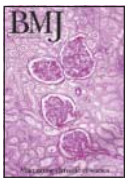
Doctor-patient relationships in chronic illness: insights from forensic psychiatry



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Collaborative management of chronic illness is undermined by neglect of emotional and psychological factors in both the patient and doctor

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Chronic diseases are the world's leading cause of death and are projected to increase substantially to become the main cause of disability by 2020.[1] In response, a common core of strategies for managing chronic illnesses has been identified that emphasises the importance of collaborative care.[2] However, less attention has been given to the effect of managing chronic illness on the doctor and how this manifests in the therapeutic relationship. We draw on our work with patients in a high secure psychiatric hospital to highlight this gap and suggest how it may be addressed in medical education.

Do doctors want to manage chronic illnesses?

Most medical students want to become doctors to heal patients.[3] In reality, most will spend much of their time caring for patients for whom no cure is possible. Medicine's success in the pursuit of cure has fundamentally changed the expectations of doctors; medical success has often become equated with cure and medical failure with the absence of effective treatments and resort to palliative care.[4] The treatment of chronic disease conflicts so fundamentally with these expectations that it tends to be neglected.

Medical education may contribute to the development of negative attitudes towards people with chronic illness. Studies report medical students' ambivalence towards the management of chronic illnesses, even if these attitudes were absent before medical school, and a trend towards cynical and self protective strategies as training progresses.[5] Furthermore, medical students are deterred from choosing specialties that involve managing chronically ill patients.[4] This is perhaps unsurprising given that the dominant model of medical education remains disease oriented, hospital based, and intent on cure. This mismatch between the way that medical education is delivered and the reality of medical practice can lead to disillusioned doctors and poorly served patients.

Relevance of forensic psychiatry to management

As most treatment of chronic illness occurs in primary care,[6] it may seem counterintuitive to draw on the experience of treating patients within a high secure psychiatric hospital. Although generalising about chronic illness from high secure settings to other healthcare settings has some limitations (box 1), we believe these limitations do not preclude a clinically useful comparison.

High secure forensic patients represent the extreme end of the chronic illness spectrum. The median length of stay is 6.3 years and patients often have lengthy contact with services after discharge.[7] Patients have complex psychopathology; psychiatric and physical comorbidity is the norm and complicates recovery. Contact is necessarily sustained, and often treatment has to given against the patient's wishes. Although the ground rules of the doctor-patient relationship will be altered when the doctor may also act as gatekeeper, some patient choice is still available. Despite the effects of severe psychopathology on their mental state, many patients retain the ability to assess their doctors' capacity to be available and responsive to emotional factors arising from the chronic nature of their illness.

It is not simply the chronicity and severity of their illness that sets these patients apart but the way in which treatment highlights many of the difficult dynamics that can arise when caring for people with chronic illnesses. By understanding the effect of these dynamics on the doctor and the doctor-patient relationship, doctors may feel better equipped to treat people with chronic illnesses.

A gap in collaborative care

Various strategies have been used to aid management of chronic illness. These include policy driven initiatives such as the introduction of national service frameworks, enhancing collaboration between service providers and patients, enabling patients to take an active role in their care and more intensive follow-up and monitoring of adherence to treatment and outcome.[2 8] Literature on collaborative management of chronic illness emphasises the concept of patient as partner.[9] Ensuring the cooperation and motivation of the patient is a multifaceted task requiring an

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Care of patients in high secure units such as Broadmoor provides lessons for other chronic care

understanding of the patient's attitudes and beliefs about their illness as well as their coping strategies, within the context of their life experiences.

The need to attend to the emotional aspects of the patient's chronic illness in collaborative care is acknowledged.[10] However, this is assumed to be achieved mainly through efficient information sharing and collaborative development of a self management plan using cognitive-behavioural principles in conjunction with evidence based knowledge and sensitive communication skills. Sole reliance on these techniques may be suboptimal because patients' decision making and capacity to engage collaboratively in these strategies may also involve seemingly irrational processes, arising from their perceptions of and attitudes towards their illness. These, in combination with the doctor's expectations and attitudes, may evoke emotional reactions in the doctor. Meaningful appreciation of these experiences and reactions is not straightforward; it requires reflective work by the doctor. Decoding these dynamic reactions and their influence on the doctor-patient relationship may enhance collaborative care strategies and interventions.

The importance of this process is illustrated by the long tradition of reflective practice based on the Balint movement in vocational training in general practice. Although valued across primary care and mental healthcare settings, service pressures can easily erode time set aside for self reflection.[11]

Bridging the collaborative gap

Main suggested that: "The best kind of patient is one who, from great suffering and danger of life or sanity responds quickly to a treatment that interests his doctor and thereafter remains completely well."[12] For some patients, the experience of developing a chronic illness may mean they are unable to function in the role that their doctor expects. Consequently, patients may present atypically—for example, with self neglect or self exposure to risk because of non-compliance with treatment.

Failure to understand the patient's emotional and psychological experience of chronic illness and how this may jar with the doctor's own attitudes and beliefs may precipitate a collaborative gap. This will be manifest in the therapeutic alliance and consequently diminish the cooperation and motivation of the patient as partner.

Box 1: Effect of healthcare setting on the management of chronic illnesses

Factors limiting generalisation from high secure care to other settings

- Additional responsibility of managing risk as well as treating illness alters doctor-patient relationship
- Need for physical security measures can reduce patients' experience of health care as collaborative
- Severity of patients' mental disorder limits joint working and may evoke more complex dynamics in the doctor-patient relationship
- Sustained contact with patients provides enhanced opportunities for thinking about the doctor-patient relationship

Factors supporting generalisation from high secure care to other settings

- Treatment goals and progress may be more difficult to define in chronic illness, irrespective of setting
- Complex pathology may erode doctors' sense of effectiveness
- Similar dynamics can emerge in the doctor-patient relationship in all healthcare settings
- Managing chronic illness calls on the doctors' capacity to accept coping rather than cure and is not context specific

Redefining expectations

It is easy to see how treating chronic illness can threaten the sense of satisfaction that comes from treating patients who more closely resemble Main's description. Doctors may become aware of a sense of frustration with, or ambivalence towards, patients who do not seem to get better. This arises from unrealistic aspirations of care giving and equating their professional capacity to heal with their sense of self worth. Some doctors may have to redefine their expectations and reformulate their own attitudes, particularly in relation to their perceived capacity to help.

Taking the patient

Almost the first thing any medical student is taught is to take a history and examine the patient. In forensic psychiatry and psychotherapy, it often helps to also take the patient and examine the history (M Cox, personal communication). The narrative accounts of patients with chronic illness highlight the person's feelings of isolation, the painful process of coming to terms with loss, adjusting to uncertainty and anxiety, and loss of trust in doctors and the system.[13] As well as taking a traditional history, doctors need to keep in mind patients' emotional experience of their illness.

A core principle of psychodynamic psychotherapy is that humans adopt various psychological defensive mechanisms to avoid mental pain or conflict.[14] Doctors who feel helpless and guilty about their inability to heal their patient's suffering may distance themselves from their patients. Alternatively, doctors may feel resentment, which may manifest as brusque dismissal of the patient. An accurate formulation of a patient's condition and prognosis is of little value if it is conveyed to the patient in an off hand or brusque way and is too painful to hear. Equally, it is of little use if the doctor becomes overly reassuring but avoids discussing emotionally painful areas.

The defensive positions of brusque and brutal or affable and ineffective may arise because the doctor's psychological defences are mobilised to ward off distress or anxiety. At times these may be mistakenly attributed to the patient, who is seen as not being able to deal with painful emotions. Finding a middle road requires an accurate evaluation of the therapeutic relationship, monitoring your own psychological reactions, and acknowledging your patient's perspective on his or her difficulties.

Attending to the system

Patients' experience of their illness is also coloured by the system's response, whether this is represented by

Box 2: Guiding principles in teaching chronic illness care

- Knowledge, skills, and attitudes relating to acute disease cannot always be applied to chronic conditions
- Learning is best achieved in the context in which it will be applied
- Many acute conditions are superimposed on chronic ones
- Emphasis on real world problems—not all patients are able, articulate, and willing
- Foster positive attitudes by exposure to chronic illness early in training
- Facilitate longitudinal, interdepartmental training
- Recognition that clinical uncertainty is both inevitable and acceptable

primary healthcare teams, multidisciplinary teams, or institutions. As chronic care is generally multidisciplinary care, the therapeutic relationship between team and patient is also key.[15] Although the most obvious aspect of security in forensic services is the walls and locks, relational security is also vitally important. This arises from a therapeutic understanding of the relationship between staff and patients and involves fostering a robust therapeutic alliance. Good relational security provides opportunities for patients to talk about the frustrations of chronic illness and explore alternative approaches to stressful situations. It also allows staff to monitor the patients' psychological state and provide extra support during vulnerable periods.

Although in high secure and mental health settings the patient generally establishes a relationship with a team rather than with the single practitioner, the concept of relational security is not dissimilar to that of relational or personal continuity in primary care. This is the ongoing therapeutic relationship between a practitioner and a patient that extends beyond specific episodes of illness or disease.[16] Although the structure and process for multidisciplinary working differs between primary and secondary care, this difference may diminish as primary care professionals take on wider roles in managing chronic illness, aimed at reducing the need for hospital admission.[8]

A threat to good relational security or continuity occurs when teams become split and staff hold polarised views about a patient. When differences are attended to they can inform management; the ability to constructively hold in mind opposing views is one indication of a cohesive team. These team divisions often result from a splitting process arising within the mind of the patient, which is not under the patient's conscious control. In other words, it is not the patient who is splitting the team but the team who need to take responsibility for their division. In these circumstances patients are often regarded as being manipulative when they are only showing their divided reaction to their illness and difficulties. For example, a patient's emotions may oscillate between angry resentment about their vulnerability and dependence at one moment and dismissal and denial of difficulties at another.

When staff identify exclusively with one aspect of a patient's experience and recruit this to resurrect pre-existing rivalries major fault lines can split the team. In such a climate the care of patients suffers a double blow: their needs are lost and they are held responsible for the divisions within the team. At the extreme end of the spectrum the psychological processes that result in splitting also contribute to other toxic processes.

Toxic processes

Just as the doctor may bring unrealistic expectations towards care and treatment, so may other staff. Working with patients with chronic illness may evoke negative feelings in teams and the perception that some patients are difficult to treat when they fail to respond. Understanding these processes is important because the teams' view of a patient as being difficult to treat can impair treatment.

If such a dynamic escalates and predominates something akin to the process of "malignant alienation"[17] may result. This is signalled by a progressive deterioration in the patients' relationships with others, including loss of sympathy and support from staff who construe the patient's behaviour as provocative, unreasonable, and overdependent. Although the description of this process originated from an inpatient psychiatric ward, it may also occur in other settings where chronic illness is prevalent. Alienation can be reduced by fostering a working environment where staff can openly acknowledge negative feelings.

The role of medical education and the future

Although medical schools seem to agree about the importance of skills in managing chronic illness, the level of teaching in the undergraduate curriculum varies widely.[18] Doctors report feeling inadequately trained to teach chronic care.[19]

Box 3: Skills required in the management of chronic illnesses

Therapeutic relationship
Eliciting patients' perspectives on their illness
Attending to your own response to the patient
Accurately assessing the therapeutic relationship
Developing and reviewing individual management plans

Within teams
Appreciation of roles within multidisciplinary and primary healthcare teams
Interpersonal skills to be an effective team member
Openness to acknowledging ambivalent or negative reactions

In the wider system
Applying disease prevention and health promotion strategies
Employing strategies that empower patients and carers
Participating in health service development and evaluation
Effective multiagency liaison

Summary points

- Collaborative care strategies underplay the effect of managing chronic illnesses on doctors and the therapeutic relationship
- Overemphasis on acute hospital based specialties in medical education may foster negative attitudes to chronic illness
- Mismatch between doctors' and patients' beliefs and expectations may undermine collaborative care
- Reflective practice directed at understanding personal and system responses to chronically ill patients may optimise collaborative care

The General Medical Council has identified the need to train students to relate better to patients and their problems.[20] Evidence on such training is sparse, but some guiding principles seem to emerge (box 2).

Box 3 lists the skills that are central to the management of chronic illnesses and could be taught in the curriculum. Many of the skills could be incorporated into the undergraduate personal and professional development theme or could form the basis of a special study module. Teaching of acute medicine could be refocused to place greater emphasis on the doctor's role in the multidisciplinary team, the role of carers, discharge planning, and liaison with primary care.[21]

Some innovative courses have been developed that introduce students to patients with chronic illnesses and aim to develop skills that can be applied across a range of chronic conditions.[22] Most students report appreciating the extended contact with patients and encountering real problems.[22] For many, it may be the first time they have met patients whose views and attitudes on treatment and compliance may not match their own. These courses all encourage students to elicit patient's beliefs and expectations and to evaluate their responses to their patient while providing a safe environment in which to express ambivalence and uncertainty. Their success and popularity may lie in their effectiveness in closing the gap in collaborative care that we have described. Greater use of this teaching strategy could strengthen the future collaborative management of patients with chronic illnesses.

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A good pizza joint

An 18 year old university student presented to the ear, nose, and throat outpatients clinic with prolonged and troublesome vertigo of unknown origin. A detailed history and examination failed to identify the cause, and the patient was referred for vestibular testing. These tests revealed a probable 14% right sided canal paresis, but a basic balance questionnaire taken by the senior audiologist revealed the true cause of the problem—a pizza generously sprinkled with cannabis the night before the onset of the symptoms. Fortunately, the patient's symptoms are gradually improving, but she is now aware that she needs to be somewhat more careful about her choice of toppings.

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