and felt forced to collude with illness behaviour that sustained incapacity. This was a direct consequence of elevating the doctor–patient relationship to be the prime goal of the consultation. The importance of doctors’ authority is well recognized, but doctors can feel disempowered in the consultation, because they have lost the capacity to intervene medically in a meaningful way with these patients. Their descriptions of powerlessness were run through with an unwillingness to challenge those behaviours that they found most difficult, and a recognition that they could not dispose of patients exhibiting them.

Conclusions

We suggest that doctors have overestimated the importance of sustaining their relationships with some patients, when doing so only maintains incapacity.
Communication skills training in medical schools and in training for general practice is rightly aimed at finding ways to improve the quality of doctor–patient interaction in ways that benefit the patient. However, clinicians need also to find strategies that permit them to recover their authority and to empower themselves in the circumstances and the types of patients that we describe herein.

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References


