The Psychology of Medical Practice

HOLLENDER

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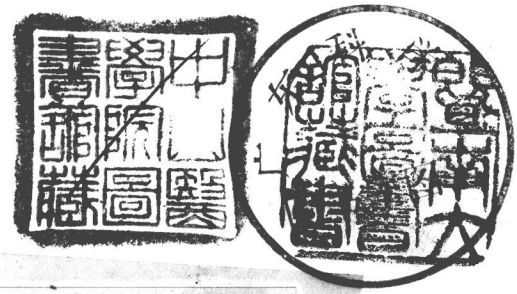

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PREFACE

WRITING A BOOK is an enriching experience for the author, much as teaching is for the teacher. To do either requires the jelling of unjelled thoughts, the exchanging of ideas with colleagues and students and the reviewing of a vast amount of material already published in the field.

My indebtedness to those writers who have made contributions to our knowledge of the psychology of medical practice is acknowledged, in part, in the references at the end of each chapter. There are other authors who have had an influence on my thinking to whom I have not acknowledged my debt in this form. Among these Sigmund Freud, of course, comes first. Insofar as this book is grounded in psychoanalytic psychology, it is an application of his insights to medicine.

There have been many persons who, through direct contact, have had an influence on my thinking in a variety of ways. Some have suggested ideas, others have stimulated me to explore or to clarify my thoughts and still others have provided literary and editorial assistance.

In terms of an approach to the subject matter and the development of ideas, I have been most profoundly influenced by Dr. Thomas S. Szasz. His practice of scrutinizing the foundation upon which a structure is built, as well as the structure itself, has been most helpful. All too often that which is automatically taken for granted—like a custom or a time-honored belief or theory—merits the most searching and penetrating examination. Many of the ideas which are expressed in this book have evolved in discussions with Dr. Szasz during the past ten years. I am

grateful to him, too, for many suggestions concerning both content and form.

As the result of considerable experience in the field of medical writing and editing, my father, Dr. Abraham R. Hollender, was able to provide me with many useful suggestions. He has placed his imprint on this book in terms of specific changes and corrections made on the manuscript. In an even more substantial way, he has had an influence on this work. I refer here to his own sustained interest in medicine and medical writing which has served as a constant source of inspiration and stimulation to me.

Dr. Leonard A. Stine, who collaborated with me on the chapter on the Medical Patient, also helped me appreciably in preparing the chapters on The Doctor-Patient Relationship, Practical Aspects and The Patient with Carcinoma. As noted in the table of contents, Dr. Ernest M. Solomon collaborated with me on the chapter on the Obstetrical Patient. Dr. Julius B. Richmond wrote the two chapters concerned with the Pediatric Patient. It has been a source of considerable pleasure and profit to work with Drs. Stine, Solomon and Richmond.

In the course of my work on the Liaison Service at the University of Illinois College of Medicine, I learned much from the exchange of ideas with Drs. Harry F. Dowling, Norman B. Roberg, Nicolas J. Cotsonas, Robert J. Kaiser and Murray Franklin, all of the Department of Medicine, and Dr. Francis L. Lederer of the Department of Otolaryngology. This was also true of my discussions with the psychiatrists in the Liaison group.

It was Dr. Francis J. Gerty, Head of the Department of Psychiatry at the University of Illinois College of Medicine, who provided me with the opportunity to establish a Liaison Service. I am appreciative of this and also of Dr. Gerty's continued encouragement and support of my work.

For a period of almost ten years I worked with many people suffering from chronic and disabling illnesses at Drexel Home (formerly Home for Aged Jews) in Chicago. A number of case notes in the text were drawn from this experience. The exchange of ideas with Mr. Ben L. Grossman, Director of Drexel Home, and the staff of the Home was an enriching experience.

A number of persons have read parts of the manuscript. To them I am indebted for their comments and suggestions. In this

group are Drs. Roy R. Grinker, Burton J. Soboroff, Emanuel M. Skolnik, Jerome S. Beigler, Robert S. Levine, Louis A. Lazar, David S. Harman, David Gomberg, Harold Balikov, Arthur D. Ecker, Mathew W. Kobak and C. Barber Mueller.

Thanks are due for secretarial assistance to Mrs. Shirley Hoy, Miss Frances Moran and Miss Mary McCargar. Mrs. Agnes Helliwell and Miss Hazel Merritt read the page proofs.

Finally, I am most grateful for the excellent co-operation and help I received from the staff of W. B. Saunders Company.

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INTRODUCTION

In a very general way I use the expression, the psychology of medical practice, to refer to the art of medicine. It is my purpose to turn a psychological spotlight on the patient, the physician and what might be called the medical situation. Although the problems which may arise in connection with one or another specific illness will be considered, perhaps even in detail, my intention is not to provide cookbook-like recipes. It is rather to evolve general principles and to illustrate an approach. At times the discussion may shift from a consideration of conscious difficulties which can be understood at a commonsense level to unconscious problems which require some knowledge of psychiatry. The emphasis throughout, however, will remain on the problems encountered in the everyday practice of medicine and what can be done about them.

In practice the physical and psychological approaches to the patient are intertwined. It should be understood, though, that this does *not* mean that they can be studied from the same point of view. Each must be examined separately, and each must be formulated in terms of the "laws" appropriate to it. In considering the physical aspects, the focus is—or should be—on the body as a machine. The emotional reaction to the patient's bodily disorder or his human environment, however, must be studied in terms of psychology. To attempt to use the same formula for both phenomena would be like using a geometric equation which pertains to a triangle for a circle. It will fit—or work—only if the circle is made into a triangle. In other words, the frame of reference for medicine will fit psychiatry only if the latter is squeezed into the mold of medicine and

loses its own individual characteristics and identity. It is pertinent, at this point, to mention that there is no incompatibility between a triangle and a circle. Both can exist side by side. There need be no conflict between the medical and psychological approaches to the patient, but each must have its own conceptual frame of reference. Most of the time the two can complement each other.

Until about two decades ago the teaching of psychiatry in medical schools was limited to a series of lectures on the psychoses. These were usually cast on the descriptive model of Kraepelin. Psychoanalysis, and the body of knowledge of human feelings and behavior which derive from it, were outside of the main stream of medicine. During this period, the orientation to medicine was: What is the nature of the illness and how can it be treated? Rapid strides were made in discovering the etiology of many diseases, in devising laboratory tests to detect them and in developing medications to treat them. And yet many questions remained unanswered and, worse, often unasked.

The existence of a gap in knowledge was evident to many thoughtful physicians. It was Freud and other psychoanalysts who first provided the body of data to fill this gap. In the beginning the focus was on the role of psychological factors in the etiology of illness. More recently it has also encompassed the emotional reactions to disease. With this shift, attention has increasingly been focused on the nature of the interaction between physician and patient. With this has come a greater awareness of the possible significance of the doctor-patient relationship. The so-called art of medicine, which in the past was based on intuition and experience, can now be more clearly described, formulated and sometimes explained.

A basic assumption, which has influenced my thinking, is that time-honored approaches to patients, selected intuitively or through trial and error, probably have value, at least for some patients. I have raised the following questions in studying these approaches: What purpose do they serve? Who will benefit from them? Who will not? I have attempted to delineate the underlying mechanism involved. When there have been two approaches to the same situation, I have tried to ascertain why one is better suited to one patient and a second to another. It

seems to me that there have been vogues in medical practice much like those in women's fashions. The style that enjoys popularity at a given time may suit (or flatter) one person while that of a later date may be better tailored for another. For example, the use of the nursery for the newborn in the hospital fits the emotional needs of some mothers. Rooming-in, on the other hand, is better suited to other mothers. Thus a current or an old practice should always be evaluated in terms of *for whom* it is used.

A few words concerning *what this book is not* are probably also in order. It is not a textbook of psychiatry. Neither is it a textbook of the so-called psychosomatic approach to medicine or psychosomatic medicine. Since overlapping is unavoidable, however, lines have not always been drawn sharply. I have tried as much as possible to maintain the focus on those psychological problems encountered in practice which the physician will attempt to handle himself. I assume that there are some physicians who will undertake more definitive forms of psychotherapy. This decision is—and I think should be—dictated by training, available time and interest.

Four specialties—medicine, surgery, obstetrics and pediatrics —to which most time is usually allotted in the medical school curriculum have been singled out for special consideration. Reference has been made to other fields only in passing. Many statements concerning general surgery, however, can be applied to the various surgical specialties. Likewise statements in regard to medicine may be applicable to the medical specialties and to the non-surgical aspects of surgical specialties. A separate chapter has been devoted to the patient with carcinoma. This illness has been singled out because it confronts practically every physician regardless of his field of work.

In addition to these chapters, there are two which focus on the doctor-patient relationship, one theoretical and the other practical. Perhaps the major contribution of psychoanalysis to medicine has been that of making the nature and significance of this interaction explicit. In the last two chapters the psychological factors related to giving medicinal and non-medicinal prescriptions are discussed.

The terms and frames of reference employed by some of the

authors quoted in the text differ, sometimes markedly, from those which I employ. Only occasionally do I comment on the differences. These authors have been quoted because their statements make a contribution to the subject under consideration. The divergent viewpoints will be immediately evident to the reader and, therefore, should not detract from the consistency of the thesis which I develop.

CHAPTER I

THE DOCTOR-PATIENT RELATIONSHIP

BASIC CONSIDERATIONS

THE DOCTOR-PATIENT relationship will be viewed here as an interpersonal phenomenon of a special type. This is not the usual approach. Most often it is regarded as a transaction in which the physician provides the patient with "something" (e.g., sympathy, kindness or understanding). This "something" is viewed as a *substance* and as such it is prescribed in much the same way as a medication.

This approach to the doctor-patient relationship is a carry-over from the traditional orientation to medical practice. Physicians have always been concerned with "things" (i.e., lesions, tumors, bacteria, etc.).* As a result, until a decade or two ago discussions of the doctor-patient relationship have usually amounted to an espousal of a humanitarian attitude and this attitude has been "prescribed." An approach of this sort (while it unquestionably has merit) is highly circumscribed.

The present interest in investigating the nature of the interaction of the physician and his patient is, in large measure, the result of a contribution of psychoanalysis to medical practice. The background for this can be stated briefly. While the initial focus in psychoanalysis was on psychogenic symptoms and intrapsychic processes, it quickly shifted to the interaction of the patient and his therapist, since this was a way of treating the patient's disturbances in interpersonal relationships. Moreover,

* In more recent times there has been an interest in "functions" as well as "things."

psychoanalysis provided a method for examining unconscious, as well as conscious, forces which influence human behavior. Thus it stimulated interest in an examination of the doctor-patient relationship in medical practice, and it also furnished an additional method with which it could be studied.

In a sense, we have traveled a full cycle. Not long ago the emphasis was exclusively on eliminating the human equation as much as possible in any investigation. What was formerly a "contaminant" has now become the principal point of focus.

The discussion which will follow can be divided into two parts. The first will deal with the basic models of the physician's relationship to his patient, while the second will take up some fundamental concepts which, since they have much to do with shaping the physician's orientation to medical practice, have considerable influence on the doctor-patient relationship.

What Are the Basic Models of the Doctor-Patient Relationship?

This question was recently considered in an article by Szasz and Hollender.[1] The discussion which follows summarizes their viewpoint. They suggested the following three models for the doctor-patient relationship: (1) activity-passivity, (2) guidance-cooperation and (3) mutual participation.

1. Activity-Passivity. Here the orientation is one in which the physician is active and the patient is passive. It has originated in, and is entirely appropriate for, emergencies (severe injuries, marked blood loss, delirium or coma). The patient is more or less completely helpless and the physician *does* something *to* him. Treatment takes place regardless of the patient's contribution. The relationship of the doctor to the patient is similar to that of the parent to the helpless infant.

2. Guidance-Cooperation. This model usually underlies the doctor-patient relationship when the circumstances are less desperate than those described above. It applies to most acute disorders and especially to those of an infectious type. Although the patient is ill, he is still keenly aware of what is going on, and he is capable of following directions and of exercising some judgment. Moreover, when the approach is geared at this level, the patient is expected to look up to his physician and to obey

him. In essence, the patient says: "You know what is best for me. That is why I come to you. Tell me what to do and I will follow your directions." This model has its prototype in the relationship of the parent and his child (or adolescent).

3. MUTUAL PARTICIPATION. This approach is often useful for the management of chronic illnesses in which the treatment program is carried out by the patient with only occasional consultation with a physician (i.e., diabetes mellitus, myasthenia gravis, psoriasis, etc.). According to this model, the physician *helps the patient to help himself*. Since it requires a complex psychological and social organization on the part of the patient, it is rarely appropriate for children or for people who are mentally deficient, very poorly educated or profoundly immature. Its prototype is the relationship of adult to adult (with one having specialized knowledge that the other needs).

It would be inaccurate and misleading to maintain that one model is better than another. It is rather a question of which model is more appropriate for (or works better in) a given situation.

How Does the Psychology of the Physician Relate to the Basic Models?*

In each model the participation of doctor and patient is complementary. The stability of this paired system must be temporary since the physician strives to alter the patient's condition. The comatose patient will either recover (become conscious) or die. If he improves, the doctor-patient relationship must change. It is at this point that the physician's inner (usually unacknowledged) needs are most apt to interfere with what is "best" for the patient. At this juncture he either changes his attitude (not a consciously or deliberately assumed role) to complement the patient's emergent needs, or he foists upon the patient the very role of helpless passivity from which he (allegedly) tried to rescue him in the first place. The process of change which the physician undergoes to have a mutually constructive experience with the patient is similar to the change a

* As in the preceding section, this discussion summarizes a viewpoint presented in an article by Szasz and Hollender.[1]

parent must undergo to behave *ever differently* toward his growing child.

This thesis can be illustrated by the following example. When a patient with diabetes mellitus is brought to the hospital in coma, the relationship must be based on the activity-passivity model. The physician must *do* something to the patient who is completely helpless (unconscious). Later the patient has to be educated (guided) and during this stage he must cooperate. Finally, ideally, he is treated as a full-fledged partner in the management of his own health (mutual participation).

Confronted by a problem of this type, the physician is called upon to change through a corresponding spectrum of attitudes. If he cannot make these changes, the patient regards him as unsympathetic and lacking in an understanding of his personally unique needs, while he regards the patient as uncooperative and difficult. Both are right. Both are confronted by the wish to induce changes in the other. Since this is no easy task, the dilemma is usually resolved in one of two ways. The patient attempts to conform to the physician's "requirements." Periods of rebellion (resulting in "poor" management) may then occur from time to time. The other, and more frequent, result is that the patient seeks another physician, one who is more attuned to his current "needs."

What Is "Good" or "Bad" for the Patient?

Since a number of fundamental concepts have an influence in shaping the physician's attitude, they are basic in any consideration of the doctor-patient relationship. "Good" and "bad" are sometimes viewed as abstractions which can be determined by the physician. This is true, however, only when the patient is in coma and hence unable to have an opinion of his own, or when the patient is seriously injured and therefore is in no position to decide what is good or bad for himself. The decision must rest with the physician, much as the decision for a helpless infant must be made by the parent. When we treat the patient who is capable of cooperating or of participating, the determination of what is good or bad for him in terms of medical treatment is to some degree shared by him with the physician.