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The group works on the cases: threats to the doctor

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As we have described in the previous chapter, agreement on the questions used to help us to understand defensive behaviour by doctors did not come easily. They were hammered out and repeatedly modified over many months of work before they assumed their final form. During this period it became clear that considerations of the available time and energy of individual doctors played an important part in what happened during consultations. The following four cases illustrate how the gradual clarification of some of the difficulties encountered led to a better understanding of why the doctors had been upset. We also consider a number of issues such as:

- the doctors' perception of how much time and energy are available at any given juncture;
- how important it is for doctors that patients should respond positively to their ministrations;
- how personal experiences in the doctor's life can determine professional actions.

The cases are analysed in some detail, as this seems necessary for

an understanding of the doctors' defence mechanisms and how the group tried to clarify them. Such a discussion would be of limited value if it only applied to the cases under consideration. We hope that readers will be able to apply some of our ideas when they think about their way of working with patients. We don't think that defences are unique to the doctors taking part in the research group!

Diagnostic confusion

Our patients look to us primarily to find out what ails them. Although they look to us for other things, without a diagnosis being made their anxiety remains. Perhaps giving the illness a name represents the last vestiges of the shaman's cloak with which some patients may still wish to clothe us. However, a name implies that we *understand* the patient's condition, whether we do or not. It is only after they have gained some understanding of their condition that patients ask for therapy. The whole process adds up to an implicit contract. The patient expects the doctor to make sense of his complaint, while the doctor expects the patient to behave in a way which seems proper to the doctor in the circumstances. In the background are emotional elements from both patient and doctor.

The word diagnosis often bears a cachet of precision but in practice we use it as a preliminary working hypothesis which can then be tested, to destruction if necessary. The passage of time taken to make a diagnosis is only one of the ways that time enters the equation. Pressure of time in busy practice can so disturb the doctor's equilibrium that the exercise of professional expertise may be blighted. For example, here is a case where diagnostic confusion appears related to the patient's apparent lack of appreciation of the value of time spent with a professional:

I am very ambivalent about presenting this patient. He is a man in his late 30s and an infrequent attender but the consultations are always incredibly time-consuming and seem to lead nowhere. He commutes to the city where he works in a library but he has told me that he can always arrange free time to do other things. He had some peculiar symptoms, as always. But there was another factor leading to this presentation.

About a fortnight ago I had thought I would like to present his case, so I reviewed the notes, after which I thought I had all the facts at my fingertips. But the case went completely out of my mind until last evening, when I was driving close to the surgery. Instead of collecting the notes I rationalised that in a Balint group one is supposed to tell the story out of one's memory store. As it was getting late I drove past the turning to the surgery thinking that I wanted to get home early to get a good night before the group meeting early the next day. I did not want to spend more time on preparation.

Before Ian became my patient he had had an illness about 5 years ago with neurological symptoms, including facial pain and numbness, so he was referred to a neurologist at a teaching hospital. The team there subscribe to the belief that myalgic encephalomyelitis (ME) is a post-viral condition and they gave his illness that label. He seems to have accepted the diagnosis for quite some years. He has only attended our practice five times in the last 5 years, but three of these have been in the last few weeks.

He saw another doctor in the practice on one occasion and asked to be referred back to the neurologist, whose letter dealt chiefly with facial pain. He came back to see me to talk about that, accompanied by his wife who did a lot of the talking, and at the end I felt overwhelmed by his collection of endless symptoms. I had sat virtually silent for 20 minutes without being able to make any connection between the symptoms and the patient's life. His wife was pushing for something to be done though it was not at all clear in which other direction to send him, though an ear, nose and throat surgeon was one of the possibles because he talked of 'sinusitis'. I decided that the only way to stop the consultation continuing all day was to take some therapeutic action. The neurologist had actually suggested that a tricylic antidepressant might help the facial pain, so I managed to get him to accept trying a small dose. He returned for a follow-up and agreed that the antidepressant did seem to have afforded some relief, but he would still like to see a surgeon if the symptom persisted. This consultation only took 20 minutes rather than the 40 of the previous one, but at the next follow-up things

were back to where they started. He did not want to see a surgeon after all. There was yet another clutch of symptoms, all described in the most minute detail, presented in such a way that I really had no idea what he did want.

He protested that he was not one of those crazy people who thinks that there is some magic bullet to cure the condition. Nor did he wish to be labelled as an ME sufferer.

This made my heart sink. I felt that he cannot be dismissed because he is being so very reasonable. Nevertheless, he was consuming a lot of my time without achieving any result. But at this juncture he declared that he didn't think he would be able to continue working much longer because he was not feeling well enough to do so. I feel ashamed that I didn't pursue this further but I just didn't understand how his symptoms would prevent him working. Although he said the pain was bad sometimes, he didn't want to take painkillers, and he seemed to be saying that there was some other symptom of his condition, actual or potential, which was concerning him. In the end he agreed to go to see a surgeon privately for a second opinion, my feeling being that it was not right that the NHS should have such a time-consuming patient. He didn't mind where he saw the consultant, saying that he had 'all the time in the world in my job'.

The group struggled to understand what happened to the doctor in the course of these exchanges. It was certain that even if the patient had all the time in the world the doctor did not. It seemed that there were moments in the consultations when the doctor knew, or hoped he knew, that essentially there was no somatic basis for Ian's complaints. However, it seemed that it had not been possible to widen the scope of the conversations into areas which were not rooted in the body. There was a feeling in the group that patients with a very marked somatically orientated view of pathology were unlikely to be receptive to psychological explanations. At this juncture it was pointed out that this view was essentially a generalisation which should alert the group to the likelihood of defensive behaviour!

Although the patient might have thought that it was essential to describe his symptoms accurately to help the doctor elucidate a complex case, his verbosity in detailing his complaints seemed to be foreclosing the possibility of any movement. The group ruminated about how interesting the underlying story might be, while at the same time noting that the doctor's curiosity had been deadened by the way in which the patient had chosen to present it. His wife seemed to be speaking on his behalf rather than her own, though the group had divided opinions about that, some suggesting she felt shut out by him in the same way the doctor did. The fact that, on paper, his CV suggested he would be an interesting person to meet was at variance with his appearance as a boring man to the doctor. This had to be explained.

The patient talks and the doctor listens, but the process seems unproductive. It is as if an apparently meaningful story produces a meaningless pattern to the doctor's mind. The patient talks in what is virtually a foreign language and the doctor seems unable to persuade him to speak in a language he can understand. And the doctor's difficulty was plain even to the reception staff as they included Ian's name on a list of 'heartsink' patients which they served up to the doctor as a joke on April Fools' Day!

It was suggested that the patient might be obtaining benefit from these consultations which the doctor felt were so dysfunctional. The doctor's great capacity to sit and listen, allowing the patient to unburden himself of his symptoms might, indeed, relieve his distress in some way which was not apparent to the doctor. It might even be connected with his thought that he was becoming too ill to work in what, on his own testimony, was a very undemanding job. Alternatively he might fear a more serious cause for his illness. He was certainly preoccupied with his symptoms, and it had to be acknowledged that they were genuinely experienced, irrespective of causation. It seemed that the doctor's calm acceptance of the symptoms might go a long way in communicating to the patient that they were not life-threatening. However, it became clear the doctor often felt that the patient was trying to make him suffer. It seemed that the doctor had as much difficulty in telling the group the nature of *his* distress as the patient did in telling the doctor about his.

How are we to understand this doctor–patient relationship? What is clear from the presentation is that the doctor felt that the patient was in control. The doctor became 'de-skilled' by the feeling that the patient was consuming an inordinate amount of

his time. This not only left the professional field in a chaotic state but resulted in the doctor feeling personally bruised and driven into a corner. The suggestion that the patient might pay for a private consultation with the surgeon might well have been dictated by the fact that the doctor half realised that the patient sucked professional time into a black hole.

Diagnostic confusion, then, may be a signal that the patient has, consciously or unconsciously, rendered the doctor's professional skills ineffective by exercising control in a way which is not immediately apparent. An overview of the unfolding story seems to demonstrate that the time factor flows throughout. This is apparent not only in the consultations themselves but even in the preliminary steps the doctor took after deciding to present the case. There seems to be an only partly acknowledged sense that a doctor has only so much time and energy to allot to each patient. If this semi-conscious 'rationing' is challenged, then the professional skills of the doctor may become compromised. Although the doctor was aware of the length of the consultations, it proved impossible for him to 'take control' because this would seem to have run counter to the laudable attempt to be a good listener. This would seem to explain why the doctor appeared to be in such a state of inner conflict to the extent that he felt 'knotted inside' (*see* Chapter 11). Here, perhaps, is an example of an occasion when a conscious defence mechanism is justifiable and the doctor's pain transmuted into a therapeutic interpretation for the patient such as: 'You may have all the time you need, but most of us don't'. While the group felt that most doctors would have been upset by this patient, this doctor seemed to be rendered particularly disabled by him, his passivity being an understandable but ineffective defence against engagement.

Threats to the personal self

Every so often a patient's presentation seems to challenge the doctor's equilibrium, not because of any intellectual challenge in terms of making a diagnosis, but because of a dimly perceived notion that the patient will drain the doctor emotionally if he is given time to unburden himself. Recent advances in neuroscience seem to indicate that the separation of thinking and feeling in the human brain is not possible. Inevitably each of us, as we enter a consultation, brings both rational and emotional elements into the relationship. Perhaps it is not surprising that we may seek to protect ourselves from too much emotional involvement.

Consider the case of a woman in her late 20s who brought her baby as an emergency at the beginning of a Monday morning surgery. She was the wife of a man whose family had been patients of the practice for a long time. Her sister-in-law had on one occasion warned the doctor that she thought the patient was drinking too much:

'My baby's been crying all night, he won't settle, he doesn't eat and he's very constipated and losing weight, here, look at him.' Tina is a striking, tall, blonde girl with a disarming, wide-open smile. I was immediately on my guard. I knew that more than one of my partners had felt defeated in trying to tackle her numerous problems which had included the suspicion that she had an eating disorder. I had seen her once myself at an antenatal clinic during her recent pregnancy, and thought she was laughing and joking in what seemed to be an inappropriate way. I wondered then if she was hiding depression. This seemed to be confirmed when I saw her at the postnatal clinic where she seemed overtly depressed. Later, her sister-in-law reported that Tina was having difficulty in her mothering role, not feeding or changing the baby regularly, letting him cry for long periods and seemingly generally disorganised at home. I realised that the practice needed to get to grips with her problems but had not been her usual doctor up to now.

I examined the baby carefully and found a somewhat underweight baby with an unsmiling expression but nothing else significantly wrong. I found it unexpectedly easy to reassure the mother. She smiled in a disarming sort of way and then said: 'But really you know it's myself, I get very low, weak and tired, and I'm feeling depressed and I feel I need something'.

I felt exasperated. It was only 15 minutes into the start of the working week. Although I ought to have been feeling full of energy, I knew I was getting 'hot under the collar' and could not face that this was the moment to grasp the nettle of her problems. I said to

her, 'I've already spent 10 minutes examining the baby and I'm sorry but your complaint is not appropriate now as an emergency. I'd be very grateful if you would make an appointment to come back tomorrow and we'll try and deal with all this then'. I then saw that her eyes were brimming with tears and she appeared hurt and disappointed.

I felt a complete heel but was simply unable to tolerate the pressure of her presence at that moment. It was if I needed fresh air to survive. I had the feeling that I had been mugged but did not know why. She went amazingly quietly but did not make an appointment for the following day. I felt guilty about the way I had treated her but felt I could not have given her any more time.

Pausing to reflect on the state of the doctor's mind at this juncture, it is clear that some of the process was conscious and some was consequent on an emotional state triggering autonomic nervous activity. There appears to have been a conflict between a desire to do the best for the patient and the time constraint on the doctor who, having made time to see the baby as an emergency, was asked to allot yet more time for the mother. The guilty feelings may well have arisen because, during the examination of the baby, the doctor had become aware that the real patient was the mother, while his feelings of 'being mugged' may well have arisen because Tina had used the baby's (largely) spurious ill health as a means to gain access to the doctor at short notice. Although the mother had been bad-mouthed by her sister-in-law, the doctor's health visitor had not confirmed the reports of defective mothering. This had made it impossible for the doctor to dismiss the patient's need for help.

I felt so bad about my treatment of her during the consultation that I was determined to make amends when she did eventually come back. I resolved to try and swallow my exasperation in order to make a fresh start. In the event she did not return until 6 weeks later. She had made an appointment to see me on a Monday morning! She came in with the baby and I felt impelled to pour out a statement of contrition. I confessed to having felt guilty that I had been unable to listen to her problem at that time. Her reaction in terms of body language was one of obvious relaxation. She expressed gratitude for what I had said and then proceeded to tell her story. She recounted how she and her partner had been planning to go away for a weekend and leave the baby with her parents but they were both smokers and she was afraid he would suffer from the effects of passive smoking. Her parents, however, were unwilling to promise that they would abstain for the sake of the baby and a blazing row developed which culminated in them saying, 'Don't bring the baby round'. Tina had sought to heal the rift by writing to them but they had not even replied. She had not spoken to them since that day. Since then she had felt awful and everything seemed to be going wrong. Her confidence in looking after the baby had evaporated. She recounted that things had always been very difficult at home. Her father had bullied her mother, herself and her two sisters to the extent that she now looked on him as a child abuser. She went on to say that she had come to hate herself and could not bear to look at her own reflection in the mirror. She had become frightened that she would put on too much weight and had become fearful of eating. She had to have an alcoholic drink to give herself the courage to go out shopping and was now more anxious than ever because she had to do this more often. I spent a full half-hour allowing her to unburden herself but in the end felt that an antidepressant was appropriate because of the depth of her depression. Interestingly, when I prescribed it, she made the remark that her sister had been prescribed that one with success. I tried to get her to make an evening appointment a week later but she said that it was difficult for her to leave the baby with anyone and so a further morning appointment was arranged.

The next day there was a baby clinic scheduled at the surgery. While I was doing some paperwork in my consulting room with the door open, I saw Tina walk past. Seeing that I was alone she said, smiling, 'I am so grateful to you yesterday for listening to me'. She then took out a parcel wrapped in silver foil and presented it to me. It was a rich fruit cake. 'I baked this specially for you'. I was dumbfounded, all the more so as it was my favourite kind of cake!

Tina cancelled the appointment arranged for the following week and did not request a repeat prescription for the antidepressant.

The doctor was ambivalent about this turn of events. On the one hand there was a feeling that he had met her need (she had said that the she found it warm and comforting that the doctor responded to whatever she said, in contrast to the long silences she had experienced when she had been sent to the practice counsellor before her pregnancy). On the other hand she seemed to have reverted to her untidy pattern of consulting as in the past.

Perhaps the most remarkable thing about the first encounter with Tina was that the doctor felt so bad about what was, on the face of it, a very conscientious approach. His partly conscious defence – deferring the mother until the next day – seemed to make the doctor almost more distressed than if he had got on and dealt with the mother's problems immediately. With regard to the second consultation, the group thought that the doctor's hesitation in getting to grips with the patient's problems was because he was labouring to overcome his defence. The doctor managed to overcome it and to achieve such a successful outcome in one session that the group had difficulty in believing it. However, the evidence of subsequent contacts appeared to confirm it.

There were no further face-to-face meetings and the patient did not see any other partner in the practice. However, the doctor often sees Tina in the street as she takes her son to the nursery. On one occasion he went out of his way to greet her. The group wondered whether this didn't show that the doctor feared rejection by the patient. He accepted this and also admitted that he had been disappointed that she didn't return after the second consultation. He sensed that there was unfinished business.

Challenge to the 'apostolic function'

There appears in many doctors to be a shadowy area where our personal feelings seem to impinge on the rational pursuit of our skill. As a result we behave as if we have revealed knowledge of what is right and what is wrong for patients. It is as if we have a duty to convert to our faith all the ignorant and unbelieving among our patients. Michael Balint called this the 'apostolic function'. It seems to be a combination of accepted traditional medical attitudes and the doctor's agenda in dealing with patients. The former may be entirely sensible but ignoring the patient's agenda is often a recipe for a dysfunctional doctor–patient relationship. This is illustrated by the next case:

The patient is a woman of about 50, whom I have known for years. She is a well-built, pleasant woman with a sense of humour. She is a scientist who has received international recognition for her work. This afforded a special interest in her for me, and I even put 'awarded a medal' on her notes. I've always had a very easy and straightforward relationship with her, though most of the consultations have only been for cervical smears and diaphragm checks. But it did occur to me recently that I knew nothing about her sexual partner.

About two years ago she told me that her sister had had a fatal heart attack. I checked her blood pressure and serum cholesterol and found the latter was raised. I gave her appropriate advice about diet but did not see her again until about 18 months ago when I rechecked the level and found it significantly raised. So I said to her, 'with your family history we have got to treat this seriously'. She bridled at that, which was the first time I had encountered resistance in our relationship.

She railed against not being able to eat certain things she was fond of. She explained that, now her work was desk-bound, she couldn't take a lot of exercise. However, she did promise to follow an appropriate diet. This did not lower her cholesterol significantly so I suggested that she go to the Lipid Clinic. She resisted this for some time but eventually agreed to go. They did the usual investigations and prescribed a statin. She was given a small dose and she was happy with that but when they increased it she complained of terrible side effects so she stopped it altogether. When I was on holiday she saw my partner as she was gaining weight rapidly. Thyroid tests revealed a normal thyroxine but a raised TSH (thyroid-stimulating hormone), so my partner gave her thyroxine, starting with a small dose. However, when urged to increase the dose, the problems recurred. My partner said: 'Your wretched patient was ever so difficult, she won't take her cholestyramine or her statin and now she won't take thyroxine'. I was cross and spoke up in defence of my patient. 'I've never found any problem with her'. I felt rather smug, thinking how I have always said how important the doctor–patient relationship is!

I tried to coax her back on to the straight and narrow and listened to her endless excuses about why she couldn't eat this, that and the other. I asked her to stay on the low dose of the statin (which hadn't upset her) until she returned to the clinic. I urged her to try and increase the thyroxine as her weight was still increasing. She then consulted a herbalist and told him about her serum cholesterol. It seemed that she was willing to take anything the herbalist prescribed, though this resulted in her adhering to a macrobiotic diet rather than keeping clear of inappropriate foods. With regard to the thyroxine, she tolerated 75 μg but when I tried to push it up to 100 μg she came back complaining of 'terrible side effects'. I persuaded her to try 100 μg again when she came back from a holiday but she said, 'I couldn't possibly tolerate 100 μg, I get these terrible symptoms'. I felt my hackles rising. I said: 'I thought we agreed that if you couldn't tolerate the dose you were going to ring me up'. She replied that as it was the weekend I wouldn't want to be disturbed. 'Anyway you'd said that the tingling in the fingers was a side effect of the thyroxine'. I thought, 'I couldn't have said that', but she was adamant.

By now, I was really fed up and I told her so. I said 'How do you expect me to treat you? I'm doing my best, I make the diagnosis, I recommend the treatment, you keep coming to see me to tell me you don't want the treatment. I've tolerated your diets, I've tolerated all these new side effects, I've referred you, I've done everything I can, you know, what do you expect me to do?' (I thought, 'Oh dear, I'm venting all my frustrations on her and I feel very bad about it because I can see she is quite upset'.) Then I said, 'I'm sorry, but I'm sure you can understand my frustration. I find it very difficult to believe that all these effects are due to your drugs, but rather that if you get any symptom you immediately blame whichever is the latest drug that you're on'. She agreed that this could be the case. 'But', she said 'I've got throbbing in the feet since I increased the dose of thyroxine'. In the end I wrote to the consultant telling him that she couldn't tolerate the increased dose. I did it then and there and showed it to her so that she would know I wasn't maligning her. So we arranged a follow-up appointment and parted on reasonably good terms though I still felt bad about what I had done. Later, I remembered that her TSH had doubled its original level which confirmed the need to get her condition under control!

The group discussion sought to understand what had changed between doctor and patient. When the doctor's partner had expressed irritation with the patient the doctor had thought that her partner must have mishandled her. After the recent exchanges the patient had changed from being an admired friend to an annoying pest. Perhaps it was that the patient did not wish to take on a passive, accepting role with anyone. Indeed, the doctor thought that her frustration stemmed from a feeling of loss of control, both in terms of the doctor–patient relationship and also the amount of time spent, but she did not see the way forward. What had made the doctor so upset? The patient had one of the very few medical conditions for which there is a specific remedy. And the remedy itself in this case was a substance that is normally occurring in the body, the very thyroxine which the patient seemed to consider more of a poison than a cure! It was as if the doctor had based the mutual relationship on the basis of the patient's sugar-coated exterior and had not realised what a tough nut lay beneath the surface. The shock and disappointment felt by the doctor were such as completely to destroy her equilibrium.

What was clear about the patient was that, in spite of her apparently worldly success, she felt unfulfilled and time was flying by. She had certainly been bereaved. Perhaps she was depressed. The group suggested that it might help if the doctor resumed her patient attitude towards anything that was brought to her. This had been their relationship before the recent problems. The doctor mused about the relationship. 'I always thought of her as a pleasant, easy, straightforward patient who is quite nice to see but, as it is, I've never allowed her to tell me anything, except about her job and her aspiration to be an artist'. It was a cocktail party relationship. Even birth control checks had never produced anything about her sex life. In fact the doctor was uncertain as to whether she really had one, the diaphragm notwithstanding!

It seemed that the doctor's defence over quite a long period had been to collude with the patient in order to avoid getting close to her pain. Because of her mounting frustration, the doctor became angry and this signalled an end to the collusion, allowing a fresh start to be made. This was confirmed at a follow-up presentation. The doctor now seemed able to contain her evangelical therapeutic

zeal, while the patient seemed to have genuinely tried to be more compliant though she had not been able to reach the dosage levels aimed for by the doctor.

The atmosphere reflected a relationship between two human beings who had been able to establish a *modus vivendi* in a professional setting, from which each was able to experience satisfaction, if not perfection. In retrospect, the emotional explosion had revealed the deficiencies in the original relationship and had enabled the doctor to realise that her entirely worthy intentions to make the patient better had foundered on the basis of an unequal relationship. The patient's autonomy had been threatened and had been defended tooth and nail. Backing off not only enabled the emergence of a more mature relationship but actually achieved a more efficient therapeutic regime. Tribute must be paid to the fact that the crisis had not destroyed the essential doctor–patient relationship, showing that even that relationship had its strengths. Indeed, the doctor might not have bothered so much about the issue if the patient had not been esteemed as much as she was.

Sylvia: three missing days

From time to time what appears to be a model of professional conduct of a case suddenly throws up something which appears to conjure up events in the doctor's personal past that seem to play a significant part in the doctor–patient relationship.

One Friday evening after surgery I received a message asking me to telephone the daughter of a middle-aged woman called Sylvia, whom I knew very well. Sylvia's notes had been put ready for me with a new hospital discharge summary pinned to the folder. It read: '?Stroke. CT scan negative. Please refer to psychiatrist'. I reluctantly took the record back to my room and rang Sylvia's number.

Her daughter answered the phone, sounding bright and intelligent. She told me that she had found her mother unconscious in bed and had then called an ambulance. It was uncertain how long she had been comatose and when she gradually came round she had no memory of what had happened. The doctors had thought she had possibly had a stroke but as she had no paralysis they couldn't rule out another diagnosis. They had discharged her as soon as possible. Her daughter then asked me when I could come and see her at home. I was thinking, 'I don't want to go now, it's late and I'm not at my best', so I said: 'Well, how about tomorrow?' 'That will be marvellous, doctor', the daughter responded. So I arranged to visit after Saturday morning surgery. The family have been my patients for nearly two decades. During this time they have suffered many losses. Sylvia's sister died of a heart attack in her 40s, her mother died shortly afterwards and her father became progressively more disabled with chest disease. Sylvia's first husband had deserted her, leaving her with her baby daughter. At about the time of her father's death from chronic bronchitis she met an old flame and they got married. After three happy years he developed lung cancer when he was only in his mid-50s and suffered an unpleasant and prolonged terminal illness. Sylvia had felt suicidal at times during this period and I had to work hard to help her through her grief.

On the Saturday morning visit, it was with a sense of foreboding that I climbed the stairs to the front door. I found a lot of visitors in the well-kept flat, friends and relatives who were gently shuffled out by the daughter so that there were, in the end, just the three of us. The daughter sat to my side, but rather far back so that I couldn't see her face. I had the feeling there was tension between them over the recent events leading to Sylvia's admission to hospital, so that I seemed to be placed in the position of a referee in a game at which I had not been present.

The daughter had apparently found her mother unconscious with wounds on her arm and neck and blood on the sheets. Sylvia was vague as to what had happened but reiterated that the wounds were of no importance while the daughter insisted that there was something to worry about. Sylvia denied that she had been drinking or had taken any tablets but had to admit that she couldn't remember any events for the 3 days before she was found. She confided that she used to see a counsellor but had not done so for some time. She then asked me to arrange for her to see a psychiatrist but it was pointed out that this would mean a wait of some months. The daughter became agitated at this point. She asked me if her mother would be all right on her own and if there were any tablets which might help her while she was waiting. Sylvia then brought up how much she missed her husband, saying she would take flowers to his

> grave every week. The tension between mother and daughter continued. The daughter was anxious about what might become of her mother if she remained at home unsupervised. But her own work commitments prevented her from being able to stay and look after her. In the end I gave Sylvia a certificate to stay off work for 2 weeks and asked her to make an appointment to see me the following week. I also prescribed one of the newer antidepressants as I felt fearful that she might intend to commit suicide.
>
> There was certainly no evidence that she had had a stroke, being fully mobile and not dysphasic. As I got up to go she suddenly brightened, saying, 'Oh doctor, I'm so grateful to you, you always come up trumps'. And then she said, 'Can I kiss you?' There and then in front of her daughter she kissed me on the cheek, to which I responded likewise.

The group were completely bemused by the story of Sylvia's illness. How could she have been unconscious in bed for 3 days without food and water? The doctor seemed to be avoiding confronting the possibility that she had attempted suicide. It was suggested that the doctor had sought to seduce the group by his long introduction to the case, in which he described the good relationships he had had with many members of the family though, at the same time, many had perished. Was his collusion with the patient's denial of a suicidal attempt an attempt to preserve this idealised image of doctor–patient interaction? Had he been rewarded with a kiss for his collusion? How did the daughter really feel? And how much risk was he taking by his strategy of leaving her at home on antidepressants and a promise to see her the following week?

At follow-up the doctor reported:

> In the event, she didn't keep the appointment but she had been seen at home by the psychiatrist who seemed as undecided as I was. He had promised to arrange a follow-up at the hospital and had changed the antidepressant. After a while Sylvia came to see me again. The hospital seemed to have lost track of her follow-up appointment so she asked me to try and sort that out. Then she complained that her right arm felt numb though it had not lost power. On parting she again railed against the higher powers that prevented her joining her dead husband but she had disappeared through the door before I could respond.

The doctor went on to say that he had a certain dissatisfaction with the group's response to this case. Then, to everyone's surprise, he recounted that, when he was 2 weeks old, his maternal grandmother had committed suicide while his own mother was confined in the maternity hospital. His mother subsequently developed postnatal depression. He thought that intense feelings about suicide had had a great influence on his recent contacts with Sylvia. It then transpired that the hospital discharge note which had reached him that fateful Friday evening had actually read '?stroke/?suicide attempt'. The group members all felt sure that the doctor's initial account of the discharge note had not included the words 'suicide attempt'.

Who had forgotten these important words? Whose defences had been mobilised? When the doctor had had the opportunity to refer to the verbatim transcript it became clear that he had not reported the '?suicide'. He agreed that when he was presenting the case his sad family history was close to the surface of his mind. It was likely that his experience of suicide in his own family had somehow made it difficult for him to share with the group the intimacy of his relationship with Sylvia. On the other hand the group, shut out of the intimacy, had made the doctor feel that it wasn't listening to him.

During the initial discussion, the doctor was asked what was really troubling him about the case. He was puzzled, and found the question difficult to answer. Although he strongly suspected that Sylvia's 'missing 3 days' were the result of a suicide attempt, he had not asked her directly (or even indirectly) whether she had tried to take her own life. The tension between mother and daughter (which made the doctor feel uncomfortable) seems to have been due to the daughter's anger with her mother for trying to kill herself. The doctor evidently felt that he had to keep out of this argument. Everything connected with suicide had to be under-

stated and marginalised. Once we know about the death of his own grandmother, this behaviour becomes understandable. Perhaps the anger of the daughter reminded him of his own mother in her postnatal depression, grieving angrily over her own mother's desertion. We cannot know and do not need to know what was going on in the doctor's unconscious feelings. What is clear is that his defences moved quickly in to protect him and there was no question of confronting Sylvia about her suicidal actions. Their collusion was sealed by a kiss. But perhaps the kiss also expressed their warm and enduring feeling for each other and strengthened Sylvia's will to continue living.

In retrospect, there were clear signs that a piece of the puzzle had been missing at the outset. After the first presentation a member of the group had verbalised the problem: 'The patient is puzzling enough but it's the doctor's distress that is puzzling to me'. The doctor's courage in recounting his personal experience of suicide produced the key to the puzzle and it is fascinating that he had no memory of the suppression of the vital word on the discharge summary, somewhat mirroring the patient's 'amnesia' about her lost 3 days.

This case shows the way in which some of a doctor's deepest personal feelings can powerfully influence his professional conduct. We may like to pretend that the 'professional self', wearing its physician's white coat, can operate independently of the 'personal self'. The more we studied our case histories, the more we realised that the two selves are indivisible, and the defences which spring up to protect our personal feelings will often impair our performance as professionals.

In some cases the influence of the personal self is obscure, difficult to detect. In the first three examples in this chapter the defences seem to be there simply to protect the professional self from external threats. The ME patient threatened to swallow up all the doctor's time; the hypothyroid scientist refused to accept the doctor's medical authority; and the young mother, Tina, tried to flout the house rules by insisting on a second consultation for herself. Nevertheless, on closer examination, it is possible to see that there might easily be a personal factor at work as well. Would the ME patient's manner really have upset other doctors to the

same extent? Did the scientist's doctor discern something in her non-compliant patient which made her behaviour personally offensive? Did Tina's doctor find that the intensity of her distress rang some sort of bell in the depths of his own experience?

We can only speculate because the personal factors, if they existed, remained well below the surface. In the last case, on the other hand, the personal factor emerges clearly. In the next chapter we shall look at personal factors in greater detail.

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