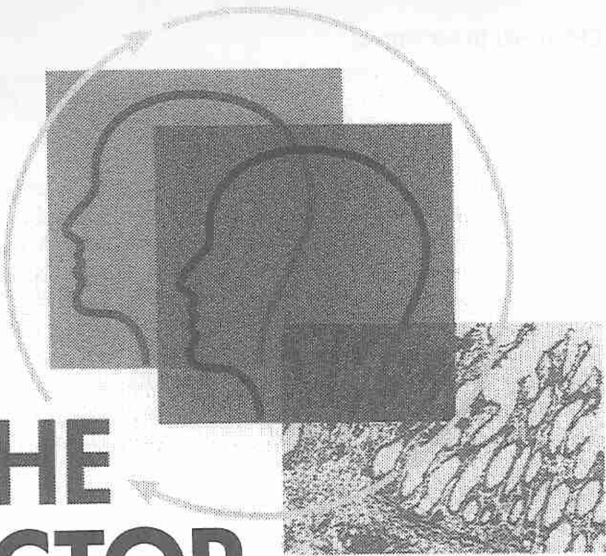
Second edition produced in facsimile with an introduction by

John A Balint MD
Professor of Medicine and Director, Center for Medical Ethics,
Albany Medical College, NY

a 1534283



THE DOCTOR, HIS PATIENT AND THE ILLNESS

Michael Balint MD

EDINBURGH LONDON NEW YORK OXFORD PHILADELPHIA
ST LOUIS SYDNEY TORONTO 2000

R
727.3
B186

HSL15/7873

CHURCHILL LIVINGSTONE
An imprint of Elsevier Limited

© The estate of Michael Balint 2000

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without either the prior permission of the publishers or a licence permitting restricted copying in the United Kingdom issued by the Copyright Licensing Agency, 90 Tottenham Court Road, London W1T 4LP. Permissions may be sought directly from Elsevier's Health Sciences Rights Department in Philadelphia, USA: phone: (+1) 215 238 7869, fax: (+1) 215 238 2239, e-mail: healthpermissions@elsevier.com. You may also complete your request on-line via the Elsevier homepage (http://www.elsevier.com), by selecting 'Customer Support' and then 'Obtaining Permissions'.

First edition 1957
Second edition 1963
Millennium reprint of second edition 2000
Reprinted 2002, 2003, 2005

ISBN 0 443 06460 1

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloguing in Publication Data
A catalogue record for this book is available from the Library of Congress

Medical knowledge is constantly changing. As new information becomes available, changes in treatment, procedures, equipment and the use of drugs become necessary. The editors, contributor and the publishers have taken care to ensure that the information given in this text is accurate and up to date. However, readers are strongly advised to confirm that the information, especially with regard to drug usage, complies with the latest legislation and standards of practice.

ELSEVIER your source for books, journals and multimedia in the health sciences
www.elsevierhealth.com

Working together to grow libraries in developing countries
www.elsevier.com | www.bookaid.org | www.sabre.org
ELSEVIER BOOK AID International Sabre Foundation

The publisher's policy is to use paper manufactured from sustainable forests

Transferred to Digital Printing 2006

Commissioning Editor: Timothy Horne
Project Manager: Fiona Young
Designer: Erik Bigland

INTRODUCTION

It is an honor and a pleasure to write the introduction for this millennium reprint of my father's book.

"The Doctor, His Patient and the Illness" originally published in 1957, was the first fruit of work started about 1950 by Michael Balint with his wife Enid at the Tavistock clinic. Michael Balint's interest in the psycho dynamics of the relationship between patients and their primary care physicians goes back to the early 1930's in Budapest. There, under the auspices of the Hungarian Psychoanalytical Society, he started seminars with general practitioners. These ultimately were abandoned because of unwelcome interest by Admiral Horthy's secret police, who thought the group was a subversive organization.

In January of 1939 we moved to England and settled in Manchester. My mother, Alice Balint, died there in August 1939. At the end of World War II, we moved to London from Manchester where Michael Balint joined the Tavistock Clinic. There he met Enid, later to become his wife, who was running teaching and research groups for social workers. They decided to apply her technique to research and training groups for general practitioners. John Sutherland, the Medical Director of the clinic gave his strong support to the project. The timing of this project was serendipitous. In 1948, the National Health Service was inaugurated in Great Britain. The role of general practitioners was dramatically changed because the NHS removed them from inpatient care entirely. This resulted in a sense of loss of status and purpose. The nascent "Balint Groups" provided a new sense of confidence and mission. These groups ultimately spread around the world, and in turn gave birth to the International Balint Society. In 1996, on the centenary of my father's birth, a conference was held in Budapest in honor of the occasion, and was attended by physicians from all five continents. It was clear from the presentations and discussions at that conference that the ideas launched in 1957 are indeed alive and well, and growing.

The work of the original group of general practitioners with the leadership of Michael and Enid Balint led to the recognition of several fundamental features of the patient-doctor relationship. These include the *basic fault, the apostolic function of the doctor, the mutual investment company, the doctor as drug, the deeper diagnosis,* and *the conspiracy of anonymity and of silence.* These features emphasize the critical importance of understanding the patient as a person, who happens to

under Dr. H., possibly involving several upheavals? Which of these doctors would have given him the best chance? Or, would Miss F. have been converted successfully to Dr. R.'s psychosomatic belief, ending up in marriage, as happened in Cases 10 and 23? Would Dr. M. have been able to make her accept the feminine rôle as he did in Case 21? Or would she have run away from either of these doctors?

These are cardinal problems, not only of general practitioner psychotherapy but of all psychotherapy, and they are far from being solved. They are, in many ways, unsolved problems for the psychiatrist too. Most of what he knows about these processes is contained in the psychoanalytic literature on the theory and practice of "interpretation." It must, however, be stressed that, in spite of the many papers written on this subject, our knowledge is very much in its infancy. Then there is the much smaller literature on "acting out" by patients, and how the therapist should deal with it. But all this refers only to events in the strictly controlled psychoanalytic situation. The extent to which these findings will prove to be applicable in general practice remains to be seen. In Chapter XIII, I discussed some significant facts which cannot fail to make us psychoanalysts cautious in extending the rules of psychoanalytic technique in their present form to psychotherapy in the doctor's surgery. We know too little to be dogmatic.

The seminar found the consequences of this unsatisfactory but undeniable state of affairs difficult to accept. Time and again general practitioners asked the psychiatrist to teach them what was right and what was wrong. Only with reluctance did they come to accept the fact that we do not know enough to be able to lay down hard and fast rules, to state categorically that this approach was definitely wrong, that technique questionable, this attitude certainly helpful, that interpretation timely and correct. The psychiatrist, however pressed, could point out problems and possibilities, but only seldom could he give positive advice.

His chief way out was to emphasize again and again that we were members of a research team, exploring and trying to map out hitherto unexplored regions of medicine. This leads us back to our point of departure, the recognition of the need for a pharmacology of the most frequently prescribed drug, the doctor. The study of the "apostolic function" is perhaps the most direct way of studying the chief—the therapeutic—effect of this drug.

CHAPTER XVIII

The Doctor and His Patient

IN the two previous chapters I discussed at some length the doctor's apostolic function, which compels him to convert his patients to his own standards and beliefs. From another aspect the process of conversion may be described as education or training. I have mentioned several times that in the last hundred years or so we doctors have successfully trained our patients, in fact the whole population of the western world, to expect a routine clinical examination and to accept it without much embarrassment or apprehension. I have also pointed out that doctors have not trained their patients to expect a frank discussion of their personal problems as a necessary part of the examination. This lack of training, however, does not seem to be an insurmountable obstacle. To repeat what was said in a previous chapter, several doctors reported that, as the rumour of their psychological interest had time to spread in the neighbourhood i.e. a year or so after they had started to give "long interviews," patients on other doctor's lists came to them for psychological examination.

Some more or less spectacular examples of this sort of education were discussed in Chapter XVI, such as the problem of night calls, of changing from one doctor to another, etc. Another, more important field of this education is the training of the patient to adopt the right attitude towards his illness. By right attitude I mean one that creates good possibilities for therapy.

It is difficult to describe in detail what this process of education should aim at and what methods it should use, because it has so many different aspects. In general, one would like to say that patients should be educated to mature responsibility towards their illness; but it is necessary to add a rider; with certain outlets for dependent childishness. As so often in medical practice, here too the problem is that of proportion; how much maturity should be demanded, and how much childlike dependence on the doctor

should be tolerated? Or, in other words, how much pain suffering, discomfort, limitation and restriction, fear and guilt, should the patient bear unaided, and at what point should the doctor start supporting him? In general, the greater the maturity of the patient, the better will be the results of a purely "objective treatment" and the less will be the patient's need of "subjective sympathetic therapy," and vice versa. Here we find another important field of medical practice unconditionally surrendered to the doctor's common sense, i.e. his apostolic function. This is the more regrettable as by his approach he prepares the ground for the future. One might almost say that the general practitioner, in fact, starts the treatment while the patient is well, and that the actual treatment prescribed when illness occurs is only a continuation of a treatment already in progress. Incidentally, this is not necessarily the case with us specialists.

Of course, the process of education is most intense during an illness, either of the patient himself or of one of his close relatives, neighbours or friends. In the initial stage of an acute illness, when the patient is still under the impact of the first shock, that is, his illness is still "unorganized," the doctor is usually a support, allowing the patient to become dependent on him. When the first shock has passed, and the illness, instead of disappearing, becomes "organized," takes up a chronic form, if at all possible the general practitioner will try to enlist the patient's collaboration in working out an acceptable compromise between his accustomed ways of life and the demands of the illness. In other words, the aim should be to make the patient the umpire in this compromise, but it is rather seldom that this can be fully achieved. Few people have the degree of mental and emotional maturity necessary for such a difficult task. The two well-known extremes are the over-exacting patient, who cannot allow himself any relaxation, and the over-demanding and over-anxious patient, who cannot have enough. Here obviously great variations are needed, according to the patient's mental and in particular emotional maturity. Every illness, however slight, always means acquiescing in the renunciation of part of one's accustomed freedom and pleasures. Incidentally, it often happens that young people are able more easily to accept these bitter facts than older ones.

In educating the patient the doctor is greatly helped by what may be called the patient's pride in his illness. This is especially

noticeable if it is a rare illness, or if the patient succeeds in coping with it to a commendable degree. This attitude is in no way peculiar to illness. Every form of growing up or maturing is greatly helped by the individual's pride in his achievements.

One must not forget, however, that the doctor is faced with great technical difficulties in this field. We have not had time to study this question in detail in our research, so all I can do is to make some brief and disjointed observations on the matter. One of the problems is *how much regression*, i.e. *returning from adult to more primitive, childish behaviour, should be permitted to the patient, and when.* In some cases the doctor may be compelled to advise his patient—or to push him gently or even forcibly—out of his maturity into some regressive, dependent attitude. There are some people who have to assume and carry more responsibility than is good for them, especially when they are ill. The opposite problem is *how much maturity should be demanded from any individual, how fast, and at what point.* As is well known, some people simply cannot bear any increase of their responsibility or apprehensions, and if it is thrust upon them they have to shed it by becoming dependent on some authority.

A well-known way of helping patients suffering from some irreversible, chronic illness which has to be accepted with all its consequences is to arrange for them to meet somebody who has achieved a good adaptation to the same problem. For some people it is easier to imitate than to devise a method for themselves.

The doctor must be on his guard, however, because *any privation imposed on the individual by his illness may be felt as coming from the doctor.* For instance, many patients feel that if only the doctor were kinder or more sympathetic, he would allow them more drinks, later hours, more interesting food, more smoking, etc. It is easy to observe the gradual emergence of this resentment, but it is much more difficult to cope with it or to prevent it. This resentful fantasy often leads to feelings of anger and hatred against the doctor for his lack of understanding, unsympathetic prescriptions and strict dietetic regulations; leading to irritation, and often—as a reaction to it—to fears and anxieties that the doctor might retaliate in kind. On the other hand, for some people, especially those suffering from unconscious guilt or those of masochistic tendencies, any strict diet or mode of life is readily acceptable, because suffering means some relief from their guilt.

We know much too little about these problems. On the other hand, for the study of the problem of maturity—or, in psychological terms, of the strength of the ego—general practice is a most promising field. People's behaviour when falling ill or when first realizing that they are ill, and their ways and methods of coping with the consequences of chronic illness, could provide as rich material as have observations of maturing children. Some intriguing problems belonging to this sphere are: What are the factors that determine the development of a childish-dependent, or a mature-independent attitude towards the illness? Are these attitudes inherent in the illness, in the patient's individuality, or are they brought about—or perhaps only reinforced—by the interplay between the patient's "offers" and the doctor's "responses?" We have come back again to the pharmacology of the drug "doctor," this time to one of its most important side-effects. And again, I have to ask for more research by general practitioners, because it is they who first see the patient when he falls ill, and it is they who can continuously observe the development of his ways of coping with the illness.

Every doctor will, I think, agree that *the patient's attitude towards his illness* is of paramount importance for any therapy, and that it is the doctor's task to "educate" the patient to become co-operative. I wish to illustrate some of the difficulties encountered in this field by a case history. The case chosen, though somewhat complicated, is not unusual. The complications were caused by the interaction of several factors, some of them already discussed: the child as the presenting symptom (Chapter III); the intervention of a consultant, leading to all the complications described in Chapters VII–IX; and the consequences of giving or not giving a name to the illness (Chapter VI). Then there was present a not admitted disagreement between consultant and general practitioner about the aims and methods of training—in this case the patient's parents; and lastly the factor to be discussed in the next chapter, the patient's—here the parents'—need for the illness to be taken seriously. The general practitioner, though right in all other points, failed to notice this need; thus his diagnosis of the whole situation remained incomplete—not "deep" enough; his treatment of the case and his training aims and methods, though objectively correct, became unacceptable to the parents and they had to change their doctor.

In one of our recent seminars a general practitioner reported Case 27 as follows—

Case 27

A twelve-year-old girl was very ill with high temperature of unknown origin. I had no idea what was the matter with her. The parents were very, very nervous and worried people, and so the moment I guessed this I said, "Why not call someone in?" and they said, "That's just what we felt." So I said, "Shall I call somebody?" and they said, "Yes," but then the grandmother rang up and said she had a relative, a child specialist. The relative came and said, "This is paratyphoid," but in my opinion it was not.

Anyway, the next day came, and the mother said, "The child has paratyphoid, what should we do?" and, though I said, "I don't know whether this is so sure," knowing that he was a specialist, I did not dare to say I did not believe it, so I said that we must wait for the bacteriological examination and that we would leave things to the specialist. So we did. The stools were negative. The parents rang up in the meanwhile twice daily for stool reports, it was really dreadful for everybody. The specialist was called again and said, "There is no doubt this is paratyphoid."

He was an extremely nice specialist, and even came to see me. We had coffee and drinks together. I learnt from him—he stayed about an hour—his life history. He is certainly very clever, and he talked a lot. He knows everybody, he lectures and he has appointments. I explained to him there were many problems involved, e.g. that I was a National Health Service practitioner, who had to pay two calls a day and answer telephone calls during the night because a specialist said it was paratyphoid. I proposed the child should go into hospital, partly to get her off my hands, and also in order not to bear the responsibility, because I really did not know what the illness was. He said he had so much experience of paratyphoid, and he was always there if needed.

The next day I had half an hour with the mother, because she refused that the child should go into hospital. She said the child would be unhappy to go into hospital and could not get things there. I told her that *she* would be very unhappy without the child. By the way, the child is a twelve-year-old, very intelligent girl. I tried to persuade the mother to accept the view that she was approaching the situation egotistically, and that it would be best for everybody, and especially for the child, however hard it might be for her. She insisted on seeing the specialist again, and he told her the child need not go into hospital. This was on Saturday, and on the same night the father came to fetch me and I had to go there. On Sunday he came again; I was not at

home, but he got from my wife the name of the doctor on duty. The doctor said the child must go to hospital, and they rang up the specialist again. The specialist said on the telephone to ring up the G.P. On Monday morning I got the blood report. It was not paratyphoid, but glandular fever. So everybody was wrong. The girl was still at home, but I got a telephone call that I need not go there any more because they realized that another doctor would be better for the whole family; and I also have come to the same conclusion.

Now, there were a number of people involved. First, the personality of the consultant. He talked much, he is a very nice, very clever man, and the diagnosis paratyphoid was certainly one of many which should be considered—but he stated his opinion emphatically and to the parents. I discussed this problem when he was with me, and he insisted it was the best thing to tell the parents the serious diagnosis. I disagreed with this. I thought of telling them it was a chill, but he refused. Now, he is a good children's specialist, and he impressed me very much, because he knows a lot better than I. I tried to insist on a less serious diagnosis, or on sending the girl to hospital. He disagreed with me, and told the parents exactly the opposite of what I had told them, and the parents lost confidence in me. Really it is not an easy problem to solve.

There are many interesting problems in this case history which were eagerly taken up by the seminar. First, was it wise to accept an unknown specialist, proposed by the family, especially as he was a relative? An unknown specialist always means hazards for the general practitioner, as no working relationship has yet been established between them. If any disagreement arises, usually the specialist's greater reputation carries the day, which in the long run may not always be a gain for the patient. This danger is doubtless increased when the specialist has ties of kinship or friendship with the family.

It was only after further questioning that we found out that at the specialist's first visit the two doctors duly examined the girl together, withdrew for discussion, but could not agree on the diagnosis. The specialist insisted that it was paratyphoid, while the general practitioner remained unconvinced, and did not want to commit himself. In the end the specialist's opinion prevailed and was communicated to the family without mentioning that the general practitioner did not agree with it; in this way the thinly disguised disagreement between the two doctors and the concomitant underground strife were started off.

Interestingly enough, the point about which the two doctors openly disagreed was whether the girl should or should not go to hospital. This was partly due to the difference in their professional relationship with the family; one was a specialist, called in only occasionally and paid for each of his visits, the other a panel doctor who had day and night to be at the service of over-anxious and rather inconsiderate parents whose demands went far beyond what was "objectively" reasonable. The problem is what to do with such people, how to "educate" them to a "reasonable" attitude. I shall come back to this, but first I wish to mention one more topic of the discussion.

We turned to the question of how it happened that the specialist visited the patient twice without the general practitioner. Should a doctor put up with this? Had the specialist behaved correctly? Further details were disclosed, and we learnt that the first such visit had taken place on the doctor's half-day off. The family had had another attack of anxiety, bombarded both the doctor's house and the specialist with telephone calls, but the specialist had correctly refused to visit the child alone. In the end the doctor's wife had telephoned him and asked him as a favour to go and reassure the family; it was only then that the specialist agreed to go.

This is a good example of how difficult it is for two doctors with different apostolic beliefs to understand each other. It is true that the issue in this case was complicated by subsidiary factors, above all their difference in status, and their disagreement about the diagnosis. The latter, however, was a minor problem in this case, although scientific, objective medicine would certainly put the chief emphasis on it. So did our doctor, who was really hurt that, in spite of the undeniable fact that his diagnosis had been correct, he was made the scapegoat and punished at the end.

This case is also exceptional in that both general practitioner and specialist were not only absolutely correct and superficially co-operative, but also tried to be really friendly, to the extent of sitting down, having a long talk and getting to know each other—a rather uncommon event. Yet, in spite of all this good will they simply did not arrive at a mutual understanding.

One of the reasons for this confusion of tongues was the difference in their apostolic beliefs about how much anxiety a

patient—or her parents—should be expected to bear unaided; the other, however, was that they stopped at a superficial level of diagnosis. It is true that they disagreed on this level, but the difference between paratyphoid, glandular fever, or high temperature of unknown origin, provided the febrile condition does not last longer than, say, a week, is not terribly important in general practice, though admittedly important for scientific medicine. I am prepared to be taken seriously to task by scientifically-minded doctors, and I readily agree that in some cases the differential diagnosis may be essential for the right treatment, but perhaps I might be permitted to ask irreverently: In what percentage of the cases treated in general practice? And further, is its importance so great that it is permissible to stop at that level and totally neglect the "deeper" diagnosis? This was exactly what our general practitioner did in this case, and though his doubts about the superficial diagnosis of paratyphoid proved to be justified, his eventual punishment was perhaps not so unfair, because of his failure to aim at a "deeper," more comprehensive, diagnosis.

The seminar came to the obvious conclusion that there exist people who must be allowed to become anxious if anything goes wrong, and that their anxiety must be accepted and properly treated by the doctor. They have to be frightened, and if the doctor sets about reassuring them they have to run from pillar to post till they find a reason to be frightened. These people have to have a serious illness, a chill will not do for them. In this way the specialist was right—though his superficial diagnosis was wrong—and the general practitioner, in spite of his correct superficial diagnosis, was unhelpful. His failure was the greater as he had known the family well for years.

Thus, the doctor's first task is to arrive at a better, more comprehensive, diagnosis. The next question is what to do next. If he can find out why the patient—or the patient's parents—have to be frightened, he should obviously aim at diagnosing the cause and at treating it. Unfortunately, in fairly serious cases such as that just reported this is but seldom within the general practitioner's possibilities. But, if he cannot do this, he must still give the patient a rational symptomatic treatment. In a case of headaches, for instance, in which no cause can be found, the patient has to be given something—aspirin, codeine, and so on—or he will not be able to carry on, either with life in general or with his doctor. That brings us back to our subject, the education of the patient to a sensible attitude towards his—or his child's—illness. When should we give palliatives, how much, and for how long? When should we stop or reduce them and ask the patient, in his own interest, to accept a certain amount of suffering or anxiety as inevitable? As already stated, we do not know enough about these eminently psychological problems and must ask for further research.

In this case history we discussed the needs of over-anxious people. This, however, is only one special case. All patients "offer" us their various needs, and we doctors must "respond" to them in one way or another. By far the commonest answer is to *give* the patient something. Perhaps the doctor's most frustrating experience is being unable to give anything "rational." This giving, however, has another aspect. With it, especially if we are convinced that what we are giving is "good" for the patient, we push the blame on to him. Henceforward it will be his fault if he does not get better.

In the seminars we often had cause to wonder whether a prescription had really been given for the patient's or the doctor's benefit. It is important for any mutually satisfactory relationship that both should be able to feel that something "good" has been done, otherwise the conclusion is inevitable that the doctor is in some way the cause of the suffering by failing to cure or relieve it. Some patients slide irresistibly into this hostile conclusion, most of them because of their personality, and some perhaps justifiably. What is more interesting and more important for our subject is that there are a number of doctors who feel the same, i.e. that they have failed the patient. The majority of these are recruited from young general practitioners. Junior hospital staff have ample opportunities for diluting their responsibility, and—except perhaps during a surgical intervention—it is rare for one doctor alone to be responsible for a patient in hospital. But the general practitioner is nearly always alone with his patient, and has no institutional means of diluting his heavy responsibility. No wonder, then, that he has to try everything to convince himself that he has really given his patient something of value.

I must mention again that our knowledge of the dynamic factors active in the doctor–patient relationship is uncertain and

scanty, and that we do not even know whether we are aware of all the important factors. Here at any rate is a sample of them. In the first place, the patient is nearly always frightened, though to a varying degree, and he is in the dark. He comes to the doctor, who knows. Then the patient is afraid about the future, and expects comfort. Often he is suffering, and hopes for relief. Patients have to face the fact that they are ill, i.e. temporarily or perhaps permanently incapacitated. Some are really grateful when the doctor, so to speak, allows them to be ill; others deeply resent it. The doctor has often to be the umpire in a complicated reality situation, such as when a patient is overdriving himself to cope with his responsibilities and his family expects this from him, or when a seriously ill patient is not properly looked after, or a patient with a non-incapacitating chronic condition demands inordinate attention and care from his relatives, and so on, *ad infinitum*.

As will be seen from this enumeration, there are many factors in every doctor–patient relationship which push the patient into a dependent-childish relationship to his doctor. This is inevitable, and the only question is how much dependence is desirable. The obvious answer is that it will depend on the nature of the illness, the patient's personality, and—we propose to add—the doctor's individual apostolic beliefs. This beautiful and true sentence, however, is only a cloak for our ignorance. The real question is how much dependence constitutes a good starting-point for a successful therapy and when does it turn into an obstacle. At the beginning of the chapter we discussed the necessity of educating the patient to a reasonably mature attitude towards his—or his child's—illness. How do childish dependence and a reasonably mature attitude fare together, how much of each must be taken in order to obtain a good therapeutic mixture? For the time being we can only point to these important problems, but cannot offer any well-founded answers. The only thing we know for certain is that common sense, i.e. apostolic belief, is an unreliable and untrustworthy guide.

To quote two common instances in which the doctor has to solve this problem of finding the right proportions: How often should a chronic invalid be visited, and how much time should be spent with him on each occasion? When should daily, or even twice-daily, visits be discontinued in an improving acute illness?

Apart from the complicated question of fees, what is the right "practice" that creates a good basis in the patient as well as in his environment for the treatment of any future illness? As the last case history shows, the answer to these questions is far from self-evident or a matter of simple common sense.

The lack of properly validated techniques in this highly important field is the more regrettable as the doctor's relationship with his patients—if we disregard the "nomads" (see Chapter XIX)—is lasting and intimate. Whatever he does cannot fail to influence his patient, and these influences will add up in the long run. In this respect it does not make much difference whether the patient pays fees, i.e. whether he feels in some way that the doctor is his personal servant, or whether some anonymous institution appoints the doctor, lending him a reflected halo of authority with all the ambivalence fostered by it.

The important thing is that the education is not one-sided only. Both patient and doctor grow together into a better knowledge of each other. This mutual influencing is not a simple process, developing either in an entirely good or entirely bad direction. Both doctor and patient alike must learn to bear some frustration. The doctor is not automatically available when he is wanted, he does not like to be called out during the night or on Sundays, and even if he comes, he cannot cure everything immediately; some pain and some anxiety must remain unrelieved, at any rate for some time. In the same way, the patient is often not appreciative of the great service that the doctor renders him, does not show gratitude, is inconsiderate, makes unreasonable demands, is disrespectful, etc., etc. On the other hand, there are joint memories of such things as a correct diagnosis and timely action which averted a major danger, of the many little acts of help readily given and gratefully accepted in many a petty trouble, of some serious shock which the doctor helped to bear, and so on.

It is on this basis of mutual satisfaction and mutual frustration that a unique relationship establishes itself between a general practitioner and those of his patients who stay with him. It is very difficult to describe this relationship in psychological terms. It is not love, or mutual respect, or mutual identification, or friendship, though elements of all these enter into it. We termed it—for want of a better term—a "mutual investment company." By this we mean that the general practitioner gradually acquires

a very valuable capital invested in his patient, and, *vice versa*, the patient acquires a very valuable capital bestowed in his general practitioner.

In his long years of acquaintance with his patient the general practitioner gradually learns a vast amount of important details. He knows the patient's background, several members—often several generations—of his family, the type of people who are his friends, the shop, office or factory where he works, the street and the neighbourhood where he lives, etc. He knows what his friends or neighbours say or gossip about him, what his work record is, how he got to know his wife, and what kind of children he has. But these are only the minor capital assets. The real assets are—as we have just seen—the common experiences in health and especially in sickness, how often and with what sort of complaints the patient comes for medical advice, how he behaves when something unexpected happens, when a member of his family falls seriously ill or dies, or when he has a minor or major illness. In the same way the patient learns how much and what kind of help he can expect from his doctor. Obviously it is of paramount importance that these capital assets, the result of persistent hard work on both sides to gain the other's confidence and to convert him to one's beliefs, should not be wasted, that is to say, that they should be used in such a way as to yield an adequate return to both patient and doctor.

Here again I have to repeat my refrain. This is a most important field, which medical science has neglected. One of the reasons for the neglect of the problem is that the research workers—our hospital specialists—have hardly any contact with it. It is the general practitioner's domain, in fact it is his daily work. It is only he who can find out which methods can be used with profit and which methods are to be avoided when "educating" his patients, when building up and managing the assets of the mutual investment company.

The consultant, in contrast to the general practitioner, is no party to this mutual investment company; he has to start from scratch, unless the general practitioner is able to prepare both his patient and his consultant for the interview. In other words, the general practitioner should be able to mobilize and lend part of the capital invested in him by his patient to be used during the specialist's examinations. That this does not happen as often as it

should is the fault of general practitioners and specialists alike. The oft-quoted request, "? chest, please see and advise," is just as helpful in this respect as some of the letters by specialists quoted in this book. On the other hand, the consultant has advantages of other kinds; he is an outsider, a stranger, his approach is fresh, his views not biased by previous experiences with the patients The illness for him is not so much a human as a scientific problem. Similarly, to the patient the consultant is an unknown V.I.P., a blank sheet, a higher authority to whom he can look up; whereas his doctor is an old acquaintance, whom he knows only too well, with all his habits, human weaknesses, even his personal problems and shortcomings.

A further aspect of the difference between the casual consultant-patient relationship and the mutual investment company is its duration. Consultants (including those in the psychiatric departments of hospitals) usually see a patient a few times only, and hardly ever follow up the results of their examinations or therapeutic efforts. As we all know from the literature, a reliable and thorough follow-up is such a rare event that its results are usually published. The general practitioner is in an entirely different position because, whether he likes it or not, he has to follow up his cases; the majority of his patients come back to him—either grateful or grumbling—again and again. Somehow general practitioners seem to be reluctant to talk about their follow-up experiences, though in fact they could be the real judges. They content themselves with complaining about inefficient consultants, but only rarely do they pluck up courage and spare the time necessary to put their experiences constructively in writing.

CHAPTER XIX

The Patient and His Illness

THE preceding chapters—in fact, nearly the whole book—have been taken up by discussion of the doctor-patient relationship. This certainly cannot be altogether right. An illness starts before the doctor appears on the scene, in some cases considerably before. I remember well one of my clinical teachers repeating a pet phrase to us students, "How much easier would the doctor's task be if only cancer, syphilis and being dirty caused pain!" Unfortunately there are other illnesses which do not cause enough pain, discomfort or fear, and permit the patient to stay away for much too long. Conversely, this means that there must be a relationship between the patient and his illness, irrespective of any doctor.

This is undeniably true, and it must be added that it is a highly important relationship, which well merits proper examination. There are many reasons why I have treated it so meanly in this book. One of them is my training and practice. Being a psychoanalyst, nearly all my experience stems from what I have learnt in the psychoanalytic situation. Nearly all psychoanalytic discoveries have come from this source, which is characterized by a peculiar, lopsided, two-person relationship. One partner in this relationship is in the position of a superior, in so far as he has more knowledge, better and deeper understanding, can and does explain—i.e. interpret—the events that happen between the partners. In return, highly charged emotions are transferred to him which he has to tolerate. The other partner in this peculiar relationship is comparatively weak, has come for help because he cannot understand his problems by himself, because, in other words, certain things are inexplicable to him. This creates rather high tensions in him; one way of relieving the strain is to transfer his emotions to the stronger partner, his analyst.

It is easy to see why we analysts cannot help explaining any

doctor-patient relationship in the light of our own experience with patients in the analytic situation. It is important to bear in mind that this is tantamount to explaining it in terms of the relationship between a child and the adult. But it also means that we have a much scantier knowledge about any one-person situation; a situation in which there is no partner to whom emotions can be transferred, in which a man is essentially on his own. Situations of this kind are probably as important as the two-person situations extensively studied by analysts. A good example of this one-person situation is, for instance, artistic creation. All the psychoanalytic explanations proposed try to turn it into a kind of two-person relationship, though it is obvious that no second person is actually present, that the artist in fact creates his work of art by and out of himself. The rather pedestrian and obvious analytic explanation is to consider the work of art as a kind of child born by the creator artist. This conception is strongly supported by the imagery of the languages known to me, all of which use words borrowed from child-bearing to describe the act of creation. To quote a few: the artist conceives an idea, is pregnant with it, has labour pains, gives birth to a work of art, some of his ideas miscarry or are stillborn, etc. All this shows that this explanation, though essentially true, is rather shallow, does not do justice to the richness of the real experience.

Roughly the same is true of our theoretical conceptions about illness. We know that for some reason or other during the initial, "unorganized" period of their illnesses—which may last from a few minutes to several years—people gradually withdraw from their environment and first create and then grow the illness on their own, *out of themselves*. This period, which, according to our experience, is of paramount importance for the future fate of the illness, and of the patient, is only poorly understood. Our psychoanalytic methods do not provide us with an adequate enough technique to follow in detail the patient in his work and struggle with the growing illness. During this time, in the same way as during the artistic creation, no second person is yet present, and certainly no external partner to whom emotions can be transferred and thereby made accessible to our analytic methods. So again, as with artistic creation, one of the psychoanalytic explanations considers the illness as a kind of child, in this case a bad, damaged child which, instead of bringing pleasure, brings pain

and disaster to its creator. (This imagery may become conscious and be expressed in exactly these words by certain patients, especially women suffering from a growth.) I have to repeat what I said before. Although this explanation is very likely true, it is certainly superficial and incomplete.

If direct psychoanalytical observation does not provide satisfactory data on which to build a theory, let us turn to medical science, which during the centuries has developed certain theories about the nature of illness. Apart from their scientific value and usefulness, all of them are also determined psychologically, i.e. they express one aspect or another of man's relationship to his illness. I propose to discuss only what is the most important theory at the present day—although, if I am right, its importance is gradually waning. In its simplest form this considers the individual as essentially healthy and well integrated. His harmony is disturbed by an *external agent* which penetrates the defences of the body (or the mind). The agent may be a physical force, causing bruises, wounds, concussions, fractures, etc.; a chemical substance such as acid, poison, lethal gas, caustic fluid; or a germ causing infection; or even a mental trauma. The illness, according to this theory, is the sum-total of the original damage and the body's (or the mind's) defences mobilised against it. The psychological source of this theory is the belief—and hope—alive in all of us, that we are essentially "good" and that anything "bad" must come from outside. Thus the appropriate treatment is to get this something "bad" out of us. Innumerable techniques, from primitive magic and exorcism, through "purgatives," enemata and phlebotomy to many unnecessary surgical operations, have been based on this primitive idea.

On the whole, one or both of these two opposite ideas shape—or perhaps only colour—the patient's conception of his illness. Roughly the same is true of medical theories of illness. According to the first, the patient was healthy, whole and "good" until something in him turned "bad." According to the second, the "bad" thing had nothing to do with the patient—it came from outside and is, in the true sense of the word, a "foreign body." In both cases the "bad" thing threatens him with pains, privation, or even destruction unless he can defend himself against it or get rid of it altogether, either on his own or with his doctor's help.

Which of these two opposite conceptions is true, or at any

rate, nearer the truth? The answer is difficult. The shorter the duration of an illness—and with it the period of observation—the better does it fit in with the theory of the external agent. A bruised finger or a bad attack of 'flu can be confidently ascribed to something "bad" coming from outside. But, if a patient returns periodically with some minor injury, we cannot help thinking of accident-proneness or deliberate absenteeism; and if he "catches" too many infections, we talk of hypersensitivity, allergic condition, etc. The longer the period of observation, the more the impression grows that an illness is almost as much a characteristic quality of the patient as the shape of his head, his height, or the colour of his eyes.

This leads directly to one of the eternal problems of medicine: Which is the primary, a chronic organic illness or a certain kind of personality? Are the two of them independent of each other, interdependent, or is one the cause and the other the effect; and if so, which? Do sour people eventually get peptic ulcers, or does a peptic ulcer make people sour? Are bilious attacks, or even gallstones, produced by the bitterness of some people, or do they become bitter because of their painful attacks? Until recently it was tacitly assumed that every chronic disease developed a "neurotic superstructure." In the last forty years or so, mainly under the influence of pioneers like G. Groddeck, S. Ferenczi and S. E. Jelliffe—all three originally general practitioners—medical thought has been gradually changing. This change has produced what is now called psychosomatic medicine.

This, of course, is not the end of the matter. The next step is to ask what is the origin of a psychosomatic or any other disposition. If I am right, psychoanalysis is about to develop a new conception which may be called "basic illness" or perhaps "*basic fault*" *in the biological structure of the individual, involving in varying degrees both his mind and his body*. The origin of this basic fault may be traced back to a considerable discrepancy between the needs of the individual in his early formative years (or possibly months) and the care and nursing available at the relevant times. This creates a state of deficiency the consequences of which are only partly reversible. Although the individual may achieve a good, or even very good, adjustment, the vestiges of his early experiences remain, and contribute to what is called his constitution, his individuality, or his character make-up, both in the

psychological and in the biological sense. The cause of this early discrepancy may be congenital—i.e. the infant's needs may be too exacting—or environmental, such as insufficient, careless, haphazard, over-anxious, over-protective, or only not-understanding care.

Should this theoretical approach prove correct, all the pathological states of later years, the "clinical illnesses," would have to be considered symptoms or exacerbations of the "basic illness," brought about by the various crises in the individual's development, both external and internal, psychological and biological.

If we accept this idea, the controversy between the external and internal origin of illness resolves itself into a complemental series. The more intensive one factor is, the less is needed of the other. The picture thus emerging is that of a conflict between the individual's possibilities and his environment. Let us suppose the "basic fault" was not too severe, thus enabling the individual to develop fairly well, i.e. to adjust himself without undue strain to a large enough variety of conditions. Should, however, the strain on him suddenly increase, or involve areas which were influenced by his "basic fault," he is faced with a problem which may be too difficult for him. From this "average" case imperceptible steps lead in one direction to the extreme case of the unviable infant and of Huntington's chorea, or in the other direction to a massive infection or to a bomb dropped by the enemy.

I readily admit that my idea is far from being new. What is original in it is the bringing together into one picture the illnesses of adulthood and the experiences in the early formative period of life and relating them to each other. A further advantage of this theory is that it may provide us with a working hypothesis for the understanding of the processes in the patient while he is alone with his illness. In any case, I wish to emphasize that the little we know about this important phase is the result of reconstruction from what we learn from the patient later, after his illness has forced him to consult us. Here again, general practitioners have a unique opportunity, inaccessible to anyone else. They may know, and often do know, the patient before he becomes overtly ill, when he is alone with his illness.

This situation changes fundamentally when the patient reaches the stage of complaining. Although his illness is usually still in

the unorganized state, he now needs—and finds—a partner, in one respect a superior partner, from whom he may expect help and on whom he may transfer some of his emotions. Here we analysts are at home and can use our methods with confidence, and—as I hope I have succeeded in showing—our ideas may be of some use to the general practitioner in his arduous task. The relation is by no means one-sided however. It is true that the general practitioner can learn a good deal from us about the all-important interaction between the patient's propositions and the doctor's responses prompted by his apostolic function. But it is equally true that we analysts can also learn a good deal from the experiences of general practitioners. For obvious reasons, this can only be mentioned but not discussed in this book.

So let us return to our main topic. We found that, when the patient is faced with a problem too difficult for him to cope with, partly or chiefly because of his "basic fault," his organization partially breaks down, and after some time, which may last from a few minutes to several years, he consults his doctor—*complaining of some illness*. This is a puzzling fact; in the doctor-patient relationship it occurs but seldom that patients come with a problem. In other words, patients consult their doctors only when, so to speak, they have converted the struggle with their problem into an illness. I am certain that a number of doctors will be startled by this formulation. What is wrong with this situation? they will rightly ask. The doctor's job is treating illnesses; of course, people come to them with illnesses. So far so good, but preventive medicine is also the doctor's task. Perhaps it would be desirable to change our apostolic function, and train our patients to consult us with their problems before the illness starts; the prospects of successful therapy might be much better in such an early phase. Then there is the possibility of an immense gain in our knowledge if we could find out what sort of people have problems but cope with them without illness, and what sort of people resort to illness. Very likely time will be another important factor. Medicine knows, for example, that cancer rarely starts before the age of forty, whereas a peptic ulcer hardly ever starts after forty. It is not impossible that these and similar empirical facts may have psychological roots, which would certainly be much more easily accessible to detailed study in the early period before the illness proper starts.

With the starting of the illness a number of secondary processes are also set in motion. One may say that the illness creates a new life-situation to which the patient must adapt himself. This readjustment drains off a good deal of his energies, much beyond what is needed by the physiological defensive processes, and the new situation may be considerably different from the immediately preceding one. This readjustment is a complicated, multi-dimensional process, and so I have to restrict myself to enumerating some of its most important aspects only.

One of the most primitive and powerful trends in the human mind is what, in technical terms, is called narcissism. This means, from our angle, that we feel ourselves whole, inviolate, imperishable, important, capable and, above all, lovable. Life and reality are not at all in harmony with this feeling; during our development and during our mature life our narcissism gets hurt time and again. It is a severe shock to realize, no matter whether suddenly or gradually, that because of illness our body (or our mind) is, for the moment, not capable, and perhaps will never again be fully capable of reassuring us that our hopes are still possible of fulfilment in some unspecified future.

Past experiences, especially during our childhood and adolescence, have taught us certain ways of dealing with such shocks. Our parents and teachers had a profound influence on this learning process and its results. Coping with an illness may be confidently compared with this process of maturing, and the doctor's rôle with that of our parents and teachers; just as the beliefs and convictions of our parents and teachers greatly helped or greatly hindered our development towards maturity, so does the doctor and his apostolic function affect us during illness.

For some people, falling ill is a severe blow, for others a welcome relief. There are people who, because of their serious "basic fault," find life too difficult, who can obtain but little gratification, whose mental or biological economy is precarious and unstable. Even minor ailments are too much for them, life is too strenuous, too frustrating and depressing, illness offers them an acceptable opportunity to withdraw and "look after themselves." No matter whether illness is a severe shock or a welcome justification for withdrawal, it is always a form of life. This is especially true of illnesses of some duration, allowing time to the patient to adjust himself to them. This adjustment is not identical

with what we called "organization," but they are parallel phenomena, influencing each other all the time. In the present connection we are concerned only with the illness as a form of life. This is a vast subject, and although we have ample empirical data about it, and a number of truly eminent physicians have tried to sum up their medical experiences of a lifetime in this field, a systematic survey is still lacking. My very modest attempt will fall far below the standard of what is needed. I shall base my discussion on the psychoanalytic theory of primary and secondary gains. Although convenient for a first orientation, this theory does not claim either to be unequivocal or to be more than a crude first attempt.

No form of life can be maintained without some gratification. Conversely, this means that if one aims at changing any form of life, one must use either compelling force or offer more acceptable gratifications in place of those to be made impossible by the change. This is rather platitudinous, but it is worth stressing that it is fully valid for the patient's relationship with his illness and also for any therapy purporting to change it. To quote a convincing example of many; the prevalence of "brutal" physical methods in psychiatric therapy over time-consuming psychotherapeutic methods. The various shock treatments, and above all leucotomy, brutally force the patient to give up some of his symptoms—his forms of life—and content himself with others, less objectionable to his fellow-men. Anyone who has had opportunity to see leucotomized patients knows how painfully true this is.

So let us first of all examine illness as a source of direct gratification. To avoid misunderstanding, I must emphasize that, in any illness, pain, limitation, apprehension, and so on are always present. All the gratifications are only partial, additional to, or almost completely overshadowed by suffering. But it is impossible not to notice the high emotional importance of eating in practically all gastric and some metabolic diseases, of the digestive functions in intestinal disorders, particularly in chronic constipation, etc. An often quoted puzzling example is the frequent faecal dreams of acromegalics which are definitely ambivalently toned, partly highly disgusting and frightening, but at the same time "interesting." Psychoanalysis can offer some help in this field through *the theory of erotogenic zones of the body*. Unfortunately all

this amounts only to a beginning. The reason is probably that the material observed by psychoanalysts has been highly selected, i.e. consists of patients suffering chiefly from psychological illnesses, with only a sprinkling of organic cases. The general practitioner, with his much wider range of patients, will perhaps provide us with further data to extend and deepen our psychoanalytic theories.

The second sub-group of direct gratifications consists of the opportunities offered by the illness for *withdrawal from all sorts of unsatisfactory or frustrating, demanding or over-exacting relationships with people.* Examples for it are legion—the frigid woman whose dysmenorrhoea is a welcome dispensation from marital duties; the urethritis of not securely potent men; the many eating difficulties and food-fads of over-pressed children, which enable them to escape from the clutches of their much too powerful parents, usually their mothers, by an apparent weakness; the asthma attacks which inevitably overcome the patient when visiting the home of his or her parents or spouse. The most impressive instance is the considerable narrowing of the personality during a serious illness; not only may interest in other people be gradually given up, but the patient's relationship to reality may become uncertain and tenuous. This sub-group is well known and sufficiently substantiated by observation. Unfortunately the whole field is treated mostly on the level of interesting anecdotes, and a systematic survey is badly needed.

Somewhere between the last sub-group and the next, that is between withdrawal and regression, there comes what psychoanalysis calls *introversion.* It is more than withdrawal, inasmuch as the individual's interest is not only withdrawn from his environment, but is simultaneously firmly anchored in himself. Mental processes and sensations, ideas and emotions attain an importance very seldom experienced otherwise. This phenomenon is well-known but its finer details are hardly understood, probably because in the early stages the patient is usually alone, and has no partner yet on whom he can transfer his emotions. Thus, nearly everything we know about the events of the unorganized phase of this period stems either from a reconstruction from what the patient tells us later, when he comes to us for help, or from our subjective impressions and preconceived theoretical ideas. More knowledge about the processes in the formative phases of introversion is badly needed. If we understood them better, we could perhaps prevent the development of serious hypochondriasis, the greatest problem belonging to this sub-group.

The fourth sub-group of direct gratifications from illness can be called *regressions.* This means more than withdrawal or introversion, because it entails in addition the emergence of infantile forms in the patient's behaviour. Though its frequent occurrence is undeniable, much less is known about regression than about the foregoing forms of gratification. The connection between illness and withdrawal is fairly obvious in many cases, but the function of regression is far from clear. It may be a consequence of the severity of the illness, an extreme case of which is delirium in high fever. It may be abandoning as hopeless, as too exacting, the task of coping with life and pain in a mature way, as for instance the adoption of foetal position in a great number of painful conditions, or the willingness or even the demand of certain patients to be washed and fed well beyond the stage when this is objectively necessary, or the institution or custom of providing a nurse to hold the hand of a patient under local anaesthesia. Regression may also be an attempt at self-healing, as high temperature may possibly be in certain infections; by regressing to a more primitive level the patient may be seeking an opportunity to make a start in a new direction, avoiding that blocked by his illness.

As I said, apart from its existence, little is known about the *significance and function of regression.* This is disturbing, because the doctor's responses to the patient's "offer" to regress are of great importance for the future. We do not even know whether regression should be prevented or encouraged and, if so, in which illnesses, at what stages, or in which kind of individuals. The obvious danger is that the patient may get too well settled either in a regressed or in an over-pressed "mature" state, too well "organized" to be accessible to a real therapy. Again I have to plead for more research.

The second great group of gratifications enabling the patient to acquiesce in or accept illness as a form of life is that of *secondary gains.* Illness, as every other quality of man, can be used to obtain something useful to, or valued by, the individual. The best known example is compensation neurosis, but this is only one of its kind. To an outsider secondary gains may seem of little

value, even rather silly, but they are important to the patient and must be recognized as such by his environment as well as by his doctor.

Many examples of this can be quoted; wearing an armband as a sign of having just been inoculated or vaccinated, arriving in a taxi at the hospital or at the consultant's rooms, meeting other patients—some of them obviously very ill indeed—in the hushed or buzzing atmosphere of a waiting-room; in general, being made a fuss of, being treated as a V.I.P. All this is pretty easy to notice, but in some patients it is not so easy to cope with. There are, however, more complicated forms, and the more complicated they become the more difficult it is to separate them from the forms discussed above, i.e. from direct gratifications. Withdrawal and regression in particular are most difficult to classify unequivocally.

Before going further, we must briefly discuss two important fields in the patient's relationship to his illness: *fears and pain.* Both offer great opportunities for the doctor's therapeutic skill, but both, particularly ways of dealing with fear, unfortunately belong to the domain of "common sense" therapy. We mentioned earlier in this chapter that some people experience illness as something in them turned "bad" and attacking them from the inside. This may create severe anxieties, which in some progressive illnesses, such as certain cancers, some infections or some degenerative conditions, may have biological justification. Then there are the fears and frustrations of chronically ill people who have to give up some of their accustomed pleasures, partly because of the illness itself—with impaired vision for instance, certain occupations, all ball games and fighting sports such as boxing or fencing, become impossible—or because of the diet necessary for an effective treatment. Before insulin the frustrations of diabetics were almost proverbial; nowadays the most conspicuous groups are perhaps chain-smoker ulcer patients and some sufferers from ulcerative colitis who can tolerate only a bland diet. And there is the ultimate problem, the patient's fears of death. General practitioners—and nurses—who have close contact with people approaching death have an inexhaustible supply of puzzling stories about fears, heroism, humiliation and supreme dignity in the face of death. Expert, firmly founded advice about what to do, how to help in this distressing situation

would be most valuable, but unfortunately our only recourse is again to common sense.

Roughly the same is true of the patient's attitude to pain. In the first place, all doctors will agree that patients can more easily tolerate diagnosed pain than undiagnosed pain—and perhaps the same is true of their doctors. Social attitudes to pain vary widely. In certain societies it is impossible for a man to weep, in others weeping by men is tolerated. Women, as usual, are given greater freedom, but I have the impression that in this country women cry and scream much less during childbirth than in my native country, Hungary. There is no doubt which custom is better for the midwives and the doctors, but it is much less certain which is better for the women. This is yet another great problem awaiting research. Is it easier to bear unrelieved pain with a "stiff upper lip" or by breaking down and crying? Medicine until recently considered pain only from the physiological angle, resulting in the building up of perhaps the best-studied chapter of pharmacology, that on analgesics and anaesthetics, and in the creation of a new speciality. Recent years have brought us the various systems of painless childbirth, first with the help of drugs, and more recently with the help of allaying the woman's anxiety and ensuring her co-operation. This shows that in the field of relieving pain a vast opportunity still awaits the psychologically-minded doctor.

I think this is a good place to mention *the patient's subjective description of his pains* and other sensations originating in his body. It is surprising how incomparably more varied and richer one's conception of one's body becomes during illness. This is an immense psychological field which has hardly been touched by science. Why is it that people report their pains or sensations, as stabbing, lancinating, lightning, burning, pressing, constricting, gripping, stifling, throbbing, blinding, etc., or use phrases like "as if a stone were inside me," "as if a part of my body were dead," or "as heavy as lead," "a dead weight in my middle," "a red-hot poker," "as if I were made of cotton wool," "I feel woolly," or "frozen," and so on? We know that certain characteristic phrases are often used by people suffering from certain illnesses, but we know very little about which part of any of these phrases is determined by physiological processes and which by the patient's fantasies about processes possibly happening inside him. This could be a fascinating study for a psychologically-minded

general practitioner who knew his patients fairly well during, before and after their illnesses.

* * *

To conclude this chapter I propose to mention a curious group of patients whom we called the "fat envelope" group. "Fat envelope" is a purely descriptive term referring to the copiousness of the accumulated notes about the patient. This may be due to—

(1) The patient's puzzling illness, which has necessitated a number of specialist examinations.

(2) His over-frequent visits to the surgery.

(3) His annoying habit of frequently changing his doctor.

The three factors are not obviously interlinked, but it is rare for one only to be responsible for the bulging envelope, and often all three are present. What does this mean?

When this problem cropped up in our seminars we went on to discuss the "natural" rate of change that takes place in a doctor's clientèle. Since the establishment of the National Health Service this can be easily followed. To our great surprise, we found that from eight to ten per cent of the patients on a doctor's list change their doctor in any one year. This is certainly true of practices in or near London; in rural areas the figures are somewhat lower, but just as constant. Only a small minority of these patients make the change openly by giving notice. Some change their addresses and use this as a pretext, even if they only move to another house in the same street. Most of them simply consult another doctor, and this initiates the change. Another surprising fact that emerged was that this figure is apparently practically independent of the doctor's personality, apostolic beliefs, skill, interest in psychotherapy, etc., etc. The first question we asked ourselves was why these patients changed their doctors. We had to abandon the inquiry, because when a doctor loses a patient he has to surrender his records to the local Executive Council and so no trace of the patient remains except in the doctor's memory; as these cases must be considered failures, this source could not be accepted as reliable. Other approaches were possible, such as having an immediate discussion on every patient who changes his doctor, or looking up samples of new patients taken over from another doctor. Unfortunately all of these proved rather

cumbersome, and, as no doctor likes to discuss only his failures, the seminar, in spite of good intentions, always found a more urgent problem to deal with.

Nevertheless, research into the real causes of these changes would be a fascinating task. A number of these people belong to the "fat envelope" class, the problem patients in any practice, the nomads who wander from general practitioner to general practitioner, never settling down with anybody for any length of time.

A special case of this nomadism is when the change-over happens within a partnership, without any formality. For some time I thought we had found a promising way of studying this interesting group. Soon, however, we came up against difficulties. It was surprising to discover that, though the partners notice the change-overs and remark upon them, they never discuss the causes and take no apparent interest in them. The usual situation is that only one doctor in a partnership is psychologically minded; the other or others tolerate this, either with grumbles or with good humour. But this toleration was severely taxed when the doctor attending our seminars wanted to discuss with his partner why a patient had left his partner for him, or *vice versa*. So we decided—at any rate for the time being—to leave things alone. Nevertheless we collected some extremely interesting case histories, three of which, Cases 1, 5 and 9, appear in previous chapters, or in Appendix III, and illustrate some of my points.

The little we learned about the causes of nomadism can be summed up in the phrase: "Self-selection of patients according to the doctor's apostolic beliefs." If patient and doctor do not "click," and the doctor cannot convert the patient to adopt his apostolic beliefs, the only way open to the patient is to find another doctor. The self-selection and the apostolic function are counterparts of each other, it is they that build up the special and highly individual atmosphere of every practice, resulting in the mutual investment company. From this angle joint practices are valuable institutions to patients. If they cannot accept the methods of one partner they can drift to the other, who, however well adapted to his partner, still has his individual apostolic beliefs. In some cases—Case 1 is one of them—the patient used the two doctors according to her needs at the time, up to a point to everybody's satisfaction. Again, these cases could form the

basis of valuable research into the kind of therapy needed by patients at different periods of their illnesses.

Perhaps the same processes are at work in the other class of "fat envelope" patients, who have to go from specialist to specialist. It is possible that in the specialist-patient relationship we shall find the apostolic function and the self-selection of patients at work in the same way as in the surgeries of general practitioners. As our research seminars have not yet been extended to consultants, I have no first-hand knowledge of the events in my colleagues' practices. For my own practice what I said above is certainly true.

The third group of "fat envelope" cases, those who come for help much too often but remain with the same doctor—Case 26 is a striking example—is a warning not to be rash in our inferences. The establishment of a working mutual investment company does not prevent a patient from becoming a problem patient. As mentioned, the three groups largely overlap, so again we can only ask for more research.

I may add that, in addition to the cases just mentioned, i.e. Cases 1, 5, 9 and 26, our Cases 2, 4, 6, 11, 12, 16, 17, 19, 21, 22 and 24 belong to the "fat envelope" class. Any research which will help the doctor to cope better with the problems inherent in this group will contribute considerably to lightening his burden. That several of them, such as Cases 16, 19, 21, 22 and 24, can be counted as real successes, inasmuch as for the time being the fatness of their envelopes ceased to increase, shows that we are going in the right direction.

CHAPTER XX

General-Practitioner Psychotherapy

AS WE have just seen, there are various stages in the history of an illness. The beginning of it all, according to my ideas, is the "basic fault"—as yet more a theory than a fact. Then comes the problem caused by a conflict between the demands of the environment and the patient's inherent possibilities which may have become more or less severely restricted under the influence of the basic fault. Some people cope with their problems by solving them, others bear the strain caused by them, while still others respond by falling ill. These last try first to struggle with the illness on their own; later, when they realize that this does not help, they consult a doctor. At this stage the illness is not yet "organized;" as we saw in Part I, there are usually several "offers" from which the doctor has to choose one to treat. His aim must obviously be to choose an illness which offers the best prospects for therapy; I mean not only a palliative help for a superficial symptom, or even for a superficial clinical illness, but a therapy which offers the best possible chances for the patient's future life.

Many cases reported in this book could be used to illustrate these points. Let us take, for instance, Miss S., Case 23. The basic fault in her case can be surmised only from its consequences. These were: a very tense relationship between a domineering and over-demanding mother and a rebellious, "managing," but guilt-laden daughter; a yearning for an understanding father who, in turn, had to be idealized; considerable difficulty in becoming, and accepting the responsibilities of, an adult woman. The basic fault in her was probably caused by the discrepancy between her mother's inadequate but overwhelmingly domineering care and her own need to be understood and in particular to be permitted to run her own life, to be herself. All this was reinforced and complicated by her parents' broken marriage, leading to an