Debate & Analysis

The birth of a ghost:

a medical essay

'My experience of the other as a subject, rather than a mere object, is based on the empathy that I feel for the other, as part of experiencing of the other in terms of his/her embodiment. The experience of the other is, in turn, instrumental in shaping aspects of my self-awareness, as I begin to experience myself as an other for an other.'
(Husserl)[1]

The consultation room is one of the most important laboratories in medicine. The scene is set with a noble purpose: the management of suffering. Above all, this is why we meet in an intimate room where people take medical advice. They carry with them hopes for care, healing, and understanding.

As a generalist I confess to the Paul Ricœur notion of a patient's suffering: *'Suffering is not defined solely of physical pain, nor even by mental pain, but by the reduction, even the destruction of the capacity for acting.'*[2] This is what we look for as generalists: our patients' creative capacities to proceed against illness and disease. With medical intervention or support, we struggle to provide patients with the means to regain or retain their capacity for action.

Having left my inner-city clinic in Copenhagen, and armed with curiosity and my stethoscope, I went on very short visits to unknown places with unknown patients in Scandinavia. Convinced that, as a locum, I could make a difference with my professional experience and my person-centred method, I travelled to the laboratories of the consultation room.

Interpretations and meaningful actions are negotiated in this room. The doctor navigates between a complicated network of 'texts' composed of the patient's underlying text of experience, the text of history taking, the text of the body as physically examined, and the technological text of diagnostic procedures.[3] The results are messages and signs to interpret, and a provisional bridge between theoretical sciences and 'the universe of one' is established, integrating these forms of knowledge. This is what makes general practice an intellectual discipline.

Being a doctor who interferes with suffering demands more than an intellectual approach. The generalist's medical competence is in making decisions that have shared meaningfulness. I have drawn on my field notes to illustrate the challenges in making such decisions.

> *"... armed with curiosity and my stethoscope, I went on very short visits to unknown places with unknown patients ..."*

CONSULTATION ROOM 1

Hamsa and the doctor sit in a room with faded colours and wooden furniture.

Hamsa has a headache, which comes from time to time and lasts several days. She received no relief from analgesics. Examining her does not bring any further explanation. She often has an itchy rash on her arms and fingers, which she says is related to the onset of her headaches. I ask if her headaches could be related to anything else she can think of. She explains that she has noticed a relation to contact with her mobile phone. She does not use her mobile phone any more, but her symptoms appear when her son or husband enter the room with their mobile phones.

Hamsa can't make her family respect or even understand that she has a problem with mobile phones. She has an almost daily headache and she feels generally bad. She wants the doctor to help her.

During the conversation I became aware of what was at stake for Hamsa. She was a refugee, very isolated, did not speak the local language well, and had no job. To restore her capacity for acting in the Paul Ricœur way, we would have to integrate symptoms and conditions in a pattern to find a way to handle them. That would call for a long journey together, which we could not have.

To deal with Hamsa's suffering, a one-off consultation does not really make sense, and I have this obscure feeling of failure in my assignment.

CONSULTATION ROOM 2

George enters the consultation room. An elderly man with a careworn face. He turns up personally to have his prescription for sleeping medication renewed. Since his wife died, he has been taking a double dose prescribed by different doctors in a long line of locums. He has had severe depression after his loss and grief. I ask him how he sleeps: 'Almost not at all,' *he says. That is why he needs medicine. Is he aware of other ways of getting a good night's sleep? He becomes increasingly frustrated, saying I would not know how he feels; it is too easy to talk about other possibilities considering his situation. Even a reduction of the dose appears unbearable to him.* 'Doctors view this so differently,' *he says* 'but all I want is to have a good sleep.'

Given the number of locums and no follow-up, this patient risks taking double-dose medication for life. From a clinical perspective this makes no sense. With occasional doctors handling his medication George becomes resigned to his fate and has no confidence in new ways to handle his sleeping problem. A shared elaboration on the sleep disorder would require continuity and trust. I am unable to bring George any further towards functioning in his life during this consultation.

Again: this obscure feeling of failure.

CONSULTATION ROOM 3

Philip calls in the morning, very upset. He is being treated with a medication that has possible side effects, and he has read that these might have a severe impact on his health. I assure him that in his case he has nothing to worry about. But as he is increasingly nervous and frustrated on the

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telephone, I propose a consultation. This seems to be a relief to him, but then I tell him the consultation will be with another doctor as today is my last day in this clinic. Philip becomes upset again: 'None of you take responsibility!' *he shouts.* 'Why can't I have ONE person to rely on?'

Philip's call for continuity hit me like a punch. I had crossed borders to share and broaden my experience, but I met with a border inside myself, a professional embarrassment and dissonance. To address the tension I had to look at myself 'as another for another' in a new professional reality. I had been a responsible doctor in the broadest sense, and now I was a fire extinguisher with narrow obligations in an emerging culture of floating liability. Making decisions of shared meaningfulness in such a setting is restricted to very specific problems, which are not always the problems that present in general practice — as we see above.

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A generalist perspective on suffering not only reveals the disruptive aspects of illness in life, but also offers the time and the expertise needed to support all the dimensions of a patient's functioning. This calls for spending time together and, in this respect, is not really possible to do as a generalist in clinics with ever-changing doctors, or in polyclinics with gaps allowing loss of responsibility.

One-person-to-rely-on is a fading figure in health centres in Scandinavia. Even Denmark faces a sudden change, having had, until now, a very stable and homogeneous general practice with responsible doctors in their own smaller clinics. A combination of underfunding and work overload in the sector makes young doctors hesitate to join. Older doctors are leaving their chairs before retirement —often they circulate as locums. This has been a reality in Sweden for many years. The attempt to solve the problem — with polyclinics, clinics with only locums, or large clinics with thousands of patients — often neglects maintaining a level of continuity. In itself, continuity, whether personal, informational, or in management, is not the genie in the bottle that puts an end to suffering.

The true genie in the bottle would be a binding relationship — the frequent result of spending time together. The drama of life is unfolded in the meeting with 'the other'. Following Emmanuel Levinas,[4] what happens is that *'... the face forces itself on me, without it being possible for me to remain deaf to its summons or to forget it, that is to say making it impossible for me to cease being responsible for its helplessness'*.

OUR HEALING PROFESSION

This moral responsivity strikes a particular chord for medicine. We cannot ignore a deeply founded professional essence of altruism. In dealing with suffering — and that is what we do as doctors — general practice and the person-centred approach must be replenished with a new (but old) level of responsibility. The assignment for medicine is with Tauber[5] that physicians move back to their historic role as genuine companions to the sick and dying.

With my visits to the laboratories of foreign consultation rooms I wanted to explore the world around me. But, ironically, I found myself exploring the ethos of being a doctor, which is the pre-intellectual sensation of the patient's suffering and the post-intellectual obligation to provide the patient with a capacity to proceed in life. In many cases I could not deliver that on a short visit with no binding relationship with the patient.

In creating new solutions for general practice we have to remind ourselves again and again of these perspectives on doctoring. We should maintain our tradition as a healing profession. Or we will be ghosts.

Nina Sybille Bojlén,
Specialist in General Practice, Research Unit for General Practice and Section of General Practice, Department of Public Health, Faculty of Health Sciences, University of Copenhagen, Copenhagen, Denmark.

ADDRESS FOR CORRESPONDENCE

Nina Sybille Bojlén
The Research Unit for General Practice and Section of General Practice, Department of Public Health, Faculty of Health Sciences, University of Copenhagen, Øster Farimagsgade 5, PO Box 2099, 1014 Copenhagen, Denmark.

Email: sybille.bojlen@sund.ku.dk

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