for suspending the cells. Many of the abnormal incomplete agglutinins are haemolytic when incubated with complement against trypsinized red cells.

Haemoglobinuria

Patients with haemoglobinuria have a haemolytic disease and present many of the features associated with the haemolytic syndrome. Several varieties of paroxysmal cold haemoglobinuria are recognized.

With a Cold Auto-haemolysin.—This type occurs most frequently as a complication of syphilis, either congenital or acquired. It is characterized by haemoglobinuria following exposure to cold. The Donath–Landsteiner test is diagnostic of cold haemoglobinuria. In this test, red cells suspended in the patient's serum are exposed to a low temperature so that the cold haemolysin may be absorbed, and then to a higher temperature so that haemolysis may be completed by the action of the serum complement. Normal red cells can be used in this test. In life the haemolysin becomes fixed to the red-cell surface during exposure to low temperatures, and when the blood circulates and becomes warmer haemolysis occurs.

With Cold Agglutinins.—Raynaud's syndrome, with acrocyanosis and pain in the extremities, may occur in paroxysmal cold haemoglobinuria associated with cold agglutinins. When titrated, the cold haemagglutinin may exceed 1/1,000 and rarely be demonstrated at up to 1/100,000. Cold haemagglutinins have been found in a number of conditions not necessarily associated with demonstrable haemolytic disease. In atypical pneumonia, for instance, they are often reported to be present.

Paroxysmal Nocturnal Haemoglobinuria

In this chronic haemolytic disease, haemolysis becomes intensified during sleep and nocturnal haemoglobinuria occurs. The patient's corpuscles are sensitive to thermolabile components of normal serum, but acidification is necessary to bring the pH of the cell-serum suspension to about pH 6.8 before the serum factors will act. This is the principle of the Ham test which is employed to diagnose this condition. Acidification is necessary because defibrinated blood becomes slightly alkaline owing to loss of carbon dioxide. Clinically, patients with nocturnal haemoglobinuria show an abnormal sensitivity to minor changes in blood pH. This may also be a factor in other haemolytic mechanisms.

Next Article on Clinical Pathology.—"Polycythaemia, Leukaemia, and Cytopenia," by Dr. Ronald Bodley Scott.

Refresher Course Book.—The first collection of articles in the Refresher Course for General Practitioners (fully revised) are available as a book containing 55 chapters, price 25s. Copies can be obtained either direct from the Publishing Manager, B.M.A. House, Tavistock Square, London, W.C.1, or from booksellers.

According to the Eighth Annual Report of the Institute of Child Health, the number of full-time students in 1953 was just under one hundred and there were also 40 part-time students. While most of the students attending were from the Commonwealth, it is interesting to note that 14 full-time students were from countries outside the British Empire. This perhaps signifies the growing importance of London as a postgraduate centre. More emphasis was laid in 1953 on clinical instruction. The number of lectures was reduced and opportunities were provided for increased ward teaching. Arrangements were made for small groups of two or three students to "sit in" with registrars during the out-patient sessions.

BEDSIDE MANNERS

BY

ERIC D. WITTKOWER, M.D.

Associate Professor of Psychiatry, Allan Memorial Institute of Psychiatry, McGill University, Montreal, Canada

AND

KERR L. WHITE, M.D.

Assistant Professor of Medicine and Psychiatry, University of North Carolina School of Medicine, Chapel Hill, N.C.

A dermatologist told the following story. A patient came to him with eczema in one axilla. A previous doctor had told the patient that the eczema was due to sweating. "I sweat here and I sweat there," the patient argued, pointing to his two axillae; "how can the eczema be due to sweating?" "What do you think it is due to?" the dermatologist asked. "I believe," the patient said, "that it is due to sugar diabetes." "You would have sugar diabetes here and there," the doctor said, pointing to the patient's two axillae, hence you can't have sugar diabetes." Subsequently the patient felt greatly relieved, and incidentally the eczema disappeared. The patient was extremely grateful.

This story serves to introduce the subject of this paper—"bedside manners" and psychotherapy. Bedside manners may be defined as an unsystematized understanding of a patient's emotional needs, whereas psychotherapy is their conscious systematized counterpart.

Systematic psychotherapy is predominantly the domain of the psychiatrist; bedside manners is a term applied to the intuitive approach used by general practitioners and specialists not specifically trained in psychiatry. Both bedside manners and psychotherapy are based on interaction between patient and doctor. It is proposed to discuss some of the more common psychological problems of patients and doctors, and some principles governing reciprocal physician-patient relationships.

The Patient

A patient is a person who seeks the help of a physician because he deviates in mental or physical health from the norm. He is not necessarily a sufferer as the word patient connotes. In view of his sickness a patient has to assume a role which imposes on him in many cases the necessity of forgoing his usual activities, of retiring to bed, and of accepting another person's help to restore him to his previous state of health. If he is very sick he may have to abandon his functional status of an adult and perhaps be attended to in a baby-like fashion.

Research in psychosomatic medicine has shown that emotional factors often play an important part in the aetiology of so-called "organic" diseases. Be this as it may, in any given patient illness as such, and the change in mode of living which it comprises, leads to a backward movement towards earlier stages of emotional development and behaviour. This state of regression, as it is called, manifested by changed attitude and feelings, is particularly significant in chronic illness. It may have the following interrelated effects: (1) patients may become childish in their behaviour; (2) they may, and usually do, become selfish; (3) they may invest the interest which they withdraw from the external world on the affected part of the body and consequently develop superadded hysterical or hypochondriacal formations; (4) they may distort reality

in other ways—for example, by wishful self-deception about their own unmistakable condition; and (5) they may manifest towards the physician positive or negative feelings of great intensity patterned after those experienced towards their parents, particularly their fathers. This mechanism is often operative in patients who show apparently irrational awe, subservience, hostility, panic, anxiety, dependence, or affection towards their physicians. If the unconscious sources of these reactions are not recognized the physician may respond inappropriately and trammel up rather than facilitate the physician-patient relationship.

Illness of necessity affects a person's mood. Dependent on the nature, site, and severity of the illness, on his previous personality and past experience, feelings of depression and of anxiety are commonly experienced. These emotions may be appropriate responses; or they may be inappropriate or at least disproportionate to the actual condition. In the latter case, feelings of badness and of unworthiness which previously existed may be subjectively experienced by the presence and "badness" of the illness; or fear of punishment for previous misdemeanour may disproportionately intensify justifiable fear regarding the outcome of the illness. Psychological defences against feelings of depression and of anxiety are denial and projection. Denial may take the form of unreasonable—and often foolhardy—defiance of obvious handicaps, or it may find expression in false optimism or jocularity, so commonly encountered in incurable illness or in the terminal stages of illness. Patients may project resentment at their own condition or their environment, or they may fasten their internal anxieties on some external event such as an impending operation. The word "complaint," not only in its colloquial but also in its medical usage, signifies dissatisfaction. Consciously or unconsciously, patients may complain about their suffering, their pain, their fate, or about the lack of attention or affection which they sorely need.

Illness mobilizes aggressiveness, which may be due to inability to accept dependency or any imposed restrictions or frustrations. No longer is the patient able to discharge his duties, to earn his wages, or to enjoy sports and other pleasures. He may be restricted in body movement or debarred from items of food which he previously relished. No wonder that many a patient becomes irritable and irritating. Whether or not he freely expresses or checks aggressiveness engendered in this way depends on patterns of behaviour established in the past and proved to be useful. The patient who pathetically appeals to us for sympathy may achieve his ends just as successfully as the old arthritic lady who angrily thumps a stick on the floor if her wishes are not immediately fulfilled.

The patient's environment responds to his moods, anxieties, needs, demands, and reactive aggressiveness, and as these responses are fed back to the patient a vicious circle may well be established. Usually people feel sorry for a person afflicted by illness; after all, it could happen to them, and should it happen to them they would like to be cared for tenderly. But as the illness drags on, and the demands of the patient continue, and the economic strain makes itself felt, the patient feels a burden and is felt as such by others. Members of his family and good friends may still cover up their resentment and hostility by lavishing gifts and apparent over-kindness, but, especially if previous bonds had not been close, the veneer may wear thin and crack. Unfortunate are the marriages which have been broken up by the serious prolonged illness of husband or wife.

The Physician

Are doctors always fully aware of their patients' needs and anxieties and of the many problems and conflictual situations which exist in their patients' families and may be produced or developed by their illness?

Let us look for a moment at the doctor's problems and "dilemma." There are many reasons why a person becomes a doctor—for example, a doctor is highly respected in the community, and, provided that he is competent, he earns a

reasonable income. Hidden behind conscious altruistic wishes to serve his fellow men, four psychological factors seem to play a part in the choice of the medical profession: (1) identification, (2) sublimated infantile curiosity, (3) sublimated and/or overcompensated aggression, and (4) persistence of infantile omnipotence fantasies.

Identification may be positive or negative. A person may become a doctor because he wants to emulate his father, who is a doctor, or because he wants to rise in the social scale above his father, who is a tradesman or owns a small business. We all played the doctor's game as children. Instinctual trends operative then may have been carried over into adult life and canalized into professional interests. Sadistic trends dating back to childhood may find sublimated expression in surgical skill or may be warded off and overcompensated by concentration and devotion to healing.

Most doctors derive much satisfaction from helping suffering humanity, but little do many doctors realize that beyond reasonable ambitiousness their wish to score success, especially where others have failed, is based on a perpetuation of infantile omnipotence fantasies.

Each of the factors mentioned may give rise to difficulties. For instance, we all know doctors whose attempts to identify with a successful father or older brother have miscarried or who could not allow themselves to outstrip their father's modest achievements or live up to their mother's over-ambitious expectations. There are doctors who had to give up surgical interests or even a promising career as a surgeon because of their inability to inflict pain or to be held responsible for the death of some of their patients. How commonly are doctors afraid of giving bad news to their patients when telling the truth and nothing but the truth would obviously be right? Why do we sometimes act in this manner? We act in this manner because cultural pressures do not allow us to tolerate free display of emotion in ourselves and in others, because we tend to identify ourselves with our incurable patients, because we are averse to inflicting pain, and because our vanity makes it difficult to admit failure. Let us admit—at least to ourselves—our limitations instead of reaching out for and taking on tasks beyond our capacities, and instead of basking in the glory of our therapeutic successes.

Some Problems

There are other problems which beset the medical practitioner.

(1) The doctor, analogous to the patient's closest kin and friends, is a person who can be trusted with the most private and intimate affairs and feelings of the patient. But at the same time the doctor does not admit his patients to intimacies with himself, does not "reveal" himself to the patient, physically or mentally. If he happens to be a personal friend of the patient he will be well advised to segregate the two roles.

(2) The doctor's "trustworthiness" and authority are based on his assumed technical competence. This technical competence, in accordance with the patient's wish to be cured and in keeping with his regressive state, is exaggerated out of proportion. Any situation or occasion which shatters the patient's primitive belief in the doctor's magic powers accentuates previously hidden negative feelings and doubts and may lead to change of doctor in the partly rational and partly irrational hope of finding someone who can repair what perhaps cannot be repaired.

(3) The doctor is an authority and wields authority as a technical expert. He can give "orders" but is in no position to enforce them or to penalize a patient for not carrying them out. His authority is strictly segmental in nature; it is confined exclusively to matters concerning the patient's health. He can impose restrictions in diet and on physical activities. He can sometimes justifiably counsel a change in occupation, but he trespasses on his legitimate rights and does more harm than good by telling a patient that all she needs is a husband, a child, or sexual intercourse.

(4) A doctor should treat his patients equally, regardless of colour, creed, nationality, social and economic status, or other distinctive features. But who of us has not been influenced at one time or another by the appearance and manners of his patients, or by their social status in the community? And who of us has not been guilty at times of giving more careful attention to a wealthy patient than to an indigent one?

(5) A doctor is supposed to assist the needy irrespective of monetary gains; but we also have to live and support our families. Moreover, living as we do in an acquisitive society with keen and often unscrupulous competitiveness, monetary gain is frequently regarded as a sign of success and as a means of much-needed recognition. Consequently the temptation is often great to place self-interest before the interest of the patients, to promise "miracle cures" against better knowledge, to prescribe injections which are not needed, or to play up to the patient's requests for gadgets which may not be required. Perhaps there is more than a grain of truth in the charge that the Hippocratic oath is in danger of being replaced by salesmanship based on the "get-rich-quick" principle.

(6) The doctor, like his patients, has unconscious conflicts which may interfere with his capacity to understand and treat his patients. For example, doctors unable to recognize their own shortcomings may be unable to tolerate similar inadequacies in their patients. Detached, aloof physicians may be threatened by patients' attempts to form close, dependent relationships with them. Other physicians may become unduly attached to or over-identified with patients whose problems are similar to their own, or whose personalities resemble those of relatives with whom they have intense relationships.

Physician-Patient Relationships

From this background discussion of patients and physicians we may return now to the principal topic—bedside manners. The points which we have been trying to make are: (a) that the practice of medicine not only consists in the application of biological knowledge but also demands considerable degrees of social and psychological understanding, described as bedside manners and psychotherapy; (b) that certain definable principles can be identified and are operative in bedside manners; and (c) that, analogous to systematic psychotherapy, bedside manners require an intimate knowledge and understanding of the emotional, social, and economic problems of the patients and their families as well as those of the doctors themselves. The classic dictum "know thyself" is an essential prerequisite for the knowing of others. From time immemorial good doctors have always paid attention to the emotional aspects and the environmental stresses of their patients. To do so, general practitioners are in a better position than consultants, who, in view of their special functions, do not see their patients over prolonged periods in their home environments. Few doctors would fail to listen to a patient's chest in a case of prolonged coughing, but many doctors fail to listen to their patients' words, which may reveal more than auscultation ever can.

Rather than speak to their clergymen, in whose presence they may feel embarrassed, patients often take their troubles and worries to the general practitioner, who is well advised to listen patiently and benevolently without taking sides, showing disapproval, or giving advice. The very fact that the patient can "get it off his chest" relieves feelings of tension and anxiety.

Psychological examination and assessment require skill and time. Yet the time factor is often overrated. Just as the beginner spends more time on a physical examination than an experienced physician, psychiatric appraisal takes less time as experience grows. One may listen for hours to a person who speaks Chinese, but would not understand a word unless one had learned the language. Symptoms are the language of disease, and behaviour is even more specifically the language of psychological disorder. Physicians can familiarize themselves with the varying ways in which patients communicate their emotional discomfort and indicate their need for help. Not infrequently the presenting complaint is only a plausible excuse couched in the language of somatic symptoms, to indicate the patient's general distress. The source of this distress—that is, its emotional and conflictual origin—may be confused readily with its somatic localization.

Time, money, and effort could be saved if patients suffering from psychosomatic and psychoneurotic illness would not again and again be submitted to elaborate laboratory examinations. Overemphasis on minor organic lesions fosters

iatrogenic illness and may by-pass the real cause of the patient's suffering. The presence of emotional conflicts whose aetiological relevance to the illness may be all-important can be revealed only by direct examination. Familiarity with the basic principles of psychopathology is essential if one wants to understand one's patients' needs, anxieties, misconceptions, faulty attitudes, and psychological defences. A patient's heroic or stoic attitude towards his illness may be most impressive but may conceal a great deal of anxiety.

In keeping with their regressive states and wishes for recovery, patients suffering from prolonged and serious illnesses are apt to elevate their doctor to the position of a god. Doctors are well advised not to be taken in by the flattery and to behave as such. Doctors should realize their limitations but need not admit them to their patients. A pose of omnipotence and omniscience, if recognized as such, may be appropriate in the case of emotionally immature, anxious, or severely regressed patients, but would obviously be out of place with mature individuals who like to know where they stand.

Methods of approach naturally have to vary from patient to patient. By and large, it is true that the "don't worry," "take-it-easy," "pull-yourself-together," or "cheer-up-old-man" approaches are ineffectual. Patients may have plenty to worry about, and if they could pull themselves together they certainly would. Equally, the general practitioner may defeat his objectives by telling psychoneurotic patients that there is "nothing the matter," or that "it is all imagination." If there were "nothing the matter" the patient would hardly consult him. Nor can much benefit be expected from vacations, sedatives, or placebos, which obviously do not solve the patient's conflicts.

Constructive help can be offered by an understanding of the family situation. As has been stated before, the patient's illness affects his family, and their conscious and unconscious responses reverberate in the patient's physical and mental condition. In this respect, a thorough knowledge of community resources through which changes may be effected is obviously essential.

Conclusion

Another story may give added emphasis to the principal points of this paper. Some time ago the charming young wife of a doctor sought help for severe and intractable vomiting. Her case had puzzled many doctors. She had been submitted to elaborate examinations of her stomach, of her gall-bladder, and of her pancreas; chronic pancreatitis had been suspected. She had spent many months in bed and had been placed on a very rigid diet, all without benefit.

Had one of her physicians spent 10 minutes talking to the patient he would have found out that this young woman felt neglected by her husband. She entered marriage knowing full well that much of her husband's time would be taken up by his flourishing practice. But she had failed to realize that he would devote himself, almost to the exclusion of everything else, to his patients. She was frankly jealous of his patients. If she wanted to attract his interest and attention there was nothing left but to be a patient herself, and an interesting patient at that. When this unconscious mechanism was made conscious to her she recovered rapidly. Needless to say, when her husband recognized her motivation his attitude towards her changed.

The annual competition of the Manchester and District Medical Golfers' Association was held on the course at Wilmslow on May 19. There were 57 competitors. The challenge cup was won by Dr. J. J. MANNING (Warrington) with a net score of 70. The Walter gold medal was awarded to Dr. R. W. FAIRBROTHER (Wilmslow) with the best gross score of 77, and Dr. D. C. ATTWOOD (Bolton) secured the Captain's prize for the second best net score of 73.