Death is Something to be Avoided
The psychodynamics of end-of-life planning
for the general practitioner.

A thesis submitted as a requirement for the degree of
Doctor of Philosophy

by
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Trust me,
this will take time
but there is order here,
very faint, very human.¹

P. PREFACE
P.1 ABSTRACT
The seeds for this research were planted in the emergency rooms of a tertiary Metropolitan Hospital Emergency Department where I practise as an Emergency Physician. My aim in the research is to develop an understanding of the psychodynamic processes that limit general practitioners from involvement in the groundwork of end-of-life planning with their patients who suffer from chronic and terminal illnesses and the dependent elderly patient. The focus in this thesis is to communicate an understanding of the general practitioners’ perception of the community and their role within it to end-of-life plan. At the commencement of the writing I acknowledge my limitations in the academic spheres of sociology, philosophy, anthropology and social history but these aspects of the thesis are developed to contextualize the research within the community of work of the general practitioners.

Over a period of days, a number of frail elderly patients were transferred from their Nursing Home by a mobile intensive care ambulance to the Emergency Department to be resuscitated. My feelings of concern for these individuals generated questions. Who decides? Who has the right to make life and death decisions for others. Where is choice? Are the patient’s wishes known at this time? Do the patients have any rights when they are incapable of making their own choices known? Does anyone know what their choices would be? Or, is ‘death something to be avoided’, no matter what the circumstances?

So this research springs from a passionate concern for the rights of the other, with the desire for others to appreciate their personal autonomy and their capacity for choice, in dying and death, as in life. As Yalom puts it:
If he doesn’t **know** he is about to die how can your patient make a decision about **how** to die? Yes, he must decide **how** to face death.¹

The research commences with a quantitative study using data derived from a survey of adult patients attending the Emergency Department in May 2002, to quantify if end-of-life planning is occurring in the community. It then moves to the process of purposefully selecting a group of general practitioners, as a series of case studies, with whom to explore and understand the concept and process of end-of-life planning within the community. Using an interpretive paradigm with a clinical method of in-depth interviewing, data are collected from these general practitioners. System psychoanalytic and psychodynamic theories and practice are applied for the analysis of the data.

The dissertation reveals the factors that limit general practitioners in end-of-life planning. These factors include: emotional collusion with members of the community, the lack of clarity in the primary task, the inability to recognize and manage the emotional experience associated with the role and limited education in communicating issues of significance. Theory is generated depicting the context of the work, and recommendations are made for future participation in end-of-life planning by the general practitioner and members of society.

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P.2 STATEMENT of ORIGINAL CONTRIBUTION

I state that the dissertation is to the best of my knowledge my original work, although it is extensively referenced by the writings of others. These excerpts are acknowledged and referenced within the text as well as in the bibliography.

Any errors in the writing of the dissertation belong with the researcher.

I state that the thesis and the material contained herein have not been submitted for the award of any diploma or degree in any other tertiary Institution or University.

Carolyn E. M. Cooper.
MBBS, FACEM, MApSc (RMIT)
P.3 ACKNOWLEDGEMENTS
I sincerely acknowledge the general practitioners who participated in the research process. I acknowledge your honesty and commitment to the exploration of end-of-life planning with me. The collected data are profound. What sits with me is an immense sense of responsibility to work with this data respecting your diversity. Each person involved has granted me a unique insight into their own praxis.

Dr Jenny Ouliaris enlisted the support of the staff of the Regional Division of General Practice by arranging meetings with the Chief Executive Officer.

Mr Ken Mansbridge, the Chief Executive Officer of the Division, in recognizing the importance of this research facilitated the participation of the general practitioners within the Division of General Practice and enabled the research to occur.

Professor Susan Long, my supervisor supported and sustained me from the beginning of the research to its completion. Her scrutiny, generosity in time and teaching are recognized.

Associate Professor John Newton has been available and always helpful.

Eve Steel, as supervisor, has encouraged my commitment and exploration; challenging me and aiding my synthesis and analysis of the research data.

Mrs Joanne Lee-Dow has assisted me to improve my writing style.

Alastair Bain and my training peers of the 2002 Fellowship group, of the Australian Institute of Socio-Analysis stimulated my interest, exploration and learnings.

My friend Beverley has encouraged my writing.

My father and my mother have fostered within me a need to explore and with the exploration to gain understanding, and so to continue to learn.

My partner Brian demonstrating his love, patience and endurance has accepted my need to close myself away in my world to explore.

My canine writing companions are always at my feet, their loyalty is ever-present.
P.4  STYLE & STRUCTURE of this DISSERTATION

P.4.1  The Style

Each chapter of the dissertation commences with an overview of the specific topic to be explored. Following, is an academic framework of the theories and concepts used in the development of the topic; these are defined and discussed. The theory used is then contextualized into the current doctoral research and the data relating to the topic is analysed and working hypotheses generated. Theory is used extensively as it aids in illuminating and analysing the data and the generated themes pertinent to the task of end-of-life planning. Each chapter culminates with a summary of the exploration and further questions derived from the exploration.

Because system psychodynamics and system psychoanalysis is central to the methodology, the analysis of the system, group and dyad are fundamental to the research, the individual is rarely emphasized. Quotations are given and used as derived from the membership of the group.

Citations from the general practitioner interviews are introduced, indented, and annotated as [Interview: 1 to 13] at the end of each excerpt, for example, [I:3]. For other references including books and journal extracts, the Vancouver System for bibliography is used. Referencing, as an endnote, occurs at the conclusion of each chapter.

The research component of the thesis is written in the present tense.

The researcher is referred to in the first person.

The general practitioner is referred to as s/he, the balance of males:females involved in the process is 7:6. The style acknowledges this balance of genders and supports confidentiality in the writing.

The patient is also stated in the male:female gender; except for excerpts relating to specific patients in case histories, where the gender is factual.
P.4.2 The Structure of This Thesis
This dissertation has three distinct sections each of which focuses on a particular component of the research.

Part 1: Context and Methods
The section on Context and Methods places myself as the researcher within the research environment for end-of-life planning and then discusses the methods which are the essence of praxis in this clinical, interpretive research paradigm.

As researcher, I consider it important to contextualize this research formally before commencing the chapters that deal with the analysis of the data collected and theories generated.

In Chapter 1, I describe the background and the origins of this research. One question is: ‘do general practitioners take up end-of-life planning as a component of their primary task?’ The chapter commences with an internationally publicized debate about end-of-life planning decisions and their complexity. It then moves to survey, through a questionnaire, end-of-life planning for the adult patients attending the Emergency Department in which the researcher practices as an Emergency Physician. The next phase of the chapter discusses the difficulties in developing a researcher-researched relationship and the attendant anxieties in performing this research. The second chapter reviews the ontological and epistemological theories used to fulfil the purpose of this doctoral research. Chapter 3 relates to the methods employed. This includes not only the aptitude and skills required of the researcher, using the qualitative platform, but also the processes involved in data collection, analysis and the generation of theory. These initial chapters form the context and the paradigm for this research thesis.
This section details the topics germane to end-of-life planning in the environment of community General Practice. Chapter 4 begins by grounding the reader, in the community of the general practitioners, communicating their perception of the attitude of the community to dying, death and end-of-life-planning. Chapter 5 communicates the general practitioners’ opinions of the primary task of General Practice as it relates to end-of-life planning. Chapter 6 gives an account of the general practitioner’s interface with the systems within his/her sphere of work. A psychodynamic perspective is used to discuss the interplay between the internal and external the psychic aspects of the individual - the doctor, the dyad - the doctor-patient relationship, the group - the family with the doctor, and the organizations - the Primary and Acute heath Sectors, for each relates to the practice of the general practitioner in the community. Next, chapter 7, the role of the general practitioner is discussed using psychodynamic frameworks of role. Finally, chapter 8 reflects upon the general practitioners’ assessment of conventional educational methods and their estimate of its adequacy in addressing critical issues and performing the task of end-of-life planning.

This segment of the dissertation reflects the outcomes of the research: on the data analysed. The themes generated which are pertinent to the task of end-of-life planning. The penultimate Chapter 9 advances the paradigms of practice in medicine; Cost-containment, Cure or Care, and their associated defensive techniques to defend against anxiety of the emotional context of the work. The final chapter of the dissertation, chapter 10, Can Death be Acknowledged, reflects upon the findings of the research using the working hypotheses of each chapter as a basis to discuss implications for future change. The relevance of the working hypothesis for Society, the Primary Task, Role and Education contribute to the development of recommendations for future action.
# DEATH is SOMETHING to be AVOIDED

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This section of the dissertation places me as researcher within the context of the research and then discusses the validity of the methodology and methods which are the essence of the praxis in the clinical, interpretive research paradigm.

The section commences with a background introducing my motivations for researching the practice of end-of-life planning in the community. It raises questions relating to choice associated with personal autonomy and competency, as well as the place of substitute decision makers through the appointment of an Enduring Power of Attorney (medical). A quantitative study of adult patients attending the Emergency Department reflects the current convention. The research process evolves through iterations finally to the in-depth interviewing of general practitioners within the community. Next, the methodology and methods are explored to define the research design.
1. Is Death Something to Be Avoided?

'Death is something to be avoided' said a well known Australian Catholic-biо-
ethicist talking with a radio commentator.1 This conversation related to the
legally and politically debated death of Terri Schiavo, which occurred in the
United States of America on 31st March 2005.

Terri Schiavo, in 1990 at the age of 26 years, suffered a cardiac arrest. As a
result of this event Terri was diagnosed as having irreversible brain injury. This
injury left her unaware of her environment, unable to communicate with or
recognize her loved ones and incapable of fulfilling the activities of daily life,
including swallowing. As a result of her brain damage she was fed through a
percutaneous entero-gastric (PEG) tube. From this time controversy raged
between her husband-guardian and her parents with multiple legal and political
interventions about whether Terri was in a 'persistent vegetative state' and
whether she should be allowed to die. Death would occur if the tube was removed.
It was alleged that Terri and her husband had prior conversions about end-of-life
planning, and it was his understanding that she would not have wished to continue
to live in this way. From 1998 on, he sought to have the feeding tube removed. On
many occasions it was, only to be replaced after legal or political intervention. The
PEG was finally removed and not replaced on 18th March 2005 after a decision by
the Federal Court. The Federal Court did not sway from this decision, blocking
subpoenas, the involvement of the US Congress, a signed document from President
Bush and a submission from the US Court of Appeals to revert the order.
Terri died on the 31st March 2005.

Who decides? Who has the right to make life and death decisions for others? Are
the patient's wishes known at this time? Do patients have any rights when they are
incapable of making their own choices known at the time of a critical decision in
their life's journey, when they are not able to write their own history? Does
anyone know what their choice would be?
1.1 Whose choice?

It is three o'clock on a cold, wet, winter's morning. Personnel of a tertiary Metropolitan Hospital Emergency Department are informed by the metropolitan Ambulance Service that mobile intensive care is transferring a ninety-six-year-old lady from her nursing home to the Emergency Department for resuscitation. On arrival, her fragile aged body is desperate for oxygen. The Emergency Department staff could intervene and monitor every cardio-vascular parameter of this old lady. We make a choice. We relieve her symptoms. The Nursing Home notes convey that she is bed bound, demented and dependent upon nursing staff for all care. She has a long history of cardiac failure. A recent urinary tract infection has precipitated acute pulmonary oedema. She dies with us, not with those who know her and have been caring for her. There is nothing familiar for her in this cold clinical environment. There are no familiar faces or voices. The activities in an Emergency Department communicate process with efficiency and effectiveness. The soothing voices of comfort are replaced by the alarms to indicate immediacy for action. Instead, the voices are incisive and directive. It feels cold. The temperature is cold as we undress her to listen to her heart and her chest. Here, individuality is lost, the person becomes a patient, and a process is followed. Bion writes:

I would make a distinction between existence - the capacity to exist - and the ambition or aspiration to have an existence that is worth having - the quality of the existence not the quantity: not the length of one's life but the quality of that life. There are no scales by which we can weigh quality against quantity, but existence is to be contrasted with the essence of existence. The fact that the patient, like the analyst, (like the world) is still in existence is not adequate.²

This quotation reflects the enquiry posed prior to commencing this current research project. What is the essence of existence for an individual? Who poses this question? When is it posed, who answers this question?
For me as an Emergency Physician in a large tertiary Metropolitan Hospital the scenario is a frequent occurrence. Kubler-Ross writes:

> Dying becomes lonely and impersonal because the patient is often taken out of his familiar environment and rushed to an emergency ward ... the beginning of a long ordeal ... we should consider more carefully the patient himself and perhaps stop our well-intentioned rush in order to hold the patient’s hand, to smile, or to listen to a question ... keep the focus on the patient’s experience, his needs, and his reactions ... the sick person has feelings, wishes, and opinions, and has – most important of all - the right to be heard.3

It is of concern to me that individuals who are entirely dependent upon others for their complete care are transferred to an Emergency Department for resuscitation and acute care. Is it an expectation that acute intervention and the prolongation of life is better than palliative care which has an emphasis of relieving symptoms and alleviating pain? Or is the transfer to hospital an intervention to allow the carers to escape the inevitable death; for it is difficult to be with death? These individuals who are spending their final years of life in a nursing home are often unable to communicate effectively as they have dementia. They are often bed-bound, incontinent, and require assistance with every activity of daily life. They will not recover from their underlying conditions. Their quality of life will not improve. Moreover, their quality of life is likely to deteriorate after a further episode requiring acute care.

How can society accept the current practice of resuscitation and prolongation of life without questioning what is occurring? The term resuscitation is used with the connotation and expectation of the restoration of good health. If the pre-morbid status is one of poor health, then the outcome of resuscitation will not improve these circumstances but add to the morbidity. What is the burden of life and continuing medical treatment to this person? What is the benefit to this person?
Assumptions are made around this action. Decisions are made on the basis that
death is no longer a natural event, a consequence of life.
But is ‘death something to be avoided’, no matter what the circumstances are
around that death? There appears to be no place to die, except in the emergency
room; dying and death must be kept away from society. Obholzer writes:

In the unconscious there is no concept of health but there
is a concept of death. Health systems serve to contain these
anxieties for society as a whole. Our health service might
more accurately be termed a ‘keep-death-at-bay’ service.4

The concerns addressed in this research project relate to issues of self-
determination and of choice. If the individuals were competent to make a decision
about their management, what would they choose? It is of concern that quality of
life questions and dignity in death are not considered as a choice before action
occurs. The Hippocratic Oath states:

You do solemnly swear, each by whatever he or she holds
most sacred, That you will be loyal to the Profession of
Medicine and just and generous to its members. That you
will ... practice your art in uprightness and honour. That into
whatsoever house you shall enter, it shall be for the good of
the sick to the utmost of your power ... That you will
exercise your art solely for the cure of your patients, and
will give no drug, perform no operation, for a criminal
purpose, even if solicited ... That whatsoever you shall see or
hear ... which is not fitting to be spoken, you will keep
inviolably secret.5

The Hippocratic Oath implies beneficence; helping the patient and non-
maleficence; doing no harm.6

Should the actions of a medical practitioner in resuscitation and acute
intervention be questioned when they are unable to bring about a significant
improvement in the health status of a patient, already terminally ill? Is continuing
to treat in the best interests of the patient? The oath also implies cure, but this
outcome is not possible in the setting of the elderly demented frail patient with terminal chronic health problems. This and similar scenarios are the focus of concern and central to the pursuit of this study.

At the commencement of this current research project, there is acknowledgement that dying and death are emotionally traumatic events for all in the journey of life. Respect for life should be ever present; maximizing health and well-being through symptom control and continuity of care at all phases in life. This respect includes dignity in death; all are part of a medical responsibility. As a medical practitioner is the primary commitment to curing the disease or caring for the patient? The latter approach seems more holistic; it encompasses both aspects of cure and of care, both are interwoven in the mesh of quality and quantity in life decisions.

In discussing end-of-life issues, the role of the general practitioner remains an important question. The general practitioner is available on a day-to-day basis to discuss healthcare issues with his patient. This practitioner has usually been involved in the healthcare of the elderly patient for a number of years, for the patient usually retains his/her family practitioner from middle age. Consequently, the general practitioners of older patients usually have knowledge of their cultural, medical, psychological and social status and their support structures. There is also the potential for ongoing review and monitoring by the practitioner of the patient’s physical, psychological and cognitive states as they age. With the general practitioner as confidant, it is my assumption that there is a tacit trust by the patient that collaboration will occur and decision-making will be in their best interests.

This trusting relationship has the potential to allow the introduction of issues and areas of discussion that are profound, where there is uncertainty and ambiguity. But, does this occur?
From the sector of Acute Healthcare, the Emergency Department personnel refer patients back to their general practitioner for continuing care. There is a supposition that the general practitioner is primarily involved in the continuity of care of the patient. It is my assumption that this continuum of healthcare would also involve end-of-life planning, that the general practitioner would initiate discussions with patients and relatives before interventions occurred. These discussions could include the introduction of district nursing or home care. Moreover it is assumed that future plans, about total care if disabled, would be broached to determine the expectations of the patient and the acknowledgement by the family.

But the initial scenario of the elderly patient attending the Emergency Department in an intensive care ambulance is too regular an occurrence to assume that end-of-life planning is occurring in the community. How might I determine what is occurring in this community?

It was my initial plan for this research to work with the personnel of aged care facilities and their affiliated general practitioners to explore with them end-of-life planning. Before commencing this undertaking a quantitative study was organized to determine the occurrence of end-of-life planning in the local community.

1.2 What is End-of-Life Planning?
End-of-Life Planning is a process wherein an individual is able to explore their own healthcare wishes with family, friends and their medical practitioner. The intent of this conversation is that care at the end-of-life reflects the personal values, objectives, religious and cultural needs of the individual. This conversation occurs within the current legal framework. An important part of this process involves the individual developing an understanding of his/her medical condition with the general practitioner or specialist.
These end-of-life conversations are inclusive. They relate to disease diagnoses and prognosis, treatment approaches, possible complications and their management, the management of pain and suffering, the right to withdraw or withhold treatment, and support for the patient and their family in the ongoing care of the individual during the progression of the disease. The purpose of this process is to create understanding of the medical condition for the patient and to ensure that his or her end-of-life plan has been made explicit with the person of their choosing, that is, a surrogate. This communication is essential to enable the surrogate to communicate the wishes of the patient at a time of cognitive or neurological incapacity. A document fulfilling the ethical and legal guidelines for others is important. The treatment choices for end-of-life can then be realized respecting the autonomy of the individual and honouring this individual's determination. The legal term given for this person of choice in the State of Victoria is Enduring Power of Attorney (Medical) – written as EPOA(medical). The role of the EPOA is important to the individual and the treating medical practitioner. This chosen person has an open and trusted relationship with the patient and knows their personal wishes. The role of EPOA(medical) is employed on the behalf of the patient at any time the patient is unable to make decisions for himself/herself. The role may be utilized temporarily, at times when the patient is unconscious or cognitively impaired as a result of illness, or permanently when the patient has dementia or another acquired neurological injury. While competent, the patient can revoke decisions at any time. The responsibilities of the EPOA(medical), as written by The Office of the Public Advocate (Victoria) are to:

- Act in your best interests
- Wherever possible, make the same decision that you would have made
- Avoid situations where there is conflict of interest.7

It is important for the practitioner caring for the patient to be informed of the EPOA(medical) to assist in problem-solving and decision-making for the patient at times of incapacity. As a consequence, it is imperative that the medical
practitioner be aware of the criteria to assess competency. In Australia an assessment of a person's competency or capacity to make decisions involves ascertaining whether the person is able to:

- Express a preference for or against a particular form of treatment
- Make right or responsible decisions regarding their treatment
- Provide rational reasons for their decisions
- Recognise decisions that are irrational or unwise, and
- Understand all the major implications of a proposed course of treatment.8

Therefore, timeliness in conversations with an elderly patient is essential to enable self-determination. The relevance of this discussion for all adults, and the appointment of an EPOA(medical) becomes a significant and important to express individual choice and personal autonomy.

Can society take this up? Or is 'death something to be avoided'? Is it too difficult to have these discussions? Are end-of-life planning discussions occurring within the community?

1.3 Beginning to research
As researcher, before commencing the research project, I am making an assumption from anecdotal evidence that the task of end-of-life planning is not occurring in the community. A prerequisite is to substantiate my supposition before discussing the process of end-of-life planning with general practitioners in the community. A questionnaire administered to adult patients attending the Emergency Department in the community meets this need.

1.3.1 Initial Survey - the Acute Healthcare Sector
I designed a questionnaire to investigate what end-of-life planning processes are occurring in the adult population who attend the Emergency Department of the Community Hospital. The survey was administered to the consenting adult patients
attending the Emergency Department. If the attending patient was unable to consent and complete the survey because of intercurrent illness or cognitive impairment, the accompanying adult was asked to enrol in the survey.

The questionnaire has two components. First, the demographic data of the adult population attending the Emergency Department during the month of May 2002 was sought. This demographic data is routinely collected by the clerks of the Emergency Department and important to the Department of Health: the minimum dataset of patients attending Emergency Departments in the State of Victoria. The data includes the parameters of: age, gender, country of birth, preferred language, religion, patient referral pattern, and current address. This data was collected to assess if aspects of the demographics assist or limit the process of end-of-life planning. Next, the questionnaire was designed to ascertain the occurrence of advanced care or end-of-life planning within the attending population in the month of May 2002. All attending patients between the ages of 20 to 99 years were requested to enrol in the survey. Data was collected from one thousand one hundred and sixteen (1,116) patients.

Prior to commencing the survey, assistance was sought from the Emergency Department staff groups to complete questionnaires with patients. The clerical staff who complete the minimum Emergency Department data set for the Department of Human Services, agreed to complete the survey, but acknowledged the difficulty in verifying the cultural information.

<table>
<thead>
<tr>
<th>Clerical Data</th>
<th>Variety</th>
<th>Completed</th>
<th>% Completed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred from</td>
<td>8</td>
<td>1113</td>
<td>99.7</td>
<td>1116</td>
</tr>
<tr>
<td>Accommodation</td>
<td>7</td>
<td>1102</td>
<td>98.7</td>
<td>1116</td>
</tr>
<tr>
<td>Country of Birth</td>
<td>50</td>
<td>1072</td>
<td>96</td>
<td>1116</td>
</tr>
<tr>
<td>Culture</td>
<td>48</td>
<td>880</td>
<td>78.8</td>
<td>1116</td>
</tr>
<tr>
<td>Religion</td>
<td>22</td>
<td>1033</td>
<td>92.5</td>
<td>1116</td>
</tr>
</tbody>
</table>
The information of Table 1 includes the range of referral sources of the patients (8 parameters) including self-referral, general practitioner, family or Nursing Home referral. The multi-cultural status of the patient profile is evident with country of birth drawn from (50) countries. Table 1 also identifies the completeness of the clerical data collection.

Table 2 describes the accommodation status of the patients (7 parameters).

<table>
<thead>
<tr>
<th>AGE</th>
<th>OWN HOME</th>
<th>R/hab</th>
<th>N/H</th>
<th>HOSTEL</th>
<th>Support</th>
<th>R/Village</th>
<th>Unknown</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>88</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>25-29</td>
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<td></td>
<td></td>
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<td>82</td>
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<tr>
<td>30-34</td>
<td>65</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td>35-39</td>
<td>77</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>81</td>
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<tr>
<td>40-44</td>
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<td>1</td>
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<td></td>
<td>1</td>
<td></td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>50-54</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>55-59</td>
<td>66</td>
<td></td>
<td>1</td>
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<td></td>
<td></td>
<td>67</td>
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<tr>
<td>60-64</td>
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<td></td>
<td></td>
<td></td>
<td>1</td>
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<td>65-69</td>
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<td>1</td>
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<td>1</td>
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<td></td>
<td>84</td>
</tr>
<tr>
<td>70-74</td>
<td>95</td>
<td>4</td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
<td>103</td>
</tr>
<tr>
<td>75-79</td>
<td>83</td>
<td>2</td>
<td>6</td>
<td></td>
<td>3</td>
<td>1</td>
<td></td>
<td>95</td>
</tr>
<tr>
<td>80-84</td>
<td>69</td>
<td>10</td>
<td>8</td>
<td></td>
<td>2</td>
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<td>91</td>
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<td>85-89</td>
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<td>8</td>
<td>1</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>95-99</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1017</td>
<td>5(2)</td>
<td>47(46)</td>
<td>14(12)</td>
<td>8(1)</td>
<td>10(10)</td>
<td>14</td>
<td>1116</td>
</tr>
</tbody>
</table>

Table 2 above, identifies that, at the time of the survey, seventy one (71/1116) individuals above the age of seventy are living in supported accommodation. The areas of supported accommodation include Rehabilitation (R/hab) facilities,
Nursing Homes (N/H), Hostels, and Retirement Villages. Usually a general practitioner and nursing staff are available to assess and care for these patients.

The medical staff working within the Emergency Department in May 2002 were asked to complete data relating to healthcare planning, the appointment of a power of attorney, including medical and financial. In introducing the questionnaire to medical staff, possible ways of asking and phrasing the questions when speaking to the patient were explored. The data of tables 3-7 (pp. 12-14) to be completed by medical staff able to be used if completed. The data is not complete.

During and after completing the survey the medical staff were asked about issues that may be impairing their collection of the data. Their answers included:

'This is too difficult.'
'I do not know what to ask.'
'I do not know how to ask these questions.'
'I do not have the time to ask these questions.'

The comments of the staff had similar overtones to those of Morrison and his cohort, in the United States, who designed a survey to identify obstacles to the performance of end-of-life planning. His survey involved medical residents and physicians.

They found that time constraints, compensation concerns, discomfort with the subject, beliefs about appropriateness and lack of understanding were all barriers to physician-assisted discussions.9

The research questionnaire was designed to assess if any aspects of personal planning are occurring, not only end-of-life planning. For the medical staff of the Emergency Department, the simple questioning of a patient about the appointment of a POA, an EPOA(medical) is difficult. How much more intense is a conversation with a patient about end-of-life planning? Perhaps any form of personal planning requires identifying with the individual and the subject matter discussed, in this case, the inevitability of dying and death. This may be too anxiety provoking.
Table 3 demonstrates that the majority of patients, one hundred and fifty five patients, below ninety years of age who live at home, did not have any form of end-of-life planning; greater than (50%) in each age grouping. This planning includes the appointment of a Power of Attorney (POA), advanced care planning (ACP), healthcare planning (HCP) and the appointment of an enduring power of attorney, EPOA. By the age of ninety years, there appears to be some acknowledgement of a need to plan. Three out of six patients had an EPOA(medical), and/or POA.

<table>
<thead>
<tr>
<th>AGE</th>
<th>Complete data</th>
<th>No plan</th>
<th>% ACP</th>
<th>% HCP</th>
<th>% POA</th>
<th>% EPOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;60</td>
<td>141</td>
<td>76</td>
<td>54</td>
<td>16</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>&gt;70</td>
<td>96</td>
<td>54</td>
<td>56</td>
<td>15</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>&gt;80</td>
<td>42</td>
<td>23</td>
<td>55</td>
<td>8</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>&gt;90</td>
<td>6</td>
<td>2</td>
<td>33</td>
<td>1</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>285</td>
<td>155</td>
<td>54</td>
<td>40</td>
<td>16</td>
<td>54</td>
</tr>
</tbody>
</table>

Table 3 also identifies that only from the advanced age of ninety years are individuals or their relatives prepared to address planning questions relating to POA and EPOA(medical). But the numbers in the survey are so reduced, by natural attrition, that statistical relevance cannot be applied. It seems that only at this stage in life death can be acknowledged. Advancing age with its potential for frailty and increasing dependence is not acknowledged or accepted prior to this, therefore planning does not occur. Crises occur! Cognitive and/or physical impairment precipitates these crises with the consequent attendance to an Emergency Department. Freud in his article on 'Our Attitude Towards Death' also acknowledges the ineptitude of our inaction by stating,

The tendency to exclude death from our calculations in life
brings in its train many other renunciations and exclusions.10
Table 4, shows the individual in supported accommodation. The only form of planning that seems to occur regularly is the appointment of a Power of Attorney (60%). Is this because of an economic reality? Financial and legal status needs to be assessed to fund the accommodation in supported care. In the four patients over ninety years of age only two had documented planning, and only one of the patients had an EPOA. No patient had an end-of-life plan. Completion of end-of-life plans does not seem to be related to: age, the place of residence, or the presence of support staff to facilitate these questions with a patient or their relatives. It appears that the questions that relate to dying or death are not broached in areas like nursing homes or hostels. A recent Australian study performed in aged-care facilities found very low rates of formal planning, (0.2%).

Table 5

<table>
<thead>
<tr>
<th>Principal person engaged in Healthcare planning</th>
<th>Table 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCP</td>
<td>FAMILY</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>60-64</td>
<td>4</td>
</tr>
<tr>
<td>65-69</td>
<td>8</td>
</tr>
<tr>
<td>70-74</td>
<td>4</td>
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<tr>
<td>75-79</td>
<td>2</td>
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<tr>
<td>80-84</td>
<td>3</td>
</tr>
<tr>
<td>85-89</td>
<td>1</td>
</tr>
<tr>
<td>90-94</td>
<td>2</td>
</tr>
<tr>
<td>95-99</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 5 above, documents that the principal person engaged in end-of-life or healthcare planning with the patient in the community is the general practitioner (GP) and this is only with 2% of the population studied (see column 3). The involvement of other groups including the family, the community hospital (HOSP) and Aged-Care Services (ACAS) is sought in the survey, but as noted these groups rarely appear to take up the responsibility in a formal way.

<table>
<thead>
<tr>
<th>Medical Data Collection</th>
<th>No</th>
<th>Yes</th>
<th>Complete</th>
<th>%age</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power of Attorney</td>
<td>240</td>
<td>74</td>
<td>314</td>
<td>28</td>
<td>1116</td>
</tr>
<tr>
<td>Enduring POA (medical)</td>
<td>274</td>
<td>40</td>
<td>314</td>
<td>28</td>
<td>1116</td>
</tr>
<tr>
<td>Health Care Planning</td>
<td>259</td>
<td>44</td>
<td>303</td>
<td>27</td>
<td>1116</td>
</tr>
<tr>
<td>Advanced Care Plan</td>
<td>291</td>
<td>30</td>
<td>321</td>
<td>29</td>
<td>1116</td>
</tr>
<tr>
<td>TOTAL</td>
<td>266</td>
<td>47</td>
<td>313</td>
<td>28</td>
<td>1116</td>
</tr>
</tbody>
</table>

In tables 6 and 7, the data was collected by the medical staff. These tables enable a comparison of the ability to collect different data types. The description of the data appears to significantly affect the ability to collect data. Table 6 requires the medical officer to question end-of-life care plans. This data has a completion rate of less than 30%. Table 7 identifies the diagnostic data collected by the same medical officer involved in the care of the patient. The medical data of table 7 are readily completed, (80-90)%. Is this completion related to the perceived role of the doctor, in diagnosis and treatment? It seems much easier for the doctor to retain a medical therapeutic perspective as expert and relate to the person as patient. Perhaps a conversation about end-of-life planning with a patient provokes an existential anxiety about death and the question is not asked. 'This is too difficult', 'I do not know what to ask', and 'I do not know how to ask these questions'. Therefore the data is not collected.
### Table 7

<table>
<thead>
<tr>
<th>AGE</th>
<th>UNKNOWN</th>
<th>KNOWN</th>
<th>% Δsis</th>
<th>TOTAL</th>
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</thead>
<tbody>
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<td>79</td>
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<td>89</td>
</tr>
<tr>
<td>25-29</td>
<td>9</td>
<td>73</td>
<td>89</td>
<td>82</td>
</tr>
<tr>
<td>30-34</td>
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</tr>
<tr>
<td>35-39</td>
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<td>92.6</td>
<td>81</td>
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<td>40-44</td>
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<td>94.3</td>
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<tr>
<td>90-94</td>
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<td>18</td>
<td>81.8</td>
<td>22</td>
</tr>
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<td>95-99</td>
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<td>5</td>
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<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>123</td>
<td>993</td>
<td>89</td>
<td>1116</td>
</tr>
</tbody>
</table>

End-of-life planning is not a simple therapeutic intervention or routine diagnostic decision-making. Junior medical staff have minimal education or experience with end-of-life planning and cannot feign expertise. Questioning the patient about the appointment of an enduring power of attorney (medical) or healthcare plans in the setting of chronic illness requires being with the patient in a role where they have limited knowledge or proficiency. Moreover, the time of a crisis in an Emergency Department of a hospital is not the environment to commence these conversations about end-of-life planning. It is the setting to ask if end-of-life planning has occurred.
The data identifies that the appointment of a POA, EPOA(medical) or healthcare planning does not occur regularly in the community or in supported accommodation. The person most commonly involved in any form of end-of-life planning in the community is the general practitioner.

But how can end-of-life planning become an expected component of the continuous care of a patient when the communication skills required of medical staff are not developed during their post-graduate education? Or does the anxiety generated in a conversation about dying and death ensure that end-of-life planning will not occur?

1.3.2 Transition - Emergency Physician to Researcher
As an Emergency Physician, I am conscious of my professional position. I am frequently exposed to extreme emotional distress and anxiety generated by life-threatening illness. This distress, although not always verbalized, is palpable. I take up my role by incorporating a holistic approach of treating the person, being with them in their critical situation, whilst supporting the relatives and the staff present. In role, I have reflected upon values like personal autonomy, respect and choice, and recognize that these values have not only a philosophical but an actionable relevance to Emergency Medicine and for each individual. I posed myself these questions. How can end-of-life planning commence? How can existential anxiety be contained to allow change to occur? How can the personal perspectives of the individual patient about their illness become end-of-life planning, and these plans become known?

Bridger talked about a ‘transitional approach to change’, encouraging people to explore together and understand their context and the potential for transformation.

The transitional approach to the management of change ... places much emphasis on enabling people to change the way they think about the problems around them, to alter their perspectives, and to discover new possibilities for action.
which can never occur to them as long as they remain on the secure rail-tracks of their habitual mindset.\textsuperscript{12}

It is with this impetus that I pursued my original research plan to work with general practitioners in an aged-care facility within the community and in so doing to understand how they perceive the concept of end-of-life planning.

1.3.3 Community Aged-Care Facilities
My first attempts to research end-of-life planning were not successful. I wanted to do the research within an aged care facility but met with resistance. This section of the thesis describes this experience.

1.3.3.1 Aged-Care Facility 1
The Director of Nursing of an aged-care facility was introduced by a friend who speaks of the aged-care facility of the organisation as innovative and an open system. A meeting was arranged with the personnel involved, the Director of Nursing and the general manager of the facility.

From my journal: August 2001

I enter the nursing home of the first organization for my initial conversation with the Director of Nursing (DON). The establishment itself is geriatric with an odour of incontinence. I am ushered into a tiny rectangular room cluttered with panoply of old, misshapen chairs - relics of the past - to await the Nursing Director. She is a vibrant, energetic woman whom I hear talking with personnel as she approaches the room. She shows me around the wards of the nursing home. Each area resembles the small rectangular room in which I sat. The residents are in dormitories of 3 to 6 people.

The day rooms are crowded with residents sitting in their therapeutic chairs, no conversation is occurring. Only one person has a private room; he is isolated because of his disturbed behaviour. It is afternoon tea, a large pot of tea has been made and this is trolleyed through the wards. The residents are given a cup of tea, in a trainer-cup and a biscuit, both are placed on their tray. The Nursing Director chats in a very amiable manner with each resident, an exchange of greeting occurs between some residents, but no conversation. They appear to be together in experiencing their aloneness. I write in my journal: I am aware of the debility and
disability. The Director of Nursing appears to be the only person who is able. The residents and the nursing staff seem to be disabled and silenced. The residents sit, waiting for the energy of life to come to them, to introject it, to respond to it. They have become dependent upon an external energy to live. Life has become a routine and they are dependent upon others to maintain this routine. For life is; a time to get up, a time to be showered and dressed, at time to sit in the therapeutic chair, a time for tablets, a time for meals, a time to be put to bed and so life does go on.

It appears it is only possible to be dependent or independent in this organisation, there are no alternative positions. If the valency of independence has been filled by the leader, the DON, everyone else appears to be in a position of dependency.

I am aware at this time of my own disability. I feel as though I have also been silenced: silenced by my own fear, anxiety and sadness. Is this the end of living for these people: a dormitory of anonymity? On reflection it reminds me of the newborn baby nursery, the dependency, the total reliance on others for life-care. I am then escorted around the new building: the DON is excited; there are individual rooms - a private space.

I had a number of meetings with the DON and the general manager of the aged-care facility to refine a document defining the structure of the research project. Preparations occurred to go ahead with the research in the organisation. The community aged-care facility was at the stage of sanctioning the research with staff. Suddenly the general manager retired. I am informed by the incoming person that this project will now be presented to Central Office; the DON is no longer involved, she has no input. She tells me she is not being respected or heard. She has been silenced.

From my journal: March 2002

I am invited to present to the Research Committee of the organisation. Feeling excited and anxious about the prospects of working with the Organization, I walk into head office. I walk up to the counter and recognize that the staff work behind an enclosure, they are locked in.
I feel like the outsider, I am locked out, they closely control who has access into the system. I introduce myself and am asked to wait for a member of the committee to facilitate my entrance into the organization. I am directed to sit in a corner and wait. I am met by a very large, tall man who squeezes all the life out of my hand in introducing himself to me. He escorts me to the meeting room. I am introduced to the members of the committee. I feel as though I am being cross-examined, there are a lot of blank, lifeless faces asking questions, there is little interaction. There is no ability to participate within this group, I need to explain myself, I am the outsider. I feel that they do not want to hear what I am saying. I feel their suspicion and anxiety. Will I be allowed into this system? I ask myself, how this organization deals with fear; I am talking about end-of-life planning, dying and death. Lock it out?

I was asked to submit a proposal for the research. The guidelines are enclosed, I do so, (abridged version-Appendices 3 & 6).

A letter of 3/2003 questioned the adequacy of my application. It can be summarized as:

- There is insufficient justification for the study,
- The theoretical framework is unclear,
- The study design is insufficiently detailed,
- There is insufficient evidence of understanding of the social science paradigm, and
- The application is incomplete.

The criticism seemed to relate to theoretical questions about the paradigm in which the research is performed, and the validity of such research. The issues reflect the questions posed by the University, but the University has approved the research plan! Psychodynamic research in the social sciences observes and evaluates the case material collected, it does not predict and control. As researcher, I felt I was being forced by the organization into a position of certainty. Is this because they needed the containment, they are unable to deal with uncertainty or ambiguity? What role has the research unit taken up for this aged-care facility?
In re-reading the organization's strategic directions and vision for the future I can see that the espoused values of respect, advocacy for those without a voice, and working in partnership with others in the community are stressed. But the research opportunity for carers and the elderly residents to communicate their needs is denied. On receipt of the rejection I was overwhelmed by sadness, and left wondering where the humanity in the organization might reside? Who does the caring for those who have no voice, or are the carers also silenced?

From my journal: May 2002

I receive another letter stating, you have applied promptly, but, would you please complete the application according to THIS specific set of guidelines for the research process. The system has two sets of guidelines. I feel as though I am being punished for behaving badly. I return the completed form. The rigidity is palpable. Do not go outside the guidelines, we are in control here; there are rules that apply, comply.

What is happening with the communication between and within the system? Be confused and incompetent like the demented elderly in their care?

What happens when there is not a process to deal with an intrusion? Is the method to delay by not addressing the request, create confusion by sending multiple forms, speak with multiple personnel who have differing expectations and agendas while behaving in a manner that is authoritarian and all knowing.

Many months passed without any communication from the first aged care facility. I was eventually informed that I needed to await the next Ethics and Research Committee meeting before receiving any communication; these were scheduled every three months. The next was said to be planned for September. My research proposal was not an agenda item for the June meeting. Meantime, as part of another piece of work I negotiated to complete an Organization Role Analysis (ORA) with the DON of the facility. Hutton, Bazalgette and Armstrong describe ORA as seeking:

To bring into view to both parties in the working relationship, the organization-in-the-mind of the client. The focus of ORA is rather on emotional experience as
disclosing the heart of the matter: what is essentially involved in carrying out the organization's task, whether acknowledged or not.\textsuperscript{13}

How the role-holder perceives the organization is through the accumulation of the experiences that occur within the organization. These experiences form the inner-scape; the perceptions of the organization are introjected and taken up as an inner object in the Kleinian concept and provide a psychic framework, the 'organization-in-the-mind'; the role-holder's reality.

The way the client patterns in their mind the realities of the organization ... which give expression to the emotional realities present in the experience of the client and in the organization.\textsuperscript{14}

With ORA, the plan was to assist the DON in examining the psychological and sociological dynamics that effect and affect her in role. The purpose was for the DON to achieve an understanding of her emotional experience in role, her own 'inner space' within the system. The ORA encourages reflection and analysis of how a particular person interprets her 'organization-in-the mind'; examining the objectives of the system through this lens; examining the inter-subjective and inter-group spaces.

\textit{My journal entry: ORA with the Director of Nursing, September 2002}

The Director of Nursing is expectant and welcoming; we go to a quiet area in the new dementia unit. I am just about to commence the ORA with her when we are interrupted by the new general manager. Taking charge of the space, she begins a discussion with the DON and then apologises for cancelling a meeting with me. The conversation appears gratuitous. The DON offers to cancel the ORA but I state I can reschedule with the GM.

After the GM leaves we commence the ORA. The DON recalls a dream from the previous night. 'I am in my house in England, it is raining and the roof begins to leak waking me from my sleep. I am concerned; can I afford to have it repaired?'
What is the reality of the system? Has the system forgotten its purpose as an aged-care facility to care for the elderly until death? Or has the system become demented, so that the individuals have become disorientated, they forget the responsibility of the time; forget their place, and person, who they are in role? The DON, the only person who seems to be aware of the task of the organization, is confused. The boundary of her role is being invaded her time and her place in the system are being encroached upon to the extent that she is no longer able to perform her work. Her dream informs her that the role boundaries are not functioning. She is being rained upon, perhaps flooded out. Can she afford to continue her role in this organization?

Perhaps through her dream she is telling me that the research is being flooded out, that I have no role as researcher in this organization. Locked or flooded out.

The final letter from the aged-care facility, December 2002:

We will not take part in the research, for we do not believe the research is going in a direction we wish to pursue. We are concerned about the method; in a business school. We have a 'well' model of care. Our medical model is to defer to the decision maker - the doctor.

From my journal: January 2003

I wish to complete the feedback cycle with the Organization, but before I am able to schedule an appointment with the Chief Executive Officer I am interrogated by the assistant. I must acknowledge to the personal assistant that I recognize the letter is final; there will be no attempt by myself to revoke the decision of the Organization in this meeting.

I state that my purpose is to develop a greater understanding of the letter written on behalf of the Organization. The appointment is cancelled and rescheduled on a number of occasions by the personal assistant on behalf of the CEO of the Organization.

As I read the letter I recalled the structure of head office where the staff are locked in. I am locked out. Is this to protect them from the external environment? I experienced their fear, as associated with an intruder trying to introduce death into the organization by discussing end-of-life planning, a fear of being flooded and being unable to control the anxiety that is unleashed in the face of death.
'We do not wish to pursue the topic or research of end-of-life planning. We have a 'well' model of care; we concentrate on wellness. If someone is ill we deal with the crisis and defer to the expert, the medical model of decision-making'.

My sense is that the system displays the paternalism that is predominant in the medical fraternity. We seek protection and support from the medical experts. Paternalism as a generic term implies paternal beneficence, the provision of protection and support. As a consequence of this attitude, the individual’s rights and choice may be denied. Beauchamp and Childress define paternalism as:

The intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.15

It feels as though death cannot be introduced into this organization, even though the purpose of the organization is to care for the aged. 'Death is something to be avoided'. But Donne recognizes that,

No man is an island entire of itself ... Any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls: it tolls for thee.16

I received a letter from the Director of Nursing: December 2002

'Hello, I am absolutely disappointed I had not been advised that the Organization decided not to support your project.'

From my journal: January 2003

Am I going to find an organisation that is prepared to work with me, is this research too difficult, like death itself will I be denied and rejected?

Eventually I am informed that a meeting could be organized with the CEO of the aged-care facility 1.

From my journal: February 2003
The CEO acknowledges that the research is cutting edge. She asks, 'how does end-of-life planning occur?' and 'how can this process be taken up to enable patients to be involved in the decision-making?' But then states, our cultural and staffing issues at this time require our time and energy. Perhaps the DON has resigned?

I looked down, closed my eyes and then smiled politely and leave the office. I wanted to cry - what an enigma.

1.3.3.2 Aged-Care Facility 2
The introduction to the personnel of the second aged-care facility was refreshingly open and honest. I was introduced to the decision-makers who were instrumental in accepting or refusing research for the organisation. The persons involved extended across each level of management, including the staff intimately involved in the research process. One of the delegates stated very clearly that 'the organisation is conservative and this research is controversial. We shall discuss it at our next Patient-Care Committee, but I have no guarantee that we shall be able to work with you'. I was given the impression that the decision would be made from all levels including personnel participating directly in the research.

From my journal: workplace Aged-care 2, Director of Nursing, February 2003

This feels personable. I do not feel as though I am knocking on death's door, hope still lives here. An occupational therapist involves the residents in activities, maintaining a quality in life, there is a sense of fun. The DON is honest in her communication, the facility is about to undergo government accreditation, a process to ensure that the facility provides quality service for the residents. This will be a significant workload for the personnel of the facility for a period of approximately eight months. The DON questions the ability of the facility to simultaneously take on both tasks. She will inform me of their final decision.

From my journal: February 2003

A call from the Director of Staff Development and Training, facility 2: 'We are excited by this research, this is important research, and "I" would love to be
involved. We are undergoing accreditation and do not have the time or resources to fulfil this project concurrently, come back in (6-8) months'.

I was pleased that the answers came back to me so quickly from facility 2, keeping me informed of their processes. Where to now? It appeared that no-one wanted to be involved in this research. Looking at the data from the hospital it is general practitioners who appear to be most commonly involved in end-of-life planning for patients. Do general practitioners see end-of-life planning as a component of their role?

**1.3.4 Regional Division of General Practice**

Early in the research process, I discussed the project with the General Practice Liaison Officer of the hospital, a general practitioner who works in the community for the regional Division of General Practice. At this stage of the process I decided that it was timely to re-discuss the research with her with the potential of re-designing the project to directly involve the local general practitioners.

From my journal: email from General Practice Liaison Officer, April 2003:

The General Practice Liaison Officer arranges a meeting with the Chief Executive Officer of the Regional Division of General Practice.

From my journal: meeting with CEO, April 2003

I am overwhelmed by the response someone else appreciates this research as important. The regional division will not only seek general practitioners to be involved in the research but will also fund the research; the interview time with each general practitioner. ‘How many general practitioners do I wish to interview?’ (10-12) people, 13 are prepared to be involved. ‘When do I want to start?’ As soon as possible!

From my journal: first interview, June 2003

I am so anxious that I put the tape in backwards. This means I am present and alert as I listen to the data. I write and question to encourage greater understanding; but there is also a sense of freedom to sit and enquire. I muse and reflect with the general practitioner. I feel so privileged to be with his openness and the honesty in the conversation.
I am aware of the personal power of this man and question myself, would a patient be able to develop a participative relationship with him? But I am sitting alongside this man in his surgery, not across a desk!

From my journal: August 2003

I have completed the thirteen interviews. This is such a privilege. I sit and re-read the transcribed interviews; the entrée into another’s world of work has been illuminating. I feel exhausted and overwhelmed.

Patton says:

Ask.

Listen and record...

Asking involves a grave responsibility.

Listening is a privilege.

To ask is to seek entry into another’s world. Therefore, ask respectfully and with sincerity.17

This data is so profound, I feel anxious!

1.4 Anxiety

The Emergency Department of the Hospital, a tertiary referral centre as a system has affiliations and working relationships with other large systems; the primary care system of general practitioners, other Hospitals, the State Government, Department of Health Services and the Federal Government of Aged Care and Health. These systems share a common purpose, the care of the patient. But each system pursues the task of patient-care from its systemic value-base. Anxieties are inherent in the work of patient-care within each system and defences are developed to enable the work. In this inter-system conglomerate another system paralleling the conscious tasks develops, these unconscious tasks develop to defend against the anxiety of the inter-system work. These defenses are difficult to observe, let alone understand. To maximize patient-care, communications between systems are the imperative. But do the anxieties between the systems enable communication or do the intra-group allegiances override the task of patient-care? (See Chapter 6: System Psychodynamics)

Will these intra- and inter-group allegiances spill over into the research data?
What also spills over into the research data are the personal and professional anxieties related to the research. These include the personal anxiety about a task relating to end-of-life planning with the experiential and existential anxieties related to dying and death, as well the associated professional expectation of the task of the research; a new field of exploration and the topic which creates anxiety for all involved. Will I be able to listen, hear and understand the data? Also, pay attention to and reliably interpret the information communicated?

1.4.1 Personal anxieties

What sat with me as I commenced this research project was an immense sense of responsibility to work with the collected data and in doing so respect the individuals involved. For each person had given me a unique insight into his/her own praxis. I was aware of commencing a new field of exploration with the general practitioners, end-of-life planning, on behalf of the patient. The responsibility of the social scientist to the research data involves veracity, neutrality and understanding. My anxieties, as defined below by Judd and Burrows, sprang from several sources: personal anxiety, professional anxiety and the anxiety of managing myself in the new role of social science researcher.

Anxiety is universally experienced - a diffuse, unpleasant vague sense of apprehension ... Anxiety may also be adaptive, functioning as an alerting signal and warning of external or internal threat.

The emotion that I experienced was fear, an internal fear and trepidation which questioned my ability to fulfil the research task. For in studying human behaviour there is a requirement for self-awareness, as described by Berg, for I may be confronted to explore personal emotional reactions in order to understand responses in the study. As well, in any relationship transference and countertransference reactions occur. Would I recognize these emotional responses?
There was also fear related to an external threat, that of the observer. Would I be found adequate for the task of social science researcher by the general practitioners, my supervisors and examiners?

1.4.2 Professional anxieties
Prior to commencing this research project, I contemplated the gravity of the topic of end-of-life planning and reflected upon my professional environment, an Emergency Department. The Emergency Department is a place of immediacy, expertise, with the dynamics of professional power and authority, and the potential of inducing dependency in the setting of knowledge and skills of the professional. This position of the attending patient is juxtaposed to my personal opinion that each individual has personal autonomy and the entitlement of choice in decision-making. But does the individual take up this autonomy and end-of-life plan? Moreover, a critically ill person frequently does not have the physical or emotional capacity to be involved in decision-making. The conversation about end-of-life plans should occur prior to the need for any critical, crisis intervention. Also, are individuals supported or prompted to discuss their own wishes in association with end-of-life planning?

My experience with the aged-care facilities deepened my awareness of the anxieties at play. I was more comfortable in commencing my exploration in the service field than in the Executive offices. The communication with skill groups involved in caring for patients diminished my personal anxieties but amplified my awareness of the transferential projections. The exploration with the management team had a sense of purpose; fulfilling the objectives of the organization (Appendix 3). It seemed that the organization recognized its underlying responsibility in taking the research project into a wider domain, to the nursing staff, the residents and their relatives. But with this, the unknown, the uncertainty in the exploration and participation, what challenges would arise? How would fears be contained?
The relationship between the Research and Executive teams within aged-care facility 1 brought a difficult set of dynamics. These seemed to relate to organizational hierarchical power with its incumbent authority. Underlying these dynamics was a fear of the organization losing emotional control. Don’t let death in! This anxiety was expressed by the organization’s head-office. The gates were locked, the entrance controlled. The organization as controller keeps death out, and therefore keeps existential death anxiety at bay; controls death. The Research and Executive team’s responsibility at the boundary limits entrance into the organization and in so doing protects patients and maintains control. The maintenance of control is delivered with vehemence in all my meetings and communications with the Research team. The organization experiences its responsibility to the staff and residents, but the ‘strategic directions’ remained espoused. The research project appears to threaten the equanimity of the organization. Their organizational literature includes:

- Encouraging personal independence in every day life and
- respecting the right to privacy, dignity and individual decision making.24

In the researcher-researched relationship participants seem to confront personal and organizational fears and emotions being generated by the potential of participating in this research project. It is as if their response says ‘How can we trust this threatening person, who wants us to accept the concept of death? Keep death out, it is unwanted in an aged-care facility.’ This picture clouded my experience in this organization. My assumptions were that: power and authority exists within the upper echelon of the organization far removed from care delivery. Decision-making occurs without the involvement of the care-givers!

This experience was not duplicated in my presentation to the Division of General Practice. The Executive and Research team recognize the potential of a reflective process for end-of-life planning with the general practitioners and the researcher. Berg and Smith recognize the timeliness in the acceptance of a research proposal.
When a human system ... (responds favourably to the
overtures) of an applied researcher, it usually does so
because it recognizes its need for help in self-reflecting -
either on the relationship with its internal parts or on its
external relationships with other entities in its ecosystem.\textsuperscript{25}

As an Emergency Physician who has regular written communication via continuing
care letters to general practitioners in the community, I experienced a sense of
being known. Rapport building with the general practitioners of the community on
the whole was less anxiety provoking than with the nursing home staff. Also with
this familiarity came a sense of a shared responsibility for the patient-care within
the community. There is an assumption of a significant relationship between the
general practitioner and the patient in his/her care.
The bias of the importance of the doctor-patient relationship is an important
conceptual construct for the research. This sense of relationship may have also
been pervasive in the relationship between researcher-researched allowing in
many instances freedom in information sharing with openness and honesty.

1.4.3 Group-level anxiety
As a staff member of the acute health sector, I was aware of the silo mentality
of the specialty system. Each specialty group retains professional boundaries as a
mechanism of defense in bolstering a sense of self in their field of knowledge and
expertise. In this environment many professionals are their role, the anxiety
takes on a personal component.\textsuperscript{26} My question was: ‘will general practitioners be
open in their attitude to the healthcare systems in which they work?’ Kram
recognizes these influences:

How are my group memberships shaping research
participant’s reactions to me and their willingness to
respond authentically to questions and probes throughout
the data collection process?\textsuperscript{27}
How might the general practitioner of the community perceive the hospital system? Will s/he trust me, a researcher from the acute care system? How will this influence the information shared?

1.4.4 Anxiety in the role of researcher

This performance anxiety remains, a familiar object in my repertoire of relations to objects, the idealized object, in Klein's terms. What a fertile field for exploring anxiety to focus on dying and death and the process of end-of-life planning by general practitioners with their patients. This research requires the creation of a safe exploratory space that enables the researcher and the researched to develop understanding of the intra-subjective and inter-subjective dynamics within systems. This enquiry requires openness in its analysis.

Can there be a more sacred act than self-inquiry?29

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16 Donne J. Now, this bell softly tolling for another says to me, Thou must die. London: The Folio Society, 1624: Devotion 17.
2. METHODOLOGY

What is the course of history or philosophy, or poetry, no matter how well selected, or the best society, or the most admirable routine of life, compared with the discipline of looking at what is to be seen? Will you be a reader, a student merely, or a seer? No method nor discipline can supersede the necessity of being forever on the alert.¹

The scientific research choices available for the social science researcher are numerous and diverse. Such complexity is daunting at the commencement. The aim of the research guides a researcher to determine the most appropriate paradigm and platform for a research project. The philosophical predisposition of the researcher also evokes the final choice. Consequently, this chapter requires that I examine why I have chosen a systems psychodynamic approach in my research.

The exploration commences with a discussion of the principles of the methodology which link research purpose with process. Because systems psychoanalytic and psychodynamic practice is central to my methodology, this theory is extensively explored.

The investigator’s commitment is to understand the world as it unfolds, be true to complexities and multiple perspectives as they emerge, and be balanced in reporting both confirmatory and disconfirming evidence with regard to the conclusions offered.²

This chapter and the following chapter on research methods have the purpose of identifying the perspectives and components of valid, empirical social science research. The aim of this research is to understand why the general practitioner as a general rule does not engage in end-of-life planning with his patient.
To this effect, a methodology designed to understand social, group and individual
dynamics is required. Equally required is a methodology that addresses the idea of
differing realities. This research is concerned with:

- the psychological realities facing patients in their decisions about end-
of-life planning;
- the psychological realities facing general practitioners in their
decisions about introducing and working with end-of-life planning with
their patients; and,
- the social dynamics surrounding the patient and general practitioner.

The question of 'whose reality' is critical. Consequently the methodology employed in
the research must be able to discern different realities, and to weigh their import in
the social dynamics studied. In addition, the methodology needs to give rise to data
that can enable the generation of working hypotheses about social avoidance,
defenses and other responses to the anxieties aroused by end-of-life planning.

2.1 The Stance of the Current Research
In the current research, my plan is to apply a number of methodological approaches
including interpretivism, phenomenology, heuristic inquiry, and systems
psychoanalytically informed research. The psychoanalytically informed research will
predominantly be based on Kleinian psychoanalytic and systems psychodynamic theory,
in order to gain understanding and make meaning of end-of-life planning in the
environment of the general practitioner. The ontological reference point used for this
research is consistent with the interpretive stance. The research objective is the
exploration of the concept of end-of-life planning with the general practitioner. The
intention for this exploration is to increase the understanding of the process of end-
of-life planning in the reality of the relationship of the doctor with his/her patient.
The interpretive stance considers the ambiguity, the not-knowing and irrationality of
the derived meanings as relevant and important.
Indeed, the meaning gained from the life experience of the individual is central to the framework of the interpretive stance. Questions about end-of-life planning address a phenomenon that effects and affects the social environments of the community in which the general practitioner works. The researcher questions the philosophical and existential understanding of dying and death to develop an interpretive conception of individual and collective meaning.³

The data collected are the perceptions and the derived meanings held by the participants, the general practitioners; the cognitive and emotional interpretation of their reality. The purpose of this research is to make sense of the individual’s actions and behaviours related to end-of-life planning. This is done through identifying and interpreting the thoughts and feelings expressed about how meaning is constructed. Such construction of knowledge is ideographic, with each person researched creating and communicating his own meaning. Thus, an understanding of one aspect of current social experience can be gained through an understanding of how its members construct their knowledge.

Habermas, in explaining his notion of Critical Theory, agrees with the interpretivists that the themes of the sciences, natural and social, are as distinct as the subject matter under investigation.⁴ As a consequence, he believes, the process for exploration also needs to be distinctive. In Blaikie’s view, the critical theorist sits between the positivist (the empirical-analytic based on technical interests of prediction and control), and the interpretivists (the historical-hermeneutic sciences based on the knowledge of human social existence).⁵ Blaikie includes a third position, critical theory based on emancipatory interests; human autonomy freed from domination. The critical theory research model incorporates all three knowledge bases and proposes that members of society are confronted by socio-economic conditions that shape their lives; they assign meaning to the circumstances and as a
result create their own destiny by acting upon the meanings they assign. With this premise it is assumed that social science cannot be pursued without political interest.

My aim is to understand why the general practitioner, within the doctor-patient relationship, does not end-of-life plan with his/her patient. In acknowledging the desire to obtain this understanding, this research is orientated towards making sense of how social convention may effect or affect professional interactions as the general practitioner assists his/her patient.

The research paradigm of interpretivism assists in unfolding the personal reality of the general practitioner and how s/he interprets actions in the social realm.

2.1.1 Interpretive Inquiry

Using Interpretivism as the methodological paradigm enables me to gain an understanding of the complexity of the individuals involved. This understanding is gained ideographically; it relies upon my interpretation to understand how the general practitioner constructs meaning. In this paradigm knowledge is tacit, the inner experience of the individual, it requires exploration to elicit its inner essence and to collaboratively make meaning of this lived experience; meaning comes through the dialogue. This framework for research facilitates the understanding and interpretation of social action. The design methods involved in the research enhance the comprehension of the social context of the action. At all times, it is my
imperative to gain insight into the phenomena studied in order to understand the
nuances of the individual participant and be true to each participant's experience and
wisdom. For, as Shapiro and Carr state,

This interpretive stance assumes that individuals bring their
own particular lenses for seeing the nature of the world around
them.\textsuperscript{7}

With this emphasis it is important to be aware of the potential pitfalls which can
influence the quality of the research. Blaikie writes of ideological frames which limit
the attainment of true knowledge for the researcher.

Idols which distort the mind and inhibit acquisition of true
knowledge are:

'Idols of the tribe', tending to see things from our own point of
view rather than letting nature reveal itself; we are inclined to
impose our own order on nature...

'Idols of the cave', refer to differences in personality and
experience which lead individuals to approach 'the facts' in
different ways and not see them as they really are.

'Idols of the market', are the result of imposing on nature
concepts which do not stand for anything, which do not relate
to objects in the real world.

'Idols of the theatre', philosophical systems influence our minds
and hence predetermine what we see in nature.\textsuperscript{8}

With interpretivism it is important that the audience and participants appreciate the
research as a reliable, authentic scientific process. Patton writes of Filstead saying,\textsuperscript{9}

It is ... an empirical,(i.e. data-based), scientific perspective. It
is crucial for validity and, consequently, for reliability to try to
picture the empirical social world as it actually exists to those
under investigation, rather than as the researcher imagines it
to be.\textsuperscript{10}
My role in the interpretive stance is to absorb myself in the realm of the subject, to identify with the person's praxis so as to accurately depict its conscious and unconscious characteristics. Blaikie succinctly defines the task and role:

Therefore, the major task of the Interpretive social science is to discover why people do what they do by uncovering the largely tacit, mutual knowledge, the symbolic meanings, intentions and rules, which provide the orientation for their actions.11

Interpretivism has its origins in phenomenology and hermeneutics; from these origins it has become pluralistic. Each theory within the paradigm has a distinctive, disciplinary background which is defined by specific values, and theoretical principles. Despite the diversity in the defining characteristics of the methodologies, the basic principles and the methods used to structure research are similar.

2.1.2 Phenomenology
Phenomenology has a long history in philosophy and sociology and is committed to understanding social phenomena from the perspective of the other. Husserl is regarded as the founder of the phenomenological movement in philosophy.12

Phenomenology sees understanding emerging at an individual personal level. It seeks to comprehend the motives, beliefs and therefore the meanings behind a person’s actions. From this perspective, phenomenology creates a shared meaning within society. Patton asks,

What is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?13

Through the phenomenological approach the researcher endeavours to gain in-depth meaning for everyday experience. Phenomenology captures the essence of both individual and shared experience. The methods used to achieve this understanding are participant-observation and in-depth interviews. These immerse the researcher in
the experience of the other. The focus for this research paper is end-of-life planning.

My purpose is to explore how this practice is understood in the day-to-day experience of the general practitioner in an attempt to understand the praxis, the role and the nature of the doctor-patient relationship. The essence is making meaning of the experience of General Practice from the individual practitioner's perspective and to identify what aspects of this experience are shared. This methodology has similar theoretical underpinnings to that of heuristic inquiry which is also used in this research.

2.1.3 Heuristic Inquiry
Heuristic inquiry as described by Patton focuses on human experiences of intensity.

> What is my experience of this phenomenon and the essential experience of others who also experience this phenomenon intensely?\(^{14}\)

Discovery comes from being wide-open to be disturbed and challenged by the experience: living in the experience and being open to the myth, mystery, and miracle of the experience. The root meaning of heuristic comes from the Greek word *heuriskein*, meaning to discover or to find.\(^{15}\)

It refers to a process of internal searching through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis. Heuristic inquiry commences with the expectation that the researched has personal experience and knowledge of the phenomenon being studied. In the case of this research, the phenomenon is dying and death and the practice of end-of-life planning in General Practice. The exploration is to develop an understanding of the process resulting in the inclusion or exclusion of end-of-life planning by the general practitioner with the patient in the day-to-day experience of General Practice.
The process of end-of-life-planning in a patient’s management is a complex, and medically challenging period for all involved. It is emotionally charged and its meaning is constructed between the players in the process. Mirroring this, the research may also be emotionally charged and its meaning will be mutually constructed. In the research, the self of the researcher is present with the self of the general practitioner as together they explore the phenomenon, end-of-life planning, to gain an increased insight and understanding of this practice and make meaning of end-of-life planning through intersubjectivity.

The theoretical perspective of heuristic inquiry is used with the qualitative methods of in-depth interviewing and participant-observation to inform and create interpretations about the conscious and unconscious processes occurring for the researched and the researcher as the general practitioners communicate about their personal experience with death, dying and end-of-life planning.

2.1.4 Psychoanalytically Informed Research
In this research the underpinning methodology is anchored in systems psychoanalytic and psychodynamic theory. The interpretive stance, with a psychoanalytic perspective, provides a way of engaging with and making sense of the phenomenon of end-of-life planning, using conscious and unconscious data as sources for generating understanding and meaning. The psychoanalytic stance draws on the individual’s experience; the foundation of his/her reality, a participative exploration and testing of that reality, and the attainment of a collective framework which enables connections for personal, societal and organizational experience.

Using the concepts of psychoanalytic praxis in my research methodology enables me to examine the research data in terms its conscious and unconscious aspects. For example, the conversations in this research involve the themes of dying, death and end-of-life planning and as a consequence have the potential to create anxiety and induce retreat into routine practice. Freud termed this dissociation, a defensive
process where traumatic interactions involving intense thoughts and emotional feelings are removed from consciousness.\textsuperscript{16} In this case dissociation occurs to protect the patient and the doctor and permits them to continue to communicate. Kubler-Ross recognized the depersonalization occurring in medical practice.

Is the reason for this increasingly mechanical, depersonalised approach our own defensiveness? Is this approach our way to cope with and repress the anxieties that a terminally or critically ill patient evokes in us.\textsuperscript{17}

Given data of this nature, it is important to be present and listen for both conscious and unconscious nuances. The unwitting escape into clinical medical routine as experienced personally in my clinical practice occurs, automatically. It is on reflection that evasion is recognized. The discomfort, the intensity of the emotional anxiety associated with a critical experience precipitates flight into the well-practised routine of medical management and treatment, rather than acknowledgement of the distress for all involved.

It is my prerogative to explore with general practitioners in this context, to listen and so to understand the meaning given to the unconscious withdrawal. Balint states it is important to listen.

‘Listening’ to such slight emotional reactions in ourselves when dealing with our patients. This does not mean giving way to our emotional reactions, or even expressing them, but it does mean that we must ‘listen’ to them, and then try to evaluate the information as part of the whole situation developing between the patient and us.\textsuperscript{18}

Psychoanalysis and psychotherapy are clinical treatment modalities which, amongst other things, enable the individual to be aware of ‘me’ and ‘not me’. They encourage exploration of personal identity and its construction. In the psychoanalytic space, the analyst aids the analysand to differentiate self from not-self (the other) and in doing
so to identify internal and external reality, to recognize phantasy and the part it plays in confusing aspects of self and other. This enables the analysand to become cognisant of the genesis of internalized objects and their relationship with self. The psychoanalytic process provides a safe space to support the individual's search into the development of the constructive and destructive elements of his/her personality and to re-integrate the unconscious repressed and split-off parts of that personality. These concepts deeply inform the systems psychodynamic approach. Beyond the individual, the theory of systems psychodynamics allows me to engage with concepts at play within the context of the healthcare system in which the general practitioner works. As Gould states,

> A systems psychodynamic perspective implies working simultaneously from 'the inside out' and 'the outside in', with neither perspective being privileged.19

The theory and concepts of systems psychoanalytic practice are of importance in this research. As described by Holloway and Jefferson, they highlight the praxis applicable to the research.

> Our research is deeply indebted to psychoanalysis, both theoretically and methodologically:

our subject is one that is not only positioned within the surrounding social discourses, but motivated by unconscious investments and defences against anxiety; our data production is based on the principle of free association; and our data analysis depends on interpretation.20

In the research setting, systems psychoanalytic and psychodynamic theory is used to aid in the exploration and understanding of the general practitioners' practices in their relationship with patients and their conversations about dying, death and end-of-life planning and their work within the health systems. What are the general practitioners lived experiences of working with patients in this context?
The data is collected and created through the application of concepts of transference, projective identification and countertransference. But the data is analysed predominantly outside the relationship in research. Whereas in individual analysis, the relationship between the analyst and analysand is ongoing, the intersubjective space is used to work through their relationship in the moment and on a continuing basis, in social research meaning often occurs following the exploration and understanding of the data collected and analysed. As explained by Holloway and Jefferson,

The primary difference between the two practices is that clinicians interpret into the encounter, whereas researchers will save their interpretations for outside it.\textsuperscript{21}

However, at times in collaborative research the relationship may bear similarities to that of the analytic encounter. For in developing a meaningful relationship with a general practitioner, I may create a space to contain the unbearable feelings associated with the projections that relate to the thoughts and feelings about dying and death. It is important to develop an environment of trust and for the researcher to hold projections in order to minimize the potential for withdrawal from the interview. This is similar to the process described by Caper.

This kind of mental processing, performed on the patient’s unconscious projections, is what is meant by containment and analytic receptivity.\textsuperscript{22}

Thus, working in a collaborative way with a sophisticated subject, the researcher and the researched are able to work together to generate an hypothesis about the data.\textsuperscript{23}

In the current research I use the psychoanalytic frame of being with the researched and attempt to be perceptive about the projections, the transference and the countertransference. But predominantly I use this information as data to develop working hypotheses outside the interview. Because the purpose of the research
involves exploring and identifying the individuals' experiences of end-of-life planning in the context of their task and role, the data is used to make sense of what is occurring in this community. After completing each interview, it is important to reflect on the thoughts and feelings elicited during the interview to make sense of and interpret the conscious as well as the unconscious components of experience. In working with a Kleinian psychoanalytic frame the data derived from the transference, the countertransference and projective identifications arising from the interview setting can guide further exploration and understanding of the phenomena of death and dying and the experience of end-of-life planning. For Shapiro and Carr:

The psychoanalytic model contains ... primary notions ...
transference (the recreation in present relationships of projections from childhood relationships), countertransference (the feelings experienced by those who receive these projections), and projective identification (the encouragement of feelings in others that correspond to disavowed aspects of one's own internal conflicts).  

During the transcription of the interviews, as researcher, I immerse myself in the world of the other to make sense of the anecdotes and stories described. Following this process, an analysis of the themes and patterns played out in each interview is used to interpret the conscious as well as the unconscious components of experience. As my understanding matures working hypotheses are developed. The hypothesis induced is used to test the understanding of the reality of the general practitioner and leads to the formation of further hypotheses as further clarity is gained. Shapiro and Carr go on to write,

The interpretive ... stance is speculative, imaginative, and heuristic ... it allows the possibility of proceeding from one hypothesis to another hypothesis rather than from uncertainty.
to certainty ... we begin to recognise them as realities that link individuals with their social settings.25

These data are also explored with the theoretical underpinnings of systems psychodynamics in the context of task, role and the boundaries associated with the systems in which the research participants work and the society in which they live.

2.1.4.1 Projective Identification

Projective identification as a concept was introduced into analytic thinking by Melanie Klein in 1926. She described the infant’s phantasy of transferring experiences into the mother both pleasant and unpleasant. This phenomenon has since been described widely. Bion uses this same concept to develop an understanding of group interactions.27 Projective identification is described as a mechanism wherein an individual dissociates from his own anxieties and experiences through communicating these same feelings into another. Because individuals have a particular propensity to take up specific projections, anger, fear, pleasure or trust, they can become recipients of these feelings from others. It is an unconscious process linking people in ways beyond their recognition and understanding. For Ogden projective identification is 'a discrete quality of intersubjective experience.'28

In this research, I understand projective identification as a constructive quality in a relationship, wherein my own experience is used to relate to the stories and case histories communicated unconsciously by the research subjects. While retaining my own integrity, it is important to recognize and experience the emotional connection associated with my projections and those of the other. The emotions and images are explored as possible projections to be understood, and interpreted as data as they relate to the phenomena under consideration and used to create hypotheses. Money Kyrle writes:

The analyst experiences the affect as being his own response to something. The effort involved is in differentiating the patient's contribution from his own.29
If these projections are introjected without reflection and analysis, the ability to retain cognitive and intuitive capacity is compromised and a collusive relationship may develop ultimately restricting the researcher's ability to interpret the complexities involved.

In this research the concept of projective identification is useful in understanding how I take up the practitioner's interpretation of the case histories and the anecdotal stories presented. Similarly, it is used to understand the relationship between doctor and patient. When the projections of the patient are not identified by the general practitioner, projective identification may result in rigidity in the behaviours of the doctor and patient, so that 'acting out' emotional responses may occur instead of understanding. For example, the general practitioner, as a naive recipient of projection, may intensify the primary tensions experienced between himself/herself as an authority, the expert and the patient, a lay person without expertise. This complementarity of projections creates collusion in a dependency relationship.

2.1.4.2 Transference

Transference is the result of a process by means of which the patient projects aspects of his current inner world into the outer world in a delusional manner.30

Transference is an important concept, first used by Freud.31 Since then, the theoretical construction has developed and extended. One current understanding is that it is the re-enactment of past learned behaviours and experiences of childhood acted out in the relationships of the here and now.32 The individual responds to current relationships, interactions, and anxieties as if replicating childhood learning. Such defensive positions are used to diminish anxiety and risk-taking in the current situation. Through an understanding of transference, the process of projection is explored to inform the researcher of the unconscious thoughts, feelings and
emotions associated with the content of the discussion. Projection produces a response both consciously and unconsciously in the other. Awareness of transference processes facilitates a deeper level of understanding. The fundamental task in employing an understanding of transference, especially when totally immersed in the data from the dialogue with the general practitioner, is to grasp intuitively the inference of the unconscious information. These thoughts and feelings, when repressed by the practitioner, are present in the transference and perhaps able to be present without repression and anxiety in the researcher. It is important to be responsive to one's own conscious and unconscious intuition, using this personal information to understand and develop hypotheses about the implications of the transference.

In the current research my purpose in identifying the transference is to recognize and contain the unconscious projections of the practitioner as they infuse the content of the data. Systemic data is used to analyse the issues occurring within the doctor-patient relationship as well as the system relationships relevant to the work. Projection and transference are never one-sided, so it is of importance as researcher to examine all images, phantasies, and constructs projected. These opinions and beliefs can influence the research relationship and the kind of data gathered, or ignored. Self-knowledge is critical for discernment. Racker asserts:

> Another person's unconscious can be grasped only in the measure in which one's own consciousness is open to one's own instincts, feelings and fantasies.³³

### 2.1.4.3 Countertransference

Countertransference is exemplified in a mother's intuitive knowing of the child's needs, and this comes with the mother recognizing how the child makes her feel. Many psychoanalysts during the 1950s developed this concept further. Hinshelwood traces the growing understanding of this concept:
1) The importance of the analyst’s feelings as an indicator of the patient’s state of mind;

2) The discovery of a normal form of projective identification which is used as a method of non-symbolic communication;

3) Cycles of introjective and projective identifications as the basis of an intrapsychic understanding of the interpersonal transference/countertransference situation between analyst and patient;

4) The idea of ‘normal’ countertransference; and

5) The importance of the analyst’s mind above all else as the significant aspect of the patient’s environment.34

Bion formulated the idea of the analyst as the container of intolerable thoughts and feelings, which are distinguished from other concepts of projective identification and the expression of empathy.35 He also recognized the impact of the analyst’s therapeutic effect with an interpretation. Similarly, in the mother-baby relation mother contains intolerable thoughts. In the positive mother-baby relationship Bion acknowledges the personal psychic interaction between mother and baby. The distress of the baby is projected, then understood and the intervention of the mother modifies this distressing experience by creating meaning, which is re-introjected by the baby; a containing experience. This state of mind of the mother Bion terms ‘reverie’. These experiences are thought by Bion to lead to the development of meaning, informing the infant’s own capacity for reflection, on his/her state of mind.

The analyst’s countertransference is an emotional response to the transference and is identified and acknowledged by the analyst as his/her reaction to the patient. The thoughts and feelings of the patient are introjected by the analyst and transformed
into meaning. Through an interpretation, an affective resonance is created. If the countertransference is not identified by the analyst it is dealt with by unconscious defensive personal behaviour. It is therefore not able to be transformed into meaning or an interpretation. Obholzer believes that recognition of countertransference is a process that can be learned:

However, one can work at developing a self-observing stance towards one’s own reactions, noticing when these seem more intense than the current situation warrants, or when one’s emotional state is similar to ways one has felt in earlier significant relationships.36

In the research setting, where possible, my countertransference is used to aid identification of the experience of the practitioners to the questions posed. Countertransference data stimulated during the interview is collated from journal entries. Data is also derived through the use of countertransference during the transcription phase and during analysis of individual interviews. The purpose of the use of the countertransference is to gain understanding of the thoughts, experiences and feelings of the practitioner as they relate to their context and the phenomena of dying and death. The countertransference assists in the creation of meaning and formation of hypotheses for the research.

2.1.4.4 Containment

Containment doesn’t mean simply tolerating the patient’s projections. It means showing the patient you understand them by interpreting the transference. By virtue of interpreting the transference, the analyst becomes a safe and logical receptacle for further projections.37 Containment is a term coined by Bion.38 It relates to the ability of the analyst to recognize projections and to ‘contain’ the anxiety involved and the feelings associated with the projection. The analyst acts as a ‘container’ for the feelings.
In containing the projection the analyst also develops an understanding. After integrating the information, s/he communicates back to the group or individual in a way that is bearable and capable of bringing about incorporation of the projections with the potential for change, described by Strachey as a mutative interpretation.39

In the current research, containment of the anxieties and the intensity of the feelings present relate to the experiences being explored in the discussions about the task of end-of life planning. This containment and integration of the feelings enables both the researcher and the general practitioner to focus on the exploration involved in the conversation.

2.1.4.5 Subjectivity: sense of self – sense of other
Understanding one's own experience, one's sense of self requires the evolution of understanding of the conscious and unconscious components of one's self. It requires recognition of the multiple 'states-of-mind' that can occur depending upon the context. These 'states of mind' are elusive; continually in the process of changing. To understand the derivation of each 'state of mind' requires working through to overtly experience the effects and affects of the unconscious. Such 'states-of-mind' are described by Klein as the depressive and the paranoid-schizoid states,40 and by Bion as the collective states of mind present in 'work groups' and 'basic assumption groups'.41 As a result of understanding one's own subjectivity it is possible to use this knowledge to understand the subjectivity of another. Long writes of the possibility of:

Cultivating a 'state-of-mind' capable of entertaining and understanding the state-of-mind of the other.42

The development of a responsive subjectivity involves the enhancing of perceptive capacity, to be wide open to the experience of another's subjectivity. Feelings and thoughts of the moment influence the state of mind and subjectivities are able to communicate. Ogden writes:
An intersubjective dialectic of recognizing and being recognized
serves as the foundation of the creation of individual
subjectivity.43

As researcher, I may be open to my subjectivity, my 'state of mind' which is
influenced by the context of the moment: the transference and the
countertransference. If achieved, this 'state of mind' is an entrée to the other's
'state-of-mind'. The exploration of subjectivity, together with an exploration using
the psychoanalytic concepts of projection, the transference and the
countertransference whilst interviewing and working with the data from interviews,
enables interpretation of the dynamics. However, it should be kept in mind that such
interpretations are limited and simply provide the beginnings for new hypotheses.

Tarnas states it concisely:

All human understanding is interpretation, and no interpretation
is final ... the subject can never presume to transcend the
manifold predispositions of his or her subjectivity ... Reality is,
simply, our experience, and objectivity is, of course, an
illusion.44

2.1.5 Systems Psychodynamic theory
Using systems psychodynamic theory allows me as researcher to make sense of how
the individual practitioner connects with the primary task and takes up his/her role in
the doctor-patient relationship as well as relates to the systems within which he/she
works and the community in which he/she lives. The following 'sensitizing concepts'
are drawn from systems psychodynamics theory and are relevant to this research.
These concepts are used as a way of considering themes and of organizing complex
data.

Primary task: defined as the task which the organisation needs to perform in
order to survive and to maintain energy and motivation in its work.45
Role: the pattern of behaviours determined by the expectations of the self and interdependent others in the performance of a task.46

Boundary: the way in which one entity is related to another by person, role, task, system, organization, and the environment. Boundary is the concept used as the separation of the inside from the outside.47 This can relate to a system or to an individual. For the system this function of the boundary is consistent with a management role; for the individual it is the ego. The function of a boundary also supports the concept of the inter-subjective capacity between the researcher and the researched to operate on the boundary of conscious and unconscious processes, simultaneously working with both to discern meaning.48

2.1.5.1 Social Defence Systems
During the social mobilization of the British nation for war, the war office became interested in social and group psychology. From these beginnings the Tavistock Institute began its work with organizations. Jacques, in 1953, used the term social defence system describing a process by which individuals use social institutions to support their own psychic defences and unconsciously incorporate these defences into routine institutional life.49 Menzies Lyth, in 1960, described how defensive techniques used by nurses in the hospital environment, to defend against anxiety in their work.50 Holloway and Jefferson in their description of a research project discuss the psychological and social implications of a defended subject.51

An anxious, defended subject is simultaneously psychic and social. It is psychic because it is a product of a unique biography of anxiety-provoking life-events and the manner in which they have been unconsciously defended against. It is social in three ways: first, because such defensive activities affect and are affected by discourses (systems of meaning which are a product of the social world); secondly,
because...unconscious defences...are intersubjective processes...
and, thirdly, because of the real events in the external social
world which are discursively and defensively appropriated.52

Cultures use mechanisms or social defences to ward off anxieties inherent in the
work and these influence how individuals engage in the primary task in their roles.

This concept of social defences and defensive behaviours also applies to the general
practitioner who works within a system and across systems (See Chapter 6: System
Psychodynamics). An unconscious culture of defensive behaviours is significantly
implicated in the manner in which an organization takes up its primary task, and in how
individuals pursue their roles within and across organizations. These defenses may be
difficult to discern.53

2.1.5.2 Basic Assumption activity
Bion’s seminal work of examining the individual and the group with a psychoanalytic
approach introduced principles of group psychodynamics.54 His work is exemplary in
facilitating the understanding of defensive behaviour developed in the group process.
As a psychoanalyst, Bion’s foundation was Kleinian and his work extended exploration
into areas of projective identification and the container-contained relationship. The
illustrative themes derived from his group studies are used as the foundational traits
of group and organizational work in this research project. In the ‘work group’ mode of
operating, cooperation and participation by members of the group to fulfil the
specific task of the group is central. The cooperation of the members of the group is
voluntary and relates to their individual skills to fulfil the task. Participation and
relatedness are relevant to the defined purpose of the group.55 His writings depict
the significant features of a ‘work group’:

- It needs a common purpose,
- Members of the group recognize the boundaries of
  [their] group, their position and function,
In the 'sophisticated' work group, there is no express need to individualize participation; the focus and responsibility is the group's purpose. Participating skilled individuals give the organized group its stability and its vitality. The activity of the 'work group' is task driven; its method of approach is rational. The group's purpose may be for instance, a formal meeting coordinated by the general practitioner to end-of-life plan for a patient with the family. In the process of end-of-life planning, sophisticated aspects of group work are required to achieve the primary task, because of the distressing potential of the task. Bion writes:

> Certain phenomena must be sought in the matrix of the group
> and not in the individuals that go to make up the group. 

Thus, whether the group engages with or avoids the task is determined by its ability to contain the anxiety associated with the task. Task and anti-task behaviours may interweave in the process of task-performance. The disruption of 'work group' activities is brought about by conscious and unconscious dynamics which induce panic within the group with a loss of cohesion and therefore loss of task focus. The group may have lost its mind, and panics into basic assumption activity:

> The capacity of the individual for instantaneous combination
> with other individuals in an established pattern of behaviour - the basic assumptions.

Basic assumption activity can be advantageous and support the group work process or it can be destructive to this process. The group, as an entity, does not have a
conscious state and is inarticulate and therefore it relies on the individual to be both conscious and articulate. The adoption of basic assumption activity does not require specific instruction. Rather, it is a propensity for individuals within a group who cooperate instinctively or impulsively with the emotional requirements of the group. There is complicity by members of the group in basic assumption activity for the purpose of the defensive behaviour is to diminish the anxiety and the unwanted emotional interactions between the members. In basic assumption group functioning, trivial matters are discussed as though life and death issues. Significant issues are avoided. Reality is avoided; the outside world is denied. Change is catastrophic. Any thinking and analytical problem solving is avoided, creating understanding is an anathema. In basic assumption activity there is collusive interdependence between the leader and the led. The leader of a basic assumption group is chosen by the group to fulfil the wishes of the group. The unconscious defensive purpose of the basic assumption activity is to allay anxiety and bring about psychological survival.

The terminology used suggests that work and basic assumption group functioning are separate entities, but in reality they are blended. Group work involves a combination of group and basic assumption activity merging as part of group function. At least five specific types of basic assumption activity have been identified, three by Bion.

2.1.5.2.1  **Basic Assumption Fight / Flight (baF)**
The overall mood of basic assumption activity fight/flight is paranoia. Members of the group act as though there is great danger which should be attacked or fled from. The members of the group intuitively take up the mode of operating of the leader. There is no questioning of the process or discussion about the relevance of the action. In BaF, for the doctor and patient the disease is to be fought or fled from.

2.1.5.2.2  **Basic Assumption Dependency (baD)**
For basic assumption dependency, the group seeks a leader who will take responsibility. The relationship to the leader, adopted by other members of the
group, is that of assumed inexperinece, as if only the leader is able to solve the issues of the group. In the environment of the doctor with the patient and family, the members of the group are prepared to accept the guidance of the doctor as the expert, the leader with the knowledge and therefore the enlightened decision-maker. The doctor as the expert is deemed omnipotent and omniscient in the doctor-patient relationship of dependency (baD). The doctor performs all problem solving and decision-making. Heteronomy or paternalism is substituted for a collaborative, relationship with information-rich patient autonomy. The leader's role is to flood the group with feelings of hope, and either solve or dissolve the difficulties.

Basic assumption Dependency (baD) mode, group members act as if the leader in the group ... is possessed of almost supernatural powers to protect the group and make its decisions.64

2.1.5.2.3 Basic Assumption Pairing (baP)
In basic assumption pairing the group is occupied with looking to the future, a hopeful future. The reality of today is suffused with hope for the future. The pairing that occurs within the group or through the influence of the leader is to create an external alliance, the outcome is optimistic. This hope can have a religious theme - a miraculous cure, a reparative theme - a spontaneous remission, or a sexual theme - giving birth to a new idea, a new drug. The group's outlook remains hopeful, the emphasis is the fantasized future, all will be better tomorrow!

Basic assumption Pairing (baP) is readily identified by the feeling of hopefulness that infuses the group ... in all cases the focus of the group turns from immediate, difficult issues to a fantasized future.65

2.1.5.2.4 Basic Assumption One-ness (baO)
The fourth basic assumption, proposed by Turquet is basic assumption One-ness.66
An oceanic feeling of wholeness and togetherness floods the group with members experiencing a sense of union with an omnipotent being. With this union comes an overwhelming desire to surrender in passive compliance to the awe-inspiring feelings of oneness and well-being. This correlates with patient willingly accepting the leadership of the doctor who as all-knowing is in control.

2.1.5.2.5 Basic Assumption Me-ness (baM)
The conscious and unconscious perturbation of modernity is the cultural and contextual zeitgeist of baM. Basic assumption me-ness is operating when members of a group are behaving as though there is no group present. BaM is associated with the individual divesting themselves of any emotional connection with the group, organization or society to maintain an inner reality which is not threatened. Personal progress and power become the intent of the individual. There is limited linking of individuals to the primary task or purpose of the organization or authority associated with a role. Links to others are based in similarity and liking, with individual and cultural narcissism, where satisfaction and needs are paramount over other’s values. In the group the individual is isolated and alone in the role that they perform in an oppressive environment of pseudo-equality.

Life in a baM culture is ordered, calm, polite and androgenous.

2.2 The Researcher and the researched
As researcher, I come to this research as an Emergency Physician of a tertiary level public hospital in the community of a large Australian city. The Department of Health of the State and the College of Emergency Medicine have together ratified the primary task of the Emergency Department:

To provide urgent care to patients with life threatening or serious health problems, they can also provide care to patients with less serious conditions. However, patients with urgent medical needs take priority.
It is within this context that I, whose role is to provide immediate assessment, resuscitation and intervention for individuals who attend the Emergency Department, am exposed to the interpersonal, intrapersonal and personal dynamics involved in the dying and death of individual patients. In this context the question arose for me about why I should be the person making crucial decisions about withholding resuscitation for another person. As established (See Chapter 1), the process of end-of-life planning is generally not occurring for the majority of elderly frail patients attending the Emergency Department of this large tertiary hospital. These patients are often referred to the hospital for resuscitation and critical intervention. Would this be their choice? In most situations, these patients have a general practitioner involved in their day-to-day care.

The research exploration aims to understand why general practitioners are not involved in end-of-life planning with their patients. An important methodological aspect of the research project is the direct involvement of the researcher with the research participants, General practitioners in the researcher-researched relationship. Berg and Smith emphasize responsibility in this relationship. It is important that this relationship communicates the ethical principles of integrity and respect so that the general practitioner can develop a sense of trust which enables openness and encourages free expression. Questions about end-of-life planning are solemn and can be associated with personal distress and emotional pain for the interviewee. This distress, unknown and unknowable to the researcher at the commencement of an interview, has the potential to induce discomfort which unconsciously provokes avoidance hence limiting communication and conversation. Sharp acknowledges the principle of listening to the transference.

An inner intention of inclusiveness is a prerequisite, take the time and compassion to listen to your own inner response. There is little we can do to alleviate another’s emotional suffering, other than to sincerely listen. In conscious listening we are
"conscious" of our own inner response to what someone else is
telling us.73

The environment for the research requires empathy and containment. This empathy implies that the researcher understands from the inside the experience and perceptions of participants for both may gain insight into the praxis. The research platform requires these characteristics to provide a suitable environment for the interviewee. The general practitioner has intimate knowledge of the topic being studied within his/her community and the data collected from the individual interview is unique. This data incorporates the personal understanding, awareness, discernment, insight, and wisdom of the individual experience of the practitioner. Some of the data collected from each interview is implied or unconscious. It is important to grasp the true essence of the experience of the researched as it unfolds, for this first hand experience communicates 'the reality' of the experience for the general practitioner.

The researcher in the process of performing the research is inevitably influenced by the relationships within the social system. It is important as researcher to separate my own implicit complexities, values and biases to identify the origins of the thoughts and feelings present. The purpose of the research project is to identify another's reality, the experience of the general practitioner. Berg and Smith would term this reflective practice, self-scrutiny.74 Such neutrality is not easy to attain; it necessitates constant personal review, reflection and supervision. As a consequence I have sought the assistance of my academic supervisor to augment my critical examination of the psycho-dynamic and psycho-analytic dimensions of the data. Miller in his work acknowledges the pervasiveness of one's own predispositions:

What I perceived and failed to perceive ... was influenced by my own predispositions, conscious and unconscious, by the culture I came from and by the inevitable selective relationships I set up.75
2.3 Summary

Prior to commencing this research I completed a master’s thesis in an organizational realm that explored team-work. At that point I became aware that an entire dimension of working together had been omitted. The emphasis seemed to be on the individual in his/her external world; the organizational, cultural and social factors that effect and affect the individual and how to politically negotiate a reality for work. The study did not recognize the dynamic interaction of the individual and the group, the internal personal environment and their external realities, the conscious and unconscious processes were not part of the learning. The complexity of the group’s psychosocial system and the implicate processes were not explored.76 The ability to work together as a group relied upon the ability of the leader to illuminate the path for the followers with a collaborative vision. There was acknowledgement of interdependence but all discussion related to external realities, the work task.

The interplay between the individuals, the culture and the needs of the organization were paramount. Group mentality was unexplored. That the functioning of the group could involve an unconscious collusion between the group members was uncharted. But, Individual behaviour in groups is largely a result of group ‘forces’ that ‘canalize’ individual action ... generated from the changing pattern of shared splitting, projective identifications, interactions, and task demands. The perspective assumes that when a person speaks ... he speaks via the unconscious for the group.77

It was with this background and awareness that I commenced the research into end-of-life planning with the general practitioners.

The interpretive stance, with a psychoanalytic perspective allows the researcher to draw on each research subject’s experience in General Practice, provides a way of engaging with and making sense of a phenomenon, end-of-life planning, using conscious and unconscious data as sources for generating understanding and meaning. The
methodology also incorporates system psychodynamics. This assists in teasing out the implications of the system and society on individual thinking and decision-making when managing one’s self in role.

Working as a researcher with an interpretive perspective requires methods appropriate to the paradigm. The qualitative research platform is consistent with the theoretical and methodological principles of interpretive inquiry. This is the subject for discussion in the next chapter.

3. METHOD

This chapter describes the methods involved in data collection, data analysis, hypothesis formation and interpretation employed in the research of this thesis. The thesis adopts the interpretivist philosophy as discussed in the last chapter. The qualitative research platform is compatible with the theoretical and methodological underpinnings of interpretive inquiry. Associated methods have as their premise a socially constructed world influenced by psychological, societal and cultural factors.¹

With this foundation, the methods available to qualitative inquiry allow the reality of the individual to be studied 'as if' from the inside and life-events to be explored as they unfold. The features chosen for this research enable a collaborative exploration. They include: a space that promotes openness to develop understanding in the generation of knowledge; the attributes of responsiveness and design flexibility; and, the ability to change with the emerging data coherent with the research process. Qualitative methods enable the collection of complex data and descriptive information.

I commence with a description of the environments within which the research occurs, detailing the relevance of context to research. Next, because a quantitative statistical questionnaire is used as a preliminary data collection method, the theory of sampling is discussed with the principles that relate to both quantitative and qualitative platforms. The major component of this chapter on method involves describing issues surrounding the methods relevant to the qualitative research platform, including the particular proficiencies required of the social scientist in the researcher-researched relationship when working with an interpretive stance. Data collection methods appropriate to interpretive methodology, the relevant analytical concepts, and the application of hypothesis formation to the qualitative research platform are also described.
Ideas from Patton,² Sarantakos,³ Burrell & Morgan⁴ and Berg & Smith⁵ are used to aid in the description of the methods. Although different terminology is used by each author in structuring his/her theory of method, the relevant components of the practice are comparable and add to this current project. Interwoven in this discussion of method is the researcher’s praxis for this current research. Schwandt concurs with Sarantakos when he writes,

The idea of acquiring an “inside” understanding – the actor’s definition of the situation - is a powerful central concept for understanding.⁶

3.1 Contexts for the Current Research
Context describes the unique features pertinent to specific research methods. It relates to aspects of time and task as well as to the participants or systems involved within their distinct territories from which research data is compiled. It is not generalizable, but specific. Berg and Smith state it this way: ‘the context relates to the setting in which it is embedded’.⁷

This research project emanates from the Emergency Department of an acute hospital where I work as an Emergency Physician, and was motivated in 2002 to explore aspects of end-of-life-planning, with general practitioners of the community. The impetus is associated with a series of events within the environment of the emergency rooms and the task of emergency care for the patient. The principle of ‘respecting the patient’s choice’ appears to be relegated to a secondary position and the course of action involves crisis intervention and the role of the expert as decision maker. These events provoke my thinking. This thinking relates to individual choice, decision-making and dignity in death, and challenges me to explore end-of-life-planning with general practitioners within the Community. As Lawrence succinctly states:
Thinking is produced as the human entity interacts with its environment or ecosystem. It is the challenge of the environmental context that is critical.8

This research project takes place within a variety of contexts. Participants engage in thinking to develop meaning and a social ideology and it is within their work-systems and community cultures that this thinking occurs. The researcher-researched relationship also is developed from within these contexts for the purpose of collaborative thinking, meaning-making and the generation of current understanding. The thinking generated is a product of these contexts. Again, Lawrence articulates:

The concept of context is crucial to an understanding of thinking ... thinking is a product of the symbiosis between human beings and their eco-system.9

The method employed to collect the data from each of these contexts is carefully chosen and dependent upon the purpose of the inquiry. Components of the data derived are a unique snapshot in time from each of the territories where data is collected. Berg and Smith recognize the importance of context in saying,

Preserving as much of the context as possible is an investment in maintaining the meaning of the data.10

The contexts include the Emergency Department of the acute hospital, the executive, research and healthcare personnel of two aged-care facilities (Chapter 1: Background) and the executive, research panel and participating general practitioners from the Regional Division of General Practice (the following chapters of the research document).

3.1.1 The Acute Healthcare Sector
The research commenced with a quantitative statistical survey of the adult patients attending the Emergency Department of the community hospital, a tertiary referral
centre (Appendix 4). The purpose of this questionnaire was to determine if end-of-life planning occurred in the adult population who attend the Emergency Department.

3.1.2 **Community Aged-Care Facilities**
My initial plan was to work with the general practitioners of the Community in the setting of an Aged Care Facility. Two aged care organizations were approached and asked to consider participating in this research (Chapter 1: Background). I communicated with the management and service personnel of these facilities to gain access to perform the research. Time was spent in negotiation to develop an understanding about the project, but permission was not granted to proceed. The methods used during entry were structured interviews, participant observation, strategic plan documents (Appendix 3) and personal journalling.

3.1.3 **Regional Division of General Practice**
The general practitioner Liaison Officer of the Hospital facilitated an introduction to the Chief Executive Officer of the Regional Division of General Practice to pursue the possibility of research with the General Practitioners within the community. I presented a plan of the project to the 'research group' of the Regional Division of General Practice to explain the involvement of the general practitioners. A summary is provided to the CEO for distribution to interested general practitioners which gives an overview of the project (Appendix 5). I state in this summary that all data derived about end-of-life planning are relevant, that is data collected from the questionnaires, the workplace observations and the emotional experience of the researcher-researched interview. This concept is captured in an anonymous comment from a Radio National programme in Australia, 'Life Matters', 2003.

> How can the emotion be removed even in scientific research.

> Truth only to be worked on by intellect rather than with emotions as well is institutionalised autism.  

67
After acknowledging acceptance of the research project the CEO sought interest from general practitioners to participate with the researcher. Subsequently he provided the names of 13 interested interviewees. Informed consent was gained from each participant prior to their involvement (Appendix 6).

### 3.2 Sampling

How are participants for a research project chosen, and what criteria are used in their selection? This is termed sampling, an essential aspect of research and a technique for choosing participants from the target population for investigation. The principles of sampling demonstrate differing aspects of relatedness to a research platform, either quantitative or qualitative. Sampling can be divided into two basic types, *probability* and *non-probability* with specific characteristics pertinent to each research platform. In the positivist paradigm of the quantitative platform sampling is of utmost significance. Sampling demands strict adherence to principles that ensure representativeness to avoid errors of bias and distortion so that the conclusions drawn can be deemed pertinent to the whole population. In qualitative research the attribute of representativeness is not universally applied, but generalizability is highly esteemed. Sampling in qualitative research addresses different requirements. The findings of the typical case are considered to be representative within the social system studied. They provide an 'exemplar' or an 'analytic' generalisation. The quality of generalizability is attained through the examination of several case studies and the findings are used to generate working hypotheses to be applied more generally to other cases.

#### 3.2.1 Probability sampling

*Probability* sampling is the method used in quantitative science, for in this research platform the purpose is to construct theories for generalization to a population. For quantitative research the sample needs to be statistically representative. In the
initial survey for the quantitative component of this research paper 'cluster' sampling is used (Chapter 1: Background).

3.2.2 Non-Probability sampling

Non-probability sampling does not purport to cover generalization or representativeness. It is the responsibility of the researcher to purposefully determine which units are chosen to achieve understanding of a particular theme. This is purposive sampling,¹⁴ as the aim is the selection of participants who have useful insight about the phenomenon investigated. The purpose of research is to generate empirically supported theory generated from the collected data with the qualities of reliability from numerous sources, validity, and honesty. The thirteen general practitioners involved in this study are members of a Division of General Practice in the catchment area of the Emergency Department, chosen because of their potential to offer extensive information about end-of-life planning. The data derived remains scientific and empirical; it depicts the perceived reality of each participant.

3.3 Characteristics Important to Qualitative Research

In qualitative research, the aptitude of the researcher and the type of method employed are important defining aspects for the procurement of valid, reliable empirical data. In this section I discuss the characteristics and skills of the disciplined social scientist. These features are recognized as 'ideal' for ethical inquiry in qualitative research, for the development of respect and rapport in the researcher-researched relationship, for validity in the research process and honesty in data collection in the context of understanding inter-subjective data. In the following sections each attribute is described and discussed explaining its application to the context of the current research. The involvement and participation of the researcher with the researched, as defined by Berg and Smith necessitates the use of a code of behaviour consistent with clinical practice in medicine and clinical
Clinical medical practice is performed in the setting of a craft expertise with the potential of the interpersonal dynamics of dependency, power and authority permeating the space. The social science researcher using clinical methods within an interpretive and psychodynamic paradigm requires the capacity for self-awareness and self-scrutiny in the milieu of the interpersonal dynamics generated. In this research, the researcher requires a willingness to scrutinize not only the superficial components of the researcher-researched relationship but also to explore the rational and irrational, the explicit and implicit, the transference and the countertransference, that is, the conscious and unconscious components of these processes in the context of understanding inter-subjective data.

### 3.3.1 Ethical behaviour

As a clinical method, the framework for this research is derived from the clinical practice of medicine and psychology. As in the practice of clinical medicine, it is imperative in clinical social research to be cognisant at all times of the responsibility to the subject of the study. Existing principles of biomedical ethics provide a reasonable guideline to initiate social science research with a clinical bias. The behavioural traits and interpersonal skills of clinical practice necessary to this type of participation contain the ethical features stated in the Hippocratic oath. These include beneficence: all forms of action intended to benefit another person, and non-maleficence: an obligation not to harm and to coexist with a responsibility which delineates the expectation of personal autonomy and justice, an acknowledgement and acceptance of the reality of the other. The compelling influence to commence this project is a perceived absence of the ethical principles of choice, individual rights for personal autonomy and decision making involving end-of-life planning for the elderly patient attending the Emergency Department with a life-threatening illness. With this attitude come the ethical principles of benefiting another and doing no harm.
In this research, there is the obligation to the participants to conduct a project that is ethical and fulfils the guidelines of social science research. The guiding principles include honesty, informed consent, confidentiality and anonymity for the participants involved. The social scientist is committed to this code of behaviour which encompasses respect for the individual, informed consent with privacy and confidentiality in participation and honesty in the completion of this research document (Appendix 5-6).

Ethics approval is granted for each sphere of research receiving endorsement. In addition, I am cognisant of the State's current legal policy relating to the Victorian Medical Treatment Act 1988.

### 3.3.2 Responsibility

The personal responsibilities of a social scientist have a tripartite membership. The code of behaviour supports this membership. The membership includes: the audience to whom the research is directed (an acknowledgement of the purpose of the research), the participants with whom the research is performed, and the researcher, by whom the research is initiated and completed. A sense of professional responsibility and commitment to the patient’s perceived needs is the impetus for the initiation of the research project. A sense of responsibility to the audience, the objective in initiating this project, is a personal recognition of the advantages to the individual of end-of-life planning. I acknowledge ‘this ideal’: that individuals pursue their personal responsibility of quality of life associated with health and wellbeing, and dignity in death associated with end-of-life planning. Individual choice is crucial in negotiating the task; this choice remains with the individual.

Participation and collaboration with the general practitioner may also act as a prompt for the general practitioner for the question: is end-of-life planning a component of the primary task of his/her practice?
As social science researcher, I have a responsibility to pursue ethical praxis in my commitment to the participants; this practice involves maintaining vigilance in self-scrutiny to preserve veracity and neutrality in this research.

3.3.3 *Neutrality*
A crucial aspect of qualitative research is to pursue researcher neutrality\(^{19}\) and veracity. In this research the purpose is to collaborate with the participant in exploring the process of end-of-life planning, and in so doing to allow the general practitioners to communicate their sense of reality and for the researcher to develop understanding. Patton writes about taking a neutral stance, and describes the imperative for the researcher to develop self-awareness, to recognize personal bias, prejudice and preconception, because the researcher is the instrument in the interpretive platform.\(^{20}\) Berg and Smith in writing about clinical methods talk about the responsibility of the researcher to the participant which involves the sharing of a first-hand experience and also of the social system being studied with the practice of ‘self-scrutiny’ as a consequence of this ‘direct involvement’.\(^{21}\) With this perspective must be a preparedness to recognize and resolve potential sources of error and personal bias with the aim of producing quality data for the research project. The stance is non-judgemental with openness and a willingness to listen and understand self and other, consistent with the perspective of Moustakas who speaks about relationships and ‘being in’ another’s world.\(^{22}\)

Self-scrutiny, described by Berg and Smith involves a comprehensive and careful examination of conscious processes, but also of unconscious processes to explore cognitive, volitional and emotional aspects of the dynamics involved in the researcher-researched relationship.\(^{23}\) This process of self-scrutiny is difficult and intricate because both the researcher and the researched are simultaneously unconsciously influencing each other in the relationship.
The process of self-scrutiny is central...it can yield information about the intellectual and emotional factors that inevitably influence the researcher's involvement and activity...at the same time provide information about the dynamics of the...social system being studied.24

Vigilance is required to practise neutrality. To assist in this undertaking, data is regularly presented for scrutiny. The review includes supervision (in this research both supervisors have extensive psychoanalytic and systems psychodynamic expertise), theme presentations to learned bodies, and personal reflective practice. The need for neutrality is taken as a responsibility for the project praxis and self-scrutiny as a means to pursuing this objective.

3.3.4 Empathy

Empathy communicates interest, with an emphasis on understanding the other in a context of caring.25 Or in Moustakas's term, 'being in' another's world. 'Being in' the relationship with the general practitioner enables the multiple complexities, different experiences, idiosyncrasies, and perceptions of each individual to gradually emerge. He describes a non-judgmental empathic stance.

Being-in...the world of the other is a way of going wide open, entering in as if for the first time, hearing just what is...I enter with the intention of understanding and accepting perceptions...I only want to encourage and support the other person's expression, what and how it is, how it came to be, and where it is going.26

The data is dealt with in a way that is empathic to communicate the other's reality.

Empathy combines the cognitive capacity of understanding with affective connectedness.27

Berg and Smith write about 'participation' with a similar emphasis.
Participation is particularly important in social research since the perceptions, thoughts, emotions, and beliefs of people constitute the primary subject matter for our investigations.  

This research requires the development of a relationship with mutual involvement and participation of the researcher and the researched in the exploration, a relationship that allows freedom to relate all facets of understanding of end-of-life planning with depth and detail.

In my professional practice, as an Emergency Physician, I perform a role with some features similar to that of the general practitioner. As a consequence of role-relatedness, the ability to explore and empathize with the reality of the experience of the general practitioner is made easier, but difficulties can arise where our practice is divergent. Self-awareness with respect and empathy, and 'being-in' the relationship is fundamental to achieving an understanding of the individual's practice, 'eschewing memory and desire' in an endeavour to explore their reality.

3.3.5 Verstehen

Verstehen (understanding) is a term used by Dilthey, Weber, Schütz, and many other social scientists, with differing emphases. Dilthey draws a distinction between understanding in the natural and cultural sciences, the former addressing external processes of the material world, and the latter, internal processes of human minds. The outward manifestations of human life needed to be interpreted in terms of the inner experience which they reflected through the method of verstehen.

For Weber, using a positivist stance, verstehen is described as a characteristic of being human, the capacity to make sense of the world, with an objective perspective of the social interaction. He focuses on deriving the causal meaning of human behaviour emergent from direct observation to identify specific, subjective meanings. Schütz, in taking up the term from an interpretive stance, places the
emphasis on understanding human behaviour, questioning 'how possible it is to form objective concepts and theory of subjective meaning-structures'? Making sense of the motives and values involved in the context of the interaction is the distinguishing characteristic of social phenomena. Winch argues that social behaviour is a rule-following not a causal process. Rules are shared, therefore to understand, one needs to determine the underlying rule governing the behaviour. Husserl believes the social scientist should disengage from the everyday world to understand and grasp the truth, a state of pure consciousness, to discover and know the essence of things. Heidegger's concept of understanding relates to a way of being rather than a way of knowing. Gadamer focuses on the process of understanding itself and asks.

- How is understanding possible?
- What kinds of knowledge can understanding produce?
- What is the status of this knowledge?

Gadamer also believes in locating understanding in the context of the language used and the setting of the conversation. Language becomes an expression of the human way of 'being in the world'. Bion's emphasis is that understanding, knowledge and growth occur in a symbiotic relationship in which one depends upon the other for mutual advantage. He refers to the psychoanalytic relationship in this way. Berg and Smith use the term clinical understanding, engagement is developed through integrating the experience of self with the experience of the other in the context of a relationship. These senses of understanding are used in the research. Berg and Smith suggest another aspect to understanding in research, that which is 'not seen', the 'other side' of the coin, known to be present but inaccessible. I will use many aspects of this concept in the attempt to achieve understanding.

### 3.3.6 Language

What is behind the language used? Language is the preface to develop understanding, but communication has social expectations, cultural traditions and
idiosyncratic representations and meanings which may create a screen to distort reality. Listening to words brings to awareness the melody that belongs to the phases and the tonality of the communication. The words themselves create a sensate experience which aids in the development of the ambience. This picture can initiate a metaphor that brings a fuller depth of meaning and understanding to the communication. A metaphor often delves into the unconscious to generate further insight and prompt complementary questions to aid in dispelling innate assumptions derived from cultural patterns and to elucidate personal meaning.

Language inevitably and inherently is built on the assumptions and worldview of the social group that has constructed it and the culture of which it is a part.42

But each of us attributes different meanings to words. Each creates our own meaning with the words we use. Through our use of language we attempt to communicate this personal meaning. But we can also use language to create an illusion. Bion warns against assuming a shared meaning.

Language was elaborated as much for the achievement of deception and evasion as for truth.43

In order to enhance the researcher-researched communication, it is important to clarify understanding in the interview setting so that the questions answered are the questions posed. As Whorf’s linguistic hypothesis states:

Language shapes the perception of reality as much as reality shapes language.44

3.3.7 Listening
Real listening demands every fibre of one’s being.45

Active listening is a complex skill, which seems to open up both internal reflection and reflective dialogue between people.46
For the general practitioner, answering the questions posed in the course of the interview requires thinking, feeling and making meaning; a dynamic activity which requires energy, personal attention and awareness for both the researcher and the researched. In so doing it is hoped that the interviewee feels from the interviewer a willingness to hear his/her story, to learn and understand, and, as a consequence is encouraged to participate.

Ask.
Listen and record...
Asking involves a grave responsibility.
Listening is a privilege.
Researchers listen and observe...
To ask is to seek entry into another's world..
Blessed are the listening questioners, for they shall gain perspective.  

With attentive listening it is possible to ask the question that creates a space which enables elaboration, elucidation and enlightenment, as Rina Bar-Lev Elieli states:

By a certain way of listening, the consultant can lead his client, an individual or group, into a state of self-attention and self-awareness. This is how the client will be able to make sense of his own experiences, emotional and others in order to regain his sense of destination.  

3.3.8 Reflexive Questions: Triangulated Inquiry
At all times in the enquiry it is important to reflect on the purpose of the research, the participants and their context, with an endeavour to explore the phenomenon in question and to perceive the reality of participants without the personal colouring of the researcher. This is performed with the additional acknowledgement of the final audience for the research.
This copy of Patton’s diagram suggests that selected participants are sought to explore their understanding of a specific phenomenon; in this case end-of-life planning.⁴⁹

Triangulation allows for exploration through combining methodologies and/or methods to obtain a variety of information about the phenomenon being studied. It can also be used to overcome the weaknesses of one method with the strengths of another with the expectation of valid and reliable results being the outcome. But the validity and reliability of each data source should be tested independently rather than as accumulated. Reflexivity reminds the researcher to be aware of these parameters.

Each individual, participant, researcher or audience, will perceive the phenomenon under investigation from a different perspective, because of his/her own reality. I recognize that the questions asked of individuals and their contexts are also asked of myself. It is important as researcher to be aware of the participants’ perspectives and voices, and to acknowledge in the searching questions the implicate and intricate connectivity of voice, words, language, and consciousness. Thus the methodology and methods draw upon their individual understandings (Appendix 1 & 2).
3.4 **Qualitative Data Collection**

This section describes the methods used to collect data in this current research which include interviews, surveys/questionnaire, observation and indirect methods. The choice of methods is guided by the purpose for the inquiry, the methodology selected and the philosophical ideology of the researcher. There are a number of methods that are applicable to social research in qualitative design. The final methods chosen take into consideration basic issues like time, availability of personnel, and resources. The quality of the research is dependent not only upon the data collected from interviews, surveys and observations but also upon the disciplined attainment of current knowledge which aids in the of generation of insights throughout the analysis.

The qualitative data collected in this research project have three major sources: the open-ended in-depth interview, participant-observation and written documentation including keeping a journal. Thirteen general practitioners are interviewed. The initial questions of the interview are structured to reveal the demographic data and the context for the individual practitioner. The major component of the interview is focused, in-depth, open-ended questions. The questions focus upon the theme of end-of-life planning, exploring issues that surface when discussing society's attitude to dying and death, and discovering the perspective of each general practitioner to dying, death and end-of-life planning (Appendix 1 & 2).

### 3.4.1 Interviews

An interview as a form of questioning has many features which relate to the type of interview used. Descriptive terminology is used to define style (structured or unstructured), application (written, computerized or direct, face to face or telephone), and purpose (diagnostic, standardized, focused or inquiring, and individual or group interviews, for example, focus group). As a consequence of this variety the interview is used by quantitative and qualitative research platforms alike. Two styles
of interviewing are used in this research. The structured interview has standardized expected responses to each question applied, and the unstructured an open-ended interview and response.

### 3.4.1.1. A structured interview

A structured interview has features of a questionnaire with a systematic and standardised format for containing the subject matter to enable the interviewer to sustain uniformity in delivery. In its structure it offers little flexibility to pursue participant nuances and associations to the questions posed because the questionnaire defines the data to be collected. The hospital survey applied to attending adult patients and the general practitioner demographic data questionnaire fits this category (Appendix 1 & 4).

### 3.4.1.2. An unstructured interview

The unstructured or open-ended interview has no set procedure to follow, but as an interview has a purpose and format with flexibility to pursue the agenda required. The interviewer may develop a collaborative way to work with the interviewee to achieve understanding of the themes to be addressed. The in-depth interview method is used for data collection when interviewing the general practitioners about end-of-life planning.

### 3.4.1.3 In-depth Interview

The key aspect of the in-depth interview is its minimalist approach to intervention and intrusion. This serves both phenomenological and systems psychodynamic inquiry. Patton also states that the quality of the data collected is contingent upon the integrity of the researcher, for practised neutrality attempts to achieve honesty in the application of the data.

During the in-depth interviews, I use the characteristics required of the qualitative platform (participant observation with empathic listening, the 'being in' the context
of the participant with awareness of language used) in an attempt to achieve understanding. The initial questions involve demographic data followed by enquiries that relate to the general practitioner's perception of role and the characteristics of his/her doctor-patient relationship (Appendix 1). The second group of questions are open-ended, allowing the participant to freely associate, to use case histories and anecdotes in describing his/her connection to the questions 'What do you believe is the Australian societal attitude to death and dying?' and 'How do these societal norms influence your own attitude to death and dying?'. These questions encourage the general practitioner to explore his/her experience. Such questions enable me not only to achieve an understanding at a conscious level but also to utilize the anecdotes and metaphors to further explore implied meanings with the participant. The narratives used, the emphasis given, the emotional connections to the questions and the non-verbal communications are all data (Appendix 2). Juxtaposed with this focused questioning on end-of-life planning is the intent to discern unconscious processes. Although the agenda of the interview is found in discussing issues about dying, death and how the general practitioner perceives his/her role, the interview is unstructured and guided by the individual practitioner and the interpretive process. Access to the unconscious originates from 'free association', the free-flowing information, ideas, feelings and perceptions available to the researcher in the conversation. These perceptions are interpreted to gain further understanding of meaning, sometimes during the interview itself, mostly later. This spontaneous conversation relates to personal experience and ideology and is in the form of personal anecdotes, stories, case histories, dreams, metaphors or assumptions.

3.4.2 Observation as a research method
Observation is a fundamental technique of the social scientist and one of the oldest data collection methods used in social research. Although there are varieties of observation used as a research method, there are universal processes. The type of observation chosen in this research plan is a form of participant-observation.
3.4.2.1  \textit{Participant-observation}

Participant-observation introduced by anthropologists,\textsuperscript{51} is a unique form of fieldwork which involves the complete immersion of researchers in the culture of the researched.\textsuperscript{52} Researchers participate as members of the society they are researching. They collect data from inside the group, systematically observing and studying the culture of the society. The knowledge of the society gleaned with this form of study is extensive. A similar form of participant observation is used extensively by sociologists and ethnologists. The relationship developed with the researched will determine the type of observation involved. In explicit non-participant observation the observer is not a part of the environment being studied but also it is important to elicit personal observations as part of the data being collected. As Alderfer writes

\begin{quote}
All of the observations including those which are made on oneself are valid.\textsuperscript{53}
\end{quote}

In this project collection of data occurs from multiple sources. The amount of participation depends upon the relationship with the researched. Some observational data is collected in the surgery prior to the commencement of the in-depth interview with a general practitioner. These observations involve a direct study of the environment including the physical setting, the tasks being performed in the environment, how its functional capacity appears to cater for people and the individuals involved, their attention and interaction. How the setting feels to someone new to the environment and the nuances in the communications are important. My perceptions and feelings as researcher become part of this observational data. During the interview other observations are relevant. These include voice, language, the feelings in the role, the environment for the interview, the attitude of the interviewee, and how s/he is coping in the role of interviewee. There are multiples of information available at a liminal and subliminal level to be observed and explored.
Bogdan and Taylor recognising the additional data available to the researcher when using participant-observation write:

Becoming a skilled observer is essential ... every face-to-face interview involves and requires observation ... to read non-verbal messages ... [to be] attuned to the nuances of the interviewer-interviewee interaction and relationship.\(^5\)

In the role of participant-observer, the self is the instrument of the research. As with subjectivity in the psychoanalytic frame, the researcher uses 'self' to explore another's subjectivity and make sense of the environment.

Participant observation refers to research that involves social interaction between the researcher and informants in the milieu of the latter ... data is systematically and unobtrusively collected. \(^5\)

A component of participant observation is the researcher's documentation of the perceptions, feelings and thoughts present during the interview. These are journaled.

### 3.4.3 Indirect methods of data collection

Other material is also reviewed as a source of data about the phenomenon being studied for social research. This process is described as an indirect method of collecting data.\(^5\) In this research paper the documents include the formal studies and reports that relate to the topic of the research which involves terms used like end-of-life planning, advanced directives, and advanced care plans. Other documents include the classical theoretical texts that relate to the methodology of the study, and the medical texts that explore the phenomenon of end-of-life planning. The relevant literature is detailed as references and in the bibliography. Public documents used as a source of data for this research are sourced from the Government of Victoria, the Office of the Public Advocate, legal papers from medical establishments including craft groups and hospitals. Contemporary documents as a relevant source of
data include novels, poetry and mass media excerpts as they communicate current cultural and societal thinking.

### 3.5 Using Inductive & Abductive Logic

As stated, qualitative enquiry is directed towards exploration of a phenomenon to discover and achieve in-depth understanding. The logical approach in this mode is of inductive analysis by which the theory emerges from the depths of the data. Using inductive logic, it is important to listen to the data to achieve understanding of the reality of participants to aid in the construction of meaning, for working hypotheses are developed from within the data. The creation of theory requires the unbiased analysis of the empirical data with its meaning derived from the reality of each participant. As the researcher, I am required to recognize personal bias and to pursue neutrality to enable a receptive mind to sit with the data to generate hypotheses. The inductive strategy is consistent with the interpretive ontology of respecting individual meaning and creating understanding from multiple sources of unique data. My task is to elicit themes, patterns, topics, and concerns as a foundation on which to construct theories. There is no predetermination given that the essence of inductive reasoning is that hypotheses arise from the data. Applying Bion's discipline:

> The first point is for the analyst to impose a positive discipline of eschewing memory and desire. I do not mean that 'forgetting' is enough: what is required is a positive act of refraining from memory and desire.\(^{58}\)

In the research project, there are thirteen case studies analysed. Each interview is recorded. Immediately after each interview a journal entry is completed to capture the environment, the mood, the perceived projections and the countertransference occurring during the interview. The recorded interview is transcribed verbatim. Replaying the interview reinstates its ambience during which the transference and
countertransference are further used to elaborate meaning. By being immersed in the data I attempt to identify the conscious and unconscious processes occurring through the intensity of the thoughts and feelings I experience and to make connections and links with unconscious processes. With a systems psychoanalytic and psychodynamic association, data occurs as part of the in-depth analysis of each interview. This is documented in my journal. The cycle is repeated for each interview. Each interview with a general practitioner is deemed a case and is individually recorded and analysed in detail to identify significant data. With each reading of the interview, the themes, patterns, topics, concerns and concepts present are extracted (Appendix 7). Absences are also noted. Data collected from each individual is collated for cross-analysis, while allowing for recovery of individual uniqueness. This diversity has the potential to contribute other important perspectives to the analysis and the theories as they emerge. The interpretive paradigm with the qualitative platform for this research project enables the acknowledgement of individual uniqueness. This recognition is stressed by Holloway and Jefferson who write:

Once methods allow individuals to express what they mean, theories not only have to address the status of these meanings for that person and their understanding by the researcher, but they must also take into account the uniqueness of individuals. 59

Blaikie attempts to stage the phases of the inductive strategy with an emphasis on openness to the data, collecting and classifying the facts without primacy and finally allowing the working hypotheses to arise from the data.

The inductive strategy has been characterised as consisting of four main stages.

1. All facts are observed without selection or guesses as to their relative importance.
2. These facts are analysed, compared and classified.
3. From this analysis, generalizations are inductively drawn as the relations between them.

4. These generalizations are subject to further testing.\textsuperscript{60}

Abduction is also used to explore and analyse the data. Abduction is not based on the linear form of generation of hypotheses of inductive or deductive analysis, but relies on the extrapolation of an alternative theory to explain the observed data.

In this research project, the empirical meaning derived from the analysed data is applied to systems psychoanalytic and psychodynamic theory in order to infer social meaning.

It is to the process of moving from lay descriptions of social life, to technical descriptions of that social life, that the notion of Abduction is applied.\textsuperscript{61}

Both conforming and non-conforming data are considered. Using abductive logic with systems psychoanalytic and psychodynamic theory a plausible hypothesis is proposed to explain the data derived, to create social meaning. Thus the incorporation of the inductive postulates with the abductive extrapolation leads to the generation of a working hypothesis.

3.6 Working Hypothesis

From the analysis theory emerges that is constructed and generated by inductive and abductive reasoning as a series of the working hypotheses.

Hypothesis infers from facts of one kind to facts of another.\textsuperscript{62}

The working hypothesis in its development aligns the understanding of the concepts derived with the patterns and themes emerging from the data. This is done using systems psychoanalytic or psychodynamic theory. The following example of a working hypothesis is derived from the data of this research. It describes the reciprocal impingements of the general practitioner and the impact of these impingements on
his/her role. It is an attempt to coalesce meaning from the reality of the individual participants in the research, to develop an objective expression of a collective experience.

The Royal Australian College of General Practitioners in defining the primary task for General Practice makes a general statement which lacks clarity for its implementation. Specific issues and processes are not defined, so the practitioner takes an individual stance and may not view end-of-life planning as a component of his/her work - as part of his/her primary task.

Data analysis of the interviews generates working hypotheses related to the themes being elaborated. Cross-referencing occurs to generate these hypotheses as they are drawn from the particular to the general incorporating the relevant systems psychoanalytic and psychodynamic theory. Lawrence describes hypothesis formation in this way:

The working hypothesis is ... a sketch of the reality of a social situation. It is the outcome of a disciplined attempt to process the subjective experiences of phenomena ... the validity and reliability of a working hypothesis can be judged by others using their experience of the same events and phenomena.63

The working hypotheses generated in chapters 4, 5, 7, 8, and 9 are reviewed in Chapter 10, 'Can Death be Acknowledged' as a basis for the development of recommendations for future action. These working hypotheses are used to further explore the reality of end-of-life planning within the community and the implications for General Practice. Suggestions are discussed to increase the capacity of general practitioners in role, and enrol them in the process of end-of-life planning for the individual in the family group in the community in which he/she works.
3.7 **Current research**

3.7.1 **Design**

This research project is designed as a series of case studies. A typical definition of a case study, derived from Sarantakos is:

> An empirical inquiry that investigates a contemporary phenomenon within its real-life context ... in which multiple sources of evidence are used.\(^6^4\)

I interviewed and observed thirteen general practitioners within the catchment area of the hospital in which I work. The context for the interview is the surgery of the general practitioner, where s/he consults with the patient. Each participant is a professional person with the potential to be intensely involved in the phenomenon of end-of-life planning and therefore an knowledgeable for this exploration. Each participant contributes his/her own reality about the phenomenon studied.

3.7.2 **Research process**

The Chief Executive Officer of the Regional Division of General Practice introduced each prospective general practitioner to the research project giving him/her a briefing document. General practitioners communicated their interest to the CEO. I contacted each general practitioner to confirm his/her interest in the research and to make an appointment in their preferred time for the in-depth interview. Each interested person was then e-mailed the document describing the project, its aim and the time to allocate for the interview, 45-60 minutes. A copy of the consent form was also e-mailed with this document (Appendix 5 & 6).

On arriving at the surgery I introduced myself to the attending staff and the observations began. Prior to commencing the in-depth interview I again described the aim of the project, to ensure understanding. The University consent form was then signed and witnessed (Appendix 5 & 6). The general practitioners allowed between one to two hours for the interview. The interview commenced with the collection of
demographic data to place the general practitioner in his/her context and to initiate the exploration of his/her conceptualization of role and the doctor-patient relationship. Any personal experience with dying or the death of a close relative or friend was also discussed (Appendix 1).

The next interview phase involved the exploration of thoughts and feelings about society's attitude to dying and death, and the personal attitude to dying and death of the interviewee. The structures they used in conversations and processes with their patients were then explored. The interview then proceeded wherever the conversation went. I attempted to 'be in' the context of the general practitioner and question to delve deeper into their thought processes to elucidate their understanding of the concepts and experiences described (Appendix 2).

After each interview I journalled my thoughts and feelings about the experience. The transference and the countertransference was explored as I reflected upon the feelings generated by the conversation. Other aspects of the interview were considered, such as: the issues discussed; the prevalence of anecdotes and stories to signify the settings; and, reflections on the quality of the researcher-researched relationship developed in the short space of time. This was used as a marker for it may represent and symbolize the doctor-patient relationship.

Can there be a more sacred act than self-inquiry?65

On transcribing each interview I again reflected on the interview to detail further thoughts and feelings generated. On re-reading and reflecting upon the interview the evolving concerns, concepts, themes, and patterns were also noted. This process was repeated for each interview. Cross-correlation then occurred between the interviews and using inductive and abductive analysis I derived working hypotheses as deemed relevant to particular conceptualizations and themes to create theories about end-of-life planning in this community. Self scrutiny and supervisor scrutiny was imperative.
3.8 A thesis

The result of the process is a thesis.

This research plan commenced with the supposition that end-of-life planning is not occurring in the community. The statistical data (Chapter 1: Background) identified that the supposition was accurate; end-of-life planning is not occurring in this community.

The design involves triangulation with participation, methodologies and methods to obtain diverse data from the general practitioners as together we explore the phenomenon of end-of-life planning. In gaining this variety of information, the themes, patterns, topics, concerns and concepts are analysed.

The culmination of the research plan is the analysis of the data collected while working with general practitioners, the understanding derived by generating working hypotheses and developing theories from the understanding of their experience.

The documentation of this exploration with the understanding gleaned from working with the general practitioner in the community is the thesis. The following chapters are generated from the analysis of the data derived from the in-depth interviews with the general practitioners.

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Encyclopedia of Science, Technology and Ethics. Anthropology: www.bookraas.com/research/mead-margaret


PART 2: THE RESEARCH ISSUES:
Research Findings & Theories

This section details the topics pertinent to the
general practitioner's perception of end-of-life
planning in his/her community of General Practice.

Chapter 4 commences by grounding the reader in the community of the general practitioner and reviewing his/her perception of the community's attitude to dying, death and end-of-life planning. Chapter 5, Primary Task, explores the concept of End-of-Life planning as it applies to General Practice and the general practitioner. Chapter 6, System Psychodynamics, gives an account of the general practitioner's interface with systems and how these dynamics within his/her sphere of work impact upon this work. Chapter 7 ascertains how Role is taken up in the task of end-of-life planning. The final part of this section, Chapter 8, Education, reviews the general practitioners' assessment of training methods and the educational requirements for addressing critical issues relating to dying, death and end-of-life planning.
4. SOCIETY’S FOCUS: KILL Death

To anyone who listened to us we were of course prepared to maintain that death was the necessary outcome of life ... death was natural, undeniable and unavoidable. In reality, however, we were accustomed to behave as if it were otherwise. We showed an unmistakeable tendency to put death on one side, to eliminate it from life.¹

These words open the account of Freud’s article on ‘Our Attitude Towards Death’. They have a similar emphasis to that which emerges from the analysis of the research data – kill death.

This chapter explores the general practitioners’ opinion of Australian social attitudes to dying and death. The choice to focus on the general practitioners’ perception of society’s attitude to death emanates from my wish to examine how this understanding may influence their practice in end-of-life planning within their community.

The chapter begins with a review of the demographic data of the general practitioners interviewed to establish their current practice in end-of-life planning (Appendix 8). Next is a dictionary definition of society followed by a brief exposé of the philosophical and sociological thoughts of the post-modern mind as they relate to the individual, the group, the organization and society. Sociological, philosophical and anthropological details are drawn significantly from Tarnas,² Sennett,³ Rustin⁴ and Lasch⁵, in attempting to determine the relevant norms and values of modernity that seem congruent with the attitude of general practitioners. This is detailed with excerpts from the interviews. My analysis of the findings indicates an unmistakable tendency for the general practitioner to unconsciously collude with broader social views and therefore avoid the responsibility of end-of-life planning with patients. The working hypothesis formulated from the analysis of the findings from the general
practitioners interviewed allows further exploration to achieve an understanding of social issues that they meet in their daily work. As Freud stated in 1915, a year into World War I when society was fragmenting and disintegrating, we show a tendency ‘to eliminate death from life’. The chapter ends with a précis of the defensive interconnectedness between society and the apparent practice of medicine today.

4.1. Demographic data of the General Practitioners
The demographic data of the general practitioners involved in the current research are diverse in every way. The female-male mix is 6:7; their ages range from 40 to 75 years; they have spent between 8 to 50 years in General Practice. Their ethnic and cultural diversity parallels their religious associations and affiliations. These data also indicate the practice of each practitioner in the process of end-of-life planning. From the individuals of the group only one practitioner routinely questions his/her patients about their end-of-life care choices. S/he sees this task as part of patient management - the continuum of care. In the group, an additional 3/13 practitioners intervene, and end-of-life plan, at times of critical or terminal illness to encourage that the wishes of their patients are known, thereby assisting the patient and their family to fulfil these wishes. The remaining 9/13 practitioners, do not take up the task of end-of-life planning with their patients. This thesis explores the practice of the general practitioners interviewed.

4.2 Definition of Society
The 1999 Shorter Oxford English Dictionary entry for 'society' is long and complex. 6
In this chapter I am applying the definitions that cover the groups of people germane to the research.

A number of persons associated together by some common interest or purpose - participating in some action through following the same profession; a collection of individuals composing a community living under the same organization or government.7
Both the general practitioner and the patient work and/or live in the community. The group of general practitioners involved in the research project are associated professionally through the Regional Division of General Practice. Moreover, they are affiliated through their educational and professional qualification with the Royal Australian College of General Practice, their professional body. Another healthcare system associated with the general practitioner is community hospital, involved in the management of the complex medical patients referred by the general practitioner to the hospital for continued medical care.

4.3 Contemporary society: from individual to organization

What kind of society does the general practitioner of the research community live and work in? The following description is general and stereotypical; the theory is derived from the work of several social theorists. It primarily represents the thinking found in the post-modern paradigm where there are few absolutes. Past and present ideologies, the political, religious, and philosophical traditions are considered as personal interpretations, each influential, but without a single definitive reference point.8 The post-modern paradigm claims that modernity brings a loss of certainty and structure in which to create a world view. The norms and values from which Western cultures derive their social cohesion in the human quest for meaning are open to individual interpretation.9 Primarily the individual is relevant and the individual’s interpretation of reality is central, reminiscent of solipsism where one’s own immediate experience has a fundamental, self-certifying reality.10,11 What is questioned is the reality of the external world.

’Self-surveillance’ ... provides the technical means of self-scrutiny ... because it renders the sense of selfhood dependent upon the consumption of images of the self, at the same time calling into question the reality of the external world."
In acknowledging this view, I recognize that other approaches to a social analysis have been set aside. Nonetheless, the views presented here represent an analysis of social conditions that assist in the understanding of current fears and anxieties about end-of-life planning for the general practitioner in this community.

For the individual, the family, and Western society after World War II, society was manifestly influenced by the world of work with a background of extreme suffering. With advances in economies, rapid mechanization and full employment, most people were able to attain economic security which created a 'relative stability'. With security came the expectation of a 'reciprocal effect', the recognition and need for complete commitment which came with an expectation of a long-term association. Individuals projected the experience of the process line onto the organization and took up other personal aims: to be a good parent, to educate children, and to advance from this menial work. The dynamics of this society were presented as success, with market domination and consumption. This ethos was built on a culture of dependency: with the formation of large private and public organizations, trade unions and the development of a social welfare system, to care for the disadvantaged. But what was often experienced by the process worker was a sense of personal failure, the submission of personal authority and alienation. The individual in the family and the community was exposed to a set of societal values of dependency, cooperation and group-preservation being woven into a culture of capitalism. The individual became alienated and compliant in this depersonalized environment of anonymity and coercion. This alienation was often associated with a loss of identity. The dream of the worker was flexibility, with the assumption that flexibility brings freedom and autonomy; instead of 'automatization'.

In the late twentieth century a new organizational system is born which incorporates flexibility, but the flexibility developed is illusory. In the new organization Sennett describes vertical disaggregation, delayering and reengineering associated with re-
structuring and down-sizing. Disaggregation of the work group and flexitime create their own alienation and isolation for the workers. But as observed by Sennett, ‘most organizations become dysfunctional in the people-squeezing process’. The older, experienced personnel are made redundant and in their place the young, flexible, free-thinking are employed; for modern production requires flexible specialization. The end-product is to meet the demands of capitalism and consumerism. Redesigning the staffing structure is as relevant to the bureaucracy as redesigning the processes. The employee, desiring flexibility and freedom in working life, becomes a commodity the means to achieve bureaucracy’s flexibility.

The culture of the community is an inherent construction of the communicated human experience of the individuals living in it. The community experiences the anxiety associated with the rapid change to the culture of commodity and consumerism. Both the inner and outer realities for individuals have become unbounded and uncertain. Many people are relatively insecure in their work-life, family-life and self-life, leading to extreme anxiety in the face of ‘unending relativism’ and ‘existential finitude’. For many the interconnectedness and commitment in the work environment are loose, ephemeral entities. The anxiety associated with insecurity, the lack of tenure and short-term affiliations of the work-world influence and impact on family life. A psychotic split in the social and cultural values is born. One respects materialism, independence, and aggrandisement, in an environment where wealth and power are predominant and the other engenders social passivity, dependency and loss of identity and empathy with the external realities. With this rapid transformation of the environment comes the potential for fragmentation and a loss of contact with the social processes. The individual in the family and the community is exposed to these new societal value sets with detachment, superficial cooperation and self-preservation woven into a culture of consumption, the materialistic prestige promoted by the new capitalism. Again, this induces insecurity and the fear of annihilation.
especially for those whose 'truth-value', the impression of what is right and proper, is based on an idealized past culture.

Narcissism, self-seeking materialism ... shape daily life.

In this environment of self-glorification, material gratification, and extraordinary technological achievement, suffering, dying, and death are pushed to the periphery of cultural experience.

Can the anxiety induced in a world of uncertainty and insecurity deliver alternatives to isolation and fragmentation?

The societal and individual psyche dwells in a state of ever 'becoming' rather than 'being', a need to endlessly strive to be, whatever being becomes, in an unpredictable world that requires flexibility without any sincere sense of identity, connection or affiliation.

You have to prove yourself every day. Being continually exposed to risk can thus eat away at your sense of character ... The good risk-taker has to dwell in ambiguity and uncertainty.

Lawrence hypothesizes that there is a split between; knowing and not knowing; a disconnection between subjectivity and objectivity; between the individual and society and with this comes a fatal split between life and death. In contemporary society, no-one wishes to be exposed to the anxieties of aging, dying and death. The mode of operating at a conscious level is learned by repressing fear and anxieties, or unconsciously by avoiding linking thought and emotion. This resonates with a private conversation of Krantz with Harold Bridger in 1995; Krantz is discussing leadership in the new world order:

Today's environment ... actually mirrors unconscious processes much more closely than in the past because of its often contradictory, unpredictable, multilayered, and non-rational qualities ... the great vulnerability and insecurity characteristic of today's environments are likely to resonate with the very
primitive fear of annihilation and terrifying potential for psychological disintegration.\textsuperscript{27}

Hence, in contemporary society the general practitioners experience, with members of the community, the anxieties associated with change. The split is between what is known and what is not known, the predictable and the uncertain. But the ability to explore these differences is limited by insecurity and limited connectedness. This is explained rationally as associated with cultural diversity and complexity or as stated by Tarnas as 'unending relativism'.\textsuperscript{28}

Identity is both fragmented by the multiplicity of choices and also depleted in its sense of depth by discontinuities, by the seemingly untenable and provincial quality of any definite cultural affiliation.\textsuperscript{29}

The Australian society has become a differing mixture of cultures, languages and ethnicity which has added diversity and complexity. This is demonstrated in the demographic data of the general practitioners themselves as well as that of the Emergency Department study. This is the society in which general practitioners live and work.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|}
\hline
\textbf{Country of Birth} & 50 \\
\hline
\textbf{Culture} & 48 \\
\hline
\textbf{Religion} & 22 \\
\hline
\end{tabular}
\caption{Demographic data from the Emergency Department}
\end{table}

An additional anxiety posed for the medical personnel is an expectation in this world of technological and therapeutic advances of the ability to cure.\textsuperscript{30,31}

The associated culture of commodity and consumerism of contemporary society has the potential to bring change in the relatedness between the doctor and the patient. Time has become a commodity; for governmental fiscal policy encourages rapid
decision-making to fulfil the service requirements of performance by the general practitioners (See Chapter 10: Care, Cure or Cost-Containment).

Sennett writes:

The pressures to produce results quickly are too intense ... so in the workplace time-anxiety causes people to skim rather than to dwell.32

All of these features may create uncertainty and therefore anxiety in the development of the doctor-patient relationship and produce an unpredictable world for both the patient and the doctor which limit the development of relatedness, to allow trust and communication. Or, a social defence system is unconsciously constructed that supports the new societal dynamics, a system that eschews interdependence and connectedness but respects materialism, psychological alienation and independence.33,34,35

How do general practitioners deal with these psychic splits and the complexity in the setting of end-of-life planning? For below the surface of every conversation with a general practitioner are a plurality of messages and a multitude of meanings. How does the general practitioner take up the imperative of being cognisant of the diversity; respectful of the individual; recognizing the implications of language and honour the taking-up of roles within the cultural complexity of the family. In considering this statement it is also the imperative for the researcher to actively create a cognitively and intuitively aware interpretation of the message of the general practitioner. Wright Mills states:

Neither the life of the individual or the history of society can be understood without understanding both.36
4.4 **Australian Society’s attitude to dying and death?**

A preliminary question posed by the researcher to explore with the general practitioners their perceptions and understanding of the attitude of their community to dying and death is: How does the Australian society deal with death and dying?

The answers to the question are given in this section of the thesis and reflect the milieu. These are examples from the general practitioner interviews:

As a multi-cultural society there are many aspects to our society’s dealing with death and dying.  

and

We are a multi-cultural society. Dying and death will be dealt with differently across the cultures. I may appear to be Australian but I may revert to my own cultural upbringing at times of death and dying; this can be confusing.

and

Death; it is hidden away still and therefore still in the taboo section. The only people who really talk about it are people in palliative care, funeral directors and priests - people who know that death is inevitable.

The anthropic principle, as quoted by Lawrence states that:

> The only things that can be known are those compatible with the existence of the knowers.  

The culture of a society is inherited through participatory thinking - the thoughts, as symbols, myths, stories and rituals become the norms and values which assist to create meaning. Over time a social reality is generated with traditions and rules that govern lives so that death is managed differently across cultural diversity. But the only people who talk about death; who know that it is inevitable, are those who see death; the priest, the funeral director and the palliative care personnel.

*Culture endows the individual with a way of thinking about and representing his society, his place within it and relation to it, and people's relations to each other ... Culture ... refers to
whatever enables the individual to live, think, and act in a way that is both adapted to the world around him and enables creative transformation of self and world.\textsuperscript{39}

Contemporary society adopts a way of being in the world that is taken up by the individual, ‘society in the mind’ and enables the individual to adapt to the world. With the concept of ‘unending relativism’ posed by Tarnas of contemporary society, it is surprising then to hear the following statement.

We make a lot of assumptions that the other person will be thinking like I am, therefore I do not need to ask. \textsuperscript{[I:13]}

Projecting sameness and behaving defensively, the practitioner does not delve into the patient’s issues, but assumes the thinking is the same; assumes a basic understanding, a cultural similarity. With this assumption no further exploration is required. In these quotations the practitioners communicate and acknowledge their identification with society by the use of the personal pronoun ‘we’ and the assumption of sameness. Unconsciously, perhaps consciously, the general practitioner does not feel comfortable about pursuing the conversation. The assumption is that the patient will not want to speak about the terminal nature of an illness and will not want to pursue the issues relating to end-of-life planning.

I have never considered doing this end-of-life planning. \textsuperscript{[I:13]}

The defensive behaviour may involve an unconscious collusion to avoid this emotionally demanding conversation. But if we consider cultural patterns we can recognize differences; we cannot presume that we think alike. As Gabriel in writing about untested cultural assumptions points out:

Exposure to other cultures enables us to recognize our own cultural assumptions ... We then recognize that what we regard as ‘natural’ behaviours ... are merely conventions of our own Western culture.\textsuperscript{40}
4.4.1 Anglo-Saxon Background

Substantive data derived from the general practitioners' interviews state that in their views, in the Anglo-Saxon society, people do not wish to communicate with others about dying and wish to deny death. This fear of death is communicated by the general practitioners who also experience the fear, as we.

The Australian society does not deal with death & dying: it remains one of the great taboos. This fear of the unknown is huge ... the fear of being alone, of a void ... or the sense of a bottomless pit. [I:8]

and

We can't deal with it. We are a Western society. We are a Christian society. We are afraid. We are becoming more secular, but we are all more afraid. [I:8]

and

The majority are probably a bit overwhelmed and confused about it and what it means and have a fear of death, so the best way to avoid that fear is not to talk about it, denial, the majority's way of dealing with it. [I:10]

and

We are terrified of death as a society, we do not want to think about it, we cannot talk about it, we cannot be with death, we keep our children away from it; it is very hard for people. I do not believe we want to think about death and dying, it is not in our mind, there are no thoughts, there is no conversation, and we do not know how to talk about death and dying. [I:13]

and

The Australian society is afraid, we fear death, we are scared of it because we do not know, I do not mention it to patients because I believe the patient would think I was saying they were about to die. [I:13]

In this Anglo-Saxon society death is taboo: it is unmentionable, unthinkable, banned, even prohibited. The overwhelming emotion is fear. This fear comes with a related anxiety of not being in control. Death is out of our realm of experience. The feelings could leave us not able to think, speechless and paralysed. As a society, as with the
general practitioners themselves, defences are developed to deal with the anxiety and fears related to dying and death. These involve being silent, excluding it from thoughts and staying away from the contagion of it. Lang describes the fear derived from our awareness of death and our existential death anxiety which promotes the development of these mechanisms and awareness-obliterating defences to deny any threat of death.\textsuperscript{41}

Death-related triggering events evoke existential death anxieties that afford dealing with death an aura of helplessness and hopelessness ... and pushes them again more towards denial than trying actively to cope.\textsuperscript{42}

Becker talks about the protective aspect of banning death as an unthinkable and unmentionable event.\textsuperscript{43} The protective mechanism of denial allows a focus on life, an adaptive behaviour to consciously or unconsciously defend against any death potential; expend the energy in living. This psychic mechanism of life-preservation has many facets. In medical illness the fear of death can promote a physiological response with the features of an elevated temperature, heart rate, and respiratory rate accompanied by the sense of feeling unwell. In the setting of a psychological threat with severe anxiety where the emotional response is hyperventilation, the physiological symptoms associated are similar to a death-anxiety, an overwhelming sense of final doom, ‘I am about to die’. This is aptly described by De Masi:

\begin{quote}
The panic attack ... is the absence of the mental function capable of containing anxiety ... the anxiety spills over into the body and turns into deadly panic. Then the thought is: ‘I am not anxious, I am dying’.\textsuperscript{44}
\end{quote}

But many do not want to know what death is. They do not want to go to that place in their mind, an anxiety-provoking place; because this exploration could have risks, discomfort, pain and suffering. The imperative is to avoid this. Thinking and feeling associated with our own death is relegated to the unconscious mind. It is deemed
better to avoid thoughts about death, to go on with life as though there is no such event as death associated with life.

With this same approach people who are grieving are encouraged to get over it, because avoiding grief assists others in society, who then do not have to be confronted by the pain associated with death and the prospect of their own death. In Yalom's ‘momma and the meaning of life’, a patient speaks of conversations with her friends after the death of her husband.

   My friends couldn’t stay with me. They themselves were too busy grieving for Jack, or distancing themselves from the ooze, or burying the fear of their own deaths, or demanding – and I do mean demanding – that I feel okay. 45

Such an idea sounds consistent with the following general practitioner's response. There is an expectation from society that a normal healthy person should be able to get over bereavement quickly.

   Cry but not for too long, get over it quickly. Also if you don’t cry there is something wrong with you. People want you to behave according to a predetermined pattern; don’t be different. [I:7]

and

   The Anglo-Saxon culture does not want to listen or cannot deal with grieving beyond the first week; they want people to move on quickly. It’s not healthy to dwell on things; get yourself together. As individuals we have not had a lot of exposure to death, we don’t have time or don’t want to have time to deal with death with the intense pain and discomfort. We can’t be with someone else, we are so personally focused. [I:7]

Is it so surprising that grieving leads to isolation? As an adaptive, perhaps maladaptive defensive behaviour, contacts of the bereaved person often withdraw because they cannot tolerate the pain and discomfort present. The conscious response is that they do not know how to communicate with the bereaved. There is such unease that the mourner is avoided and isolated within the community. In our
secular society there is no ritual for mourning. Is this because of our limited understanding of what is occurring for the bereaved relative or friend, or is it because we do not wish or are unable to sit with our own or with someone else's pain? This pain is too close to death itself; our own death. Unconsciously we move away.

We ... become so swept away by our own fears that we're not present at all ... we are elsewhere in our mind, reacting and relating from behind impenetrable walls, a place of seeming safety and protection from death's dark power.46

These mechanisms play themselves out in our inability to be with another at a time of dying or during their death. The observable features of the pain borne and the visible withdrawal from the world of the living by the dying person can be too painful for others to experience. Bowlby states:

Loss of a loved person is one of the most intensely painful experiences any human being can suffer. And not only is it painful to experience but it is also painful to witness, if only because we are so impotent to help.47

Another projective emotional response associated with the personal trauma of death of a loved person is anger. Anger can be directed at the loved person for not being present, for deserting; or anger at self for not doing enough to prevent the death; or anger at anyone else in the community who could have done better, provided a better service, done something differently. Anger can also be present for we are reminded of our own finiteness. Death should not have occurred. One general practitioner comments:

Our society does not deal with death or dying very well, we do not prepare for death; we fear it and if it occurs we blame the system; the death should not have happened, someone should have done something differently. [I:12]

Bowlby writes:

Loss of a loved person gives rise not only to an intense desire for reunion but to anger at his departure ... it gives rise not only
Kubler-Ross describes the anxieties and fears of the patient and others involved as the patient approaches death. A number of the interviewed general practitioners in my research acknowledge the assistance and personal understanding achieved through reading 'On Death and Dying' by Kubler-Ross. Many of the phenomena she describes are discussed by the general practitioners during the interviews. Although Kubler-Ross talks of stages of acceptance of death and dying and they are recognizable in the journey of the individuals, they are by no means sequential but infiltrate the being of the individuals involved in the grieving process. The social defence mechanisms described by Kubler-Ross that are paramount are: denial of the diagnosis of a terminal disease and denial of death. Isolation by the sufferer and from the sufferer is self-protective for all involved; it perpetuates the denial of death by limiting the thinking and associated feelings about the imminent death and therefore limits the pain of the death anxiety. The other stages prominent in the current research include, anger, depression, bargaining, and acceptance followed by mourning. The latter is encapsulated by this general practitioner as s/he reflects.

I can look back with a clear conscience and think I have done the right thing by the person, I feel OK, but sad, I miss them, I have known them well. [I:5]

4.4.2 Multi-Cultural Influence

How does multi-cultural diversity play itself out in the community of the practitioner, asks the researcher who is attempting to consider dying and death as an emotional societal issue. A person from one culture may not know how to be with another of a different ethnic origin. This general practitioner speaks of the supportive environment that his/her culture provides at the time of death and grieving:

In my culture there is a gift giving custom wherein a gift is given by each person who attends the funeral to someone in the grieving family of the same age. This is a way of
connecting to the thoughts and feelings of each other, a way of remembering those who have died and a way of sharing the feelings of grief and loss. [I:7]

and

There are ceremonies at the time of death and set intervals for twelve months. Grieving takes time. This provides a space to meet, give support, and potentially provide learning and understanding for the meaning of life and death. [I:7]

But it appears that this same cultural group also has defences against thoughts of dying. There is a fantasy about the contagion of death: if we think about death may we let it in, will we accept it as inevitable? Perhaps it is also like the plague, can we catch it? We do not want to accept the inevitability of death.

There is an enigma about death, there is a need to keep hope alive; if death or cancer is spoken about this conversation will destroy all hope and you are inviting death in. [I:7]

The mythical thinking about the contagion of cancer and significant disease processes is present in some cultural systems; as though death is a communicable disease.

Considerable distrust of authority accompanied belief that scientists did not really know what caused cancer. Everyone was potentially vulnerable to it and it was always fatal; its name was dangerous to speak, and it could be caught from close association with its victims.51

The burdens and benefits of the cultural differences and their impact upon medical practice and involvement is noted:

Some cultures have extreme fear, but seem to be able to grieve. [I:3]

Another general practitioner with difficulty in understanding other cultural mores and customs states:

To the Greek, Italian and Celtic cultures death is a disaster and grieving is excessive in many cases. [I:6]

The general practitioner discussing the excessive display of emotion may be communicating his/her Anglo-Saxon stoicism. This response may also create
significant anxiety for the practitioner as s/he lives his/her own vulnerability and potential for loss of control. Taking a defensive position s/he explains the behaviour as excessive. This definition enables a spitting off from his/her own anxiety and a retaining of professional control. Such statements indicate the difficulties encountered when attempting to work with grief within cultural diversity.

Another general practitioner having recognized the cultural bonds of the community and the associated support deals with cultural diversity, saying:

Some ethnic groups have more difficulty, in all ethnic groups it is much better to talk together with the family. [I:4]

Wells recommends that it is important to recognize the group-as-a-whole the communicated cultural experience

The group-as-a-whole perspective mandates that the individual is not seen as an isolate in a social vacuum, but rather as an interdependent social creature bond-connected, inspired, and in part, governed by the collective forces.52

To a number of general practitioners (7/13) the presence of the support system is fundamental to how the cultural group experiences dying and death.

I have a lot of Somalian patients. I have not been exposed to their beliefs around death and dying yet. As a culture they seem to be family orientated, have a supportive group structure and an extended caring network. [I:11]

and

In some cultures ritual and community support provides assistance. [I:7]

This general practitioner is generally optimistic about the state of assimilation of the diverse cultures into this society and makes this statement,

Different facets and cultures; different components. Traditional Anglo-Saxon stiff upper lip cope with it. This is changing a lot. Society is open to change. [I:3]
Eight of the thirteen general practitioners recognize that there is difference in the rituals prescribed within the different cultural frameworks. Diversity occurs in the traditional practice of different cultural groups and their behaviours at the time of dying and death of a relative or a friend. The sense of difference may unconsciously deter the practitioner from relating to the person, accentuating the difference, rather than the shared humanity. Bowlby writes about loss and the social anthropologist’s knowledge of the social framework stating that although the rituals may be different the underlying emotional response is similar across the cultures.

Social custom differs enormously. Human response stays much the same.53

4.5 Religion & Ritual as Container
In reviewing the general practitioners’ demographic data, their secularism, cultural difference and diversity in religious belief is evident (Appendix 8). This general practitioner recognizes the Western beginnings as a Christian society, as well as the growing secularism.54

We are a Western society. We are a Christian society. We are afraid. We are becoming more secular, but we are all more afraid. [I:8]

The majority of the group (9/13) do not identify a practising religion. But when asked about issues they consider vital to the exploration of end-of-life planning; that may play a role in an individual’s ability to deal with dying, death and end of life planning; religion and ritual are both considered important.

Religion is important for some. It can be a crutch to help, for those seeking help it can be a comfort. It can also benefit by adding structure and ritual, so that the person has a sense of what is right and proper and can conform to the practice, especially if there is lack of direction, and who do not know how to behave. It can be extremely helpful, the person is provided with a ritual around death. [I:1]

The sociologist Seale would agree with the affirming nature of ritual.
A ritual is a pattern of behaviour, performed at appropriate times, involving the use of symbols. Participation in ritual ... affirms membership of the collectivity.55

While recognizing the growing secularism of society, the general practitioners who do not practise a religion (9/13) identify the diversity that exists within the community and the different needs within their patient group.

I think it probably depends upon one's religious or philosophical beliefs about death and after life and all that sort of thing. Some people who have got those beliefs are more comfortable about their understanding. [I:10]

Religion offers meaning, a sense of an after life, a context for the meaning of life. [I:7]

Spirituality is another dimension, things are meant to be, things have a meaning and this can also affect how people grieve: as this is my karma, my destiny, the way things are to be. [I:7]

Everybody needs a belief system to create a framework to explain life and death. Religion is one of those frameworks. [I:3]

This general practitioner believes that religion prepares the individual for an after-life; it imparts a sense of peace.

Religion probably prepares people for their death, they believe in an after-life or reincarnation and therefore they are not so fearful of death but are at peace with themself. [I:12]

Ritual or religion acts as a container to reduce the sting of death.56 Religions succeeded in representing this after-life as the more desirable, the truly valid one, and in reducing the life which is ended by death to a mere preparation ... all with the purpose of depriving death of its meaning as the termination of life.57
Becker writes that some religions enable the creation of hope by expanding the notions of the unknown and the unknowable to develop in life, the mystery of everlasting life. For the believer religion becomes the container for death, the future and hope is born.

Religion ... gives hope ... it holds open the dimension of the unknown and the unknowable, the fantastic mystery of creation that the human mind cannot even begin to approach ... that make a mockery of earthly logic.58

The religion of Islam gives meaning to life and death for a practitioner.

You come here out of God's will. The time on earth is dictated by his will. When it is time, he calls you back, it is time for you to go; it is a continuum, you are here temporarily, by God's will and you go back to him at the time of his will. [I:12]

Within the religious community the relationships provide support and acknowledgement; an important holding environment for the individuals involved.59

The priest or the rabbi is also another important person to the patient and the family for end-of-life planning. [I:1]

and

People meet every few days for a week or 10 days and pray together. [I: 12]

and

They seem to be family orientated supportive group structure and an extended caring network. [I:11]

and

Community support and ritual provides assistance. [I:2]

Another important function of religion appears to be how to deal with death. Religion provides a safe haven for the dying and the griever, as this life is seen as preparation for the next.
All historical religions addressed themselves to this same problem of how to bear the end of life ... Christianity, featured a healer with supernatural powers who had risen from the dead ... Hinduism and Buddhism performed the ingenious trick of pretending not to want to be reborn, which is a sort of negative magic.\textsuperscript{60}

The containment of religion and religious institutions also bring structure to the believer; a way of being supported within the faith of knowing, being known and reached out to by others who are prepared to be with the pain, who give permission to grieve. Not the anxiety of the unknown, uncertainty and dread. As noted by one general practitioner.

The ritual is a way of sharing the feelings of grief and loss. [I:7]

Bion uses the terms ‘container’ and the ‘contained’ to describe the interaction in the relationship between the mother and the child wherein the child projects anxiety and foreboding into the mother.\textsuperscript{61} The mother introjects these feelings and as a container reformulates the distress to reshape the emotion and modify the anxiety. In the same way at the death of a loved person the believer unconsciously projects, at times of emotional disquiet, anxieties and disturbing feelings into their religion. The people fulfilling religious roles and the institution of religious practice; or the process; to contain their intolerable feelings and anxieties. This occurs with the expectation and hope that the religion and the celebrant of the burial rites will act as a container for the unbearable emotions and create hope.

Institutions are used by their members to reinforce individual mechanisms of defence against anxiety.\textsuperscript{62}

These practitioners recognize the convention of the death service as the opportunity to celebrate the life; putting death on hold.
Catholics have a way of accepting death. At funerals they celebrate the life of the person which seems to make a difference. [I:10]

but

In the Moslem community, the ceremony is not around the celebration of the life, the most important aspect is the soul, you pray for the soul. It is not sad because you are not exposed to the body or the coffin or to death. [I:12]

Religion acts as a container for the fear of loss associated with death. It provides a belief in an after-life, reincarnation or resurrection, the returning to life. It acts as a holder for the fear of death. The person in role who contains the fear of death and the experiences of loss and pain associated with death fulfils an important defensive function. This person in role does not have to address his/her fear but maintains him/herself in role; the specialized role is the container.

Our unconscious, then, does not believe in its own death; it behaves as if it were immortal.63

The formal procedures about death also have a specific containing function. It is held at an organized time, the task is defined and the territory is selected. The observance has a structure with individuals fulfilling set roles - an important holding function for the believer, relatives and friends. Becker recognizes the focus of control.

All social life is the obsessive ritualization of control in one way or another. It automatically engineers safety and banishes despair by keeping people focussed on the noses in front of their faces.64

The process of the rite provides a structure, enabling people to follow the leader, knowing what to do. It provides a distraction from overwhelming emotions and a personal knowledge of acceptable practice, fulfilling social and cultural constructs; a sense of belonging and being held. The observance may alter the experience of the feelings, by creating a diversion by celebrating the life, rather than acknowledging
the death, to hold the fear and distract from the present loss. This is consistent with Bion's understanding of group behaviour and the role of the group to contain the individual as they meet together to fulfil the aim of support in a relationship. Hinshelwood says:

Bion regarded the social group as containing the individual. A social group functions to establish a fixed social order of things.65

At the time of a death, religion can create a structure to support people during extreme emotional fragmentation. The object of their love has been lost, but it is not possible to think about or acknowledge that loss. All their strength is required to deny that loss, to retain the integrity of the lost one within them, to preserve the lost object, to protect the lost object and therefore protect self from the loss.66 It is not time to begin mourning. In this setting religion provides containment; gives structure, a ritual to be followed, no thinking is required. A process is designed to support and assist the bereaved. All emotional energy involved is expended in following the ritual's prompts. For the Western religions, the sting of death is removed for the religious believer, separation is not permanent. For as stated by Freud religion represents the after-life as desirable, there is no ending, it is the beginning.

Religions succeeded in representing this after-life as the more desirable, the truly valid one and in reducing the life which is ended by death to a mere preparation.67

The constructs used are drawn from cultural narratives that are an expression of the traditions and core values of the cultural group to enable the griever to feel supported and comforted by a community of like-minded individuals. Ritual can create an impersonal routine where the individual is removed from the overwhelming emotion by the ritual process, to diminish the unbearable chaos. It enables the containment of
the feelings of disillusion and despair with the associated fear of personal
disintegration.

4.6 Diversity in Defensive behaviour
Defensiveness in the face of death may be diverse. One patient dealing with disease
may deny its significance and avoid all association with death while living in hope. It is
important to the carers to recognize the inability of this patient to address their own
death and work with this way of being. Alternatively, the doctor and patient may
collude in avoiding or denying the diagnosis of a terminal illness for the sentence is
death.\textsuperscript{68, 69} In a similar vein, awareness cannot be imposed upon a doctor or patient;
but support in breaking this cycle may be given by addressing the fears of death or
dying.

An observation from a general practitioner is that individuals will approach their own
death in their own way.

The obituaries say, and he fought to the bitter end. It is like a battle, the approach to
death, fighting death, fighting a terminal illness. [I:8]

Becker talks about the paradox, fighting death without acknowledging that it is not
death that one is fighting, but the disease.\textsuperscript{70} While unconsciously avoiding and
denying death and its inevitability, a fight to the end is viewed as a courageous
struggle. Defensive behaviour appears more manageable than acknowledging the
emotional despair and the fear associated with existential death anxiety. The
alternative is to expose oneself to the truth about death and become exposed to the
reality of the loss of self and the loss of relationships.

An impossible paradox: the ever-present fear of death in the
normal biological functioning of our instinct of self-
preservation, as well as our utter obliviousness to this fear in
our conscious life.\textsuperscript{71}
Another general practitioner talks of a different defensive behaviour. By not questioning the patient about religious affiliation this general practitioner does not have to acknowledge religious wishes about the dying process or death. By denying these requirements deeper conversations about personal requirements during dying and at the time of death do not have to be addressed. That is, the need for emotional support, ritual or containment, can also be denied. As a consequence a deeper conversation about death can be avoided.

In fact I don't tend to know the religion of the person. I don't ask. [I:9]

4.7 Resounding Themes in Defensive Behaviour
4.7.1. Fear, Avoidance, Denial

From the research data, the perception of the general practitioner (9/13) is that the patient is likely to find speaking about dying or death confrontational, therefore conversation should be avoided. The general practitioners collude with this silence for as members of this society they associate with these fears. This is demonstrated through their language. Plural pronouns of inclusion are used when describing the fears and anxieties of dying and death. So that in this mode of being, the anxiety and dread of dying and death are split off and a ritualistic process and pattern of interacting is used. 'She'll be right mate' is the tenor in an attempt to maintain a semblance of control and to contain the anxiety, fear and personal panic.

In society it does not seem possible to speak about one's own personal dying or death. This would be considered sombre and aberrant behaviour.

It is indeed impossible to imagine our own death; and whenever we attempt to do so we can perceive that we in fact are still present as spectators ... at bottom no one believes in his own death.72

In this society, people can cope with only a little thinking about dying and death. The only way to cope with the dread and fear assumed about death is to relate this event
to another and feel the sorrow for the other. To bring these thoughts closer to our own dying or our own death is an anathema to us. Zilboorg states: ‘The affect of fear is repressed.’73 For society at large empathy would bring to bear feelings with which we would not wish to contend. Sympathy comes more easily. Fear comes with the hormonal response that initiates fight or flight. We do both, with hope. We fight death, and we flee from the thoughts of death.

Fear is supremely contagious, and its immediate reaction is to make one try to run away.74

In the medical consultation, maintaining personal and professional control is critical. By avoiding thinking about the critical nature of an illness, feelings can also avoided. The imperative is to deny the finality of death and avoid thinking about dying. Under these circumstances no one has to consider end-of-life planning.

One could argue that in these modern times, we are less preoccupied with the issue of immortality, as we no longer live ‘in the presence of death’.75

Death has been removed from the home and the family into hospitals and aged care facilities, as ninety per cent of all deaths occur in hospitals and nursing homes.76

Solutions are roughly congruent with those identifiers in the denial of death thesis: sequestration, the imposition of social death, the management of the dying by experts, a decline in formal, community inspired rituals.77

Even following death there is the medicalization and institutionalization of all procedures. For example, all deaths are certified by a medical practitioner or the coroner. Institutions have developed final ceremonies and rituals with services. Relatives do not have to be involved, or to see the body of their dead loved one. The family members’ exposure to the dying and the death of their relative perpetuates the culture of denial of death. They can remove themselves physically from their
dying relative and can also remove themselves from the emotion associated with dying and death. Gordon writes,

Alienation from the actual experience of losing someone known and cared about is ... increased ... by the fact that dying takes place ... in the physically and emotionally sterilized atmosphere of a hospital or a [hostel]... The old have been banished to 'homes'.

As stated by a general practitioner, as a society we avoid any close contact with dying or death and members of society remove themselves from the fear associated with dying.

Death occurs in institutions rather than at home, it changes the whole dynamic. The patient dies; not in isolation, but removed from their familiar surroundings and family. It may be a relief to the family generally but sometimes to the detriment of the dying patient, the pre-terminal patient. [I:6]

The horribleness and enormous suffering of dying is banished from public visibility ... it is isolated within the professional, technical confines of the hospital.

Klein first used the term denial in association with the phantasy of annihilation, an actual loss of part of the ego. She described denial as a primitive defence mechanism which involves omnipotent obliteration without reference to reality. Lang defines denial as:

The fundamental obliterating defence: it eradicates and falsifies reality and involves gross misperceptions and erroneous beliefs.

Today's society adapts to existential death anxiety by removing death from its immediate environment into the hospital and aged-care facility and with finesse medical modernity pushes the boundaries into myth and illusion, a maladaptive unconscious behaviour. As confirmed by Lang,
The unconscious fear of death, expressed through a deeply unconscious sense of total vulnerability, plays a critical role in the psychic economy and in determining adaptive and especially maladaptive conscious behaviours.82

But denial of death may also facilitate our capacity to live; to put death aside rather than be caught up in the anxiety of our finiteness. It is a paradox, because at the same time this finiteness adds meaning to the now.83

4.7.2 Myths & Illusions
Death is the enemy - KILL death. As a society, death can only be lived with if it is reframed. It becomes a myth, and, in grandiose fantasy as omnipotent beings, individuals can overcome death. Or death is repressed, and denied or it is eliminated, therefore it can no longer create anxiety. Through politicization and polarization and media mastery, contemporary society is able to create the myth that the current technology, pharmacology and therapeutics of medical control can prevent death and therefore one does not need to prepare for death.

A myth is a discourse organized in the same fashion as a fictional account … it can give reality an increase in meaning and new opportunities for interpreting it.84

This notion is convenient to the medical fraternity so that the obligation or responsibility to discuss end-of-life planning with a patient also becomes obsolete. Time is spent in a way that is valued; finding solutions, preventing death, rather than addressing the prickliness, that death is inevitable.

Myths deriving from the technological developments of our time have contributed to a sense of omnipotence. Our contemporary world has placed death within a scientific form of knowledge, entrusted to the professional skills of those experts who put it within a framework of knowable events and submit it to the
scientific practices based on measurable efficacy and efficiency.  

Modernity and modern medicine has seen significant advances: reduction in infant mortality, genuine cures with the advent of vaccination and pharmaceutical agents. It is easier to take on the mantle of the medical myth of always cure: prevention of death. Modern medicine elaborates and perpetuates this myth stating that all suffering is able to be relieved.

Our community carries an unconscious expectation that all suffering can be relieved, a myth perpetuated by modern medicine.  

As succinctly stated by this general practitioner who colludes with the societal myth:

We are too busy trying to find solutions for everything; keep everyone well and healthy; prevent death rather than accept that it is inevitable. [I:12 ]

The patient and the relatives of the person diagnosed with a terminal illness or suffering a chronic illness want to believe in the omnipotence of the medical fraternity that the disease is curable, or upon the practitioner’s omniscient expertise to make it recede.

Contemporary society has generated the medical mythology that hope is eternal; medicine can cure or bring about remission. Death can be avoided. If death occurs, somewhere the system has failed. Who can we blame within the system? This is consistent with a statement by Gordon when she writes:

Doctors and the general public, came to share the illusion that death is, after all, merely the result of medical inefficiency, that it can, and should, be avoidable and actually eliminated in the foreseeable future.  

For humanity to face the reality of death it would be advantageous for the medical societies to put aside their defensive processes of omnipotence and omniscience; to be present to the reality of the death to support the dying, to plan with them.
In doing so, individuals can acknowledge their own death. For as Yalom succinctly expresses in the conversation between Nietzsche and Breuer:

‘Each person owns his own death. And each should enact it in his own way.’

‘Yes. he must decide how to face death: to talk to others, to give advice, to say things he has been saving to say before his death, to take leave of others, to be alone, to weep, to defy death, to curse it, to be thankful to it.’

4.8 Working Hypothesis
An analysis of the above discussion leads to the following hypothesis:

**Generally speaking there is a fear of death in Australian society.**

The general practitioner, being a member of this society, is consciously and unconsciously influenced by that attitude. Because s/he lives in this same fear, s/he wants to avoid and deny death and as a consequence does not take up role and its attendant authority to end-of-life plan with patients.

The institution of General Practice drawing its membership from the general society is imbued with the cultural values, norms and traditions from that society.

The human resources available for an enterprise come from the society in which it is located. The members of the society create its culture and hence bring to the enterprise ... the cultural constraints of their society. Environmental constraints are therefore inevitably built into enterprises and thus become part of the internal culture.

General practitioners express the norms, values and traditions of the culture and collude with the unconscious defensive attitudes of the society. So how do general
practitioners, with our society's imbedded cultural attitudes, take the authority to end-of-life plan with the individual in their care and support their relatives? Can general practitioners enter into a conversation about dying with a patient if they are unable to explore their own finitude; their existential fear? Can they find their voice to communicate their theoretical expertise and experiential knowledge and their awareness of the terminal nature of the illness with the patient?

A component of the role of the medical profession is to diagnose and treat illness. This is an expectation of the professional body as well as of society. Therefore the role of general practitioner requires the acknowledgement of critical and terminal illness, of dying and of death. But the existential anxiety surrounding the fear of death is present as an unconscious, instinctual protection. In this role there is an expectation that the medical practitioner will not only cure illness but prevent death. It seems that the medical fraternity holds the function of conquering death for society. Society and the doctors as members of society collude in order to defend against death anxieties. The doctor's role is to protect society from the fear of death and to eliminate his/her own sense of failure in the face of death.

The conscious system strives mightily to deny and shut out death-related thoughts, images and events.

It is argued here that this fear of death needs to become conscious, recognized and externalized. Under these circumstances the fear can begin to be understood. For to address the inevitable death of oneself, a loved one, or a patient, there is the need to have personally recognized and acknowledged this fear, to come to terms with its presence and be able to work with the patient who is dying, or their family, to enable them to end-of-life plan.

From the collected data, the general practitioner who has had personal experience of the death of a loved one, a sudden infant death, death of a father as a child, or who has worked through this adversity, seems more easily and openly to participate in
end-of-life planning with patients. From the data of this research, the ability to
discuss and allow patients and their relatives to explore end-of-life planning lies with
the minority (4/13). To extrapolate from Tarnas, there is choice available to the
general practitioner and patient, to engage or not to engage in the process of end-of-
life planning.

The human challenge is to engage that world view or set of
perspectives which bring forth the most valuable, life-
-enhancing consequences ... an irreducible element of human
choice supervenes.92

Not all doctors consider it helpful to expose their patients to the reality of their
impending death.93 This seems to be consistent with the Anglo-Saxon perspective
communicated unreservedly by a number of general practitioners (6/13). In the Yalom
novel 'When Nietzsche Wept', Nietzsche states,

If he doesn't know he is about to die, how can your patient make
a decision about how to die? 94

One general practitioner, in reference to exploring a patient's concerns about their
illness and its terminal nature, says:

I did not or have not even thought it may be considered as helpful. [I: 13]

4.9 Medicine in Society Today
Australia is one of the most culturally diverse countries in the world, and the health
system is increasingly consulting to individuals from non-English speaking backgrounds
who bring their cultural traditions, beliefs and values. Such cultural patterns become
internalized and part of the personality of the individual. Without understanding the
design of the individual's rich cultural tapestry, the healthcare system attempts to
impose its own design.

Accelerating rates of change in social, economic and community
life are producing an ever greater sense of social dislocation
and anomie, and are leading to the loss of stable support
systems for people and their families.95

The dislocation Krantz characterizes is replicated in social structures, with
significant changes occurring in the very fabric of society. The individual and the
family unit have become isolated. There is often a loss of the sense of other and of
the responsibility to other. The sense of responsibility lies with self, and often to
self alone. In the last three decades, the family unit - the basis for the growth of
social cohesion, with the development of the values of nurturing, support, the sense
of other - community and responsibility in role, has undergone significant
transformation. These changes in the family unit include the patterns of their
formation, their participation and their dissolution. The composition of the household
has also changed; the extended family with three generations living in close proximity
to each other is a rare phenomenon. Generational care for the young and old is no
longer provided within this framework.

The world becomes too uncertain, a sense of normlessness,
meaninglessness, or isolation may obtain ... The anomic individual
finds himself or herself unsupported by significant others,
comforted by no hope.96

Living for people occurs as individual units, in apartment blocks separated and
isolated from the traumas and tragedies of others lives, only exposed to their own.
As a consequence, the individual is rarely exposed to the illness, tragedy, trauma or
growing old of others.

Emotionally, the individual often lives alone.

The extended family ... has now shrunk to the small units of
parents and their children ... The increase in social mobility and
the housing of people in huge, anonymous, urban clusters ...
deprive[s] the individual of a meaningful neighbourhood group ...
society is made up of people who have very few emotional ties linking them to each other.\textsuperscript{97} 

Society has progressed from the industrial era to the technological era, from a setting where the work-group was necessary for the functioning of the mechanized equipment to the current scene of computerization and automation. The individual is isolated, social cohesion is continually being dissipated.\textsuperscript{98} 

Cohesiveness is created from connections based on a shared sense of belonging and attachment, similar values, trust and a sense of 'social solidarity'.\textsuperscript{99} 

This parallels the workplace environment. Communication is no longer face to face but via e-mail and electronic media. The close work-group is obsolete; the remote work-group is current. Individuals are deemed to have access to the necessary ingredients, education and knowledge to allow them as persons to communicate and participate in their work tasks.

Medical modernity with its advanced technology has also implemented a mechanized model: an investigative production line. The emphasis that focuses the practice of medicine; an humanitarian knowledge-based profession, can be reduced to technological findings with economic rationalism involving workflow, throughput and performance indicators. The practice of medicine becomes a defensive mechanism to separate the emotional aspects of being with the patient from the intellectual diagnostic process.

Another significant change in the practice of medicine has occurred for the family doctor who in the past knew everyone within a family and was known by every family in the community. This is greatly reduced in the contemporary nuclear family. Has the sense of relationship and the trust associated with the doctor-patient relationship lost the depth of interpersonal knowledge required to engender the ethical sense of beneficence and non-maleficence? As for post-modernism, capitalism, and
secularization, doctor shopping occurs. An alternative set of social and cultural values is born that respects materialism, independence, and self-aggrandisement with a social environment that respects wealth and power.

More recently death has been reframed onto the television screen. The cause of death is a tragedy - a tsunami, an earthquake, a flood, a drought, a landslide, or a trauma: terrorist bombing, suicide bombing, war; or a crime - murderous individual violence and brutality. Death is an external event, it is unnatural. Death can only be tragic, traumatic or in relation to war - deemed heroic!

War seems to bring back the most primitive organisation in relation to death: it presents foreigners as enemies to be eliminated, and pushes people to become heroes who deny the reality of their mortality.\textsuperscript{100}

It appears that for the Australian society and for individuals within the society it is difficult to be reflective, or introspective about death unless suicidal or mentally ill. Or, with issues of extreme difficulty that invoke personal fear, there is too much anxiety and fear in the world, we prefer to remain cocooned, and not think about our own dying or death. Death is unnatural!

This is the gestalt for the work of the general practitioner.

Society-wide, individuals do not want to settle down or be committed to an occupation; the emphasis is lifestyle and convenience. This lack of commitment is working both ways, the patient is not committed to their health and what the GP recommends and the commitment of the GP to the patient may also be decreased as a consequence.

[\textsuperscript{I:11}]

De Masi writes that death is conceptualized by psychoanalysis from three perspectives. The first concerns the presence or absence of the construal of death in the unconscious; secondly, themes that relate to loss and separation; and finally the presence of an existential anxiety which causes personal mental anguish.
Death, as a natural occurrence, is inscribed in our internal world as a psychotic disaster, a state of disintegration of one's personal identity which is not easy to conceptualise or tolerate.101

It is the final aspect of; how the projected and introjected fear of personal death can be acknowledged and worked with in the doctor-patient relationship and by the family group to enable end-of-life planning to occur?

If end-of-life planning is deemed as a choice to occur by the patient, the family and/or the general practitioner, does the practitioner develop the capacity to recognize and manage these fragmenting anxieties or seek assistance from an allied health practitioner? To broach end-of-life planning personal existential fears require acknowledgement and the capacity to work with these debilitating feelings. For the containment to be good-enough to facilitate the articulation of these personal needs.

The development of a capacity to use an object is another example of the maturational process as something that depends on a facilitating environment.102

There is a requirement for respectful intersubjectivity and the development of a transitional space.

Perhaps end-of-life planning can be explored as a ritual with the structure of the process acting as container? The patient and the relatives can be enabled to begin a conversation about end-of-life planning. This may result in the cessation of the conversation with no wish to pursue it further, or the desire to continue the conversation, to create their own reality, to own their own death.

Tarnas acknowledges the sense of freedom and openness to pursue existential answers.
The more complexly conscious and ideologically unconstrained
the individual or society, the more free is the choice of worlds,
and the more profound their participation in creating reality.\textsuperscript{103}
74 Levi P. If This is a Man. London: Folio Society, 1964: p. 185.
5. The Relation of PRIMARY TASK to End-of-Life Planning

This chapter plans to explore the idea of primary task as it relates to General Practice and the task of end-of-life planning within the definition of primary task. It is argued that there needs to be clarity in the specification of the tasks to be implemented in General Practice, as the tasks are multiple and complex. It is considered that in the clarification of the multiplicity of tasks to be performed, general practitioners will be assisted in determining which task has primacy ‘in the moment’. This defining will also encourage the Royal Australian College of General Practice to determine and establish the resources required by general practitioners to assist fulfil these tasks. As well, the delineation of the tasks will enable general practitioners to comprehend the fullness of the tasks to be performed, plus the skills and resources required to accomplish specific tasks. It is then postulated that guidelines can then be developed for the focus of healthcare. Clarity, in the description of the task, will also assist in the evaluation of the outcomes as the processes involved in the performance of the primary tasks are reviewed. But in summing up, it appears that the process of end-of-life planning is an absent task. Generally, it has not been thought about and therefore is not a constituent of the primary task.¹

To achieve the goal of the chapter a number of specific areas are explored. In the first instance, the concept of ‘primary task’ as defined by Rice² is examined with acknowledgement of the variation in definition and performance of the primary task.³ This is followed by the definition of General Practice given by the Royal Australian College of General Practice (RACGP). The definition is examined using a working hypothesis derived from the analysis of the research interviews illustrating the ambiguity in the task definition. A dialectic employing excerpts from the research data demonstrates how this current RACGP definition is inadequate in achieving end-
of-life planning for the individual patient by the general practitioner. Other factors important to the endeavour of end-of-life planning are then discussed. These factors include timing for a conversation of end-of-life planning and the resources required relating to the task. For example, the role of the Enduring Power of Attorney (Medical) to assist the patient and the general practitioner take up the task of end-of-life planning, for times when the patient's cognitive competence is diminished. The final discussions relate to the responsibility of the task, inhibiting factors in fulfilling the task and the potential of developing and 'funding a legitimate planning tool', a process, a transitional object, to assist general practitioners in their role.

5.1 Theoretical concepts of primary task
The concept of primary task, first coined by Rice in 1958, is used in the consultant-client relationship. It is used principally as an aid for the organization to achieve greater understanding of its ultimate purpose. Personnel, as a consequence of this understanding of primary task are able to develop and accomplish organizational goals. Rice encouraged members from sub-systems within an organization to elaborate the tasks of each sub-system and from that multiplicity of tasks to develop understanding of the constituent parts of the organization and then to shape this understanding into a negotiated primary task for the organization. Primary task is defined as the task which the organization needs to perform in order to survive and to maintain energy and motivation in its work. This understanding, Rice argued, is then used by the organizational executive to ensure resources are made available to perform the primary task. The outcome, through cooperation and collaboration, is that personnel are enabled to take up their role as it pertains to the primary task with satisfaction in the performance of the necessary task without confusion; it also provides the client with the required product.
In many organizations the primary task is easily definable. For example, in a fast food outlet it is the provision of food, fast. But in areas such as health, welfare and education the multiplicity of tasks that could have primacy render the procedure of determining the primary task difficult. All of the tasks may be considered essential and individuals within and external to the organization may label different tasks as primary. Ultimately which task is given priority is guided by the leadership of the organization taking into account the changing priorities within and external to the system. It is necessary for organizational leadership to regularly review the system to maintain currency in setting the primary task for the organization, especially within the contemporary environment. It is the responsibility of leaders within the system need to communicate with personnel to ensure currency of knowledge.

A recent incident in an amalgamated teaching hospital demonstrates the difficulties associated with defining primacy in task processes. A planning panel sought contributions from staff members to communicate and facilitate the development of a desired system. A staff member stated to the hospital panel that he 'considered it imperative to ensure that the service commitment provided for patients throughout all specialties in the new establishment is consistent, for patient care is the primary task of the organization, followed by teaching and then research'. This contribution was opposed by all members of the hospital panel stating vehemently that 'from their perspective research has primacy of place in this organization', and that 'at the moment as a panel we are unsure where teaching and patient care are in the order of tasks. The hospital panel was unambiguous in its view. There was an explicit lack of emphasis on patient care. The staff member was confused at this mismatch with his thinking and even more, concerned for patient care. Having considered patient care as the primary task of the hospital, he was left questioning how this concept of a hospital identifies itself to the patient.
Review of this interaction enables me to gain a better understanding of the disparate components of a large organization. This divergence in the understanding of the primacy of the task can also create confusion and division. Without clarification of an organization’s primary task, its staff members perform their role within the framework of their own explicit or implicit understanding and discretion in relation to the task, with little guidance from a collective, consciously decided view. Menzies Lyth clearly states in her writing that such divergence leads to discontent and confusion.

This overt and covert conflict between the task definitions makes effective performance of the explicitly understood task difficult and often leads to staff feeling unsupported in their roles, to low job satisfaction and to high stress.9

Lawrence also writes about alternative perceptions of primary task as they relate to conscious and unconscious components of task-performance by individuals within an organization. Lawrence and Robinson10 define the alternatives as:

- The ‘normative’ primary task that is the task that people in an organization ought to pursue (usually according to the definition of a superordinate authority),
- The ‘existential’ primary task that they believe they are carrying out, and
- The ‘phenomenal’ primary task that it is hypothesised that they are engaged in and of which they may not be consciously aware. 11

The normative task is the stated operational task of the organization, as defined by the Executive and stakeholders, to fulfil the charter of the organization. Clarity in the definition aids in fulfilling the primary task rather than that of avoidance of the task which tends to result from misunderstanding or ambiguity. For example, if
research has primacy in the hospital, emphasis would be placed on creating knowledge and understanding to cure disease which in turn would tend to ensure that the economic funding model provides resources, staffing and structures for research. The objectives of the hospital need to be continually contested and the task defined and redefined as negotiated.

Leadership of the organization in communicating the primary task of the organization to personnel and patients will assist the focus of staff to maintain their energy and motivation for all aspects of their work. Hoggett writes:

Far from a primary task being some kind of 'given', objectives are continually contested and, whilst some may dominate over others, impermanence of objective is the rule rather than the exception.\textsuperscript{12}

The performance of an existential task for the role-holder reflects personal values and tenets consistent with the individual’s meaning of their role. Using this same example of the hospital as research establishment: if staff members believe patient care is the priority they will sabotage research projects by not enlisting patients into any clinical trials conducted or by not completing important research data, therefore corrupting the primary task data for the researchers. In so doing they validate their actions to diminish any guilt about performance and rationalize these conceptions of patient-care as the primary task.

The task performed is the existential task. It is egocentric in its derivation rather than socio-centric, the normative task.\textsuperscript{13}

Phenomenal tasking is predominantly an unconscious activity indicated by the behaviour of the staff member. It supports the psychological requirements of the individual, group or organization. Again, using the research hospital as an example; in the hospital emergency department, a staff member may unconsciously use each patient contact as an opportunity to educate medical and nursing staff about the
intricacies of emergency medical practice and patients about their responsibility for personal care. In this situation, because the staff member is unaware of his practice, he may be informed by the head of the Emergency Department that he is spending an inordinate amount of time in the care of the patient, instead of completing the administrative and research requirements as determined by the organization’s procedures.

It is fundamental for leadership in an organization to emphasize and clarify the primary task for personnel and to provide the resources required for its completion. This is to ensure that employees understand what they are employed to achieve and how to accomplish this. Within an environment of clarity in task definition and support; its performance, staff satisfaction and the patient’s requirements could be met within the framework of the primary task. Thus a clear explanation by the leadership of the organization of the primary task; or the primacy of task within a context, tends to provide clarity for personnel to take up their assigned roles with its applicant authority, to fulfil the task. The emphasis in providing clarity in the definition of task is to ensure all components of task are known, understood and taken up.

The cooperative consensus of the primary task for an organization is the culmination of the thoughts and negotiations of the leaders and stakeholders of the organization. But there are tasks of an organization that are feared, that generate significant anxiety for personnel that they are not taken up. Tasks that are avoided or absent cannot be thought about. There are also tasks that are hated and perhaps transformed into manageable tasks, and tasks that are corrupted. End-of-life planning may fulfil all of these criteria, feared, avoided, absent, hated and corrupted. Might they be transformed into a manageable task? Is it because death cannot be thought about and discussed by society that end-of-life planning cannot be taken up?
It is hypothesised in this thesis that the task of end-of-life planning is absent from General Practice as an organisation and also absent from medicine as an establishment. The fear or antipathy is defended against by non-performance. By not recognizing the need for the task; it becomes an absent task. As Long writes, a task may not be taken up for these same reasons,

Absence when thought to be persecutory, may give rise to intolerable anxiety so that the thoughtfulness is not possible.
Further engagement is rejected.\textsuperscript{16}

This lack of recognition of a component of primary task to be taken up by the general practitioner, for contemporary society, ‘the absent task’, appears to be what is occurring with end-of-life planning in General Practice in Australia as shall be discussed in the next section.

5.2 Royal Australian College for General Practitioners

While the general practitioner is not directly employed by an organisation such as a hospital, he or she is regulated through a professional establishment. The idea of primary task can be applied to the work of General Practice through its regulation by the medical establishment.

The academic and regulatory body for General Practice in Australia is the Royal Australian College for General Practitioners (RACGP). The College defines the nature and scope of General Practice in accord with the contemporary needs of the society. As a College, it sets, promotes and maintains the standards for clinical practice, education, training and research for high quality General Practice, and, as a regulatory body it accredits individuals to practice within the specialty of General Practice and upholds the maintenance of the high standards of conduct within the specialty.\textsuperscript{17} The RACGP in a Strategic Priorities draft document states that it actively ‘embraces its responsibility to take a leadership role in Standards, Quality, Education, Research, Advocacy, and Equity’ and the requirement for ‘understanding
and addressing the needs of all our members, recognising the broad scope and
diversity of General Practice and general practitioners'. 18 From this statement the
theoretical intent of the RACGP is to recognize the resource needs of practitioners
in the broad scope of the primary task and attend to these requirements. The
following definition of General Practice from the RACGP online is from the official
web site of the RACGP.

5.2.1 Definition of General Practice in Australia
The primary task is written as 'General Practice is to provide universal unreferred
access to whole person medical care for individuals, families and communities. For
General Practice care means comprehensive, coordinated and continuing medical care
drawing on biomedical, psychological, social and environmental understandings of
health'. 19

In our regulated, economically driven paradigm of health care for today we are given
an expansive and altruistic model of medical care that encourages general
practitioners to approach their specialty from an holistic perspective; a notable
model. In providing care that is accessible to all involves a concern for the whole
person, an approach to patient care that is integrated for patients within the context
of their own environment and situation. This definition communicates a quality of care
that is comprehensive and inclusive, a model of care that aids the integration of
individuals, their illness and their life’s processes within society. The model
encourages the enrolling of the individual to the recognition and then potential
acceptance of an organised healthcare programme with continuity of care that
assists and works with the person within their own circumstances. This definition, as
is the care to be provided, is generalized, universal, inclusive but not explicit. It does
not lead general practitioners into areas that require greater clarity and explication
but relies on them to be observant and focused on the contextual task and to unravel
the issues and implications for the individual who is presenting. The definition does
not give suggestions or guidelines to focus healthcare. Much of the specific work of
general practitioners requires their significant emotional commitment, and so creates
the potential for them to become emotionally defended.

In interviewing general practitioners about their attitude to end-of-life planning
some of the answers include the ideas that s/he has not considered this process and
that for the chronically ill patient it would be extremely difficult. When would you
start? S/he recognizes that it is an essential component of the primary task of
General Practice but has not considered taking up this responsibility nor does s/he
feel enabled to perform this task because of time limitations or educational
limitations. A practitioner states,

I suppose I should be doing this really. It is just another thing to add to everything
else I should be doing. [I:12]

How does the RACGP take up the ethical imperative of its leadership role, to enable
general practitioners to focus on a primary task that is inclusive of whole person
medical care? How do general practitioners take up their authority in this primary
task to apply theoretical knowledge and clinical expertise and be congruent in the
relationship with the individual to provide the comprehensive care associated with
end-of-life planning?

5.3 Working Hypothesis
The Royal Australian College of General Practitioners in defining
the primary task for General Practice makes a general statement
which lacks clarity for its implementation. Specific issues and
processes are not defined, so the practitioner takes an individual
stance and may not view end-of-life planning as a component of his
work - as part of the primary task.
This working hypothesis is derived from the analysis of interviews with the general practitioners and excerpts from these interviews demonstrate its validity. The phrase 'lacks clarity' refers to the necessity for further description and explanation to guide the practitioner into areas of care in which s/he may require support and endorsement; areas in which guidelines may assist his/her practice. The lack of clarity in the definition and delineation of the multiplicity of task leads the general practitioner to take up an existential primary task reflecting personal values and life experience. The task then becomes ego-centric rather than socio-centric. The assumptions drawn by general practitioners may equate to patient-care reflecting personal priorities rather than patient-focused priorities. This working hypothesis also brings to mind an initial research interview scenario.

This vignette demonstrates how uncertainty about how to implement a primary task can influence interactions and performance. In the vignette it can be seen that my inexperience with the primary task of researcher elevated my anxiety in its performance.

From my journal: June 2002

As I commence my interview with the general practitioner I become aware that we are both manoeuvring to achieve a position of personal authority or power. I focus on the primary task of my research questions but also acknowledge the issues brought to be addressed. I retain my alignment with my primary task progressing to create a space to work. I do not wish to experience any judgment in the comments made, I do not want to go to a personal zone of incompetence or of embarrassment but want to protect myself from the risk associated with failure in a 'dilemmatic space' where position is contested. With commitment I remain focused on the primary task of my research. I gradually proceed to the basic demographic questions as the general practitioner (GP) satisfies needs to validate my legitimacy. With acknowledgement s/he states that s/he 'develops relationships with patients by talking with them, they listen and they trust'. We proceed to do this in our relationship, as we each hold our
anxiety of performing a task that is on the boundaries of our experience. In this setting both the general practitioner and I are experiencing new roles and we are uncertain about how to take up these roles and work with each other. The general practitioner, instead of being in control of the environment and having the authority in role as the practitioner to a patient, is being questioned about issues that are potentially anxiety provoking. This position is unfamiliar and s/he struggles with the change in perspective and the diminution of positional power in the role as interviewee. S/he does not retain the authority as general practitioner to me as patient, or even colleague. But, in attempting to retain the customary authority in role s/he poses questions to challenge my authority in my role as researcher which could unsettle my sense of task and role. This challenge creates anxiety within me because of my own unfamiliarity in this new role. We negotiate psychologically and palpably our new roles. As I focus on the primary task which is my legitimate objective for being with him/her at this time, we create the space to work.

This statement by Stacey recreates my feelings of anxiety,

I am thinking of situations of considerable uncertainty in which it is not clear what the primary task means ... In such situations managers are working in a state of not knowing what the task is and their roles emerge as they struggle to identify tasks or to develop their meanings ... Such situations are anxiety provoking.23

The statement by Stacey is also relevant in the setting of general practitioners and the task of the process of end-of-life planning with a patient. The analysis of the interviews demonstrates that the pervading attitude is that of fear. General practitioners are afraid of entering an area of the unknown and feel that they do not have the ability or authority. There is a preference by practitioners for the patient to initiate this discussion. These following representative comments from interviews demonstrate the major difficulties faced in envisaging a conversation.
I have never initiated a discussion about end-of-life planning with a patient. I would want the patient to initiate this discussion; but patients do not want to think about dying or address death. They only want to be positive. [I:3]

Or from another interview:
The patient would need to have a reason like a chronic or terminal illness before I would have this conversation; something that would give me permission; allow me. [I:13]

The research data reveals what general practitioners identify as priorities to fulfil their role; they relate to theoretical knowledge and clinical skills. The following quotation is stated in a context of the doctor-patient relationship where the general practitioner considers that the important aspects s/he brings to this relationship with the patient are medical expertise and listening.

Knowledge, expertise, experience, confidence and reliability for their healthcare coordination and planning. Someone to confide in or discuss issues with. Generally give people some opportunity to talk about what is going on for them. I am prepared to be with them, sit and listen. [I:10]

Another general practitioner phrases the relationship with the patient in this way:
The importance of relationship to me means the provision of a safe place to explore inner feelings. Listening leading to personal understanding, the ability to trust and grow to know someone over time. To have a perspective knowing their context, what is going on in their life and that of their family and to be able to support both. [I:7]

In addition to these, general practitioners have the expectation of providing a space for the patient to discuss issues of importance. It may be that in providing this space practitioners assume that patients will confide and talk about what is going on for them. However, this makes the general practitioner a passive observer, listening not initiating, not taking up the task of end-of-life planning. It may be that the doctor does not have the ability to rally 'be with' the patient, or that s/he gives out subtle messages that death is not a subject to be broached.
The questions to be asked might be: are general practitioners able to access within themselves the feelings present as they listen to the patient? Is s/he able to aid the patient to move to a place of exploration? Does the general practitioner feel s/he has the internal resources to be able to take up this component of the primary task? An alternative, do general practitioners have a systematic process to guide the patient through end-of-life planning? Or does the doctor’s awareness of personal feelings and fears result in moving away from extending this conversation? Racker explains these aspects of being with a person in this way:

One can only know in another what one knows in one’s self ...
another person’s unconscious can be grasped only in the measure
in which one’s own consciousness is open to one’s instincts,
feelings, and fantasies.²⁴

5.4 Taking up the primary task?

There are components of whole-person medical care which have guidelines by RACGP. These involve taking into account stages of life, patient groups and illnesses. For example; the infant, the pre-school child, pregnancy or the medical management of many conditions like; carcinoma of the bowel, asthma, hypertension, post-natal depression, multiple trauma, chronic heart failure, diabetes mellitus and numerous others are each defined as important. These recommendations have been developed consensually from suggestions within a group of specialist workers or from research with evidence-based guidelines. The basis for the development of guidelines is to enhance the medical care provided for the individual and provide consistency in care.

But even in conditions like carcinoma of the bowel, severe asthma, malignant hypertension, heart failure and diabetes mellitus which can have significant sequelae and morbidity, the guidelines do not address the issue of end-of-life planning. A significant transition would be to include guidelines and the treatment options at various phases of the disease so that general practitioners could navigate with the
patient management options in a timely fashion in the endeavour to provide opportunities to understand the disease process and its prognosis.

These management issues might then be performed at a time of comprehension and competence for the patient rather than at a time of physical, cognitive or emotional crisis when it is not possible to discuss issues like end-of-life planning. An alternative to the current method for general practitioners would be to complete the responsibility of end-of-life planning as a part of the process of patient-care. This might be performed as a routine, especially in the setting of the elderly patient.

The following quote exemplifies current practice for one practitioner:

I explore their wishes by asking them a direct question and they give an answer. I do not know what they are thinking or feeling, I do not ask. I fulfil the process, I ask the questions. The way families are now days they are reasonably isolated and therefore have very little contact with death, or the elderly dying. It is their first time. [I:9]

5.5 Timing
The timing of a conversation with a patient about end-of-life planning is important. It is entirely inappropriate under extremely stressful circumstances such as presentation to an Emergency Department for critical intervention of an acute exacerbation of a significant chronic illness. At the time of critical illness the physiological responses of the body; tachycardia, sweating and hypotension are overt manifestations of the hormonal and metabolic features of critical illness and the patient has a conscious sense of imminent danger: the predatory death anxiety fills the person's being. At this time their entire energy is focused on survival, to avoid death; a time of fight where the patient is expecting the physician to destroy the enemy, death. This experience has a tendency to cause the patient to regress to a position of helplessness and dependency wherein their mature ego is unavailable to work with end-of-life planning information. There is no space to ensure comprehension or the capacity to contemplate end-of-life planning. It is inadvisable
to assume that the mature ego will be available to the critically ill or their relatives in the setting of a life-threatening illness.

The mature ego is one that can differentiate between what is real in the outside world and what is projected onto it from the inside, what should be accepted and incorporated into experience and what should be rejected.\(^{26}\)

Joseph Sharp has profoundly stated:

Fears explode into consciousness.\(^{27}\)

It is an inappropriate time for individuals to be challenged about their wishes, for they are unable to take on the responsibility of decision making about critical treatment choices; their immediate physiological and psychological response is to survive death. Obholzer speaks of the defensive processes at play.

The danger [is] of the primary task being infiltrated and corrupted by defensive processes arising in the response to the work\(^{28}\)

Another relevant consideration is to recognize and use the internal resources available within General Practice and develop guidelines to enable their competence in the process. As a general practitioner states:

It is much better if the patient or parent does write down their wishes while they are still capable of making their own choices, because the family does seem to struggle when the decision is left to them. Even medical families have difficulties. [I:1]

Guidelines would be helpful in areas that have not had significant change in their management orientation over time, or when the treatment options have been exhausted. It is in such situations where the maintenance of a quality in life may be important for the patient; for individuals with chronic illness or terminal disease and for the elderly. Here general practitioners are required to encompass the psychological, emotional and social aspects of health as significant to the continuing and complete care of the individual.
Currently end-of-life planning is left to the individual practice of the practitioner rather than as a planned and detailed framework for practice. Obholzer in talking about the importance of leadership with vision also relates the significance of the development of strategy to achieve task-performance. Leadership from the RACGP could assist general practitioners in this way.

One of the core elements of the task of the leadership ... is to see that the concept of the primary task of the organisation is not only uppermost in the minds of all the members of the organisation, but that it is constantly reviewed in the light of the external environment and the functioning, structure, and staffing of the organisation.29

5.6 Enduring Power of Attorney (medical)
The most appropriate planning, as practitioner [I:1] states, is for individuals to communicate their wishes while they are able and have the capacity to make their own decisions. For personally s/he has found that in his/her own family setting they struggled at the time of a crisis to make management decisions.

It is the general practitioner, often with the guidance of the specialist, who is most often involved in informing patients of their medical condition, its course and prognosis. At this time, the general practitioner with the informed consent of the patient can communicate with the family or a person selected by the patient - someone whom they trust and respect and who is prepared to fulfil the patient’s wishes at times of incompetency. This person may be given Enduring Power of Attorney (Medical) (EPOA (medical)). The person primed to take on the role of EPOA (medical) is prepared to act on behalf of the patient for the choices about intervention and continuing care plans have been articulated, the desires and wishes to be fulfilled have been communicated. But how informed are general practitioners of the concept of the EPOA (medical) or of the role of this person in end-of-life planning?
I do not know what EPOA (medical) is. I have had no association with this concept. [I:9]

Only one general practitioner routinely takes up the task of up end-of-life planning with his/her patients. A very small number (3/13) of the general practitioners interviewed appear to take up end-of-life planning as part of the primary task at the time of a terminal or critical illness. The following doctor does recognize the importance of the role of the EPOA (medical) with patients and comments:

EPOA (medical) empowers the person rather than me. I like to know who they want to be responsible to communicate their choices and decision making and who they do not wish to involve. My preference is that the family attend with the person at the next consultation. There are no breaks in confidentiality and no misinformation. [I:11]

For, as another practitioner states,

With an EPOA (medical) it is no longer the family responsibility to make the decisions. The individual is asking for their requests to be fulfilled. [I:8]

5.7 Competence
Another general practitioner recognizes that end-of-life planning,

It is not a big part of my professional life, it should be more. I do not bring this subject up very often and very rarely by patients. When the conversation does occur with me it tends to be via a family member or a social worker, most commonly at the time of placement in supported accommodation, a very emotional time. But it is so late at this time the individual frequently has mental deterioration, they have lost their capacity for personal choice and decision making. [I:10]

Most general practitioners do recognize that planning is an important component of the comprehensive, continuing care of the individual. But in some cases because of dementia or frailty, it is no longer legally possible to have this conversation with patients because of their diminished capacity and comprehension. Therefore as a consequence of delaying or avoiding end-of-life planning, elderly patients losing their
capacity to live independently may forfeit their opportunity to communicate their wishes. Moreover in a crisis with high anxiety levels, it is often impossible for the individual’s wishes and requirements for care to be established. The family with the practitioner may arrange home support systems or residential care for their parent but less often address end-of-life planning. For the relative, the significance of the cognitive decline of their parent is too difficult to discuss, and death is not broached. When there is recognition that the elderly parent is unable to fulfil basic daily activities the prime concern for the family is for the physical safety of their relative.

The Australian Medical Association has written guidelines to assist medical practitioners in the assessment of competence stating:

In Australia, an assessment of a patient’s competency involves ascertaining whether the patient is able to:

- express a preference for or against a particular form of treatment;
- make reasonable, right or responsible decisions regarding their treatment;
- provide rational reasons for their decisions;
- recognise decisions that are irrational or unwise, and,
- understand all the major implications of a proposed course of treatment.  

But general practitioners sometimes address this decline by an alternative process. They are able to refer the patient to the Emergency Department with the diagnosis of a potential intercurrent illness. The debility and frailness of the patient may not be stated in the letter of referral. No-one in the community - general practitioner, family or friends - wishes to admit to the physical and neurological deterioration and the setting becomes a crisis; perhaps a fall.
As Long states,

Every task, every action or ‘doing’ raises some form of anxiety
... people in systems collude, structurally and dynamically, to
defend themselves from the pain of these anxieties.31

5.8 Whose task?
End-of-life planning does not have to be the exclusive responsibility of the general practitioner. It could be taken up by other professionals with the medical profession supporting the family and allied health practitioners. However the emotional intensity involved in this work is another reason that end-of-life planning it is rarely taken up by any craft group within the medical fraternity, allied health workers, the family, or members of society. Even when the need is seen, introducing and supporting change is difficult. Miller and Rice explain very succinctly some of the constraints involved in organizations.

Definition and performance are ... constrained by the external environment and by the internal culture, and the interaction of the enterprise and its environment strengthens and confirms the constraints ... new knowledge, fresh experience ... are frequently difficult to introduce.32

5.9 When to take up the task?
In many situations the task to be performed by general practitioners is easily identified, for example the suturing of a wound, the vaccination for the pre-schooler. But even in these settings discretion is important. What is the precipitating cause of the injury, safe practice and tetanus status, for example? For the pre-schooler, what are the language skills, vision, hearing, the social impact of attending school for the child and parents?

Similar considerations should apply to the elderly, the terminally ill or the individual with chronic illness. It is not only the current state of health that needs to be
reviewed but the progression of the disease process, the confounding factors, as well as prognosis. For often future possibilities beyond immediate symptoms and their medical implications need attention. The psychological and social state of the patient may also require consideration. Nonetheless, the anxiety of death and its denial is ever present and often prevents these considerations from becoming part of the task of the doctor. Ambivalence about reality preserves the denial of responsibility.

Most of our world will support us in denying our mortality. No one wants to look at your reality unless they are also willing to look at their own.  

For with prognosis comes management concerns, discussion about personal choices for treatment and end-of-life planning, thus ‘practice’ evolves. From an interview with a general practitioner,

If I go to a home and have a discussion with a patient who is nauseated and vomiting, it is much easier to deal with the physical conditions, their diagnosis, management, therapeutics and counselling, rather than have a conversation with someone who is dying as a result of a terminal illness. This is a different form of counselling that does not fit into things. I would find it hard to initiate this conversation and then charge for it. [I:3]

This practitioner does not include counselling of a patient with a terminal illness as part of the primary task; the whole person medical care is not broached. The emotional and psychological issues related to dying and death are avoided. Both the patient and the doctor are avoiding the fear of annihilation, the anxiety of facing the ‘unknown known’ as termed by Obholzer, who expands on this concept:

It is as if what is required is beyond the make-up of the individual, and in order to master the task, psychic elements have to be summoned that cause discomfort and emotional turbulence.
5.10 The inhibiting factor of the task

There are many conversations between the doctor and the patient that could be extended into a specific dialogue about end-of-life planning. During the following interview a practitioner reflected upon a longstanding relationship with a husband whose wife was in a nursing home. The husband and his wife with the immediate family talked with the doctor on many occasions about the continuing care of the wife who had a significant chronic illness.

But it is the husband who develops a chest infection and dies. You cannot know what will happen. Maybe it was important to have those conversations. It allowed everybody to talk. [I:10]

The general practitioner goes on to say:

Primarily the issue is immediacy, dealing with the current medical or administrative problems; time is difficult, and the uncertainty and unknown limits the conversation. [I:10]

[At this time our conversation is crowded out by noise, going on alongside; this makes me think of the personal noise, the fear, the anxiety when discussing dying and death, the 'unknown known', that will be going along inside.]

From my journal: June 2002

This is an apt description of what does occur in these consultations, it is the immediate; what is perceived as the pressing medical problem that is easiest to address, the physical components of illness, or the administrative issues. The emotional, fearful, and stressful issues that implicate the unknown that involve feelings of dread create the noise. It is the unconscious in the individual that recognizes these feelings, this dread, and they are crowded out, avoided, denied.

What is required is an act of discernment which necessitates a containing ego with a reflective, interpretive stance that has the capacity to make present the tacit and the implicit to create 'practice'. The doctor, by attending to the physical components of illness management, defends against feelings and the projected terror
of hopelessness and impotence in the face of this inevitable death, which unconsciously reminds him/her of his/her own.

The defensiveness of the doctor is not surprising when there is little guidance in the medical guidelines or little education about how to deal with these complexities. S/He has little but past experience to go on. Sharp in his writing says,

Acceptance of our dying must become an ongoing action. What changes us is not the bad news, but the daily, experiential living with it. In this process we cultivate the courage and honesty to really live with our dying and not hide in denial.\textsuperscript{39}

The individual patient in this setting also feeling helpless and hopeless avoids a conversation about inevitable death and this conversation is not enabled because the space is not provided by the doctor. Anxiety is invoked and inhibits taking up this daunting task. This is confounding for at the time of greatest need for care and emotional support the doctor deserts.\textsuperscript{40} Racker here states that it:

Depends upon the degree to which he himself is conscious of his own unconscious ... the countertransference ... is ... an emotional response to the transference ... not only does the countertransference disturb or help the analyst's understanding and capacity to interpret the patient's unconscious conflicts, but by determining the analyst's attitude towards his patient, it also determines the destiny of the transference.\textsuperscript{41}

General practitioners will require clarity in the defining the primary task and the component sub-tasks as well as the internal psychological resources and emotional empathy to begin to want enter this reality and to participate in this conversation; let alone initiate it.
Another interview demonstrates very clearly the major difficulty faced when in conversation. This general practitioner states,

As a topic for me, dying and death is not an easy subject as a doctor or as a person. I do not broach this subject early enough or as early as I think about it theoretically. It would be better to do this earlier and in much more depth than I currently do. [I:10]

Menzies Lyth in talking about hospice settings in England states staff have begun to be with patients in their distress but this has not extended into the hospitals where,

Staff still find illness and death, anxiety and distress terribly difficult to listen to and talk about with patients and relations.42

How do general practitioners become resourceful; to tolerate and understand the emotional and unconscious projections that they inevitably receive? They are aware of the distress within themselves in initiating this type of conversation, sometimes acknowledge its relevance, but are unable to act.

5.11 Authorisation for Task
From review of the data, it is the general practitioner who is available on a day-to-day basis to discuss medical care issues with the individual patient. From the perspective of continuing care there is also the potential for ongoing review and monitoring of the physical, psychological and cognitive state of a patient; in time. For the practitioner has usually been involved in the healthcare of the chronically or terminally ill patient and the elderly patient for a number of years and developed a relationship of trust and respect. This general practitioner, as carer, also has knowledge of the cultural, psychological and social status of patients and their support structures. The medical care of the patient is all encompassing.

Even in this setting the consequences of caring for a patient are often too risky because the anxiety induced in attempting to address the emotional, social and psychological implications of care is too stressful. It often cannot be done in a
culture of isolation where doctors are left to their own devices. The task requires
authorisation from the medical establishment, guidelines and education for
performance and resources for support. Work tasks generate anxiety; as Long states:

The unconscious organisation of social systems is
understood as a defence against the anxieties inherent
in particular work tasks. Whilst these tasks often revive
unresolved childhood anxieties, they also generate new
anxieties related to job performance and its associated social
relations in the workplace.43

The task of end-of-life planning generates many anxieties.

As one general practitioner states:

I do not make the opportunity to end-of-life plan with patients, I am not confident. I
have not been trained to explore an issue like this with patients; it is different from
delivering bad news. I am afraid of creating more anxiety in people by discussing
morbid subjects. The patient may question whether I am trying to tell them
something, or is their death inevitable. Will I take away their hope? [I:12]

But general practitioners are unable to take up this aspect of the primary task
because of their own fear and because the primary task as stated by the RACGP
guidelines does not authorize them. Thinking about death brings forward personal
existential death anxiety; the personal sense of failure as a doctor who took up
medicine to treat disease; to cure. Hellman in a recent journal article talks about the
removal of illness, dying and death from the community. But with this comes another
complication, that experienced by the doctor who also has a similar difficulty.

The 20th century has hospitalized illness, death and
dying ... the medical profession sees death as a failure of
modern medicine. It is not only hard for patients and their
families to face death and dying - it is ... hard for doctors.44
Another general practitioner recognizes that this work is not being done by him/her:

Even receiving this information before having this talk together I recognize how fundamental this work is, that I do not do this work, and that I do not have a systematic process to do this work. If end-of-life planning has occurred at least the options have been explored. When it is unplanned everything is a crisis. [I:1]

When general practitioners with the authority in role take up the task of end-of-life planning, there is an acknowledgement of a task being performed for the benefit of the patient and family. There is also a sense of holding the anxiety of the group while recognizing the importance of the task being accomplished.

But when people believe that their roles and skills help them create value for others, they feel more secure in acting aggressively to accomplish their work. Because roles and skills help people feel that they are good, they become confident that they can contain and direct their aggression.45

The following quote indicates a doctor who recognizes that authorisation is one way to bring about change.

Perhaps by formalizing advanced care planning (ACP) we could charge a fee. It would give ACP a rightful place in General Practice; because there is a medical requirement that ACP occur. People attending with chronic obstructive pulmonary disease or a terminal illness come to the surgery with a physical illness, but they may get something they did not ask for. Therefore how can I charge them for it? A formal legitimate planning tool may be a good thing for the practitioner. [I:3]

Currently the Federal Government only recommends an annual medical assessment for patients over the age of seventy-five years. This assessment reviews cognitive, physical and functional capacity in the activities of daily living. But the review provides funding only for the medical component with no acknowledgement of a component for end-of-life planning. An officially authorized assessment tool needs to be generated and funded for medical and also allied health to provide for the
continuing care of the chronically and terminally ill; a tool which recognizes the need for end-of-life planning.

But authorisation is only the first step. If the process of end-of-life planning is accepted and acknowledged as an important component of a formal legitimate planning tool for a patient's continuity of care will the psychological boundary between the patient and the doctor retain the same level of risk? Will the preferred option remain to avoid the task, rather than to manage the existential death anxiety with the emotional tension and uncertainty of injuring or harming another? This interviewee identifies his/her concept of the issues involved and another approach. 

Most people are a bit confused and overwhelmed by the concept of death and afraid. The best way to avoid that fear is to be silent; denial the majority way of dealing with death and dying. Perhaps a conversation about EPOA (medical treatment) is a good way, it may potentially release them from the taboo, people may respond to some sort of permission. [I:10]

There are also other requirements in association with the development of a process. There are emotionally intense issues that may need to be explored with the patient and the family. A form, a transitional object, could minimize an extremely evocative period to formalized fact gathering, in which listening to emotional overtones and working with the countertransference becomes restrained. Is it better not to communicate at all rather than inadequately: as stated by this general practitioner?

What remains for me is the fear in having the conversation as well as what the conversation will uncover; if this becomes formalised. This now just becomes a process with lines to be filled in on a form, without any sense of communication about the deep issues involved in the process. Neither issue would be met. [I:3]

Long in her précis of a symposium 'Turbulence in Organizations' states,

Conscious defences like distancing, formality and careful structure might either promote or interfere with the health of the symposium.46
Would the defences associated with the process of formalizing end-of-life planning either promote or interfere with the purpose of the task?

The appointment of an EPOA (medical) may be very beneficial to all. But this needs to occur in an environment that respects the autonomy of the individual.

5.12 Conclusion
End-of-life planning has the features of an impossible task. From a societal perspective death can not be thought about because of associated fears and finitude. To attempt to end-of-life plan with a patient requires thinking, a preparedness to take on the fear of not knowing and to move to a place of ideas while retaining the not knowing, the uncertainty, the anxiety. But if there is such dread about end-of-life planning it may miss the concept of a task to be performed and therefore not be present within the role-idea.

If you dread certain work, the need for it may miss the role –idea completely.47

Is this why the task of end-of-life planning is an absent task?48 Mostly, it cannot be thought about with a patient sitting in front of the doctor. Does the inability to think about it mean it cannot be a task for the future?

General Practice can be an isolating experience.49 The determining of the primacy of a task is often a patient by patient decision, affected by personal factors. In the setting of a patient with a chronic illness; as the quality of life for this individual is deteriorating, both the patient and the doctor are aware of this deterioration. But also, both are wishing to deny the inevitable outcome of the disease. The anguish and anxiety in the room are palpable, but both individuals are fearful about initiating a conversation about end-of-life planning to elicit the patient’s wishes. The conversation does not occur.

As this general practitioner states:
I have never considered doing this end-of-life planning. I would not know what to say. I would have to have a significant real reason for beginning this sort of discussion. I can only envisage myself having this conversation with an old person or someone with a chronic condition. I would have to have a reason. [I:13]

The definition of General Practice from the RACGP allows enormous scope for general practitioners to determine the essence of their practice. The RACGP also 'aims to increase the capacity to accurately forecast and revise this vision'. Review of the College’s accepted wisdom and society’s political and social thinking is required to assist in the development of guidelines for end-of-life planning. General practitioners require clarification to take up this task, with the applicant authority applied to the role, to fulfil it. This is discussed further (See Chapter 7: The General Practitioner in Role). As well, utilizing personal psychodynamic resources by experiential learning may assist General Practitioners to develop the capacity to take up the emotional aspects of role. The development of a structured format, a transitional object, may be of benefit to assist in the process of end-of-life planning.

I have completed the thirteen interviews. This is such a privilege. I sit and re-read the transcribed interviews: the entrée into another’s world of work has been illuminating. I feel exhausted and overwhelmed.

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5 Interview 3
44 Hellman A. Narrative and illness: the death of a doctor’s friend. MJA 2005; 182: 9-11
6. **SYSTEM PSYCHODYNAMICS**

A catastrophic life event,\(^1\) like a terminal illness, dying or death of a relative or close friend, may have a significant impact on the physical, contextual, psychological, emotional and social aspects of the individuals involved,\(^2\) causing fragmentation, a 'sense of going to pieces, a normal experience under stress and exhaustion'.\(^3,4\) This may occur also in social systems. In this research project, features of fragmentation are observed at many levels of the healthcare system. These are due to the interplay of system psychodynamic complexities which are unconsciously mobilized through the transferences and countertransferences in group processes which elicit primitive anxieties and patterned defensive techniques. As Gould writes:

> The 'psychodynamic' refers to the *psychoanalytic perspectives* on individual experiences and mental processes, as well as on the unconscious group and social processes, which are simultaneously both a source of unresolved and unrecognised organizational difficulties.\(^5\)

These outcomes in the healthcare system are explored in this chapter. The initial description involves an outline and examination of the concepts of system psychodynamics that will inform the analysis of the research data and give a framework for discussing the dynamic complexities occurring in the contexts of general practitioners' work. The theoretical exploration commences with an introduction to system learnings for the infant and the psychic dynamics of behaviours learned from their first relationship with the mother and father. Klein considered the interactions of the first small group, the family, as rudimentary learning re-expressed later in the psychic interplay of the adult in organizations.\(^6\) System psychodynamic concepts recognise the importance of the interface between the system processes and the psychic state of the organization which is inclusive of the individuals who make up the organization.
The following discussion incorporates the influence of primary learning on the individual with the elaboration of potential interactions of the individual in the system and the system in the individual. A theoretical exposition then introduces some key conceptual characteristics of systems thinking: the ideas of: boundaries, double task, the holding environment and containment. This leads to a discussion of the dynamics of fragmentation associated with the dissolution of defence mechanisms at an individual and organizational level. A working hypothesis generated from the analysis of the research data is examined with its application to this data. The exploration involves the interplay of the dynamics of the systems within which general practitioners work and how they influence the outcome of the process of end-of-life planning.

The system concepts of primary task and role are explored in Chapters 5 and 7. General practitioners are involved in a number of system interactions. Consideration of the doctor-patient relationship (the dyad) is followed by a review of the interaction of the general practitioner with the patient and their family (the small group). The next system discussed is the organization. The general practitioner is considered in the setting of his/her own craft group, the Primary Health Sector. The general practitioner’s perceptions of their interactions in the Primary Health Sector (community-based) with the Acute Health Sector (hospital-based) and the inter-systems dynamics of the large group are then explored. The final inter-system discussion relates to the Primary Health Sector and the Federal Government, the very large group. These system interactions are illustrated in Table 1.

<table>
<thead>
<tr>
<th>SYSTEM INTERACTIONS</th>
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<tbody>
<tr>
<td>The dyadic system</td>
<td>The doctor-patient relation</td>
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<tr>
<td>The small group</td>
<td>The doctor, the patient and the family</td>
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<tr>
<td>The Organization</td>
<td>The Division of General Practice</td>
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<tr>
<td>Inter-organizational systems</td>
<td>The Primary &amp; Acute Health Sectors</td>
</tr>
<tr>
<td>The large system</td>
<td>Federal Government, PHS, AHS &amp; Society</td>
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The concluding observations relate to the perception of fragmentation within and without the healthcare systems and the impact of this disconnect on the healthcare of the individual, especially as it relates to end-of-life planning.

6.1 Rudimentary System Learning
The exploration of psychodynamic learning in systems is fundamental to this research thesis. It is hypothesized that:

- contextually and culturally learned behaviour from infancy is the beginning for the individual's learnings, and,
- knowledge of this is useful in understanding how an individual's adult outlook is coloured by these rudimentary learnings.

These early learnings act as conscious and unconscious triggers for thoughts, feelings and behaviours in all social interactions for the individual during life. Wells acknowledges in the theoretical construction of 'group-as-mother', that the earliest relationship of infant and mother is the fundamental learning environment of the 'individual-in-relation-to-the-group'.

The 'group-as-mother' analog fundamentally draws the parallels between 'infant-in-relation-to-mother' and 'individual-in-relation-to-group.' The central thrust ... is that the group situation creates such ambivalence and anxiety that it unconsciously returns the group members to earlier relationships with the primal mother and evokes all of the psychosocial mechanisms involved.7

My review of system learning commences with work by Klein,8 Ogden,9 Winnicott10,11 and Bick,12 whose observations of infants and children and their analysis of children and adults are used as the theoretical underpinnings of system psychodynamics. The basis of an individual's response to stressors and anxieties and the adult's approach to being, is expressed as an outcome of developmental learning during infancy.
Klein\textsuperscript{13} and Winnicott,\textsuperscript{14,15} during therapy with children recognized that the maternal care experienced during infancy is fundamental to the emotional development of the infant. The experiences of the holding environment are critical as a first system encounter.\textsuperscript{16} The dyad is the original small group. From the learning environment of the relationship with the mother and then relationships within the family, the individual develops for future social and psychic participation, their way of being in the world. Each phase of development during infancy is pivotal to the achievement of ego maturity and therefore to future participation in the multiple systems encountered in society. How the individual interacts within a system encounter is dependant upon the ability of the ego to manage internal and external anxieties, to act as boundary manager and to adapt to life's anxieties and stressors. Successful evolution of the emotional experience enables development of a stance which allows the person to tolerate uncertainty and ambiguity.

The level of ego maturity of general practitioners influences their ability to develop relationships within each system context, as Davis and Wallbridge point out and is manifest in the defensive behaviour deployed.

The adult who is mature is able to identify with the environment, and to take part in the establishment, maintenance, and alteration of the environment, and to make this identification without serious sacrifice of personal impulse.\textsuperscript{17}

Klein uses the term 'position' to describe different psychic phases of being. The infant's development of maturity occurs linearly with each stage building upon the previous one. In her study with children, she details the paranoid-schizoid and depressive phases of maturation of the ego and how meaning is attributed to the experience and the behaviours learnt in these earliest stages of life.\textsuperscript{18} Ogden uses an
additional term *autistic-contiguous*, because he believes a more primitive learning phase occurs before the *paranoid-schizoid* position.\(^\text{19}\)

In adulthood, the psychic position taken up by the individual depends upon the intensity of the anxieties evoked, the regression involved in the response, and hence the defensive behavioural pattern developed. This pattern can be adaptive or maladaptive as the individual attempts to maintain a sense of sanctuary without annihilation or fragmentation. When the defensive behavioural pattern is maladaptive and associated with rigidity it becomes a retreat.

> Our adult experiences are influenced by our basic attitudes, which either help us to cope better with misfortunes or, if we are too much dominated by suspicion and self-pity, turn even minor disappointments into disasters.\(^\text{20}\)

In the reality of the individual, these positions, as demonstrated below in Table 2, are in a dynamic interplay with interchange dependant upon the contextual stressors.

**'POSITIONS' TAKEN UP in PSYCHIC DEVELOPMENT**

<table>
<thead>
<tr>
<th>POSITION TAKEN UP</th>
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<tr>
<td>or 'RETREAT'</td>
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<tr>
<td>AUTISTIC-CONTIGUOUS</td>
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Bick in explaining the autistic-contiguous position of the earliest phase of infancy, the immediate post-natal period, states that the ego has limited ability to introject and project because of the lack of an internal space; a characteristic of autism.\(^\text{22}\)

She describes the skin as having an extremely important receptive purpose that performs the boundary function of containment. The skin is used to enable the first introjection of an object. The nipple and clothing are important sensate ingredients in the creation of internal space.
In adult life a trigger may evoke feelings which replicate a childhood incident. The context and circumstances relating to a previous experience, or the anxieties invoked, influence the position taken up in the moment by the individual and therefore the defensive mechanisms played out. The response may become the patterned behaviour, a psychic retreat. Ogden writes:

Associated with each of the positions is a particular quality of anxiety, forms of defence and object relatedness, a type of symbolization, and a quality of subjectivity. Together these qualities of experience constitute a state of being that characterizes each of the positions.

The following theories relating to emotional development and social defensive behaviours are relevant to the understanding of general practitioners in their interface with the healthcare systems.

6.1.1 Autistic-contiguous position

Ogden believes the infant commences experience as a dependent being with an impression of the world as sensory experiences with relations to shapes and objects. These are machine-like in their reliability and their capacity to be imitated ad infinitum. This sensory world gives the infant a sense of security and ritual in an otherwise uncertain, unpredictable human world, and provides a perimeter of bounded being which is sensate; the autistic-contiguous position. This rigidity provides a buffer from the uncertainty and pain of human relationships. Bick and Meltzer use the term 'adhesive identification' where external objects are adhered to provide a second skin because of the absence of an internal space. An interruption or intrusion into this predictability leads to the terror of sensory disintegration. By adhering to objects, which are an extension of the self, the phantasy is that the external world can be either completely controlled or denied.
There is no real relationship with an external, object world. Ogden writes about this primitive stance where the mode of generating awareness is predominantly sensory, associated with tactile sensations, where anxieties will be defended against by withdrawal and isolation. Fear is experienced when: the nipple is taken from the mouth; clothing is removed from the infant or the infant is held precariously. What arises (it is hypothesised) is; the fear of annihilation, falling, the leaking into a shapeless oblivion, and the perception of a faceless gloom.

A form of isolation in which the infant replaces the mother-as-environment with his own sensation matrix, [it] involves a radical withdrawal from human beings.27

The term autistic-contiguous used by Ogden describes the mode of behaviour of the most undeveloped mind and its first attempt to master anxiety and the fear of annihilation. The infant, being unable to experience external objects as individual entities imitates and uses objects as part-objects to fulfil his narcissistic purpose, self-love and perpetuation. The object in the external world is an extension of the self and is omnipotently controlled for the maintenance of security. Security also originates from the rigid control of routines. If these are thwarted, withdrawal and muteness or endless prattle intervenes. The infant has no concept of ‘me’ and ‘not me’: all is me, until the phantasy is shattered, when the controlled becomes uncontrollable.

At this stage of development, the child withdraws with the extreme fear of disintegration. He symbolically and physically barricades himself away to shut out the external world, by rigidity of the bodily habitus, or wrapping him/ herself around himself, or through echolalia. With repeated impingement and the consequent inability to develop an internal world the infant is predisposed to the disturbance of autism and the associated preoccupation with bodily sensations. These phenomena are observed in individuals and groups as an unconscious replay of childhood learnings.
The autistic-contiguous position as applied to a social system is depicted by Elieli in a case review. Here the group studied is unable to expose itself to external reality with its associated fears and barricades itself from this reality.\textsuperscript{28} She describes how in holding hands the group defends against being exposed to the external environment, the pain, suffering and potential loss of support, in order to limit feeling and thinking. The emphasis for the group is to maintain closeness and contain their anxiety.

- Focussing all their attention on keeping themselves together,
- holding hands ... The group had surrounded itself with an impenetrable wall.\textsuperscript{29}

Similarly this may be observed as the patient withdraws back into a seat with arms folded while the general practitioner attempts a conversation about end-of-life planning.

### 6.1.2 Paranoid-schizoid position

In the next position, from the Kleinian stance,\textsuperscript{30} the infant alternately believes in omnipotence, with gratification, trust and ease if s/he believes s/he is able to influence the external world and its part-objects, or of impotence with a sense of destruction, distrust and extreme anxiety if s/he believes s/he is unable to influence the external world. The infant is unable at this stage of maturity to recognise that both the sense of gratification and persecution are derived from the same mother. For although the mother is the infant's entire world, she is experienced in a way that splits good from bad into two part-objects. The infant is unable to recognize that all feelings, good and bad, love and hate, pleasure and pain are stirred by this same being. In this position there is no ability to recognize the whole. The world is split into parts, as part-objects, good and bad. With this concrete thinking the subjective internal world is perceived in part as a reflection of the object world. When the breast (mother) is introjected by the child as a loving, warm, generous part-object, this is ego constructive for the child.
The creation of an inner world of positive part-objects enables the development of loving self-relationships. But the breast is also introjected as a harsh, cold, withholding and offensive part-object. In this setting, the child learns of a destructive, hostile external and internal environment. If the child has an innate distrust in the capacity of the mother to love and has a sense of destruction and hostility, this internal hostile world with the potential of annihilation creates destructive and persecutory self-relationships. The immature ego deals with anxieties by the mobilization of primitive defences and manifesting omnipotent phantasies, by splitting, introjection or projection.

In the paranoid-schizoid position these types of self/part-object relationships are kept separate by the immature ego. These relationships are extremes, the excessively good – idealized, and the extremely bad – persecutory.³¹ The anxiety-creating destructive feelings are projected into the bad part-object. This bad part-object with the bad-self is then projected externally. The loving self-relationships are projected into the good part-object and introjected by the good-self. Most often, the good self-object is introjected as self whilst the bad self-object is projected as not self. The awareness of bad self/part-objects changes the good self/object into a persecutor.³²

At this time of maturity of the ego, the whole self and whole object are not discernable. The conflicting feelings of these internal and external worlds in the paranoid-schizoid state create a sense of immediacy; of being acted upon rather than having agency. This is the first experience of the individual in a social framework, the recognition and interaction of subject and part-object. During the learning experience an immature ego manages the boundary and primitive defense mechanisms are invoked at the interface of these interactions with the boundary.
6.1.3 **Depressive position**
The depressive position is the state of being wherein the infant, with ambivalence, is able to bring together the good and bad part-objects of the mother, acknowledging the polarities of these feelings towards these part-objects and identifying them as a whole-object. The infant recognizes that the breast that satisfies him is also the breast that frustrates and thwarts him. The child is able to lament the loss of the idealized good-object and has a sense of guilt that he may have damaged the object. This leads to the emotion of concern. In the depressive position, the mature ego is able to tolerate ambivalence in the recognition of the whole-object, to accept the good and the bad, together. Klein described this process as:

> The working through of the depressive position [which] implies that in this struggle (which is renewed at every mental and physical crisis) the ego is able to develop adequate methods of dealing with and modifying persecutory and depressive anxieties - ultimately of diminishing and keeping at bay aggression directed against love objects.\(^{34}\)

The integrated ego, no longer focusing solely on the survival of the subject, acknowledges the dependence of the subject on the object. A sense of harm to or loss of the object develops with concern associated with mourning and the need for reparation. There is acknowledgement and acceptance that the good-object is not perfect, and feelings of shame are associated with the phantasy of harm inflicted upon the mother. There is a change in the balance between the use of introjection and projection. The emphasis in the depressive position resides in the introjection of positive, constructive entities into the inner world and relaxing the need to project bad aspects of self. The whole self and the whole object are able to be identified and accepted as imperfect, with recognition of the affirmative aspects of the external world and the unsavoury aspects of the self.
Attaining the depressive position is a lifelong journey. But at any time, with provocation or significant impingement the individual in the group may regress to an autistic-contiguous position; a sense of holding oneself together, or a paranoid-schizoid position, believing that the group is the enemy; that it has become a crowd.

The individual at times may experience in a very small group ... the same problems of holding onto his skin as he may experience in a crowd.  

### 6.2 Bion’s binocular vision: Group experience

But the system is not merely a sum of the individuals involved in a group and their individual psychodynamics: there is much greater complexity. This is explored through understanding group behaviour. Bion considered it helpful to juxtapose the psychoanalytic study of the individual with the psychodynamic study of the group to obtain a binocular vision, to move with the individual dynamic into the dynamic in the group, being inclusive of both; and in doing so to recognize that to unravel the experiences of the group means to explore the conscious and unconscious feelings and thinking of the group as it relates to the group’s task.

Two methods provide the practitioner with a rudimentary binocular vision ... The psycho-analytic approach, through the individual, and the approach ... through the group, are dealing with different facets of the same phenomena.

Biran and Lawrence expand the thinking Bion generated from group work, as demonstrated in Table 3. They acknowledge that the mobilization of instinctual thinking is derived from either the metaphor of Oedipus or the metaphor of the Sphinx. The oedipal metaphor explores the life of the individual and his/her ‘narcissism’. This metaphor explores the finite, ‘what is’, the individual, who is focused on identity creation, self-fulfilling needs and object relations. The myth of the Sphinx, as told in Greek mythology, is associated with the infinite, ‘what if’, in a
world in chaos, beset by war, famine and disasters, events beyond the control of the individual.

The individual in life, oscillates between 'narcissistic' and 'social-istic' polarities. When the individual embarks on the pathway to social enlightenment there is an exploration of the mysterious and the infinite in the search of knowledge for social meaning.

### BION’S BINOCULAR VISION

<table>
<thead>
<tr>
<th>Ego-centric</th>
<th>Socio-centric</th>
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<tbody>
<tr>
<td>Narcissism</td>
<td>Social-ism</td>
</tr>
<tr>
<td>Oedipus</td>
<td>Sphinx</td>
</tr>
<tr>
<td>Past</td>
<td>Future</td>
</tr>
<tr>
<td>Finite</td>
<td>Infinite</td>
</tr>
<tr>
<td>Establishment</td>
<td>Mystic (Change agent)</td>
</tr>
<tr>
<td>Ps(psychiatric)</td>
<td>D(depressive)</td>
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In this endeavour, the individual suspends narcissism and accepts the enigmatic, the disturbance of learning through experience and not-knowing. In this inter-subjective group, the realm of exploration creates anxiety and fear, an explosion in thinking, to concepts of the unknown and unknowable with the adjunct generation of disturbance:

- The individual’s feeling that he [is] being persecuted by the group, both internally and externally.

The inability to contain the emotional disturbance created by the group’s conscious and unconscious processes leads to the development of persecutory feelings. For in the setting of the group, the individual and ‘the-group-as-a-whole’ are exposed to the predisposition for neurotic or psychotic extravagances, and the susceptibility for paranoid-schizoid thinking (Ps) - splitting, disintegration and fragmentation. Bion’s description of the group reflects on the rudimentary learning of the infant as expressed by the work of Klein.

- The adult must establish contact with the emotional life of the group in which he lives; this task would appear to be as
formidable to the adult as the relationship with the breast appears to be to the infant.  

Bion was able to recognize in the collective responses of the members of the groups he studied, primitive machinations and primal defensive structures: the outcome of the fears and anxieties to which the individuals were exposed. These occurs as the individuals in the group struggle with their sense of self and personal identity in their attempts to maintain their ego boundaries. The desire to maintain individual distinctiveness rather than be absorbed into the group process and mentality is forever a state of tension for the individual in the large group or organization. How does the individual contain fears and anxieties whilst paying attention to the projections or splitting in the large group setting, the system, the organization? The psychic processes involved in the group setting are reminiscent of the infant’s rudimentary learning, of ego maturity and boundary definition, individuation and a sense of self.

Bion writes that every human being is a group-being whether actively participating in the group or isolated from it. If the individual is able to recognize the projections present and taken up by group members and him/herself, there is a greater possibility for understanding the motivations and chaotic behaviours in the group and the defensive strategies at play that may limit group work. But presence is not necessary. Projections can be taken up by the individual unwittingly and without recognition of the process. In hierarchical systems the unconscious and collusive nature of the ‘groupishness’ and ‘group-think’ are pervasive. The explanation of certain phenomena must be sought in the matrix of the group and not in the individuals that go to make up the group.

In an endeavour to understand the functioning and defensive behaviours of the group it is helpful for the individual to retain the ability to reflect on his/her internal
reality while ascertaining and sustaining contact with the external reality of the group. To achieve this it is important for the individual in the group to maintain a capacity to think with emotional integrity. In thinking and feeling together in role, individuals are able to pursue organizational tasks and processes. The cogent ability of the depressive position is to be open to and aware of the intersubjectivity within the group as well as the intra-group dynamics. The individual member in the group who is conscious of the relevance of the dynamics generated and is aware of the projections present aids the group's understanding of itself and the political dimensions of the interactions taking place. Withdrawal or splitting occurs because the group is unable to contain the triad of experiences, thoughts and emotions. Being unable to contain the reality of the context and wishing to avoid its unpleasant aspects, the group may split off the unacceptable aspects of the intra-group reality into an individual or external group by scapegoating.

This thinking and behaviour also occurs at community and societal levels. Each individual, group, organization, system, culture, and society has its perception of acceptable and unacceptable behaviour and practice. What is unacceptable within the group may be projected out onto an alternative group, organization, system, or culture with a monocular bias – splitting off the unacceptable. This is the basis of the following Table 4 by Biran, who depicts the cultural narcissism between Palestine and Israel.

<table>
<thead>
<tr>
<th>GROUP NARCISSISM</th>
<th>ABILITY to LOVE the OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impressed by the Similar</td>
<td>Accepting the Different</td>
</tr>
<tr>
<td>Projection on the Other</td>
<td>Ability to contain weaknesses and urges</td>
</tr>
<tr>
<td>Dehumanizing the Other</td>
<td>Ability to defend human dignity</td>
</tr>
<tr>
<td>Superiority</td>
<td>Reciprocity</td>
</tr>
</tbody>
</table>

MONOCULAR versus BINOCULAR VISION Table 4

175
In monocular vision what is known and familiar is acceptable and superior. Differences create anxiety and the potential for splitting and are therefore, unacceptable and inferior.

6.3 Systems thinking
Systems theory provides a framework for integrating information about a complex whole made up of multiple parts or sub-systems. It assumes purpose with interrelatedness and interdependence in its basic structure with integrated processes involving participation through other systems or sub-systems.\(^{50}\) A system is viewed as an entity in itself. The structure and operation of the system can be analysed at the system or sub-system level.

Systems theory deals with encompassing wholes; with the complex patterns of interaction between the wholes and their parts, and with their interrelationships between the wholes and their context or environment.\(^{51}\)

The concept of the system implies complexity, for example the human being as a biological system, or as a social system; the solar system as a scientific, or astronomic system; the computer as a technical, or information system. Systems come together for a purpose which can be interactive, participative or cooperative. System psychodynamics explores the relationships of a system which encompass the internal and external socio-technical components of the system, subsystems and individuals with, for example, its client networks.\(^{52}\) As well, it encompasses the internal and external socio-psychic components of the system, subsystems and individuals, who are, for instance, the organization. These psychodynamic relationships are comprehensive in that they involve the conscious and unconscious components of the emotional experiences of the system, subsystems and the individuals working for the organization. With the interplay of the psychodynamic
The complexity of the human biological system aptly correlates with the social organizational system. Both are complex, inter-related, interdependent systems communicating between the unit (cell, individual), sub-system, (organ, group) and the system (human being, organization). The multiplicity of complex communication networks within biological systems ensures a degree of interdependence, responsiveness and integration unattainable in a social system because its primary task is 'normative', the purposeful preservation of the whole. It is not exposed to the psychodynamic boundary tensions the cognitive, volitional and emotional interactions experienced in a social system. The psychodynamic concepts of organizational systems that are significant to this thesis are further developed later in this thesis in primary task (See Chapter 5: End-of-Life Planning in the Primary Task), boundary (following section), and role (See Chapter 7: The Role of the General Practitioner).

6.3.1 Boundary

Boundaries are an integral part of a complex social system. They are discussed here because they are fundamental to the performance of the task within and across systems; especially as they relate to the complexity of the healthcare systems involved in end-of-life care. A boundary is a region which has a relationship with its inner and outer environments regulated according to the requirements of the system. It allows flow of products and communication while focusing on the completion of the primary task of the system. Each component of a system is separated from its sub-systems by a boundary. Processes occur across boundaries; these include relationships and functions. The purpose of the boundary of each component of a system can determine whether it is open or closed, and the degree of responsiveness it exhibits; its permeability. Miller states:
Both enterprise and individual, therefore, can be conceived as open systems, engaged in continuing transactions with an environment; each has a boundary region exercising a regulatory function between the inner world and the environmental systems with which it interacts.\(^{53}\)

In social systems there is a dynamic tension and perpetual motion between the cognitive, volitional and psychodynamic interactions of the individual, intragroup, intergroup and the organization.

For the individual, psychologically this boundary region is the ego. For the group or organization this boundary region is usually presided over by leadership. The relationships across boundaries rely on the dynamic ego maturity of the participants and the ability of the group to retain the function of a sophisticated work group.\(^{54}\) It is valuable if the individuals involved in these interactions recognize the importance of transference and the countertransference in the relationships. Exploration of the transference-countertransference relationship potentially creates greater understanding of the anxieties at the social-istic interfaces of the organization. With the ability and openness to explore the transference-countertransference feelings, the group is encouraged to work with the context, in the depressive position. This position also enables reflection and review with the linking and inter-relatedness of roles in the performance of the organization's primary task. In simple terms this means that people attempt to understand one another without attributing motives or feelings to others for which they have little evidence. It means that there is a willingness to listen to the other and accept them as 'other'.

Encroachment on the boundary of the individual may bring about injury to the ego and this injury may also initiate defensive techniques to repair the damage. There may be a need for the individual to withdraw while repair is occurring. Primitive defense mechanisms are involved at the interface of these interactions at the boundary. How
the individual interacts depends upon the ability of the ego to act as manager and adapt to the anxieties and stressors in life, to develop a stance which enables toleration of the uncertainty and ambiguity in the arena at the moment. Internal systems often require adjustments to be made. These changes can be negotiated across boundaries, and so the systems remain semi-autonomous. Boundary management in the interaction is the responsibility of the individual ego or the system manager. It is the responsibility of this individual to be receptive to change in the internal and external environments and to attend to the requirements of the system. System interfaces bring uncertainty and choice; complex negotiable connections of narcissistic and/or social-istic endeavour. The complexity, diversity and instability of these dynamics may move to spontaneously self-organizing processes which can evolve as chaos, bounded instability or stability, thus producing dissolution, creativity or stagnation in the systems involved. The functioning of the systems is dependent upon the inter-relatedness and responsiveness of the boundary agents. In the appointment of a leader, it is important for sanctioning of the leadership role by role-holders to develop leader-follower relationships, for task performance is related to inter-dependence. An organization in a turbulent world requires of leadership an ability to manage change, and deal with ambiguity and uncertainty. Organizations have moved from a mechanistic world of structure to an organismic world, emphasizing process where change can be transitional.

Transition is essentially a psychosocial process [and] draws attention to the fact that what we are dealing with in social system transition is fundamental change at two distinct levels at the same time.

This extrapolation in social systems enables the binocular vision referred to by Bion: the psychoanalytic approach for the individual as well as the psychodynamic approach for the group experiences of the system and the system to the external environment. It encourages the organization to analyse its performance from a system and sub-
system perspective, as well as from an internal and external perspective. These concepts will be important later when I look at the primary health system in which medical practitioners are embedded.

6.3.2 Double task
Bridger has a similar conceptualization for social systems.\textsuperscript{59} Individuals need to gain greater understanding of the system in which they are working by recognizing and incorporating the organizational task with the requirements involved in fulfilling the task. Bridger used the phrase double task, which incorporates both the primary task of the organization: 'what we are doing at this point in time?' with a review question, 'how are we going about it, are we approaching it in the best possible way?'

A transitional approach to change emphasizes the enabling of people to change the way they think about the problems around them, to alter their perspectives, and to discover new possibilities for action which can never occur to them as long as they remain on the secure railtracks of their habitual mindsets.\textsuperscript{60}

A systemic view allows the workers to participate in their own system and to introduce innovation and change, with the propensity to adapt to the external environment. The view enables a state of being that, as Gould would say, develops the penchant to work from the 'inside out' and the 'outside in' simultaneously, without prejudicing either perspective; a double task.\textsuperscript{61} This view is particularly relevant to the interactions within the doctor-patient relationship and the acute and primary healthcare sectors.

6.3.3 Holding environment/containment
A feature important to the Bridger framework of systems is the phenomenon of 'holding' as described by Winnicott.\textsuperscript{62} Psychologically this 'holding' communicates 'ego-support', fundamental to the development of ego-maturity. Winnicott stresses the
importance of this care in the holding environment, to create a sense of safety and security for the individual, which enables the development of trust in the relationship, through empathy. The 'holding environment' in the world of systems also provides ego-support, a sense of safety and security, within a stressful, anxiety-provoking situation which threatens disintegration and fragmentation for the members of a group or the group. Derived from Klein, the term containment is a concept of projective identification, where a person contains an aspect of another. This was used by Klein and her followers to describe the quality of mother’s emotional containing of the infant’s intolerable anxiety and dread.

The containment of anxiety by an external object capable of understanding is a beginning of mental stability.

Bion defines three basic forms in the 'container' and 'contained' relationships that also apply to social systems: the organizations in which we work. The first is Symbiotic: a productive setting wherein one depends upon the other to mutual advantage. This environment enables the group to work together for the purpose of the organization while the group and the individual learn and are creative in the process. Commensal containment creates an environment where the groups independently work without influencing each other’s process, development or learning. Parasitic containment sets up a rigid destructive space where productivity and creativity are subjugated for all involved. The parasitic container is destructive to all parties where violent pathological projections including hatred and envy are unconsciously forced into individuals or groups, thereby leaving the individuals or groups feeling uncontained and experiencing dislocation, violation and fragmentation. The form of the relationship within a containing environment is critical to the productivity, understanding, and creativity of the individuals and groups within an organization. The symbiotic setting alone allows constructive learning to occur for the individual, the group and the system. It enables modification of the stressors
amended after being contained bringing with it a sense of emotional safety and learning.

Bion develops his model of projective identification as communication to a recipient/container capable of modifying the projection so that the transformed content can be taken in again by the individual in a less distressing form.65

As discussed in the data analysis, holding and containment are critical concepts to both the internal and external functioning of the systems involved in end-of-life care.

6.4 Fragmentation

6.4.1 Fragmentation in the Individual

The concept of fragmentation is important to understand both for the individual and for the social system. In this thesis it is relevant to the patient, the general practitioner and the primary health system in relation to the anxiety associated with end-of-life planning. With the dissolution of social defence mechanisms, fragmentation can occur. Hinshelwood defines fragmentation in the individual as 'severe splitting of the ego, typically in relation to the difficulties encountered in the paranoid-schizoid position, which gives rise to a sense of fragmentation, of going to pieces. Though a normal experience under stress or exhaustion' (Italics added).66

External or internal environmental failure leads to a shift in the dialectical interplay of the autistic-contiguous, paranoid-schizoid, and the depressive positions. When there is a breakdown in the functioning of the mother as provider of a buffer against feelings of helplessness in a world of 'not-me' objects, this dread is taken on by the infant. What had been either an intersubjective or an inter-objective form of defense or phantasy becomes increasingly an intrapsychic act of self-defense on the part of the infant. The infant protects himself/herself through the use of increased reliance on omnipotent forms of thinking. Any disruption to working patterns, or continued impingement can bring about anxiety, defensive behaviour and also withdrawal. An autistic-contiguous or paranoid-schizoid defense is constructed when
the intensity of the anxiety experienced overwhelms the defence mechanisms, the ego is depleted. What remains is delusion, an omnipotent unconscious phantasy, and loss of the sense of the external reality. This results in:

An intense sense of immediacy to one's experience. In the absence of a sense that experience can be thought about, psychological defense tends to be enactive and evacuative in nature.67

When an individual is confronted by an anxiety provoking stimulus that disturbs stability and overcomes basic defensive processes fragmentation can occur. Defensive organizations function to secure, defuse or contain this primitive destructiveness. The forms of construction depicted by Steiner, and redrawn in Table 5, are inclusive of the defensive behaviours splitting and projection.

'POSITIONS' TAKEN UP by INDIVIDUALS

<table>
<thead>
<tr>
<th>POSITION TAKEN UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTISTIC-CONTIGUOUS</td>
</tr>
<tr>
<td>RETREAT</td>
</tr>
</tbody>
</table>

| | Pathological | Normal | Fear of loss | Experience of |
| | fragmentation | Withdrawal | Splitting | loss of the object |

The psychic states are in a dynamic continuum, neither position dominating with any degree of stability. There is significant difference between the state of integration in the autistic-contiguous, paranoid-schizoid and the depressive positions. The former two are fixated on survival whilst the latter is able to demonstrate concern for the other. The anxieties encountered by the individual will initiate a shift in the horizontal axis of the continuum; the intensity of the anxiety will determine the
position taken up, as splitting, withdrawal or pathological fragmentation, or whether the individual moves into a retreat which is a protected pathological organization. Another dimension of fragmentation can be involved which initiates the autistic-contiguous position. Here the individual removes him/herself from all physical and emotional participation, being unable to connect thinking and feeling, s/he responds by completely withdrawing to a sensate place of physical safety, security and ritual. In an organization, the demobilization of an individual into an autistic-contiguous position may find the person withdrawn into their own world of work, in a safe, enclosed environment of known external objects that maintain personal control with routine and regularity to retain coherence.

Fragmentation is the result of thinking and thought being separated from feeling and from the body.⁶⁹

6.4.2 Fragmentation in Organizational Systems
Obholzer believes criteria used for assessing the performance of the designated primary task of an organization can be employed in assessing an individual’s psychological functioning.⁷⁰ He stresses the importance of listening to each other to develop understanding of professional roles and inter-professional cooperation. Shapiro and Carr acknowledge the role taken up by institutions for society, especially in mental health, because society is unable to cope with unbearable feelings.

The institution ... may be used by society as a place to lock away unacknowledged and uninterpreted problems of unbearable human responses to patients’ psychopathology.⁷¹

The defensive behaviours deployed by social groups may limit the performance of the primary task by personnel, who in turn are unconsciously asked to contain the overwhelming anxieties associated with the management of psychological dysfunction. In medicine, the care of the human being is removed from the central focus. Hirschhorn advances several concepts to explain the situation.⁷² He states that in undertaking tasks that present risks to personal and professional identity, the
individuals or groups involved will step out of role and create an alternative task to alleviate the anxiety for the individual and the group. A defensive mechanism will be introduced by the group to supplant the anxiety and through depersonalization, the existence of pain or suffering is denied.

This may be expressed in Australian society by hospitals and aged-care facilities containing the unbearable feelings associated with dying, dementia and death. Failure within systems brings evidence of fragmentation within society.

> The roots of our thinking about how to cope with death are, I believe, deep in the fabric of our essentially death-defying society. We have removed old people and sick people from our view ... No longer is death a part of life to be expected ... it is a failure in the system\(^7\)

### 6.5 Psychodynamic features of system interfaces

What are the psychodynamic characteristics and the defensive behaviours developed by the general practitioner at the interface of the systems in the workplace? Charles describes the creative aspects of defensive behaviours relating to task and enabling professionals to fulfil their role within each system.

> The autistic-contiguous mode, in a positive sense, moves towards soothing (rhythmicity), affirming existence; the paranoid-schizoid mode moves towards affirming experience; and the depressive mode moves towards affirming links.\(^7\)

The following hypothesis is presented in terms of systems psychodynamic thinking. Data from the general practitioner interviews are used to derive the hypothesis.
6.6 Working Hypothesis
How the general practitioner takes up the role of end-of-life planning within the community is effected and affected by his/her interface with the psychodynamics generated in each system that s/he encounters in role.

In their day-to-day work, general practitioners work across a number of system interfaces. The dynamics within these situations effect and affect their ability to take up authority in role. The description applied by a general practitioner to the groups of work illustrates his/her conceptualization of the psychodynamics within each system. The language used in communication further identifies the defensive mechanisms at play. The focus of end-of-life planning attaches an additional level of intensity to the anxiety and the dynamics in these system encounters where general practitioners often appear to abrogate their authority in role at the system interface.

Table 1 show the groups studied.

<table>
<thead>
<tr>
<th>SYSTEM INTERACTIONS</th>
<th>Table 1 (p.162)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The dyadic system</td>
<td>The doctor-patient relationship</td>
</tr>
<tr>
<td>The small group</td>
<td>The doctor, the patient and the family</td>
</tr>
<tr>
<td>The Organization</td>
<td>The Division of General Practice</td>
</tr>
<tr>
<td>Inter-organizational systems</td>
<td>The Primary &amp; Acute Health Sectors</td>
</tr>
<tr>
<td>The large system</td>
<td>Federal Government, PHS, AHS &amp; Society</td>
</tr>
</tbody>
</table>

In the following sections the research data is used to explore the system psychodynamics experienced by the general practitioner.

6.7 The dyad: the doctor-patient relationship
The central relationship for general practitioners is the doctor-patient relationship.

In the majority of circumstances, general practitioners appear to develop a stable
relationship with the patient. In the dyad, the general practitioner appears able to work with emotional maturity, in what Klein would call the depressive position, to create a holding environment which is available to contain the anxieties and fears for the patient. A trusting relationship contains the emotional experience involved in the day-to-day work of consultations without persecutory or destructive behaviour occurring. The general practitioners believe that the patient is able to bring issues of health or psychological stress for discussion. Yet 9/13 of the surveyed general practitioners do not feel sufficiently skilled or experienced to have a conversation with patients or their families about death or dying; especially end-of-life planning.

I can only speak for myself; I do feel uncomfortable about talking about death and dying. It is not an easy subject, as a doctor or as a person. [I:10]

The following examples from interview data illustrate how general practitioners believe the doctor-patient relationship enables the development of a safe, contained space for patient-care. The limiting factor seems to be curative medicine. But issues related to dying and death, the psychosocial, emotional and spiritual issues relevant to the management of chronic and terminal illness are not consistently able to be contained, heard or discussed. The doctor in the consultation is unable to take up the 'double task', thereby fulfilling both the physical and emotional components of the task.75

6.7.1 Containment in the Transitional Space
For general practitioners the basis for in-depth communication and conversation is the doctor-patient relationship.76 Most of the general practitioners interviewed believe the skills and experience they bring to the relationship enable them to address day-to-day patient issues.

The importance of relationship means: the provision of a safe place; to explore inner feelings; the ability to grow to know someone over time; to have perspective knowing their context; knowing what is going on in their life and that of their family, and to be able to support both. [I: 7]
and

I bring a degree of honesty and someone that they trust. I develop this relationship by talking with people. They listen and they trust. [I:5]

and

It really helps to have a longstanding relationship with the patient and family, for you are often able to gauge from experience their approach. For some of them you gauge they want it to be open and direct, but others you may have to gradually move towards getting to the deeper issues. [I:10]

and

In the normal relationship, there is honesty, trust and faith in what you say. A lot of knowledge over a number of years - the things, the sort of standard things; the old-fashioned things that are important for the elderly. They will talk to you about things that they will not talk to a lot of other people. I am not afraid of it. I am quite open. I see it as part of looking after them. I see it is another issue, as part of their medical management. [I:11]

Qualities the majority of general practitioners (10/13) bring to the relationship are an ability to create a safe place which allows honesty and trust to develop. A containing environment enables the patient to be open in their communication and allows general practitioners to engage with the patient enabling them to talk about significant issues; knowing them and their context. Another important attribute of the doctor-patient relationship is listening.

This general practitioner in speaking about the management of borderline patients noted benefit from the therapeutic activity of listening. The listening leads to personal understanding and therefore containment and reduction in the need to act out, an important aspect of relationship. The ability to trust somebody and be with that person, in a full and meaningful way. Listening is an important therapeutic intervention. [I:7]
The listening is of a nature that enables the practitioner to 'be in' relationship with the patient: a form of listening to what is, and, what is not spoken. The information is in the transference, between the lines, the listening with self scrutiny to the emotional reactions going on inside. Beauchamp and Childress acknowledge this attention.

Insight into the needs of others and considerate attentiveness to their circumstances often come from the emotions more than reason.

In many situations in a long-standing relationship a predictable communication style develops. The doctor-patient relationship develops a patterning where projections imply kindness on the part of the doctor to take the fear and anxiety of the patient and manage these emotions. But projective identification and empathy may diminish the capacity for honesty in the doctor's communication; it may make it more difficult to communicate disturbing diagnoses. [I:9 & 10]. The inability to contain the emotional disturbance created by the group's conscious and unconscious processes leads to the development of persecutory feelings. In the setting of a terminal illness, the outcome of the patient's transferential projections may differ depending on the ego-maturity of the doctor and the nature of the doctor-patient relationship. Is the doctor, experiencing the fear associated with the patient's illness, able to hold it and then proceed with support and symptom management? Is the doctor able to contain and integrate the sense of helplessness and anxiety in the space and progress to the task of end-of-life planning?

Only (4/13) of the practitioners interviewed were able to proceed to end-of-life planning with patients. In these circumstances the doctor creates a safe space to work together. In containing the emotional intensity, an environment is created to enable thinking together, and therefore supporting the patient to develop and learn.
If in these settings the patient’s transferential anxiety and the doctor’s existential anxiety become overwhelming, the practitioner may be unable to hold the anxiety, or openly discuss the anxiety and the fear present within the space. Ultimately this means the task of end-of-life planning is unable to occur. Predominantly in these settings general practitioners address the immediate issues which involve ‘medical activism’, symptom relief for the patient.

6.7.2 Creating a safe place
The creation of a safe place for general practitioners may involve the physical structuring of the room where the doctor sits behind the desk to aid in containing emotional equanimity. Of the practitioners interviewed 7/13 sat behind large desks during the interview process. The creation of a safe environment, a physical place or emotionally safe setting, for discussing emotionally intense situations seems relevant. This differs from physical withdrawal, and the use of euphemisms. These latter behaviours may be consistent with taking up an autistic-contiguous position associated with internal or external threats enabling routine management to continue.

This general practitioner acknowledges the requirement for a safe space both externally and internally.

   End-of-life planning is a step. But there also needs to be emotional and medical support; they need a safe environment, to be secure about it. [I:7]

and

   As individuals we have not had a lot of exposure to death. We don’t have time to develop rapport, or, perhaps life moves so fast that we don’t have time for that intense relationship. We can’t be with someone else, we are so personally focused. [I:7]

Most often, end-of-life planning and discussions about imminent cognitive decline with loss of independence are displaced. They are not discussed because the time constraint inhibits the development of deep rapport: ‘they need a safe environment’.
The patient is able to bring issues related to their illness, but death cannot be posed. There is no time to create a safe space to end-of-life plan.

What occurs for the patient with a terminal illness, a patient whose needs are outside the cure task of the general practitioner? Perhaps for both in the relationship a situation of psychic retreat occurs:

Projection occurs and psychotic defenses are created when the individual is terrified of the reality that is posed - death. This is a reality that cannot be accepted and a new reality is created. The subject projects these extreme fears and disillusionment into the object who has initiated the fear.85

For the patient who has a terminal illness, for whom there is no curative management, only therapeutic and pharmacological support, the role of the general practitioner mostly involves the management of the physical symptoms. It may be that the doctor turns to medical routine and emotional self-preservation when the anxiety in the countertransference is intense. When this occurs it is problematic, for at the time of greatest need for care and emotional support for the patient, as written by Kubler-Ross and Yalom, the medical fraternity deserts.86,87 The emphasis for the doctor shifts from patient cure to self care, as stated by a practitioner [I: 7], 'we are so personally focused'. Perhaps a précis for the modern society?

The doctor being unable to create a safe space to contain him/herself and the patient spends time in medical activism.88 Security also originates in the rigid control of routines.89 Without recognizing the meaning in their actions, the practitioners, 9/13, move away, physically and emotionally.

6.7.3 Failure to Cure
Modern medicine perpetuates that the task of medicine is to cure.90 How can a doctor communicate news of a terminal illness to a patient, when this information leaves general practitioners [8/13] feeling impotent and guilty?91
Medical education does not prepare doctors to deal with death and dying. The emphasis of modern medicine is on cure ... Accepting that death is inevitable for a particular patient usually invokes a sense of failure. The following quotations from the research data illustrate the thoughts of several practitioners who are unable to end-of-life plan with their patients. In considering a diagnosis that pronounces death to a patient these general practitioners acknowledge that the 'thinking feels uncomfortable'. To articulate this information seems even more uncomfortable, 'the living, [do] not [want] to think about [their] the dying. [I: 3]

There is discomfort and tentativeness about offending or broaching a subject that might cause fear or distress in the person. Having to negotiate those issues: of doing it prematurely before they are ready; the time is not right; advancing their fear about the future? 'It is the core issue, isn't it? It's making me feel uncomfortable; facing their death before it's time. [I:2]

and

It is an intrusion into their own privacy to have a conversation about feelings. I would need a real reason for beginning this sort of discussion. I could have a pamphlet in the waiting room and tell them to collect it on the way out, saying, 'we shall have a talk about this next time'. [I:13]

and

What, before they reach the stage that they can see a finite time for themselves? I think people want to look at the positives; the living, not to think about the dying [I:3]

The anxiety is overt, but its aetiology remains covert. The unconscious fears relating societal expectations and personal vulnerability are often not expressed. Stacey writes:

Emphasis shifts away from concern with the primary task, boundary, and roles, to how, through patterns of personal relationship, people may cope with the dynamics at the edge of
disintegration where they struggle to give expression to what they might know but can not yet think.  

This general practitioner reflects on personal emotional issues:

You need to deal with the emotional aspect of your own issues related to the diagnosis of cancer in your patient before you can be available to your patient. Dealing with our own stuff; in the first instance, before you can redevelop your connection and relationship with your patient. [I:7]

The anxieties seem to relate to failing to cure, as well as how to deal with the patient who is dying. The not knowing is threatening, a conversation would involve risk, a risk to the patient and perhaps a personal risk; how to deal with this uncertainty? Further personal questioning by the practitioners occurs [I: 2, 7, 8 & 13] leading to deferring or abandoning the conversation - more uncertainty.

This general practitioner reflects on the possible ramifications of making a mistake or effecting the outcome of patient care.

Deep inside, I care. Perhaps that is imprinted upon us when we do medicine; you actually care about the outcome of your patients, and, feel terribly guilty if it goes wrong. I often think about the guilt factor. [I:8]

and

Our medical training makes it impossible for us is to consider making a mistake, and therefore the guilt. We cannot make a mistake. [I:8]

In the medical system there is no room for error. It is difficult within the medical fraternity to acknowledge failure. If death occurs there is failure in the system, who is to blame? The paranoid-schizoid position of blame and self-blame seems to be easily taken up. Persecution sits in a frame of the fear of failing in the work. The alternative paranoid-schizoid state of omnipotence has a basis in the myth of cure. Shame is experienced, states Hirscchorn, there is no room for fallibility. This harsh judgment is destructive.
Such voices are frightening, because they lie within us. They can 'spy' on us and hold us accountable for failings we hide from everyone else. These are the voices that shame us in front of ourselves alone.  

Medical practitioners, although exposed to the psychodynamics of systems have no formal education in systems psychodynamic ideas. As a consequence, there is limited theoretical or practical understanding of the experiences and the associated conscious and unconscious social defence mechanisms played out. The skills acquired by general practitioners in managing the feelings involved are learned through trial and error. The behaviours may become a practised psychic retreat especially for the management of troubling emotions. These rituals may not be questioned. The dyad of the doctor-patient relationship is a containing space that allows the doctor to work with the patient in the day-to-day consultation and give expert advice. As the dyad work together a transitional space may develop respecting relatedness with acceptance, collaboration, negotiation. But with the recognition of existential finitude, kindness with medical activism is often the behaviours displayed.

6.8 The Doctor with the Family as a System

General practitioners are perfectly placed in the healthcare system to contain the fears and anxieties of the patient as well as to introduce the patient's family into the role of advocate and support, to function as a cohesive working group.

I think that this is a fantastic conversation for GPs to be having with each other: with the patients, and, with their family. Maybe this is all that is required for the empowerment of the family: knowing that they are fulfilling the wishes of their relative. [I:2]

6.8.1 The Doctor as container

Dying and death is a catastrophic event for a family and the individuals of the family unit watching a loved-one die. The ability to bring together the complexities of
thinking and feeling for the members of the family at this critical juncture is extremely difficult. It is so important for medical personnel to recognize this dislocation and assist by acknowledging the intensity of the fears and attempting to contain the anxieties related to dying while providing symptomatic physical relief for the patient. The content of the projections from the patient and members of the family is the primitive emotions related to the primal anxieties associated with the fear of annihilation, nameless dread, helplessness, and hopelessness.

If containment is inadequate, primitive defensive reactions may occur to limit the ability of the medical practitioner and family to function as a cohesive working group. Ego disintegration and fragmentation with a sense of falling to pieces or splitting could include withdrawal, anger, hostility, and overwhelming distress for all concerned. Or as stated by practitioners, [I:8 & 11], there is recognition of the distress involved and the need for containment of the feelings, which are borne by the practitioners.

The other thing you learn is to put up with a patient’s anger or the anger of the families. This is very wearing; you cop a bit of that in General Practice. I find this so hard to deal with. [I:8]

and

A patient in the past: he refused any treatment for his renal failure and died in chronic renal failure. He got very angry. He had an attitude that was different from other involved people. But he had the right not to do anything, not to accept treatment. [I:11]

Projective processes are primitive attempts to relieve internal pains by externalizing them.

General practitioners, who are able to discuss issues related to end-of-life planning, also believe in the importance of respecting the wishes of the patient and maintaining a depressive stance acknowledging another's subjectivity.
The relevance of discussing the critical issues involving the patient's personal wishes in the presence of family members is recognized by several general practitioners:

It is important to be proactive and end-of-life plan with these individuals. [I: 11] These general practitioners appreciate that at times during illness, the patient's capacity to think and make decisions may be significantly curtailed and therefore their personal wishes need to be known to be respected. At this time the role of a surrogate is critical to fulfil the patient's wishes. There is also a group of elderly patients who live alone and their ability to care for themselves with their illness is diminishing.

I become proactive and involved with the family if the patient lives alone or if the illness is starting to become significant. [I:11]

The doctor in containing the patient's anxiety is able to enlist the role of a surrogate, and family members to identify and articulate the patient's personal wishes. Balint acknowledges that where general practitioners know the family system they are appropriately placed to recommend a family meeting to enable the wishes of the patient to be expressed. It gives the opportunity in a containing space for the thoughts and feelings of the individuals to be expressed. If practitioners in role are able to contain projections and metabolize the fears this will enable the thinking and working through to continue to develop understanding.

Most general practitioners acknowledge the importance of working with families as a component of continuity of care. Several interviews communicated case studies (6/13) of family interactions as data.

Everybody is different, and families are different. You cannot talk about them as a whole because they are always so different. Everyone has the opportunity to think and feel and say what is important for them; it will not always be the same. There is often a black sheep, a prodigal son, an estranged son; I could not deal with the son but with the persons that the patient wishes me to deal with. [I:5]
I like to know who they want to be responsible for their choices and decision making, and, who they do not want to be involved. We can get into a lot of trouble if we discuss it with members whom they do not have a lot to do with. [I:11]

6.8.2 Roles and Boundaries in the Family

The doctor also has a societal role that the patient and family expect. This involves knowledge of the disease process, the skill to problem-solve, decision make and treat; often on behalf of the patient, and the willingness to understand and empathize. The role an individual takes up in a family is often a learned, patterned response. Individuals tend to move into ritual roles during anxiety-provoking discussions. In situations of extreme stress when feelings are magnified they may resort to psychic retreats for containment.

While general practitioners acknowledge the personal autonomy of the patient as primary decision-maker and the doctor-patient relationship retains a responsibility to the patient which involves confidentiality, they also recognize that there are times when family members need to know. For the benefit of the patient it becomes imperative to work in a collaborative, open system with the family. The general practitioner is authorized by the patient to involve the family system. The patient determines which family members to involve.

I do not see any ethical issues. Single-mindedly as a doctor I think it is cut and dried; you are there to serve the patient. There are some curly decisions to be made sometimes. What I tend to do is negotiate everything through with the patient and the family; it is an on going negotiation. [I:8]

and

I respect the patient’s choices. But I know that sometimes you have got a lovely oldie and I have to say; ‘I know that this is your illness, but, is it OK if I now bring your family in? Yes, I am sorry, I am not saying that you are not capable of making your own decisions, but, is it OK, for this is so important?’ [I:8]

and
If someone lives alone I chase up their next of kin; who they would like to be their contact. I have that all documented. Sometimes I ask; or get a feeling of what they would like to do themselves. Some patients give me a form to say they do not wish to be left on life support; so I have them. I discuss with them and then discuss it with their family; so everybody knows. [I:11]

This practitioner states:

If you get them together and talk with them all, they get the same information. It makes it easier. With all ethnic groups it is much better to talk with everybody. It is much better to talk to the family and the patient together. [I:5]

For appropriate medical management and intervention to occur, respecting the choice of the patient in the setting of cognitive capacity and acknowledging the role of the surrogate are both important.

A general practitioner recalls many conversations with a husband about the possibility of withholding treatment in the management of his demented wife. Both were living in a hostel. The doctor respected the choices of the husband for his wife.

A totally demented old lady; her husband had a stroke and was disabled, but was with it. He was insisting we treat her recurrent chest infections. Suddenly one day he changed his mind. I do not know why? Who talked him into it? What made him change his mind; how it happened? We would have treated her chest infections a dozen times in the last few years. Nothing had changed for her: her dementia, her peg tube, nothing much had got worse. But he said, 'we shall not give her antibiotics this time'. Why did he suddenly let go? He suddenly let go and said, 'that is enough, I will die without her'. But he didn't. He is still going. Was the change: the change in his state of health, his stroke and the recognition that she may continue on, but perhaps he would not? Who would then make decisions for her? [I:4]

A general practitioner, during the interview did discuss the relevance of the role of the EPOA (medical).

EPOA plays a role now. I prefer it if they all come in and discuss it with the patient next time. If people are getting into that realm I say to them, 'well you come in and we
will discuss it in front of your relative'. So there are no breaks in confidentiality and no misinformation. [I:11]

6.8.3 Monocular vision
General practitioners (2/13) rarely speak about destructive and persecutory encounters with patients and their families. Is this because in the paranoid-schizoid splitting only the positive can be thought about? A personal incident is recounted by a practitioner who as a member of the family is exposed to the experience of loss of a loved person: the father of the family. His dying occurs in a private hospital. At no time during his illness is it possible for the family or the medical and the palliative care personnel to talk about the treatment or the emotional ramifications of his dying. The emotional pain of the experience remains.

The next death in the family was that of my father. At the time of his diagnosis he had brain metastases from carcinoma of the lung. His dying and his death were horrible in every way. He was managed in the private acute health system. There were no conversations about his illness: no one was prepared to talk about what they were thinking or feeling, my family, or the staff caring for him. There were no discussions about the possibilities for treatment or what to expect; neither the medical nor the palliative care staff helped prepare us for his death. He was very ill and the management of his illness was chaotic and erratic. [I:13]

Is the assumption that because the relative is a medical practitioner there will be an understanding of the events that relate to dying and death? The hospital staff do not ask if support is required. Is it assumed that medical people need no support? Or do the specialists, the oncologist and the palliative care team believe they have nothing to offer? Do the specialists in the area feel too inadequate to communicate?

The family is overwhelmed by the sudden and critical nature of the terminal illness; here everything is catastrophic. It appears that both, the family and the staff, in their defensive behaviour seek isolation and withdraw from the emotional devastation of the trauma involved. Acknowledgement that death is imminent is not given; an
autistic-contiguous posturing is used to maintain individual integrity. Nobody is present or able to assist to contain the emotional distress. Everybody, staff and family move away from each other and the acknowledgement of death; it is too close. There appears to be no ability to articulate that death occurs. Death happens to medical personnel; the profession is not omnipotent; it cannot save itself!

An alternative explanation for the unconscious defensive behaviour involves Bion’s concept of monocular vision. Neither group is able to be in relationship with the other; they huddle together in their sameness. The family sense the superiority in the tending staff; who huddle together in their knowing. The withdrawal is perceived by the members of the family as a lack of empathy. They feel inferior and bereft as they struggle with their helplessness, hopelessness, and the unknown. The difficulties in coping with the stressors of the impending loss of a loved abject are not able to be acknowledged. The unconscious emphasis appears to be, as a member of the medical profession; you should do better, or, you are not coping. It appears that the aspect of professional role is emphasized and humanity is forgotten. Rigid boundaries are maintained as staff maintain their professional separateness. Unconsciously the boundaries may be more rigidly held in the professional environment; because if they do not maintain their separateness; the phantasy, the contagion of death and loss may attach itself to them!

Another general practitioner recounts the death of a family member, this time the death of a grandparent.

They said they were keeping him comfortable: but in fact they were finger pricking him every couple of hours; they were continuing to naso-gastric feed him; he had an intravenous line; and he was groaning in an enormous amount of pain. With limited English it was difficult for him to communicate. I found that very distressing. But my view was different from my family’s view who respected that what the doctors were doing was right and they could not say what they wanted. In fact [my family] could not
say it is all right to let him die comfortably: because they felt they did not have the ability; or the place; they were too scared to question the experts. [I:7]

The medical fraternity is not questioned by the family. Relatives depend upon the superiority of the experts to use their skills and knowledge; to know how to treat their loved one. Even in the narrative, the medical member of the family is silenced for a period of time, watching the continued unproductive medical invasion. The silencing; a disconnection between thinking and feeling; is an inability to think and make sense of a process while overwhelmed by feelings for a loved one. The medical fraternity also appear to experience the silencing. A splitting of thinking and feeling occurs along with the inability to communicate about the imminent death of a patient. A state of dependency occurs during the process, leaving the decision making to those with specialist knowledge.

At the time of death it was a very difficult for anyone to make a decision. It was much easier to leave that decision to the experts. [I:7]

Does this also mean keep him alive because to let him die would be acknowledging defeat? Failure of the medical fraternity until his death is accepted by the family.

Eventually I said, this is it, he is dying and he does not need all of this: distress, intervention, blood tests. [I:7]

The practitioner is not able to manage the disordered feelings and thoughts at the time of the grandfather’s final illness. No one is able to listen to or hear the internal dialogue ‘there is nothing further we can do’. The desire is to keep him alive. The acknowledgement of the terminal phase of an illness and the wish for him not to suffer, to accept death, are separate phases to be worked through. As this practitioner states,

We, as medical experts, have all the facilities around us; we have the knowledge, the skills, the technical and the mechanical facilities. We can go on and keep doing in a
paternalistic way. We do not want to say to somebody, ‘there is nothing further we can do’. [I:7]

6.8.4 Paternalism or Basic assumption activity
Paternalism is mentioned by the general practitioner as a mode of operating by the medical profession, a defensive mode that allows the doctor distance from the fearful and emotional aspects of patient management. The features of paternalism are the desire to help, to do no harm, to advise and to protect. This attitude discounts the patient’s personal autonomy and choice. Paternalism encroaches upon the identity boundary of the person as well as their protective boundary. Paternalism in the healthcare relationship allows the professional; with superior training and knowledge; in an authoritative position; to determine the patient’s best interests. This may invoke a dependency stance from the patient and their relatives, or defiance associated with the seeming control of the doctor.

A general practitioner recognizes the potential for paternalism.

I always try to bring the family in without undermining the patient. For the patient quite rightly can say, 'I am quite capable of making my own decisions'. Generally they will say it is OK. [I:8]

Basic Assumption dependency (baD) and basic assumption fight/flight (baF) are terms used by Bion to explain a defensive mode of group behaviour. In baD, the family looks to the doctor for leadership, the leader is phantasied as omnipotent with the ability to protect the group. The family feels unable to problem solve or make decisions and absolves itself of responsibility to perform these functions. In the baF posturing, the family looks to the doctor as the leader to fight the battle of the disease for them. Not having the ability in this defensive mode to articulate the issues themselves or address the difficulties to be faced, they prefer to rely on the leader to fight their fight or flee; avoid, if this is the better option. A member of the family may take on
this barrier, leadership role, to fight the medical profession in its failure to manage the disease.

The majority of general practitioners (9/13) in my study do not perform the task of end-of-life planning with patients and their families. Defensive behaviours are demonstrated; hopes for cure, fighting or fleeing from the disease or medical activism.

6.8.5 A 'sophisticated' Work Group
The sophisticated work group is a functioning group that performs the designated task; in a cooperative and collaborative fashion. Only a few practitioners in my study (4/13) have had any involvement with a collaborative work group that is available to support the patient with the family, when the loved person dies at home. In these cases their relationship and the relatedness around the task creates a sense of security and interdependence in their participation: characteristic of 'work group' functioning. Timely and honest communication by the general practitioner with the patient, the family and friends about terminal care is critical to ensure a sense of safety and support for all concerned. For unless conversations have occurred at a pre-crisis time, a time prior to the gradual emotional withdrawal of the dying individual, relatives may feel alone in the decision. In this setting emotional fragmentation with disintegration, a sense of going to pieces can occur, with crisis intervention required for the family. The result being the patient is transferred to the hospital for continuing care.

For at the time of the imminent death of the loved one, physical and emotional exhaustion is experienced by all; the complex emotional experience for the family is unadorned and unrelenting. At this time, thinking may become chaotic and feelings overwhelming for loved ones and decision making may regress to a more primitive mode. The emphasis for the general practitioner is containment with empathy.
When a family is prepared to take the role of carer support structures are in place, the spouse is committed; important people are around. They are not alone. [I:8] and

I have only been intimately involved with the care of two people when they have been dying. The first patient was a lady whose choice was to die at home with her family and her friends. Family meetings were arranged by the palliative care services so that her wishes were known to me, and the entire family; there was a sense of sharing the caring. [I:13]

For a work group to function containment for all participants, including the general Practitioner, is crucial. For at times of extreme anxiety and intensely painful emotional experiences, like the dread of losing a loved one, the potential for withdrawal, splitting or fragmentation is ever present. The requirement is to safeguard the depressive position with empathy.103

6.9 Primary Health Sector - Division of General Practice

I think that this is a fantastic conversation for GPs to be having with each other. [I:2] The recognition of the relevance of a conversation about end-of-life planning to occur with a group of general practitioners seems insightful. The comment is consistent with the work performed in Balint groups where an individual practitioner discusses management of a complex patient with a group of colleagues.104 The material used in Balint groups is the doctor’s countertransference; that is, how s/he uses his/her personality, assessments, and his/her automatic reaction patterns. Not only would the work of a Balint-type group facilitate the development of a transitional space to discuss the difficulties involved with end-of-life planning, but it could also introduce General practitioners to group work.105 Scenario training provides a context where practitioners, who often feel alone and isolated in their work, work together to develop recognition and understanding of conscious and unconscious processes. But can a training and ongoing education for general practitioners using Balint-type groups be achieved in the context of changes to the health system. For example, changes
brought about by government restructuring and fiscal policy which create tensions in relation to valuing the primary task and role of General Practice?

### 6.9.1 Change in the System

The general practitioners interviewed acknowledge that primary care is changing. There is change in: work practice, hours of work, gender distribution of general practitioners, how the primary task is taken up, as well as, advances in technological and pharmacological practice. The Federal Government has also contributed to change with an additional administrative load to General Practice to fulfil funding regulations and requirements. All of these factors impact upon general practitioners' availability for patient-care. The societal and governmental expectations are for General Practice to: extend routine and out-of-hours work; manage increasing complexity of work, involving an aging demographic with associated co-morbidities; as well as, home and nursing home visits. The expectation is the quality of the work is preserved.

- It is a hell of a problem. Primary care is changing; there are changes in work practice, increasing feminization of the workforce, and unwillingness of the current generation to take responsibility for after hours work, they have 0900-1700 schedules. [I:6]

and

- In the next ten years there will be no phone calls, no home calls. Nursing Homes will probably have to pay someone to call. [I:8]

and

- I used to do a lot of work in the area of Palliative Care Medicine but this has been highjacked by the College of Physicians and the nurses. The emphasis is on fiscal policy: nurses are much cheaper. But who attends the patient at three o'clock in the morning? I am always so conscious of Medicare and like big brother watching for overservicing. [I:8]

and

- The Supermarkets [Community Health Service] are taking over. They do Palliative care; but they don't go out; they don't do home visits. They ring me to see their patients, because they do not go out to see them at home. [I:11]
The health care system is now economically driven, the rebate system means I cannot allow myself a lot of time to talk with people, I employ a counsellor to fulfil that role, and then I pay the counsellor more than the consultation rebate. The rebate needs to be increased, but the Federal Government is not going to do this. [I:11]

The problem is time. In our system you cannot run a small business and survive unless you see patient numbers and this does not leave a lot of time for issues that need a lot of counselling to fit into a busy daily schedule. The palliative care patient, the elderly patient and the chronic medical patient will have multiple complex problems, all of which need time. [I:11]

From my journal: July 2003

Are some general practitioners delineating their areas of work schedule around time, avoiding what may be considered complex and complicated?

This question arises at a time when the external noise is almost crowding out the conversation in the room and my ability to hear the taped conversation. It raises the issue of what is going on alongside, personal noise and/or political noise? In discussing death: the nameless dread, an overwhelming fear is generated that is often too personal to discuss with anyone.

For the doctor this brings with it a need for patient-care time as well as an emotional commitment. Can these questions about end-of-life planning be crowded out by internal (personal) or external (social and political) noise?

Another fear and discomfort could be associated with the changes occurring within the PHS. There is no ability to hear the concerns of the PHS. The interventions of the Federal Government are producing structural change. Is the Federal Government palliating the PHS with an economic rationalist’s regime?

An alternative but inappropriate form of care for the patient with chronic illness and co-morbidities is available through the AHS, through the Emergency Department. The State system is cheaper for the Federal Government. This change would bring death to General Practice, as we know it.
General Practice is changing, where to from here?

6.9.2 Task value
For general practitioners there are logical and realistic divisions between the pressure of time; for the complex work involving an aging demographic, with multiple co-morbid medical, social and psychological issues and the survival of the business. For now general practitioners retain the responsibility for patient-care in the community - the health of a nation.106 Is this responsibility part of what General Practice has been unconsciously asked to carry on behalf of society? Where is the recognition of the task value by peers, society or the government?

In the end I believe the doctor carries the can, wherever, the responsibility is yours. I noticed it was me who was there at three o'clock in the morning with the family; no-one else was there. The doctor always does carry the responsibility. In the end he does run the show. [I:8]

and

I return to the role of the GP; and sense of work value within the medical fraternity. Here you feel that few of your peers really understand your role; and respect the intensity of that role. The peers in other specialties will see the work from the perspective of their own specialty. Do they then judge the quality of that work from that perspective? [I:2]

In the interviews there is little reference to the representation by the College of General Practice or the Regional Division of General Practice in their day-to-day work. Does the absence of discussion of this relationship also highlight the sense of isolation of these doctors?

What the group of general practitioners interviewed presented about General Practice relates to their own and society's expectation of work value. The isolation of the work;107 the perceived judgments and devaluing of the work by the specialty systems of the Acute Health Sector; and the policing of their work by the Federal
Government system, with the sensed totalitarian state of big brother watching; all contribute to the stressors involved in the work.

Underlying task value involves: survival, responsibility, accountability and infallibility while working independently. The emphasis is the economies not the humanities. Do the expectations of peers and the public exceed the ability to provide? Changes are bringing about a fear of dys-function associated with dys-satisfaction and poor morale, changes in work practice and reduction in general practitioner numbers. These anxieties and fears associated with the work have the potential to produce persecutory and self-destructive thoughts as well as primitive defensive mechanisms with splitting and projection.

From my journal: June 2003

This feels very depressing. I feel overwhelmed by the work-pressures and the inability of general practitioners to recognize their own psychological needs. The general practitioners are very judgmental in their attitude to their own patient care. They compare General Practice with specialty practice; recognize their own mistakes and devalue their own work. The outcome feels persecutory. This judgement sits in a frame of fear of failing in the work; they are aware and afraid of their own limitations, and they are not permitted to be fallible. They introject their own harsh judgment and the projected judgements of society. Do they appraise the mistakes of others with the same stance?

In their position in the medical chain of referral they are observed by their medical associates and the governing bodies; a vulnerable position.

Ambivalence in association with another seeing your work and therefore judging it.108

Splitting and projecting the blame onto the Primary Health Sector is presented. This 'primary task' as defined by the College of General Practice sits within the context of society and the limited understanding of the Acute Health Sector.
The role of the GP and their sense of work value within the medical fraternity - I feel very few of my peers really understand my role and respect the intensity of that role. [I:5]

and

We provide all aspects of healthcare, the physical, emotional, psychiatric, preventative care and health promotion. [I:10]

These general practitioners state clearly the anomaly between the expectations of the funding body for General Practice, the Federal Government and the complex patient with co-morbidities.

The health system is not designed to look after the elderly patient and their requirement for home visits, the elderly, the complexity and co-morbidities are not catered for. There needs to be an economically viable basis to contain and maintain the complexity of multiple co-morbidities within the system. [I:11]

and

The Medicare system rewards us for the short sharp problem-focused, solution-focused interventions rather than work like [end-of-life planning] that does not pay dividends except very subliminal. [I:2]

There is little recognition or support for the intensity of the work or the workload of general practitioners' who work in isolation in the community. The task is valued by society but the expectations are illusory. Survival of a small business in the community becomes a focus for general practitioners in association with the primary task and the government's fiscal policy of economic rationalism. The ability to include complex and complicated medicine in the primary task and retain financial viability is becoming increasingly difficult.

Medicare does not fund in-depth or long term work with patients or their families. The Health System is resourced and funded for short interventions, documentation, and prescription writing, a systemic framework with the emphasis on documentation and medico-legal constraints. [I:2]
6.10 The Acute Health Sector: Inter-organizations

6.10.1 Systemic & Systematic dehumanization

The inter-system issues at the interface of General Practice with the Acute Health Sector are not formally discussed or addressed by the component systems. Perceived inadequacies relate to the management of the chronically and critically ill patient. The Acute Health Sector's emphasis relates to the diagnosis and management of the disease process; particularly its cure. It is not concerned about the personality of the patient.

General practitioners have been trained in hospitals by specialists. Specialists know how to cure illnesses belonging to their special field if they are curable, and know ... the limitation of their skills; but they are less concerned with, and one may even suspect they do not know enough about, the total personality of the patient.109

The Acute Health Sector does not seem to have the patient or their family 'in-mind'. General practitioners have a different perspective; the emphasis is holistic, to the overall benefit of the patient. Because the purpose of General Practice is 'to provide universal unreferred access to whole person medical care for individuals, families and communities, care means comprehensive, coordinated and continuing medical care'.110 This involves developing a working doctor-patient relationship which is inclusive and utilizes the family and community as its context for the basis of exploration.

The Specialist will have a deeper knowledge [of the disease process]. But not the general knowledge of the GP, of the life cycle of the patient and their pressures of life. [I:2]

General practitioners recognize the different practice of the Acute Health Sector. But they emphasize the anomalies of this system as they relate to their own ability to work with members of the AHS. They state that they are not identified or sought out by the AHS for communications to contribute to the continuing care of the
patient either during an inpatient stay or on discharge. There is no sense of
interdependence between the systems for the benefit of the patient requiring care.
They state that, to the contrary, information is hoarded by the AHS. .

The silo existence of the acute hospitals; where people often finish up with terminal
illnesses. The pace of life in the acute institution, does not lend itself to incorporate
the information that could come in from the community sector to manage the people
more appropriately. This is my bias as a GP. This is chronic across all areas of health
but it brought into particular focus by the issues of dying. [I:2]

and

In the AHS there is little time to sit and identify the patient in the bed. Rather the
emphasis is the diagnostic challenge: to identify the disease process. [I:5]

and

Lack of communication processes between Hospitals and GPs is so endemic. It is the
fast pace of Hospitals; whereby nobody really has time to sit down to identify the
individual in the bed, rather than the disease process. [I:2]

and

The AHS, in terms of curiosity and support for family members is quite perfunctory
and usually utilitarian in terms of management of the patient. I feel that it is very
fragmented, with few practitioners prepared to talk about the difficult issues at any
depth in terms of choices of treatment and minds (feelings and thoughts) of dying.
[I:2]

and

They don’t articulate well around treatment issues; much less around spiritual issues
and issues of choice and responsibility. The individual is not present in their
expectations. How do they separate out me; as an individual, who has this condition,
with these co-morbidities, as well as the personal concepts that I have about quality
of life; my goals for the rest of my life, and the potential life-quality? They have no
consideration of the heart felt needs of the person before them. [I:2]
General practitioners are suspicious of the AHS and their differences in practice. The practitioner as an individual from the outside is attempting to influence another system. There is an expectation by general practitioners, with the patient as focus, for communication to occur between the AHS and general practitioners and for their contribution to care of the patient to be valued. But this communication does not occur with significant regularity to acknowledge the interdependence of the systems. General practitioners feel isolated and alienated from the source of current relevant information for patient care; the boundaries feel impermeable. Anxieties emerge because of the uncertainty about the continuing care of the patient, and anger about de-valuing their role in the patient’s continued management. Both of these emotions lead to regression and splitting by the general practitioner in association with what is deemed as unacceptable practice. The thoughts and feelings experienced by practitioners in relation to the AHS are of anger, discontent, suspicion, disappointment and disillusionment.

This general practitioner would concur with the earlier quotation from Balint.

It appears that humanity is lost within the system.
Where is the caring, where is the concern, individuals yes, the system no.
The care gets lost in the system.
The individual gets lost in the system.
There are individuals within the system who do care about their patient, but the system does not care.
There is systematic dehumanisation. [I:4]

General practitioners have long-term relationships with their patients and have supported them through a number of life events and illnesses. At a time when specialist intervention is required general practitioners are dependent upon the AHS for acute or critical intervention; perhaps a life threatening event. But it is seen that the AHS absorbs the patient. Communication between general practitioners and the AHS is fraught with frustration and perturbation by the 'systemic dehumanization' of
Attempts by general practitioners to communicate for the patient are often thwarted. In communication with the AHS as superior, it usurps all knowing; and in a condescending manner, communicates intellectually, with innuendo, about the patient’s management. The AHS is seen as having a monocular view, the expert with authority.

The representative of the AHS on the boundary of the system is often a most junior member of the institution. This person imbibes the cultural context of the AHS; but is unable to digest the multiple dimensions of the experience of their own primary task of patient-care in an extremely busy AHS, and now, has an interruption from a general practitioner. The maintenance of boundary function is made vulnerable and fails. Often both parties in the setting of work pressures take up the transference projections and become dysfunctional. Responsiveness and interdependence associated with the flow of information is lost. The representative of the AHS feels threatened and unconsciously takes up ‘groupishness’ with defensive basic assumption behaviour, baF. Feeling provoked, the staff member is unable to recognize and respond to the complex feedback generated by their internal environment (as individual and intra-group) and reacts to the external provocation of questioning. Defensive behaviours occur from both aspects of the discussion. The ability to relate role-to-role on behalf of the patient is lost. There is no acknowledgement that both parties are performing a similar primary task; the healthcare of the patient. This is lost in primitive defensive behaviour, the unconscious collusion of group behaviour. Both individuals develop a relationship that is counter-productive and destructive.

An enterprise has no independent existence as an entity; it is a product of the actions and interactions, beliefs and assumptions of the people located inside it and outside.111

There seems to be no time to adopt a binocular vision, to acknowledge the difficult issues experienced, or to accept the role-to-role differences. There is no time to
take time to be with each other and listen as a means of developing understanding; an inter-professional respect; to take up the depressive position and focus on the task of the healthcare of the patient. The response of the general practitioner to the encounter can be construed as first an attempt to pursue interdependence with the AHS, but perhaps later to resort to a haven of retreat with withdrawal because the encounter is deemed so destructive. The difficulty in communication is amplified with this excerpt from an interview,

*My most savage criticism is across institutional communication, the Acute-Primary care interface. They do not have a good perspective on how to assess their role in the terms of the context of the human life that they are dealing with, it is a blip. This is not to underestimate their capacity to save life or to give life.* [I:2]

As a consequence of these experiences defensive behaviours are adopted involving alienation, suspicion and anger. The origins for these thoughts are demonstrated within the following sections. The general practitioners relate by: feeling shut out, being envious of another's practice, of taking over the care of the patient without due regard of continuity of care, and abdicating from patient involvement when cure is not a possible.

### 6.10.2 Shuttle-Out

It seems for general practitioners that the AHS understands the admission of a patient to hospital as a change in the responsibility of patient-care. The AHS assumes all power and knowledge, heteronomy, rather than interdependence or any personal autonomy for the patient. There is limited sharing of information for the patient's benefit between the Acute and Primary Health Systems. General practitioners feel diminished and defeated by the attitude of the AHS.

A woman with bilateral renal cancer requiring bilateral nephrectomies went to her GP telling him she wanted to have an advocate with her in her decision making process about the illness; the interventions, the surgery, etc. The comment of the AHS registrar was, 'if this GP is so concerned for this patient why doesn't s/he come along
to her outpatient appointment to have these discussions? It is so difficult to for the
general practitioner to have a meaningful interaction and to facilitate with the family.
We are really locked out. [I:2]

and

I can not let it get me down when I am not listened to by the tertiary referral centre,
it would be ego destructive. Some people I am sure do. Some people stand out against
it but that would be difficult. Sometimes I know that not the best is being done by
the patient, but that is the way it is. [I:5]

6.10.3  Envy
In the setting where general practitioners are devalued and their role is chronically
diminished they feel envious of the practitioners within the AHS. With a
competitive stance to achieve some form of recognition by the AHS, general
practitioners experience envy and rivalry. The AHS seems to determine its own agenda.
The Acute-Primary Health interface is a matter of consternation. The Acute Health
Sector chronically overestimates its significance in the acute episode and chronically
underestimates the role of the GP in relation to the patient, the family, and the life
course of the patient. [I:2]

and

They do not have a good perspective on how to assess their role in terms of the
context of the individual life they are dealing with; the pace of life in the acute
institution does not lend itself to incorporate the information that could come from
the community sector to manage the people more appropriately. [I:2]

and

The AHS treats me as an idiot. A workable system needs to be developed between the
GPs and the public hospitals. An interface; between who the patient is in the
community and bring that to the bedside; to ground the patient in their reality, rather
than be caught up in all that is flying past. [I:5]

Even so, this general practitioner hopes for change to occur!
Here the skills of the GP are doubted by the Acute Health System. But we are
developing shared care projects; it is a significant challenge and encouraging. It is a
tedious process to coordinate but it is happening slowly. [I:10]

6.10.4 Acquisitive Motive
The general practitioner's knowledge of the patient's wishes seems to be disregarded
and deemed obsolete. A significant feature of contemporary society is isolation and
fragmentation in relationships (See Chapter 4). This is a feature of the interface
between the general practitioner and the AHS. As Mann writes:

In order to benefit from resources provided by an institution, a
patient must become a patient of that institution - leading,
advertently to fragmentation of healthcare.\(^{113}\)

Because the patient is isolated in the healthcare system, healthcare becomes
fragmented as a consequence fragmentation in healthcare relationships.

Social and psychological dislocation make it doubly hard for
people to collaborate.\(^{114}\)

We get a lot of it taken out our hands, especially for the cancer patients. The
oncology people take over and patients disappear into hospital systems and they
thrown them out when they are about to die and they need a bed. This is a bit
awkward; you can lose that space in time, for they can disappear for about a year,
they go from oncology to chemotherapy. It is only when all of that is finished and they
will say, go home. [I:11]

and

It is difficult to influence the Specialist in the AHS. I have telephoned and
documented in the medical record that: I know this patient well, I know her wishes,
and her request to withdraw all treatment, and, I am prepared to take responsibility
for her care in the Community. But it is not heard. [I:5]

The Hospital of the community studied in this thesis has commenced a new project.
This is termed Respecting Patient Choices. It is a process where conversations occur
with patients (and their relatives) with chronic and terminal illness to determine their end-of-life treatment choices. This occurs while the patient is an inpatient of the hospital.

The Respecting Patient Choices process completely sidelines and undermines the role of the GP. The coordinated carer; who does the listening and working with his patients

[I:2]

Again, the general practitioner feels marginalized (7/13). The conversation involving ‘Respecting Patient Choices’ occurs when the patient is removed from their familiar social environment and at the time of an acute illness when their energies are focused on survival. The general practitioners resent these intrusive and acquisitive moves. Attempts to communicate are not heard. Eventually the patient is returned to the care of the general practitioner but often without communication.

6.10.5 Abdication
Who now takes on the responsibility to care for the dying person?

It feels as though there is limited communication and collaboration between the patient, the family, the general practitioner and the Acute Health Sector. Responsiveness and interdependence in the care of the patient by seeking to know the patient’s wishes are not a priority. The perceived culture of the Acute Health System involves cure, the patient is discharged to die. Where is the care? The AHS takes on the responsibility to cure the disease, not to care for the patient. The bureaucracy invests its authority in the regulations of the system, the bed-days, fiscal policy, not in relationships with patients and their families.

Distrust of the institution grows out of the reality of repeated unproductive interactions with hospitals. [I:2]

and

We as GPs, often need to take on the responsibility of failed discharge planning, or no D/C planning, for the public system. I was unaware until he was home: no-one had
talked with me about taking on his continuing care. The system should not require so much rescuing. The system off-loads their difficulties on to you. We are the rescue mechanism. If you are occupying a bed you are a problem really, they want to get rid of you as soon as possible. [I:4]

and

They only recognize the role of the GP when they think they have done all they can for the disease. But it is the patient who has the disease who is told to go home. [I:11]

and

They deal with the treatment and cure issues they don't deal with the death or continued caring issues. [I:11]

There is a recommendation from general practitioners that a letter or telephone call identify the discharge of the patient. But the most junior medical member of the Specialty Unit with limited understanding of complexities involved in overall management and plans for the continuity of care of the patient writes the letter.

6.10.6  The Interface with the Acute Health System
General practitioners project authority, knowledge, expertise, experience and competence onto the Acute Health Sector, leaving themselves emptied of these attributes and with a sense of isolation and not knowing. In this frame the AHS takes management control of the patient. General practitioners deny their authority as the patient's practitioner. But then feel they are abrogating responsibility to advocate in role and lapse into vengeful resentment and envy, because they are not heard. This dichotomy feels destructive and persecutory. The AHS is seen as all-powerful and general practitioners feel incompetent to act on behalf of the patient and assume a position of limited ability to influence. Hirschhorn states:

Adults [in] professional roles expect to feel competent. When they feel incompetent - they feel ashamed.\textsuperscript{116}

The thoughts and feelings communicated by the general practitioners are depicted in the Table 6.
THOUGHTS & FEELINGS of the general practitioner at the INTERFACE with the Acute Health SYSTEM

<table>
<thead>
<tr>
<th>General Practitioner</th>
<th>Acute Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in practice</td>
<td>Groups in practice</td>
</tr>
<tr>
<td>Impotence</td>
<td>Omnipotence</td>
</tr>
<tr>
<td>Ignorance</td>
<td>Omniscience</td>
</tr>
<tr>
<td>Incompetence</td>
<td>Competence</td>
</tr>
<tr>
<td>Powerless</td>
<td>Powerful</td>
</tr>
<tr>
<td>Subjugation</td>
<td>Domination</td>
</tr>
<tr>
<td>Lacking authority</td>
<td>Authority</td>
</tr>
<tr>
<td>Sharing of knowledge</td>
<td>Hoarding of knowledge</td>
</tr>
<tr>
<td>Open</td>
<td>Closed</td>
</tr>
<tr>
<td>Generalist</td>
<td>Specialist</td>
</tr>
<tr>
<td>Personal relationship</td>
<td>Impersonal attitude</td>
</tr>
<tr>
<td>Whole-person care</td>
<td>Diagnosis-based cure</td>
</tr>
<tr>
<td>Holistic</td>
<td>Biological-system based</td>
</tr>
<tr>
<td>Community care</td>
<td>Hospital-focus</td>
</tr>
</tbody>
</table>

Table 6

The perceived inability to advocate on behalf of a patient, the devaluing of the work, the incompetence and the silencing are transferential projections and produce internal destructive behaviours taken up by members of the Primary Health Sector. The resultant ignominy produces an environment of envy and mistrust within the Primary Health Sector. The mode of operating for general practitioners is with a paranoid-schizoid frame of splitting and projection of all the ills of the health system into the Acute Health Sector and the Federal Government Sector. The relationship between the PHS and AHS in general is parasitic rather than commensal or symbiotic. The defensive techniques of projection and splitting exploit the natural boundaries across the systems, between the insiders and the outsiders especially when there are limited opportunities made for the groups to communicate. The isolation of general practitioners in the community potentiates the splitting. The gaps between the systems are available to be filled with many differing emotions and phantasies.
The general practitioners’ anxiety about being portrayed as incompetent heightens their envy of the staff of the AHS. Seeing the AHS as overpowering and paternalistic allows general practitioners to blame the system, rather than see themselves as abrogating the role of advocate or deviating from the task of continuity of patient-care. The task of both systems is the healthcare of the patient. Reality at times of destructive self-criticism becomes blurred.

The management of oneself in role ... implies the ability to develop one's own authority in order to interpret prevailing environmental, business, and organizational conditions, and to learn to differentiate between aspects of reality and illusion/fantasy.\textsuperscript{118}

The classical medical organization has two roles that of the doctor and the patient.\textsuperscript{119} Perhaps in this relationship with the AHS, the general practitioner takes up the emotions of the role of the patient; ignorant, passive, obsequious and grateful. This is done enough to mobilize the primitive defensive techniques and engender anger, resentment and envy! How does this impact on the task of patient-care? An ability to reflect on the dynamics occurring within and between the systems and recognizing the underlying anxieties and phantasies would aid the general practitioner in focussing on the primary task and taking up their role on behalf of the patient in collaborating with AHS staff. Stacey recognizing agency writes:

Whether the network is stable, chaotic, or at the edge of chaos depends upon how responsive agents are in relation to each other; and how richly connected they are to each other; and how diverse they are in relation to each other. In other words, the dynamics are determined by the pattern and nature of agent relationships.\textsuperscript{120}

The need for advocacy on behalf of the patient with their family in the AHS is particularly relevant to end-of-life treatment choices. As general practitioners retain
the formal authority in the doctor-patient relationship and recognize the priorities for the patient at these times of extreme stress, their ability to contain the fear and anxiety involved while working in a depressive stance, is critical.

What does the AHS unconsciously introject on behalf of society and for the PHS? I believe it is to keep dying and death out-of-sight and out-of-mind. Is the containing of these expectations too significant a responsibility for the members of the AHS who may have little concept of the role that they unconsciously assume for society?

Hospitals are ... an embodiment of a social system that exists to defend society and its citizens against anxieties about death.121

Is this the experience of AHS junior staff when assailed by the general practitioner, the patient or their relatives? Unable to bear the questioning and confrontation with dying and the potential of death, do they fragment?

6.11 Federal Government
One of the general practitioner's interviewed stated clearly the need for integration between the systems to benefit the patient.

If the government could make a workable system, could develop a method by which GPs could attend the Public Hospital, an interface between who the patient is in the community, and bring that to the bedside, to be with the patient and ground her again in her reality rather than be caught up in all that is flying past her. [I:5]

The Federal Government is the funding body for the public health system, but the attitude of general practitioners is that the government does not appear to be focused on the healthcare of society but on its own fiscal policy about health. The Federal Government is the source of funding for the PHS, the AHS funding is provided by each State Government. This creates an impediment between the AHS and the PHS, who each disregard regulations of funding bodies to exact their own budgeting needs. As a consequence of the dual system, splitting and blame occurs if deficiencies are encountered within the systems. The general practitioners
interviewed emphasized a number of aspects of the impact of the funding body and the fiscal policies on the management of patients within the community, including patients in Nursing Homes.

A lot of Nursing Homes are struggling to ensure that the system can provide even basic levels of care; much less end-of-life planning. There are difficulties around; failure in medication, after-hours care, delivery of care, and communication. They don’t get to conversations about end-of-life plans. [I:2]

and

I do not believe that the welfare of the individual is the focus of healthcare planning in Australia. It is the budget. [I:10]

and

How we practice as general practitioners is regulated by the system. [I:8]

and

Our Healthcare system is not geared towards pro-active healthcare. A programme is brought in because it is cost effective. It is based on a fee for service model, not on preventative, whole person healthcare. There is no integrated policy in the Australian healthcare model it is very patchy. What is in this year’s budget: economic rationalism reigns. [I:10]

Although the Primary Health Sector is pivotal to the health of the nation, the Federal Government has only recently commenced funding preventative health measures to improve the health of the nation. The major emphasis of the system remains the budget, leaving the impression that a programme is adopted because of its cost-effectiveness not its impact on preventative healthcare. There is limited acknowledgement of the increasing complexity of the patient profile and the need to address this through budgeting mechanisms.

There must be time to do this work and a community connection. Real work should be done in the community with pastoral care workers and palliative care teams. [I:2]

and

Medicare does not fund in-depth or long term work with patients or families. [I:2]
There needs to be an economically viable basis to contain and maintain the complexity of multiple co-morbidities within the system. [I:11]

The best health initiative by the Federal Government in the last few years has been the healthcare assessment of the greater than seventy-five-year-old. It involves a yearly review of the individual which includes physical and functional as well as cognitive and psychological capacity. Unfortunately, it is costly to the patient for it involves a nurse assessment at home, as well as the medical consultation. The whole person picture is advantageous. [I:10]

The rebate system is such that you can’t allow yourself a lot of time to talk to people. It is economically driven. [I:11]

The role of the general practitioner in the community is not identified by the Federal Government. An initiative to encourage yearly assessments of individuals over seventy-five years of age is an acknowledgement by the government of the aging population, but the associated, allied health staff assessments are not funded. The Federal Government by limiting funding to provide for the complex, elderly patient unconsciously derails its own intervention of elderly healthcare assessment in the community. Does the individual living alone want to fund a professional person to determine if they have cognitive or functional impairment?

End-of-life planning is not included as a part of the process.

The attitude of the Federal Government also encourages general practitioners to refer elderly patients to Emergency Departments. The State funded system will then assume the responsibility of assessing the cognitive and functional state of the elderly patient. The burden of the conversation about Nursing Home placement is then assigned to the Acute Health Sector. Is the general practitioner unconsciously
or consciously relieved of the responsibility of evicting the elderly patient from their own home? Obholzer expresses it this way:

The natural inclination is to reduce the "length" of one's vision – keeping one's head down as regards the future, and perhaps carrying on as if nothing had happened or was about to happen.\(^\text{122}\)

The emphasis in both systems is performance; to acknowledge the fiscal policy of the economic rationalists. In the hospital; bed-occupancy and access to a hospital bed either through the Emergency Department or through the waiting list is a funding determinant of performance. In General Practice it is appropriate patient numbers, regulated by Medicare. But the State and Federal systems and the public and private systems overlap.

Where does the responsibility lie for resourcing and the effectiveness of the overall health of the nation? The emphasis on performance related to fiscal responsibility allows all systems to collude and move away from the anxiety provoking aspects of patient-care. As a defensive mechanism, this assists in eliminating situations that would precipitate anxiety, doubt or uncertainty; silence the thought about residential care, obliterate the task and transfer the patient to another system!\(^\text{123}\) Little is done to initiate a conversation about end-of-life planning; the communication and the relationship is controlled. While consciously or unconsciously splitting the technical aspects of task and task-performance between sectors and funding bodies to assist the routine of medical activism; the double task is eliminated. Members of the healthcare systems then effectively limit their experience of the psychodynamic aspects of the splitting.

For example, general practitioners, in transferring an elderly patient who is not coping in his home environment to the hospital, act without acknowledging the underlying reason for the transfer and refer for medical intervention. The action
reduces their own anxiety of arranging with the patient and the family a residential care assessment. Overt and covert practices have conscious and unconscious sequelae. Different funding sources for curative care (usually institution-based) and chronic care (usually community-based) create tension in the provision of medical care and in decisions about how that care should be funded.\textsuperscript{124}

Perhaps another fear and anxiety in General Practice is that the Federal Government will inadvertently annihilate, because of inadequate funding, the PHS. The Sector will not survive because of work-load demands and the lack of reasonable financial support mechanisms. Or, general practitioners will not survive will burn-out, being overwhelmed by the demands of the work.

From my journal: May 2003.

There does not appear to be a 'healthy' relationship between the Federal and State Health funding systems.

How can healthcare be taken seriously if the funding model to provide for the healthcare of the society is so confounding. There is a limiting relationship between the systems.

How is resilience built into these relationships?

For the maintenance of any healthy relationship it needs clarity about primary task, with connectedness, communication, collaboration, and commitment.

This health relationship needs trust and resilience, a realistic attitude and energy around the task, with a generosity of intent.

The multi-dimensional systems complex about the healthcare of a nation requires reality and clarity about the primary task ascribed to each system. A group is required that is prepared to assist with integration and has propensity to work with primitive defensive mechanisms. These defenses are currently denied in the rationalization about health, so that the distribution of tasks between the systems enables splitting, disruption and fragmentation to occur. This could be minimized. The
management of role-to-role relationships within a containing environment is critical to
develop understanding of the inter-systemic needs to improve patient-care.

Of course, in all of this, governments are made anxious about the rising costs of
health care brought about by new technologies that extend life, the ageing population
and changing attitudes toward healthcare. These anxieties drive governments to pull
in fiscal restrictions and so the defences multiply across the systems involved.

6.12 FRAGMENTATION: the Outcome for Society
How does psychodynamic fragmentation relate to the features of the systemic
fragmentation occurring in the health system? Or as questioned by Stacey:

> How do ... complex networks with their vast numbers of
> interacting agents function coherently to produce patterns of
> behaviour. ¹²⁵

The definition of individual fragmentation by Hinshelwood is ‘severe splitting of the
ego, typically in relation to the difficulties encountered in the paranoid-schizoid
position, gives rise to a sense of fragmentation, of going to pieces ... a normal
experience under stress or exhaustion’. ¹²⁶ The Concise Oxford Dictionary describes
fragmentation as ‘breaking into pieces’. ¹²⁷

What does inter-system fragmentation look like? If the ego is the boundary control
for the individual, how do the multiple systems involved at the patient-care interface
control their boundaries? Do the numerous individuals interacting at the boundary on
behalf of the patient realize that they are fulfilling the ‘normative’ primary task for
each system of patient-care? Also, individuals involved in a patient’s care may not be
familiar with the patient’s needs and expectations, but interact on behalf of the
patient as a member of the family, the general practitioner, and a staff member of
the AHS. System interactions create psychodynamic responses at the interfaces
which are often not understood by the players.
What then, would create the links; the connectedness between the system and systemic issues, where patient-care is the ‘normative’ primary task? The patient in a crisis is frequently left out of the conversation, with the remainder of the interacting agents believing they are contributing in a useful manner. These agents include:

- Neighbours
- Carers: Wife, Relatives, Nursing Home Staff
- Family
- Friends
- **PATIENT:** Metropolitan Ambulance Service
  - General Practitioner
  - Community teams: District Nurse & Patient Care
  - Specialist’s room staff
  - Specialist
  - Acute Health Sector

Self-organizing networks display the three broad kinds of different dynamic: stability, disintegration, or chaos, and between them, a paradoxical bounded instability at the edge of chaos. Networks at the edge of chaos evolve ... they learn from their own experience and ... are ... history dependent.\(^{128}\)

In medical modernity, technology, pharmaco-therapeutics and molecular biology with economic rationalism, as the determinant, are also usurping the importance and place of relationships, interdependence and diversity between the healthcare providers and their patients. There appears to be an impermeable barrier rather than a boundary between the systems. Systems demonstrate limited responsiveness to the needs of the 'other' for patient-care. This is confirmed by the limited flow of information, lack of direct communication, disrespect for the expertise of each role player, and a lack of focus on the inter-relatedness of the task: patient care. Something gets in the way?
Biran, talks about the Oedipus metaphor and the narcissistic bias of the individual with the associated instincts being a focused response of constructing self in the affiliated organization with a paranoid-schizoid response to any perceived or potential challenge. The group narcissism focuses on functioning with and for the group without acknowledging the role or the needs of another. She writes,

Social and political context influences the atmosphere of organizations. When we analyse the different roles and the communication among them, we can feel difficulties in accepting the other and a tendency to departmentalize.130

With the metaphor of the Sphinx as the focus of the exploration, the world widens to an inter-subjective space of the social unconscious with inscrutability, complexity and change the order of the day. Control is outside of the domain of the individual/group while anonymity and ambiguity reign. The emphasis becomes a search for meaning and knowledge which can be patient-focused. Instead of an ego-centric bias at play, a socio-centric stance can be adopted with patient-care as the focus. The depressive stance enables the participants to contain the anxieties. Instead of splitting and adopting defensive techniques to disguise their disquiet, participants collaborate at the edge of chaos. Instead, what appears to occur at a time of crisis is the delegation of authority to a 'deemed' expert, without relevance to the required task or the personal autonomy of the patient involved. The irrational, unconscious assumption is that authority resides at the top of the hierarchy, instead of a positional or personal authority relating to task or to the role.131 In this setting little negotiation or consultation occurs about the primary task or the roles of the individuals involved. de Mare describes:

The large group, through lack of opportunity, may have to resort to an overly-developed control by hierarchy. This easily becomes an abuse of hierarchy resulting in mindless and dehumanized organizations.132
Hierarchical structures become impervious to their own and each others informational requirements, resources and responsibilities.\textsuperscript{133} This general practitioner presents a recent case history.

A story of a man with lymphoma who was discharged home; the Palliative Care team rang me to ask me to care for this man, no general practitioner had been notified from the Hospital. I was unaware until he was home; no-one had talked with me about taking on his continuing care, I did not know he was terminally ill; the family was unaware of what could be done. He was in a lot of pain and agitated. The Royal District Nursing Service was sent without morphine for him. We had to start from the beginning. I also had to explain to the family that he would not live very long. I felt very dissatisfied with his care; the patient’s family were unprepared, they knew he was terminally ill and he would die; but no more than this. The communication with family was to inform them of my purpose, ‘I was not practising euthanasia but providing their relative with pain relief’. Once they understood my purpose, they were at ease. A phone call would have been helpful. The Oncologist could have informed me that the patient was being discharged: for terminal care, with the assistance of the Palliative Care team. This discharge deserves a phone call to enable continuity of a care plan. [I:4]

The quotation from Hinshelwood states a potential outcome in this type of setting.

The barrier to communication between the groups which are caught up in a mutual projection system ... [results in] distorted group identities, based on primitive projection and introjection ... a very concrete transfer of feelings and experiences between the groups. They are often transferred in the form of a patient.\textsuperscript{134}

Care is lost between the systems and communication becomes obfuscation. ‘Systemic and systematic dehumanisation’ appears to be the result. The involved groups do not communicate together or with the patient to attain a shared understanding of
expectations. Care-providers are often unable to openly discuss together issues like prognosis and end-of-life planning with the patient and family.

I personally feel that it is very fragmented. Few practitioners [are] prepared to talk about the difficult issues at any depth in terms of choices of treatment and the feelings and thoughts in the mind of the dying. [I:2]

But they attain an adaptive ability through the conscious and unconscious defensive mechanisms at play: to deny any thought about death, to repress or deflect these feelings and either avoid communication about death, or intellectualize all communication, engrossed in routine. As a result conversations about the process of dying or the management of death do not occur, with peers or other medical colleagues. As a consequence systematic fragmentation and systemic dehumanization occurs within the system, the ultimate defensive mechanism protecting from psychic fragmentation.

The fear of annihilation by fragmenting is central to the life of a community and to feelings about it which touch on the internal phantasies about one's self.135

In the environment of the large group of the Acute & Primary Health Sector, thinking becomes impossible between the players, because of the enormous capacity to generate overwhelming, frightening emotion with associated transferential projections. Psychotic mechanisms are prominent. As a consequence the emotion can become unmanageable with the resultant splitting in uncontainable panic or spilling over into ephemeral emotion, where no thoughts are available to articulate the issues. The consequence for the members of the large group is mindlessness, and routine.136

The real problems are: depersonalization, alienation, being turned into automata.137

To limit this fragmentation, improved communication needs to occur between the Acute & Primary Sectors to identify individual patients and streamline their
processes. The interacting agents have the capacity and potential to produce integrated, coordinated delivery of care for patients. Mann believes this fragmentation could be reduced.

We could reduce this fragmentation of healthcare by improving communication and sharing resources within the healthcare system. It would involve the patient, rather than interventions or healthcare practitioners, becoming the centre of care.\textsuperscript{138}

Fragmentation endangers all levels of healthcare because of the internal and external socio-psychic components of each system and sub-system, and the interplay between the conscious and unconscious experiences of the members of each system within their groups. The internal psychodynamic complexities unconsciously mobilized through the transference in group processes elicit primitive anxieties. Hinshelwood acknowledges the effects and affects of emotional disorder and the resulting lack of collaboration across the healthcare organization.

Emotional disorder interferes with the functioning of an organization, particularly in relation to tasks which require co-operation or collective change.\textsuperscript{139}

The result is dehumanization, routinization and intellectualization: the 'phenomenal' task.\textsuperscript{140} These resulting psychodynamics of fragmentation in the systems keeps the reality: death at bay.

7. The GENERAL PRACTITIONER in ROLE

A role is a phenomenon that cannot exist in the individual's space; it is always connected with the existence of the other.¹

The role of general practitioner is a leadership role within the community. S/he holds the responsibility to provide guidance and healthcare for members of the community. The capacity of general practitioners to manage themselves in role is critical when dealing with tasks like end-of-life planning which induce profound personal, organizational and societal dynamics.

This section of the research dissertation reviews the theoretical concepts and organizational dynamics of role. It commences with definitions of role and then examines the implication of the concepts described as they relate to the role of the general practitioners in their community of work. In this chapter, I explore differences between those practitioners able to take up and manage in the role of general practitioner as it might ideally be in end-of-life planning, and those who avoid this role. I recognise that the ideal that I discuss is difficult to achieve, but it is worth presenting both theoretically and in the way it is described by a minority of practitioners in the study.

Figure 1: Person, role and system (Sievers, Workshop: London 2000 cited in Coaching in Depth)²

The segment begins by exploring the understanding of the concept of role for both the individual and the organization; for role; as demonstrated aptly by Figure 1 above, is the setting in which the person and the system meet.
Role does not exist in isolation. The above diagram depicts that role is the setting where components of the structure, required by the system, and the functional aspects of role, provided by the person acting for and in the system, fulfil the tasks of the system. The concept of role also has numerous associations within sociological and management literature.

The complexity is described in this chapter with the assistance of literature which has a basis in psychodynamic, psychoanalytic and socio-technical concepts. The importance of the interface of role is here examined using system psychodynamic concepts. For example, the influences of the system on the individual in role from the perspective of role-given, the individual in the system with a framework of role-taken, and the individual and the system influences on the role are examined using the theory of role-idea, and organization-in-the-mind. These system psychodynamic and psychoanalytic concepts are then used as a foundation for assessing the experience of role. They are then used to identify the importance of subjectivity and inter-subjectivity, the impact of group dynamics and the relevance of the contextual and social aspects of role. The concepts explain the significance of the interplay of conscious and unconscious dynamics for the person-in-role in the system and managing oneself in role. A working hypothesis, created from the analysis of the interviews with general practitioners, elaborates their experience in role. Next the role of the general practitioner as defined by the RACGP is examined. This segment uses the research data to elaborate concepts like role-given, role-taken and personal factors, as well as contextual and societal factors that influence how the role is taken up by the general practitioner in the context of end-of-life planning.

### 7.1 How is role defined?

General practitioners in role have a multiplicity of system associations to which they are responsible and accountable as a component of the role-given. The Royal Australian College of General Practitioners endorses the qualifications and skills of
practitioners and credentials and authorizes their practice. In each Australian State, for example Victoria, the State Government, with the sanctioning of the RACGP, registers the general practitioner to work in the community. The Federal Government of Australia funds primary health care, the work of general practitioners.

General practitioners in their role-taken are responsible to patients for providing community healthcare. Guidelines for a role to be performed are important to assist the individual working in role, as authorization for a role-taken is contingent upon the endorsement of the role-given. The term role is used extensively in the organizational and sociological literature. Krantz and Maltz develop a slightly different connotation aligned with system psychodynamics.

(a) The duties, tasks, expectations and responsibilities of a particular position;

(b) The behaviours of individual members in response to the duties, tasks, responsibilities and expectations associated with a particular position ('playing a role'); and

(c) Individual's internal conception or image of the part he or she assumes in the enterprise.

Work role is a dynamic, complex, task-orientated concept which links the person, the system and the society in which the role is performed. Role as a subjective experience occurs at the interface of the person with the system. For the person taking up a role, it is important to recognize the internal and external dynamics that impact upon that role and to have clarity about the aim of the system. This then enables the role-holder to fulfil the tasks required within the cultural context of the system, and community. Role enactment is influenced by the how the role-holder takes ownership of the role. For the person-in-role, the performance of the role-taken gains complexity as the implementation of the role-given is interwoven with the
conscious and unconscious expectations of the organization. The fulfilment of role is influenced by the conscious and unconscious collusion of the person-in-role with the society in a manner compatible with the covert defensive mechanisms applicable to the role in society.\textsuperscript{16}

The dynamics of role and the complexities of the enactment of role in the moment include the person-in-role’s unconscious analysis of the reality of context at the time and the perception of the audience. Reed acknowledges Banton in stating that role-enactment has both personal and societal aspects.

1. a position in the social structure,
2. the individual’s own standards,
3. others’ expectations of what he \textit{will} do, and
4. others’ expectations about what he \textit{should} do.\textsuperscript{17}

In fact, Mant would go as far to proffer that,

\begin{quote}
Your real ‘role’ is determined by the perceptions of those surrounding you.\textsuperscript{18}
\end{quote}

The concept of taking the role,\textsuperscript{19} or managing oneself in role,\textsuperscript{20} acknowledges the individual’s internal and external interactions with the system. These are related to the recognition of the ability to work with the reality of the context of the system and with behaviours congruent with an understanding of the aims of the system.

A role is a mental regulating principle, based on a person’s lived experience of the complex interactions of feelings, ideas, and motivations, aroused in working to the aim of a system(which is itself an internal object to the person), integrated consciously and unconsciously and expressed in purposive behaviour.\textsuperscript{21}

Mant describes the requirements of the person managing in role as taking up the authority of the aim of the system to perform the primary task.\textsuperscript{22} It is through paying attention to the dynamics of the organizational environment and being
cognisant of his/her personal reality that the person-in-role is able to work with and act upon the information available. Reflective action involves acknowledgement of the dynamic internal and external complexities of the individual and the system.

The management of oneself in role requires an extremely high level of consciousness with respect to the internal and external forces and demands - the conscious and latent dynamics - on one's role, in order to act and decide as autonomously and as appropriately as possible.23

Mant24,25 and Reed26 use similar referential correlations for role as Lawrence and Robinson use in clarifying how primary task is perceived and performed.27 That is, role is viewed in terms of normative, phenomenological and existential role and therefore how the individual consciously and unconsciously constructs and perceives role. These descriptions are also refined by Krantz and Maltz using the ideas of normative, phenomenal and existential role-idea.28 The 'normative' role is consistent with the role as given, the job description; deemed by the organization as what is required. The 'normative' role can be taken-up and reframed by the individual as the 'existential' role or 'experiential' role; that is, what actually happens in-role.29 The individual recognizes this on reflection. The role performed, as observed by others, is the 'phenomenal' role engaged in by the individual but of which the individual is not always consciously aware. As a conveyed role, it is significantly influenced by conscious and unconscious dynamics of the moment, the culture of the system, and the societal context.30,31,32 Role-idea is a distillation of these aspects.

7.2 Role-idea or role-in-the-mind
Mant33,34 and Reed35 both use the term role-idea to confer understanding of the person-related dynamics of role. Role-idea is an internal construction of the person-in-role in the system, bringing to the role the individual's conscious and unconscious concepts of role which are expressed through personal attributes, values and behaviours. Mant defines role-idea as an 'unconscious pre-programmed set of
assumptions about the role in the organization' which shape the enactment of the role, the behaviours and attitudes of the person-in-role. Reed recognizes role-idea as a complex dynamic constantly being revised and changed by the immediate context. The role-idea is self-regulating effecting and affecting performance and behaviour and is dependant upon the task being performed and changes in the environment of work. Role-idea unconsciously filters information to meet the formulation of the role given, hence determining the actions perceived relevant to role.

Understanding one’s role, then, requires unpacking the various dimensions that constitute that role at any given moment and learning how to identify the features.

The role-idea is developed from the criteria provided by the organization to fulfil its the primary task and from the individual’s unconscious desires. It is influenced by the person-in-role, role-to-role relationships, inter-systemic roles, tasks, boundary relationships and the resources provided to fulfil the aims of the organization. The overt task-related behaviour of the individual is influenced by understanding the complexities involved in the systemic role-given and by recognising the personal conceptualization of the role-taken-up.

Moreover since role-idea is in part unconsciously constructed, it is significantly influenced by the underlying dynamics of the system in society and also shapes the behaviour of the individual. When the perceptions of the role-given and the role-taken are misaligned an outcome may be role conflict or role dilemmas. This is because the role-idea may demonstrate a miscommunication or misunderstanding within the organization. This may also lead to the corruption of task performance.

Bion uses the concept of ‘evocation’ of the work group, to engage the work group in maintaining contact with a shared reality and accordingly working with the primary task. The general practitioner’s membership of to the RACGP (the general
practitioners’ work group) functions by giving stability to the performance of role-related tasks. As written by Lawrence:

Each role-holder is not only concerned with the management of himself in his role but is also having to hold the management of the work group ‘in the mind’.41

The person-in-role, the general practitioner in the research project not only gains recognition and meaning in role from the RACGP but relies upon the community for identity, status, prestige, and acknowledgement for the work performed. Lawrence,42 Reed and Bazalgette,43 and Sievers and Beumer44 use the phrase ‘role-in-the-mind’ when describing the individual’s internalized construction of role.

7.3 Managing oneself in role
A psychodynamic perspective recognizes the importance of managing oneself-in-role especially in the setting of the delegation of responsibility to the person-in-role during change.45 Not only the processes and throughput of the primary task of the organization are of relevance and importance, but also the ability to acknowledge and work with the associated emotional experience; the primary process.46 Holding the anxiety, uncertainty, confusion and persistent turbulence of change is aided by the containing function of role.47,48,49 Krantz states:

The success of New Order organizations is deeply connected to the ways they develop to contain anxiety. The focus here is ... on the ways in which emotional experience effects the ability of people in the organization to think and collaborate.50

Today’s world of work necessitates acknowledgement of rapid change where there is loss of organizational hierarchical structure and a move toward more widely dispersed delegation of responsibility and self-regulation.51,52 This free-flowing environment is often experienced as chaotic and un-managed by personnel. To manage oneself-in-role in an organization and especially in leadership requires the capacity to recognize and manage personal and organizational conscious and unconscious processes.53 In General
Practice, managing anxieties would involve recognizing the transferential projections of the patient and containing one's own and the patient's vulnerabilities whilst attending to the requirements of the individual patient as well as fulfilling the systems requirements.

An article by Reed and Bazalgette reinforces the attributes beneficial to the role-holder:

- **identifies the aim** of the [employing] system
- **relates their own desire** to that aim
- **takes ownership** of the aim as a member of the system
- **chooses the action** and personal behaviour which from their position best contributes to **achieving the system's aim**. 54
- **[identifies system interfaces to manage oneself in role]**
- **[recognize the dynamics in the interactions within and across the systems and takes appropriate leadership]**.

In taking ownership of a role, the individual attempts to develop clear objectives for the organization and acknowledge role-to-role relatedness in fulfilling the aims of the system. Commitment to role in the organization encourages the person-in-role to reflect upon personal history, values, attitudes and endeavours that influence how the role is taken-up. Containment of the psychic dynamics present within the organization enables personnel to manage possible confusion, uncertainty, and a sense of chaos and in so doing to focus on the aims of the system and align energies to these objectives. The work role does not exist in isolation; the role-taken includes an organizational perspective.

It is important for the person-in-role to retain a systemic or binocular view in order to develop a socio-centric view of role for the organization. 55 Alignment to the primary task and working in the depressive position with a self-observing stance assists the person-in-role to contain their anxiety and encourages working collaboratively, role-to-role, in support of the primary task. 56,57 The capacity to
manage oneself in role,⁵⁸ with a depressive stance allows the integration of the internal and external realities and 'a disciplined approach to the emotional experience present or presented'.⁵⁹ Gould describes the characteristics involved in achieving a self-managing stance:

- Taking behavioural responsibility for oneself,
- taking emotional responsibility for oneself,
- taking ethical and moral responsibility for oneself, and
- fully recognizing interdependence.⁶⁰

The above capacities are those considered as prerequisites to managing in role.

These attributes encourage the individual in leadership to become reflective in their organizational role and to use their own subjectivity as a means of understanding and working with self and of understanding and working with the other.⁶¹ In taking responsibility by taking up a self-observing stance, the person-in-role can focus their energies on fulfilling the aims of the system.⁶² In so doing it enables their behaviours and actions to be congruent with the systemic view through role-to-role relationships which amplify the aim and purpose of the system. This aptitude of managing in role also encourages the role-holder to identify transferential projections (which inflate conflict and systemic dilemmas) and hence take appropriate leadership.⁶³ For role-to-role interactions, relations and activities prompt thoughts, feelings, metaphors and value responses which influence, constructively or destructively. The emotional experience is rarely located within the individual space.

The ways in which organizations support or erode peoples' ability to maintain an integrated, realistic psychological connection to the people and the events around them should be considered a competitive advantage (or disadvantage) in today's world.⁶⁴

The role-holder in managing in role pays attention to and interprets the emotional experience present and uses this to interpret the relatedness between the individual
and the organization - the workplace within.\textsuperscript{65,66,67} The medical faculty, in the training
for leadership and management of the general practitioner, rarely pays attention to
or interprets the emotional experience within self and within the workplace.\textsuperscript{68}

This lack of theoretical conceptualization and experiential learning for the general
practitioner in managing oneself in role may limit his/her capacity to recognize the
emotional experience present in the space of the doctor-patient relationship. This
may therefore limit his/her ability to contain the space and therefore the ability to
work from the depressive position.

7.4 \textit{Organization-in-the-mind}

For the person-in-role the 'organization-in-the-mind' reflects the emotional reality of
the organization.\textsuperscript{69,70} This personal construction consciously and unconsciously
informs his/her relatedness to the organization. As an internal psychic construction,
the 'organization-in-the-mind' is the individual's reality. This inner experience is used
to create and derive meaning and fantasy in the work for the person-in-role. The
role-holder's perceptions of how the organization is organised and structured create
this internal dynamic which is instrumental in the enactment of task-related
activities by the person-in-role and the role-to-role relatedness with other members
of the organization. It is of advantage for the person-in-role to reflect on and pay
attention to the organization-in-the-mind in order to understand how his/her
behaviour is shaped as written by Hutton et al.

'Organization-in-the-mind' ... the mental picture of the
institution in its context which is informing the managers'
experience, shaping their behaviour and influencing their
working relations, both overtly and covertly.\textsuperscript{71}

Each individual creates an organization-in-the-mind through his/her experience in
role. This construction, which contains rational and irrational thoughts about the
organization, is a result of the role-holder's conscious and unconscious sense-making
about the organization. It is similar to what Winnicott names the transitional object, an ‘intermediate area of experiencing’ informed by both the external reality and inner reality.\textsuperscript{72}

By recognizing that the organization-in-the-mind is a personal internal construction, the individual can be freed to make present his/her emotional connections to the organization. Role-to-role communication contributes to the recognition of differing realities in role.\textsuperscript{73} The containment created by focusing on the task and managing in role enables role-holders to explore their organization-in-the-mind and the gap between their inner and outer worlds, bringing creativity and innovation to the task and adapting behaviour and actions for the task purpose of the organization. Krantz recognizes the relevance of containment.

\begin{quote}
The key element in enabling people to operate from the depressive position is containment.\textsuperscript{74}
\end{quote}

In the context of the task of end-of-life planning with a patient it is important for the general practitioner to provide containment while working and managing in role. How is this achieved while working with intense vulnerability? Krantz talks of the social defences evoked to assist in maintaining the depressive stance. For the practitioner in role, the priority is the care of the patient and the choices the patient wishes to make relating to his/her care. Within the empathetic doctor-patient relationship it is possible that both can work together to formulate a plan using the medical expertise of the general practitioner to assist the patient end-of-life plan.

The performance of tasks and responsibilities associated with role are often taken up differently by individuals in similar settings, leading to differing outcomes. What each practitioner brings to role is determined by an individualised mix of theoretical learning and skills, experiential learning contexts, technical applicability, personality, and overall his/her integrating capacity which shapes how role is taken up.
In addition, how the practitioner manages in role is determined by his/her ability to own the authority in the task. This is done by using medical expertise plus working with the emotional experience of the moment while consulting to a patient.\textsuperscript{75,76}

Creating an appreciation of the interactional context of competence, and seeing knowledge as collectively developed, require[s] structures and methods that can contain primitive anxieties and irrational emotions ... inevitably stirred when people ... expose their experiences, link them with others, and be vulnerable enough to learn in public.\textsuperscript{77}

I give an hypothesized scenario by way of illustration. A general practitioner acknowledges the doctor-patient relationship but is unable to work with the patient’s reality of terminal illness and impending death because of uncertainty, ambiguity and extreme emotional distress. Being aware of the emotional intensity present, the general practitioner may feel anxious and unable to contain the anxiety and therefore disconnects from the task at hand; in this case, end-of-life planning. Instead s/he denies the emotional context and works with the illusion of a different relationship and avoids any conversation about loss of independence, terminal disease or end-of-life planning.

Tolstoy postulated that it is possible to be emotionally aware in an empathic relationship and work with this knowledge.

\begin{quote}
Gerasim alone did not lie to him; it was obvious from everything that he alone understood what was happening, saw no need to hide it, and was simply sorry for his sick and wasted master.\textsuperscript{78}
\end{quote}

So too, it might be possible for general practitioners (Appendix 8).

\section{7.5 The Role as given for the General Practitioner}

The general practitioner’s role is to serve the community in which s/he works through the auspices of the RACGP. In the Australian healthcare system the general
practitioner is the crucial point of access for medical care to the individual. The purpose of the role is to provide comprehensive care as required for the presenting person.

General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.79

This definition for the care provided is generalized, universal, inclusive but not explicit in detail. It includes the expectation that each consultation with a patient is taken up with the emphasis of whole person care, taking into consideration the reality for the patient which compels regard for an individualized practice. The healthcare to the person presenting to the general practitioner involves history taking, physical assessment, diagnosis and decision making, immediate management and appropriate follow-up. The decision making may involve referral for specialist assessment and management or hospital referral.

The Royal Australasian College of General Practice defines the role of the practitioner. S/he

- Has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care; and
- Maintains professional competence for General Practice
- Through Australian General Practice works to improve the standard of health care for all Australians especially groups of people with special health care needs, and will see demonstrated improvements in health outcomes. This includes attention to the role of general practitioners working with Australians living in rural and remote areas, Aboriginal people, people of low socio-economic status, people of culturally and linguistically diverse backgrounds and people with chronic health care problems.
- Aims to increase the capacity to accurately forecast what the future holds for Australian General Practice and will have a process for continuing to revise this vision over time.80
The RACGP grants the role of general practitioner upon completion of a training programme based upon theoretical knowledge, diagnostic expertise, and appraisals by qualified general practitioners within training secondments. In General Practice within the constraints of availability in the community, the patient selects the general practitioner of choice to provide healthcare. The role of general practitioner is respected within the community. The practitioner builds the doctor-patient relationship by providing comprehensive medical care and continuity of care for the patient.

The complexities in the role-given are difficult to articulate but are an expression of the individual contract of the patient with the doctor in the here and now. A significant component of the therapeutic role of general practitioner requires that the assessment and integration of the psychological and social dynamics of the presenting person be aligned with physiological parameters. In so doing the general practitioner acknowledges care of the whole person in a social context.81 Currently the education of the medical graduate does not provide the training appropriate to this integration.82,83 The skills involved in the development of the doctor-patient relationship,84 that is, the communication of bad news, the integration of complex care involving withdrawing and withholding medical treatment, discussing treatment goals and end-of-life planning, are rarely explored during under-graduate or post-graduate training.

While the role-idea of the general practitioner shapes the provision of medical services, there are significant differences between the role-given (normative role) from the RACGP and how the role is taken-up (existential role) and perceived to be taken-up (phenomenal role). The role-given is also influenced by the context, changes in cultural and sociological demands and the evolution of medical practice.
How does the general practitioner perceive the role-given in terms of providing comprehensive medical care for the community? Data from the research interviews indicate:

The general practitioner is service provider, decision maker, initiates management and patient support. [I:1]

and

Knowing and caring for the patient through recurrent episodes of acute illness. [I:2]

and

We provide comprehensive care to individuals and families within the Community. The Clinic is commitment to: continuity of care, providing information and medical education, complete follow-up in an environment of confidentiality. [I: 3&5]

and

We in General Practice are only recognized for those bits of work that we do: diagnosis, management, counselling, therapeutics. But the patient recognizes that it is defined. [I:3]

and

Having a regular general practitioner who knows you is so important. Continuity of care is a different experience. [I:7]

and

I bring: knowledge, expertise, experience, confidence and reliability for their healthcare, coordination and planning, someone to confide in or discuss issues with. Generally we give people some opportunity to talk about what is going on for them. [I:10]

and

Personal care and being a solo practitioner more direct involvement with families. Continuity of care; because I have been long term and long serving, and probably expertise. I get involved in palliative care. [I:11]

Generally, in role general practitioners provide a extensive healthcare services for their patients through knowledge and expertise. The care is personalized, comprehensive and involves continuity in the care.
7.6 Role as taken
The role taken-up in a systemic capacity is significantly influenced by the person-in-role, the system, societal expectations and needs, and the emotional experience within the systems. How the general practitioner takes up the role is influenced by the perception of the primary task of General Practice as well as personal, organizational and societal factors that influence his/her role-idea. The societal role of general practitioner has significant prestige and with this status comes expectations about the provision of care and the standard of care practiced. As Mant suggests:

Your real ‘role’ is determined by the perceptions of those surrounding you.85

The relationship between the role-holder and the affiliating organization, the RACGP which authorizes the role, as well as the multiple systems which interface with the person-in-role, influences how the generation of role-idea occurs for the general practitioner. These inter-systemic memberships give meaning to the role, confer it status and prestige, and identify the role within the systems and the community.86

But the paradox is, that even in the community practice, the general practitioner works in isolation.87 The context of the practice, and community's needs and expectations, his/her own unconscious conception of role-idea and perception of the medical organizational systems may significantly influence the person-in-role. The role-idea conceived by the general practitioner provides a self-regulating influence on how each task is performed and the priority placed upon the task which changes with the patient's requirements. It is also influenced by the context of his/her work as well as the feelings and the transferenceal dynamics present in the consultation space. From the research data there are several personal attributes and values important to how the role of general practitioner is taken-up and instrumental in the development of the doctor-patient relationship.
These include, trust and honesty, ability to communicate openly and the authority in-role allowing the general practitioner to take-up specific tasks as responsibilities. But this does not necessarily transfer to include end-of-life planning. These general practitioners describe the importance of the doctor-patient relationship,

The most important thing to me is the relationship between the doctor and the patient; rather than the offering of medical technology and pharmaceuticals. [I:2]

and

They trust me to do what is right for them. It is a matter of getting used to seeing one person. They have been with one person for a long time; the continuity of care and the relationship. [I:5]

and

The ability to trust somebody and be with that person in a full and meaningful way. The value for the person is to speak what is inside. The therapeutic outcome of being able to understand their own issues and being able to work with them. [I:7]

and

Having the type of relationship and being able to say to a patient, I do not know the answer to that but we can explore it together. The basic thing is to help. [I:8]

and

Even though you may not have a great relationship with them, I think you still care for them. In that general sense, you still put in your 100% for them. That’s your job to care for them; that’s the role of the doctor. [I:8]

and

In the normal relationship, there is honesty, trust and faith in what you say. A lot of knowledge over a number of years - the things, the sort of standard things, the old-fashioned things that are important for the elderly. They will talk to you about things that they will not talk to a lot of other people. I am not afraid of it. I am quite open. I see it as part of looking after them. I see it is another issue, as part of their medical management. But I am like the corner milk-bar I am a disappearing entity. [I:11]
The importance of the doctor-patient relationship which brings a sense of care, with trust, openness, honesty and continuity is stressed for the work of General Practice (9/13). Humanistic values add to the ability of the general practitioner to converse with the patient about difficult emotional issues. The doctor is then able to focus upon the needs of the patient whilst remaining authentic and empathetic; perhaps, working with subjectivity and projective identification in a depressive stance. A few practitioners (4/13), mainly female, acknowledge the importance of accessing their own feelings to develop a greater understanding of what is occurring for the patient. These practitioners have taken the responsibility to formally train in areas of counselling and family therapy recognizing and using intersubjectivity, using the transferential projections of their patient and the countertransference as data.

I realized that I needed to get in touch with my feelings and to be able to communicate using my feelings. [I:13]

During the interviews, it is possible to identify general practitioners who are able to work with their emotional and cognitive capacities. Below is data from general practitioners who recognize and manage the interpersonal emotional intensity; being present with the patient in a cognitive and emotional capacity. The role-idea of the general practitioner here is a person who can listen and communicate with his/her patient whilst being respectful, acknowledging diversity and being empathetic.

It is not easy but somebody has got to create a real picture for the patient and the best person is the general practitioner. [I:4]

and

I think you need to tell people the truth. If you tell people the truth as you see it you cannot do much more. Say simply what you think; people will be more comfortable with that. It seems very easy to say! You do not have to beat around the bush with people or tread lightly, or go behind their backs. I am open with my patients. [I:5]
The way I have handled nasty information is to go around to their house; they know if I come there is something wrong. So if I have a report that they have metastatic cancer from an xray, I will go around; they will know. They will say ‘come in, there is some bad news isn’t there’. I go to their home because I feel more comfortable than them coming in here in the middle of the day, sitting there and then confronting them with bad information, and then going home. It creates disequilibrium and not the right timing. You have a bit more time to talk with them as well. [I:11]

The doctor-patient relationship described in these quotations is able to provide a safe transitional space for the doctor and patient to work. For the doctor, managing in-role contains the emotional experience present allowing him/her to use medical expertise and personal experiential capacity in fulfilling the task and discussing issues of significance. The general practitioner recognizes the extraordinary difficulty of the conversation, the anxiety and uncertainty that it may arouse. But by being mindful of the patient, known through the doctor-patient relationship, and respecting the patient’s personal autonomy and authority, s/he is able to speak honestly with the patient.

The communicative space of end-of-life planning develops an intensity that resonates for the doctor, the patient and the family. Few practitioners (4/13) feel able to contain the feelings and communicate in this space. The research data communicate explicitly some of the difficulties. If emotionally explicit areas are broached there is a defensive need; often justified as being respectful of diversity, for the communication to remain emotionally detached and impersonal. This inhibits the capacity to deepen the conversation to explore feelings.

If you dread certain work, the need for it may miss the role-idea completely.89

In the immediate context of the doctor-patient relationship the general practitioner may collude with the patient to perpetuate defensive mechanisms that alleviate anxiety and thus either corrupt or avoid the task of end-of-life planning.
The following quotations depict some defensive mechanisms that are used to avoid or evade the conversation, to defy death, to continue with the status quo. Although there is recognition of the importance of end-of-life planning, the task is declined, deferred to another conversation or deflected to another person. It may miss the role-idea completely. The interview data acknowledges an inability to contain the anxiety present in the transitional space of the doctor-patient relationship. The ego maturity required to work in the depressive position to contain both self and the patient is not manifest.

It is the core issue, isn't it! It's making me feel uncomfortable, facing their death before its time. I feel the discomfort and let the time go by. If they have not expressed a need for that sort of discussion for me to raise it is presumptuous.

There are many ways to dodge this discussion. [I:2]

and

It has to be the right person. This process does not have to remain in the domain of the general practitioner. It just has to be the appropriate person for the patient and the family, someone who has a relationship with the patient and the family. [I:2]

and

What remains for me is the fear in having the conversation as well as what the conversation will uncover. I have not been involved in end-of-life planning, I would not bring it up. I would not encourage that discussion. What, before they reach the stage that they can see a finite time for themselves? [I:3]

and

There are a lot of people out there that just do not talk. When something is wrong they say send him off to Hospital. It usually is the well meaning interventionalist who comes in and does not know the situation who comes in and says lets do something and mucks up things for everybody. [I:5]

Four of the thirteen practitioners appear to have a capacity to engage in the task of end-of-life planning and are able to take-up the authority in role to fulfil task-related
work. These general practitioners, in managing in role, state that they retain an emotional connectedness, internally and externally, and work with the emotional experience while focusing on the patient’s requirements. They are able to make available to the patient and their relatives the medical, technical and emotional expertise to assist in collaborative decision-making that respects the patient’s autonomy.

I am really good at dealing with the common man on a level that they understand, a good communicator because they understand what I am talking about. [I:4]

and

If you get them together and talk with them all and they get the same information it makes it easier. With all ethnic groups it is much better to talk with everybody. It is much better to talk to the family and the patient together. [I:5]

and

The majority of people I see would prefer to die at home or where they live or in a nursing home, and die there comfortably, reasonably without crisis intervention. There is no absence of discussion in these circumstances. I know if someone is going to die or if they have had a catastrophic event I will talk with people about it and say, ‘This is what is going to happen. This is what you can and cannot do. This is my opinion, on what you should do.’ [I:5]

and

I do not see any ethical issues because single-mindedly as a doctor you are there to serve the patient. There are some curly decisions to be made sometimes but I tend to negotiate everything through with the patient and the family, so it is an on-going negotiation. I hope that one acts with good ethical standards, and then negotiates so that everyone is going in the same direction. [I:8]

The ability to be with the patient in the emotional experience of the here and now is communicated in this interview. These conversations just happen in time. I do not have a formal process, it is part of knowing the patient. [I:11]
The primary process, the emotional task of the general practitioner in fulfilling the primary task of comprehensive health care involves managing the uncertainty and the distress around a disease process. In the setting of end-of-life planning it implies working on an emotional edge, facing a taboo - death. If the emotional experience of distress is not managed defensive behaviours directed at keeping the distress at bay will become operative. These include avoidance of thought, denial of the disease or a sense of omnipotence that the disease can be cured. In managing in role the emotional experience is acknowledged as a conscious process and articulated. It is brought from the unthought known position of the emotional repertoire to the position of a thought known where its importance can be considered in the decision-making processes.

7.7 Personal factors influencing the person-in-role
The capacity to manage oneself in role is of importance when dealing with tasks which have profound personal, organizational and societal dynamics that may undermine the task intention of the person-in-role.

> Until the containing functions have been introjected, the concept of a space within the self cannot arise.

In taking up the authority of role, at a fundamental level the role-holder requires self-awareness and capacity to contain the anxieties associated with engaging in the responsibilities of the role-tasks and role-boundaries in the performance of role. The personal commitment to be with the emotional experience present at the interface of the doctor-patient relationship, in the transitional space, is significant for the role-holder. There is acknowledgement by the general practitioners generally that these conversations are difficult and anxiety provoking, with several practitioners (7/13) recognizing a sensation of impending doom. The focus of the conversation remains the welfare of the patient, and a critical aspect for the practitioner is an ability to converse as part of managing in role.
Personal attributes and attitudes of the general practitioner are explicit in the interview data while discussing end-of-life planning. In colluding with personal, group, and societal defences, the conversation about dying and death is avoided. Of personal importance is survival, to block out death and in so doing block out the fullness of living. The defensive need in society is to avoid the reality of death and in so doing avoid the emotional contact and connection with the emotional pain, feeling the pending separation and loss.

It seems that the intent is to: Deny the inevitable! Just survive, live a lie! The paradox is that in defending against emotional contact with the impending death of a loved one, the defensive behaviour, the lie is itself a deadening experience. The responsibility in role is to communicate with empathy, clarity and honesty in the doctor-patient relationship, whilst working from a depressive stance to contain the fears present in the space. The responsibility is not to evade the difficult tasks but to be with the patient through this time.

The following general practitioner recognizes that some peers do not have the maturity and corrupt the task.

The doctor needs to be a realist, not to provide false hope, bullshit, they are still told bullshit. May be it is an abrogation of responsibility, maybe they are scared of their own mortality. They are too scared something is going to happen to them. It is someone else’s job to tell the bad news, a sign of immaturity.

This is not an easy conversation. The relationship is often longstanding and significant anxiety is present in the countertransference. The focus of the task is the patient and his/her care. The emphasis for the doctor could be intersubjectivity, being with the patient in empathy and honesty. In managing in role the emphasis should be to treat the patient with dignity and respect, honouring his/her thoughts and feelings in fulfilling the task of continuity of care.
The emotional commitment of the general practitioner to fulfil the task of end-of-life planning is palpable in these quotations.

It is not easy to have this conversation, but it would be uncommon for you to be saying something that you have not known for years - familiarity with the patient and they expect you to be honest and straight. If you were not honest, you would lose their trust. It is also treating the patient with respect and respecting their intelligence. [I:4]

and

If I think I have done the right thing, fine, I can look back with a clear conscience. If I think I have done the right thing by the person, then it cannot make me feel anything else but fine, sad sometimes. I miss a lot of people, and feel sad every now and again when I think back about all the people I have looked after. I miss them, I have known them well. [I:5]

and

You need to deal with the emotional aspect of your own issues related to the diagnosis of cancer in your patient before you can be available to your patient: dealing with our own stuff in the first instance, before you can redevelop your connection and relationship with your patient. [I:7]

and

In General Practice I have looked after many people who were dying or who have died and the importance of relationship in this situation is significant. [I:8]

and

All you can do is live a good life. A sense of cosmic consciousness; to contribute something to the world. Your health is to do with your spiritual understanding and a deep respect. [He acknowledges his space by saying] 'It is time to retire, I am getting old, these issues are touching me.' [I:11]

and

I tend to be fairly straightforward, so I am happy to discuss it all, I am very open and very frank. I will talk with them if they want to talk. I will put it back to the family if that is how they want to handle it. [I:11]
The conversation with a patient and their family is emotionally demanding, but respect for the patient, honesty and sincerity are important. Reflecting on these patient circumstances informs the general practitioners of the significance and importance of connectedness through the doctor-patient relationship.

Some general practitioners (7/13) acknowledge their inability to fulfil the task of end-of-life planning. The following data epitomize conversations with the practitioner and convey the implicit and explicit fears and anxieties involved in contemplating the conversation. It appears that, for these general practitioners end-of-life planning is an unknown known. Death is known but put out of mind. There is an unwillingness to acknowledge death. The conversations during the research interviews communicate the inability to contain the overt feelings of discomfort and distress. Even the interview 'makes me feel uncomfortable thinking about it'.

The same general practitioners (7/13) are empathic and caring of their patient but unable to contain the anxiety involved to end-of-life plan. The morbid nature of a conversation admitting to the potential for death in the setting of a chronic illness is not conceivable. It is acknowledged during the interview that defensive behaviour will be employed, consciously or unconsciously, 'there are many ways to avoid this communication'. The general practitioner 'does not have to be the person involved but it has to be the right person, someone with a relationship with the patient and the family'. General practitioners (9/13) recognize that they have not thought about the continuity of care aspect of the disease and its prognosis and extended this through to dying, death and end-of-life planning. They have limited their thoughts and feelings and therefore the conversation.

Even receiving this information before having a talk together I recognize how fundamental this work is. I do not do this work. I do not have a systematic process to do this work. [I:1]

and

I don't know. It feels morbid to have this conversation when a person has a chronic illness. I don't know how to time this conversation. With terminal illness, it is easier
because the conversation is under the umbrella of the terminal illness. This gives me permission to have the conversation. When illness is chronic it is very difficult. The possibilities can be explored but it is more difficult. Things can change. It feels like being morbid, dealing with death. [I:1]

and

It is just the discomfort, the tentativeness around, about offending or broaching a subject that might cause fear or distress in the person, having to negotiate those issues, of doing it prematurely before they are ready. The time is not right, advancing their fear about the future. [I:2]

There are alternative ways to avoid and/or corrupt the task of end-of-life planning that allow both the general practitioner and others involved to maintain the status quo. In this, they are fulfilling a functional role; a role consistent with their role-idea in the management of the patient. The role-idea unconsciously filters information to meet the defenses required and determining the actions perceived relevant to role.

I use my hypnotherapy skills, time distortion, pain and anger management and to alleviate the distress of over-grieving, and enable the Anglo-Saxon to let go. [I:6]

and

There are words that have strong emotive value, cancer, I don't use this word unless the person is comfortable with it, I use growth, condition, malignancy. Death has a final, oh my gawd, reaction from many people. So, I talk about serious things, you probably only have a certain length of time, why give them an emotional shock. Unless some patients are ready to have that word thrown at them, a lot of them feel uncomfortable about it and I feel uncomfortable about using something that is so final. [I:6]

For this practitioner in this setting, a communication style that combines euphemisms and hypnotherapy to manage the emotional content of the work in role is used. This enables a communication that distorts the senses of pain, grief, anger and time; including the existential finitude of death.
This following quote is from a general practitioner who has been caring for an elderly lady with her elderly neighbourhood friends for many years. The practitioner is aware of her end-of-life plans but she is admitted to a private hospital far removed from her home environment. The outcome is that her carers, her counsel and her community are also removed from her. The practitioner is unable to influence her continuing care. Her planning wishes are ignored. It appears that someone else has a plan which can rescue her and defy death.\(^{105}\)

I have a 96 year old lady in a private hospital, I have rung 3-4 times saying send her home and her friends and I can manage her end-of-life at home, the answer is no. At some stage someone thinks they know better than someone who has been looking after her for 10-15 years, but they do not see the big picture. It is sad for this old lady. [I:5]

The humanistic values communicated by some general practitioners interviewed for this research project seem insufficient to enable them to pursue a task of continued care that involves end-of-life planning in role (9/13). For these practitioners, crises intervene and their patient is transferred to the community hospital.

7.8 Working Hypothesis

The general practitioner does not take up the authority in role to fulfil the task of end-of-life planning because the emotional experience present in the encounter creates intense anxiety about his/her being unable to contain the vulnerability.

The working hypothesis is constructed from the analysis of the data relating to how the practitioner perceives the role of General Practitioner.

The fulfilment of role is influenced by societal, contextual and personal experiences which evolve a conscious and unconscious collusion for the person-in-role.\(^{106}\) The majority of practitioners do not take up the task of end-of-life planning as part of
role because confronting the terminal nature of death, as stated during the interviews, may be associated with 'an emotional shock'. It 'might cause fear or distress in the person'. The fear seems to be that their patients' emotional vulnerability may not be containable.

7.9 Contextual and societal influences on the role-taken
The research project reviews the role of the general practitioner in the context of end-of-life planning in a medical and social context that s/he recognizes is defensive about conversations relating to dying and death. A parallel process occurs between the conscious and unconscious contribution of the individual to the role and the expectations of the medical and social community. Simplistically, cognitive and emotional contemplation about dying and death are avoided by the system. As part of this, the doctor will unconsciously avoid a conversation about death. The ego maturity of the doctor in taking-up the role will influence the defensive processes employed. The ambient culture of the system has a substantial unconscious and at times conscious contribution to the behaviours of the person-in-role through task requirement, expectation and the stressors associated with role.

There are powerful forces shaping behaviour ... that have little to do with rational task and purpose but arise from the irrational sources of meaning that exist in group norms and psychodynamic underpinnings of people's connection to their organization.107

The medical fraternity is faced with extraordinary theoretical, technical and therapeutic interventions that have changed the face of the practice of medicine. Interactive technological changes available to society enable the patient of today to have a greater awareness of the potential practices available for the management of a disease process without the expertise to differentiate what is appropriate care. The medical system is continually being questioned because of the irrational expectation that death can be avoided.
Change is occurring. People feel more confident to ask questions. There is better information and access to information. There is greater technology and more choices in treatment and a greater ability to deal with complexity. [I:1]

and

It may be so obvious but I don't think as doctors we are trained at all to accept that we can't cure everyone and we can't fix everyone. There is a fear of failure so we don't want to discuss it either, because we are then owning our own failure. [I:7]

How does the general practitioner maintain a leadership role in an ever changing environment where the provider-customer rationale implies catering to the needs of the customer which may involve colluding with these needs and those of society? 108,109

7.10  Leadership capacity in-Role

The role of general practitioner is a leadership role within the community. The position holds the responsibility to provide healthcare guidance for members of the community. But does the general practitioner take up the task of General Practice with the authority designated? The role given is credentialed and authorized by the governing body of the RACGP. The role is taken-up by the practitioner who has the medical and technical skills to fulfil the appointed position. The research data also demonstrate that the general practitioner who manages in role acknowledges the feelings present in the consultation and the importance of working with his/her feelings which creates a greater understanding of the patient. By staying in role there is congruence between the role-idea, and working with the resources present that enables the task of end-of-life planning. The individual in contact with his/her own feelings pays attention to the emotional experience present in the transitional space of the doctor-patient relationship. In working with the patient in a trusting empathic relationship, both the doctor and the patient, even though the anxieties involved in the task are intense, are able to work creatively together to fulfil the requirements of the patient.
It is important to acknowledge strong emotions that come up in these discussions. Whether the strong emotion is anger, anxiety, or sadness, it is useful for the clinician to acknowledge the emotion in a way that allows the person with the emotion to talk about why they feel that way.\textsuperscript{110}

To end-of-life plan with a patient and their family, the general practitioner needs to be in contact with his/her own emotional experience and existential finitude. If the general practitioner is able to manage in role and pay attention to the emotional experience within the transitional space of the group, s/he may assist the patient to contain the intense vulnerability present and work with his/her own dying to make significant choices about medical and social management.

Physicians themselves must listen and learn; accept their own mortality; be compassionate, honest and 'present' to their patients.\textsuperscript{111}

The containment created by the doctor in focusing on the task of end-of-life planning and managing in role enables role-holders, the patient, the family members and the doctor to explore the gap between their inner and outer realities. Through managing in role and containing the vulnerability of the emotional experience, the general practitioner enables role-to-role engagement, a doctor-patient relatedness with communication that brings the medical, psychological and spiritual integration to the task. The trust and openness in the relationship makes possible end-of-life planning for the patient with the doctor.

General practitioners who end-of-life plan with their patients are in the minority (3/13). How might the general practitioner who has not developed the capacity to manage in role be assisted? Could this occur through education, the development of a transitional object, a process, or a team approach? From Armstrong,
The available repertoire of reflected experience which the client can draw on in thinking through these dilemmas and challenges from the perspective of his or her own role: assessing risk, foreshadowing responses, modulating actions, communicating goals, containing anxieties, releasing energies.112

The next chapter will approach the topic of education for end-of-life planning.


27 Lawrence WG. Management Development...some ideals, images and realities. In: A.D. Coleman, & M.H. Geller, eds. USA: A.K Rice Institute, Group Relations Reader2, 1985: p. 236.


52 Lasch C. Culture of Narcissism. USA: W.W. Norton & Company, 1991


269
83 Swick H. et al. Teaching Professionalism in Undergraduate Medical Education. JAMA, 1999;282:830-832.
   www.psychematters.com/papers/benjamin.htm
8 EDUCATION

The need for physician training in the conscious recognition of their emotions is based on the professional obligation to care for the sick.¹

Meier et al recognize the necessity for the conscious recognition of personal emotional experience in medical education. But attention to and interpretation of the emotional experience within self and within the workplace is not a form of learning regularly taken up by the medical faculty as part of the training for leadership and management for the general practitioner.² ³ As written by Clode and Boldero:

The need to better equip medical practitioners to deal with the emotional stresses of their work has long been recognised, but is often poorly addressed.⁴

This chapter of the current research thesis considers the effectiveness of the medical education system in preparing general practitioners to take up the authority of role in complex communication issues and emotional tasks such as end-of-life planning. This formal education is compared with the general practitioner's perception of personal experiential life-learning.

The chapter commences with a recapitulation of the responsibilities of the general practitioner in role. It then considers the relevance of identifying and working with emotional responses, the conscious and unconscious defensive processes with their emotional implications in the doctor-patient relationship. A working hypothesis synthesizes the concepts drawn from the interview data in my research. The hypothesis is substantiated with excerpts from the interviews which are discussed using theoretical and experiential perspectives in the attainment of knowledge in the practice of medicine. The final segment reassesses data derived from the interviews to elaborate on Revans’ concept of action learning and the doctor-patient relationship in the 'here and now'.⁵
8.1 Preamble

The question asked in this chapter is: are general practitioners prepared for the intensity of their tasks through medical education? As stated by Clode:

Medical training appears to be a particularly stressful process, not just because of the academic demands, but because of the lack of emphasis on interpersonal and communication skills among students and their teachers. Absence of interpersonal support not only has a negative emotional effect on students, but may fail to provide them with necessary emotional skills for their subsequent medical practice and self care.6

What does General Practice require of a person in the role of general practitioner? The primary task of the general practitioner is addressed in Chapter 5 and is inclusive of all facets of healthcare, spanning from paediatric to geriatric ages, drawing on biomedical, psychological, social and environmental understandings of health.7 The person-in-role, as discussed in Chapter 7, brings theoretical knowledge, technical skills and personal lived-experience to the role, to support the task. But do the general practitioners use their emotional resources and lived-experience in role as a diagnostic instrument? To do so involves a combination of medical knowledge, intuition and judgement, the art of medicine. Novack et al recognize the relevance of:

Physicians [using] themselves as instruments of diagnosis and therapy, personal awareness can help them to 'calibrate their instruments' using them more effectively in these capacities ... [for] insight into how one's life experiences and emotional make-up affect one's interactions with patients, families, and other professionals.8

Dealing with critical and chronic medical illness and emotional distress remains a part of the role of general practitioners. Through daily lived-experience they develop relationships with patients. The continuing care of patients involves the responsibility
to communicate significant, emotionally-demanding information. Communication may involve discussing the diagnosis of breast cancer with a woman; the deterioration to terminal respiratory failure for a chronic asthmatic patient and the recognition that an elderly patient has progressed from independent living to requiring residential care. Each of these conversations, in an ideal setting, requires the general practitioner to be present for the patient; in communicating the diagnosis, in recognizing the patient's feelings, and in working with the specific personal implications involved. As Meier et al state:

Physicians work daily with patients and families struggling through devastating illness and loss. That such work has an emotional impact on health professionals is indisputable. Because feelings influence behaviour and decisions, it is necessary for physicians to learn to identify and assess their feelings consciously.9

If general practitioners do not identify and work through the emotional dilemmas that impact on their daily work, these feelings may impact upon their behaviour, actions and decision-making.10

In society today the breaking of bad news about health remains almost exclusively a medical responsibility.11 How does the medical or societal education prepare general practitioners for this and the task of end-of-life planning? To what extent do these arenas both unconsciously collude to disable the practitioner? Menzies Lyth states:

When societal pressures against realistic task-definition are too great ... task may implicitly slip over into anti-task; the education system not being realistically orientated to maturation and preparedness for life in society.12

Bolas13 in his work with autistic children speaks of the language-less world wherein the child lodges himself in the other through a transferential process. Does the general practitioner, knowing the character of the patient through the patient's
transference, feel for the patient, but being unable to think about these feelings, sit silently with them? In a similar way, society casts its shadow on general practitioners without their consciously processing its affect and as a consequence they collude with the societal anxieties and sit with, or deny them. For society's shadow falls across the ego leaving a trace of its modes, values and feelings in each of us especially in relation to the fear of death and consequent denial of death.

Death silences. This includes silencing the general practitioner as a member of society. If the individual understands the processes occurring there is the potential to work with the emotional experience in fulfilling the role.

If the individual citizen has a fuller understanding of the processes operating in society of which he is a part then he will learn to manage himself in his own roles with greater maturity.14

But how does a general practitioner develop a fuller understanding of the conscious and unconscious processes operating internally and externally which affect and effect decision-making and allow them to evade the fullness of their role? Moreover, how does s/he learn to manage in role and perform the task of end-of-life planning?

While the medical student is bombarded with significant advances in medical diagnostics, therapeutics and intervention, often via technology rather than the human interface, there is insufficient training in interpersonal and communication skills. While the medical interview remains a major determinant of the accuracy and completeness of patient data, medical education and medical practice is becoming increasingly theoretical and technical at the clinical interface. The implication is that investigative procedures are used as diagnostic tools rather than as an aid to clinical acumen.15 The following quotation by Fallowfield et al concludes that inadequate communication skills hamper the professional performance of practicing oncologists.
Poor communication results in faulty clinical data, worsened clinical and psychosocial outcomes, and greater likelihood of litigation.\textsuperscript{16} Even so, medical schools and specialty colleges appear to be slow to respond to the recommendations of maximizing interpersonal and communication skills. The focus of education remains the 'rational and biological issues of health' while continuing to neglect the 'intuitive and emotional aspects'.\textsuperscript{17}

Medical training appears to be a particularly stressful process, not just because of academic demands, but because of the lack of emphasis on interpersonal and communication skills among students and their teachers.\textsuperscript{18}

Perhaps the modernist dynamic of a provider/consumer based medicine is at play where the supposition of the enlightened consumer becomes an alternative focus.\textsuperscript{19} Yet this is a distraction for the educationalist because the rationale is that the consumer is informed. Fear of litigation is also promulgated by media and society with the emphasis of evidence-based medicine and an adversarial system.\textsuperscript{20} Where does the patient, the medical student or the doctor fit into this complex conundrum? The vulnerable patient with intricate needs and values is lost in the mechanized system. This is the person who attends the doctor's surgery.\textsuperscript{21} In medical school nobody tells you that you are not treating a disease. You are treating a person who has come to you with a problem.\textsuperscript{22}

\section*{8.2 Working Hypothesis}

The following working hypothesis is proposed.

\textit{Because the course of undergraduate medical education and postgraduate placement does not adequately prepare general}
practitioners with interpersonal and communication skills; emotional issues like end-of-life planning may not be addressed.

This hypothesis is generated from the data of the interviews and gives a précis on how general practitioners view this topic. During the general practitioner interviews the overwhelming emphasis remains on the limited opportunity in undergraduate and postgraduate education to develop interpersonal skills involved in communication with patients. Correspondingly there is limited awareness of conscious and unconscious personal emotional responses and the information available from this source and its potential impact on the doctor-patient relationship.

Most nonpsychiatrists are not trained to use identification of the emotions generated in clinical encounters as therapeutic information.23

General practitioners (5/13) uncommonly recognize the importance of self-awareness and emotional maturity in contributing to the effectiveness of patient-care.

Becoming a mother changed the way I understood the practice of medicine. Intuition can be as powerful a diagnostic agent as a battery of expensive medical investigations.24

There is limited conscious recognition (2/13) that the doctor uses personal life-experiences and emotional resources in communicating with the patient as tacit information in diagnosis and decision-making. S/he does however consciously acknowledge the importance of the values of empathy, compassion, respect and honesty (10/13).

Interpersonal and communication skills considered essential by a general practitioner involved in end-of-life planning would involve the following.

Education needs to be about: family processes, basic counselling skills, understanding family structure and the significance of death in the family, enablers and disablers of conversation within families around death, active listening. To do it properly it will
take more than a simple educational package about the Medical Treatment Act and the way to document it. It is general education around communication. [I:2]

William Osler would agree with the above interview excerpt believing that the greatest contribution to the care of a patient comes with an accurate history and a careful physical examination 'by the bedside'. The information is brought together at the bedside with thoughtful and insightful communication. These findings together with an extensive knowledge of medical facts correctly appraised can lead to appropriate investigation to confirm a diagnosis. Osler stated in the eighteenth century,

\[ \text{Medicine is learned by the bedside ... not in a classroom.}^{25} \]

The intense theoretical commitment to learning in medicine today surpasses any acknowledgement of the necessity for experiential learning.

\section*{8.3 Theoretical Knowledge}

Medical knowledge advances exponentially. The emphasis in practice for modern medicine becomes theoretical knowledge, technical intervention followed by curative therapeutic and/or procedural management for the disease process. The development of interpersonal and communication skills to facilitate the relationship between the doctor and the patient have lost their ascendancy and become of subsidiary importance, while skilled, intellectual, analytical work occurs with fervour. The patient brings the disease: the emphasis is the disease. In the setting professionalism with depersonalization is paramount, and the emotional contribution to the interplay of symptoms and disease is lost to intellectualization. In Australia, the education of the undergraduate and postgraduate student of medicine follows this trend.\textsuperscript{26} A general practitioner claims that:

\[ \text{Clinical and technical issues can be broached but not the other mindful issues. [I:2]} \]

\[ \text{There is now a danger that it has become so technical that it has ceased to bear all the relation it should to the here and now immediacy of demanding tasks.}^{27} \]
Balint, at the time of his work with general practitioners in 1964, recognized that limited training occurred to assist these practitioners develop a therapeutic doctor-patient relationship which enabled exploration of emotional issues and assisted with diagnostic acumen. By developing an awareness of the psychological issues, listening and taking heed of the transference and the countertransference the doctor is able to not only assist the patient but also develops the ability to listen to himself. Balint’s conclusion was:

> Although the need for a better understanding of psychological problems and for more therapeutic skill is keenly felt by many a practitioner, they are reluctant to accept professional responsibility in this respect.

Little has changed. Medical education remains hierarchical, academic and competitive with little emphasis upon the development of interpersonal and communication skills. Consistent with this, Schofield et al in their research paper discuss the communication between the doctor and the patient at the time of transition from curative to palliative care. They find that there is a paucity of scientific research relating to managing this transition. Their extensive database search between (1990 - 2005) finds 57 articles. Five (5) of these articles involve randomised controlled trials and only one relates to palliative care. There is also recognition in the group of researchers that the medical education system does not attend to ‘mindful practice’, where the practitioner uses the science and art of medicine to the advantage of patient-focused care.

Gordon in researching the Australian medical education system says,

> The psychological wellbeing of ... medical graduates found that rates of emotional exhaustion and depersonalisation rose significantly during the intern year.
Nowhere is the deficiency in medical education felt more than in hospitals. The hospital’s environment of fleeting interpersonal relationships diminishes the crucial nature of patient-based information. The task of communicating intense emotional information is often delegated to junior medical personnel, who are left feeling frustrated and disillusioned; the most difficult task. Communicating life and death issues is often side-stepped by senior staff; the responsibility is allocated to the most junior member of the team who appears unable to question this delegation of role.

There was no training in my undergraduate education about communicating issues of significance. I started my medical career as a child and blundered along making some terrible mistakes on the way in talking with people. There was no learning in the hospital environment either. I would be told to go off and tell a patient and their family a diagnosis without any guidance or mentoring about how to give such significant information. I remember being the designated person to speak with a patient and family in a neurosurgical rotation. I recall feeling distant and removed from them in my communication. At other times I recognized when I had blundered because people recoiled from the conversation or changed the subject. [I:13]

The intensity involved in communicating is acknowledged, but the question of how to support another peer during the process remains unanswered. Avoid or persecute? An interviewee recounts an incident,

It was in the Hospital environment, as a junior house officer that I was first exposed by a Consultant to a conversation with a patient about the need to prepare herself for her death and to discuss this with her family. This was very moving and I left the room. The Registrar later stated that I was impolite and inappropriate to leave the room and my inability to cope with the emotional content of the conversation was a personal failure. The Consultant did not approach me after the conversation. [I:3]

General practitioners have little supported training in undergraduate or postgraduate years to realize a communication style that is personal and authentic. There is little opportunity to develop an approach that recognizes the patient as the focus of the
relationship or facilitates a cooperative learning environment in the transitional space, in the here and now. Little time is spent in education in developing an approach that respects the autonomy of the patient, honours personal authority and encourages informed choice with involvement in decision-making. The political/economic emphasis in modern medicine is cost containment and the clinical emphasis on fighting the disease. Communication is diagnostically posed, problem-based and solution driven with negligible emphasis on interpersonal and listening skills or the social or emotional impact of illness. For the medical student, the junior medical staff member and the patient there is little acknowledgement of contextual or cultural diversity. In the teaching environment the student and the patient are often treated alike as in a mechanized system. Emotional understanding is regarded as indulgent and disparaged; perhaps because of the uncertainty it brings.

For postgraduate GPs, this is an important component of the work; it needs to be focused upon. It could be part of the Continuous Practice Development. [I:1]

and

Medical School did not provide the environment for learning to discuss issues of significance; doctors were mass-produced. There was no acknowledgement of difference in the individual student; let alone the diversity in patients. [I:3]

and

The diagnosis could be found in the history; so the communication had a problem-orientated focus, solution driven, with no emphasis on the importance of relationship. No skills were stressed or taught, like reflective listening. The emphasis was on decision-making and problem solving. [I:7]

and

I hated the traditional medical training. I feel my learning began once I left medical school. I struggled with it, we were sausages pre-designed. I hated Medicine I wished I had never got into it; it was rote learning, no creative or lateral thinking, I was quite angry about it. I can use my own qualities in General Practice. [I:3 ]

and
For new graduates this is fundamental, as fundamental as communication is to the practice of medicine. Everyone in their practice will deal with death and dying. It is more important than much of the other theory. [I:1]

and

In postgraduate training we had a mentor process that was mandated. This was not effective. Un-officially I self-selected with the recognition that I related to certain people better than others. It happens by accident; difficult to encapsulate in words what occurs. There is some form of identification; a philosophical system, beliefs, respect, a style of work, the way they communicate, their actions, often just a feeling. [I:10]

Communicating issues of significance like terminal illness, dying, death and end-of-life planning highlights that universal cure is a myth and significantly increases the difficulty imposed on general practitioners. General practitioners who are left to deal with the personal failure of inability to cure avoid the conversation.

I don’t think as doctors we are trained at all to accept that we can’t cure everyone and we can’t fix everyone. There is a fear of failure, so we don’t want to discuss it either, because we then own our own failure. A ‘never say die’ attitude; something might come up; a new drug might be invented. [I:7]

Du Boulay, biographer of Cicely Saunders, founder of London’s first hospice says:

> Medicine was about cure, if they couldn’t cure doctors felt they had failed. It was about having the answers, they had no answers for the dying. Doctors did not see it as their job to ease the process of dying beyond prescribing pain-killing drugs; as far as possible they avoided dying patients, embarrassed by what they saw as failure.\(^{37}\)

### 8.4 Experiential Learning

Menzies Lyth described how her research broadened her understanding and view of life and therefore her appreciation of ‘how ordinary people feel and behave in their
ordinary work and personal lives'.38 In bringing their own beliefs and opinions which influence their attitude and actions, people can explore the basis of personal ideologies and together create an environment for experiential learning.

Our lived experience, or that of close friends and relatives, is probably one of the most valuable resources, helping us to a more immediate understanding of human illness than any medical textbook, or even a study of a narrative, can do.39

On the one hand there is adequate theoretical and didactic education. On the other hand, analysis of the research interviews indicates there has been limited endeavour to develop a dynamic experiential model for learning in undergraduate or postgraduate medical education especially in areas of interpersonal and communication skills.40

There is potential for experiential learning, but how does an individual develop self-awareness and a reflective capacity? Is the capacity to recognize and manage conscious and unconscious processes related to life-experience, maturity or a way of being in the world with insight and intuition? General practitioners (6/13), state that personal life-learning and postgraduate experiential learning are significant arenas for acquiring understanding of the lived experience. It is this personal learning that has become the foundation for their interpersonal and communication skills. They state that this learning occurs within the family setting or in postgraduate rotations. In both situations the individual and the context aids in the learning and development of self-awareness and a reflective capacity.

Learning these skills is a matter of on-the-job training for most caregivers.41

Most of this personal training is derived from experiences that impact them directly. Life comes back to, maybe it's because we had a SIDS death. [I:11]

[From a place of defensive behaviour with depersonalization as he retained his aloofness, I felt him move to a space of self-awareness and sensitivity as he spoke of
his personal learning in association with the sudden death of his own baby. His mien changed.]

and

My attitude is informed by my family experience and my family's experience with death. [I:2]

and

I learned by experience, through my own life experience. I was a child when I began as a hospital intern, I became a mother and ... realized that I needed to get in touch with my feelings, to be able to communicate using my feelings. I promised myself psychotherapy or a similar process. It helped me to recognize the importance of communicating. [I:13]

and

A rotation as senior resident staff on the Oncology ward was invaluable to my learning, as the patients and their families often learn how to deal with the diagnosis of cancer. [I:11]

and

Prior to graduation there was no training or learning but I spent 6 yrs in hospital training and a year of this as a Psychiatry Registrar. I got used to talking with people about personal problems and problems that they would not normally talk to people about. [I:5]

Personal life tragedies; family encounters with death; postgraduate medical rotations that explored intrapsychic dimensions requiring personal integration, interpretation and reflection: all required a reflective capacity to attain personal understanding and aid the development of interpersonal skills.

The main enablers are personal experience and personal maturity. The older you are the more likely that you will have had experiences that inform your practice. [I:2]

Winnicott describes a social space that allows play, creativity and innovative thinking, an unrestricted space that allows imagination and innovation to intermingle with fantasy and illusion without limiting thoughts and perception. Here interplay
between internal and external reality achieves meaning in life. There could be a place where the practitioner could work with thoughts and feelings to create understanding and meaning. The practitioner in role would then have the potential to recognize transferential projections and the countertransference. Armstrong calls this ‘work in progress’.

The available repertoire of reflected experience that the client can draw on in thinking through these dilemmas and challenges from the perspective of his or her own role – assessing risks, foreshadowing responses, modulating actions, communicating goals, containing anxieties, releasing energies. Work in progress.\textsuperscript{43}

These general practitioners consider that context, life experiences, intuition and self-awareness are life’s teachers.

Maybe it is life’s experiences that are the teacher: the desire to live a good life, a sense of cosmic consciousness, a wish to contribute something to the world. My health is to do with my spiritual understanding and a deep respect for humanity. Perhaps it is time to retire, these issues are touching me. [I:11]

and

An evolving process as I have matured. Australian attitudes have not shaped my attitudes. Personal and professional experiences and learning from how other people coped with death, professionals as well as other people, how they cope with death. A huge amount to learn from other people. We continue to learn from our patients. [I:3]

and

My son, who is five years old, is afraid of hospitals, he visits his grandfather who has a cancer and is admitted for treatment. We have never talked about dying or death but he seems to be aware that his grandfather is getting older, and also intuitively illness is something to fear. [I:10]
Often children catch from us a sense of deep fear and anxiety - perhaps the shocking recognition that the adults in their lives are afraid of the subject of death itself.\textsuperscript{44}

This child picks up the unconscious feelings.

But individual medical personnel may not be supported within their own environment, social or psychosocial setting, in their life-experience to recognize and work with the stress of these processes.

The most striking outcome of this literature review is not the paucity of evidence for emotional ill-health, but the apparent past lack of interest in addressing the problem in an effective manner.\textsuperscript{45}

In most professional medical settings, the only exclusion being psychiatry, peer support systems are not readily available to enhance the reflective capacity of the practitioner. The result, they may or may not develop a capacity in their personal learning for reflective process.\textsuperscript{46}

As stated by these general practitioners,

I have had no personal contact with the death of a close relative or friend. All of my relatives are overseas. There is no immediate family in Australia. [I:9]

and

I did a Masters in Family Medicine that emphasised communication as part of the Geriatric module; death and dying and that sort of thing. I did it as distance education, so you use your own style. [I:9]

and

The next death in the family was that of my father, at the time of his diagnosis he had brain metastases from the carcinoma of the lung. His dying and his death were horrible in every way. There was no freedom to communicate with him before his death. There was no ability to talk openly about feelings. The family was only capable of having urbane, intellectual conversations. [I:13]
Most doctors felt their attitudes and beliefs were based on personal rather than professional experience. Twenty three [23/25] felt ill equipped by their medical school training.47

Currently reflective skills are not a component of the medical training repertoire.
8.5 Action Learning - Exploring the Unknown

Training of the medical student seems not to cater for the interpersonal and communication skills required to address issues of emotional intensity. When and how does the medical student gain the competency to discuss these matters and subjects of existential significance? These concerns are associated across numerous specialty areas.

Calls for improved training in interpersonal skills, communication and acknowledgement of emotional values in medicine have come from a variety of sectors.48

The RACGP’s capacity to provide resources to support the primary task is contingent upon its understanding the needs of members of the faculty.

Understanding and addressing the needs of all our members, recognizing the broad scope and diversity of General Practice and general practitioners.49

Following the implications of the research discussed in this thesis, a specific educational course for general practitioners could be devised to focus on the skills required to manage in role. Such a course might involve aiding practitioners to work with emotional communications.

Balint in his work with general practitioners designed seminars to enhance the therapeutic effect of the role of the general practitioner.50 The style of the seminar involved participating in group-learning to discuss 'difficult cases' presented by a practitioner. The intent of the course was to develop the capacity of the practitioner to work with the transference and the countertransference issues of the case and in doing so gain insight and enhance empathic connection with the patient.51 He stressed:

The importance of 'listening' to such slight emotional reactions in ourselves when dealing with our patients. This does not mean to giving way to our emotional reactions, or even expressing
them, but it does mean that we must 'listen' to them, and then
try to evaluate the information as part of the whole situation
developing between the patient and us.⁵²

One general practitioner states that there has been no specialized education or
learning to achieve a way of being with a patient to end-of-life plan.

If communication about difficult issues is an imperative in the role of the GP then this
needs to be initiated in Medical Schools. I do not know what is being taught there at
present but this would be a good place to start; to assist medical students and to
start with role playing for themselves. When I did a course at Swinburne University
we had to role-play, we took up the roles ourselves. [I:13]

Physicians should be alert to their own reactions to ... patients
and situations and closely monitor and control their behavior so
that the patient’s best interests remain the principal motivation
for their actions at all times.⁵³

In conjunction with the work of Balint, a course for practitioners might also consider
the work of Revans who recognized the importance of members of a work group to
learn together as 'comradeship in adversity'.⁵⁴ This same possibility is potentially
available to general practitioners.⁵⁵

The wise, as distinct from the clever, remind themselves that
there may be important questions still to be asked that had not
crossed anybody's conscious mind. It is this need for being
doubtful about one's own qualification and ability to deal with
the here and now that is the essence of Action Learning.⁵⁶

To extrapolate, the doctor, the patient and the family, the small group, could use this
same method of action learning to learn together to understand more about the
issues that are relevant to the patient in the here and now. But at the initiation of a
conversation with the patient and the family there may be little knowledge. Often the
only substantive information is the diagnosis itself, with its prognosis. In this initial
context the general practitioner may be required to create a safe space to contain
the dependency needs of the patient; to provide for basic exploration and understanding. This may need to occur before the doctor is able to create a transitional space; a space that tolerates fear and uncertainty, which is capable of containing the anxiety of the group allowing the group to listen and learn together. As pointed out by Elieli:

By a certain way of listening, the consultant can lead his client, an individual or a group, into a state of self-attention and self-awareness.57

Many general practitioners (9/13) fear initiating a conversation that may bring about anxiety for the patient and therefore also in themselves, and of not being able to contain the anxiety. This general practitioner interprets it as causing harm.

People do not have a language for discussing difficult emotional situations. People cannot sit very comfortably with people’s distress. If you distress someone or make them cry, you are upsetting them. [I:7]

There is recognition by general practitioners (9/13) that few members of the medical profession are able to talk with a patient about death, the personnel who work in the area of palliative care. But palliative care focuses on a distinct event, the transition from curative medicine to palliation, a stressful event. Who has this conversation prior to and at the time of transition, to transfer to care and symptom management?

The only people who really talk about [death] are people who work in the health professions or actually the people in palliative care, funeral directors and priests. People who know that death is inevitable; are already skilled and trained in that area and experienced. [I:10]

The sociologist Searle, in his book 'Constructing Death' frames death in many paradigms. He states that personnel working in palliative care have difficulty in working with the dying patient and their family. Defensive behaviours prevail. The ‘interactionist’, working in the hospice manages disruptive events like death by routinizing their work to distance themselves from the patient facing imminent
death. Glaser and Strauss describe the work of palliative care and recommend open awareness to reduce the stress and personnel burnout. They also acknowledge the importance of personnel, medical and nursing staff, exploring their own feelings about dying and death to facilitate communication about emotional and psychosocial issues.

In the same section of the book, research by Field recommends that instead of withholding information it is preferable for staff to openly involve patients in ‘planning their own death trajectory to engender order, rather than the chaos that modernists assume will result’. An interview with a general practitioner, whose friend had recently died, would concur with the recommendations of Field.

It puts me in mind of a friend who was able to relate, communicate. There was a real sense of freeing her up, it was liberating. She was generous in preparing everyone else for her death. Talking to others about things in their lives, not only about herself; I wonder if we were all freer in our conversation would that help us all relate, about personal issues, instead of holding in our fears, if we could extravert or externalise them and explore them? [I:7]

By occupying task-appropriate roles and mastering task-appropriate skills, people may be able to stay at the boundary because the inherent value of the work they do contains their fear of hurting others or being hurt in turn.

I would encourage this conversation with the person, their family or friend. To get them to think about: what it is important to say, what they would like to think about, what might be going on for the other person, what might be preventing them from responding., Get into the other person’s shoes and feel closer as a consequence.[I:7]

In the quotation below, an intensive care physician recognizes that the education provided by medical schools is inadequate in their provision of training to enhance the communication skills of medical personnel in the area of end-of-life planning.

Whatever the reason, educational programmes for training in end-of-life care skills are still woefully inadequate. Although many medical and nursing schools offer ethics of death and
dying courses, these courses are for the most part conceptual; formal training in practical end-of-life care skills is not routinely offered in many postgraduate training programmes.\textsuperscript{63}

Clinicians are silenced in the face of dying and death and avoid conversing about thoughts and feelings that relate to dying and death.

Why is it that every time we sit down to speak with a patient or family about death ... that moment of silence starts, we panic?\textsuperscript{64}

In concluding this section, it is noted that the approach of practitioners at this point in time is to respond in a professional manner by removing themselves emotionally from the anxiety provoking components of the conversation by depersonalizing the communication.\textsuperscript{65} The general practitioner retains a therapeutic relationship by providing symptom management for the patient rather than addressing the anxiety present in the emotional experience. The emotional experience, the vulnerability associated with the knowledge of a terminal disease silences both the doctor and the patient.

But there is an alternative method to dealing with issues of significance, instead of the current behaviour where the setting becomes professional, theoretical and technical. This comes with the capacity to manage in role, to contain the emotional vulnerability to create a transitional space in the doctor-patient relationship. For the very values that make for good doctors are often also those that render them vulnerable.\textsuperscript{66} As stated by Armstrong:

The challenge [is] to contain the vulnerability, not to control it or project it. But to contain it, it had to be acknowledged not as a hazard but as an occasion: the occasion for real work - the proof of being in touch and the means of keeping in touch.\textsuperscript{67}

In recognizing and working through one's own fears related to dying and death and then taking up the responsibility and authority of the role, and learning task-
appropriate skills to contain and recognize the fears and anxieties present for the other, the doctor could develop the skills to end-of-life plan with the patient and their family, and for himself. 68

Increased recognition of emotional health issues and improving psychological training has the potential to assist doctors to maintain their own emotional health, the health of their spouses and families and more effectively address the increasingly frequent emotional health issues seen in their patients. 69

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PART 3: THEMES in this THESIS

This segment of the dissertation reflects on the data analysed from the in-depth interviews with the general practitioners and generates theory and proposals pertinent to the research.

The final chapters of this dissertation explore the potential for the general practitioner to support individuals and their families through the process of end-of-life planning. Chapter 9 reviews the paradigms relevant to the practice of medicine and the researcher's opinion about how these paradigms integrate patient-care requirements. Chapter 10, the final chapter, reflects on the working hypotheses from the field data which are germane to the objective of end-of-life planning and examines these to develop proposals for future progress in the task of end-of-life planning.
9. COST-CONTAINMENT, CURE OR CARE?

Why is this particular dynamic configuration happening now? What is driving the emotional state I am both registering in myself and hypothesizing as a factor in and a function of the group? To answer this question I believe one has to ... interrogate the particular quality that attaches to the work group function: not just the nature of the task but the psychic meaning or meanings that attach to this task and the particular anxieties that this meaning or meanings can arouse.¹

This section of the dissertation involves an overview of the analysis of the interviews with general practitioners, a postulation of the paradigms affiliated with their medical praxis and some associated defensive behavioural patterns as they pertain to end-of-life planning. The paradigms, or approaches to, or models of practice considered relevant relate to Cost-Containment, Cure, and Care. The defensive behaviours deployed are described and align with Bion's ideas of basic assumption activity² and social systems defences as described by Jaques³ and Menzies Lyth⁴. As depicted in the quotation at the beginning of this chapter, Armstrong portrays the importance of recognizing the configuration of the defensive design as it relates to the task and the underlying conscious and unconscious consequences implicated and derived from the task. Care, Cure, and Cost-Containment as models of practice each develop within a specific societal context. The pertinent pattern of defensive behaviours deployed by general practitioners focuses their approach to medical praxis. These defensive mechanisms mitigate the stress and anxiety associated with the performance of task and the significant fears that the task arouses, especially where the task is end-of-life planning.
Three approaches to practice are reviewed: the cost containment, the cure and the care and their connected defensive behaviours are explored in an attempt to understand the social, psychological, emotional, and psychodynamic needs of the individuals, groups and systems within healthcare practice. Each is presented in their idealised or 'pure' form, although it is recognised that in reality they probably present in a mixed way.

9.1 Which Paradigm – Which Defense?
The culture of the practice of medicine is modified through changing paradigms which are congruent with the systemic and societal context; the zeitgeist of the period.

Barbato reflecting on the practise of a mentor writes:

The care of a dying person requires qualities of a medical practitioner that do not sit neatly within the prevailing medical paradigm.5

Defensive patterns of behaviour develop which appear to be linked with the medical approach to practice and its context. These defensive mechanisms, through adaptive or maladaptive routines have significantly enabled the medical fraternity to maintain the penchant of hegemony required by society. In these approaches to medical practice, the routine for the practitioner and the ritual for the patient become reciprocal and the unconscious processes, ubiquitous.

A system of activities set up to perform a task also provides a system of defenses for those who perform it; and if, as in many health care systems, the task itself is painful, dependency relationships are a significant part of the defensive structure.6

This section of the dissertation concentrates on the paradigms underlying the primary task of General Practice. Or as Lawrence and Robinson define primary task, it is the task performed by the individual in the organization - the phenomenal primary task.
The ‘normative’ primary task that is the task that people in an organization ought to pursue

The ‘existential’ primary task that they believe they are carrying out, and

The ‘phenomenal’ primary task that it is hypothesised that they are engaged in and of which they may not be consciously aware. 7

In the introduction to Harrison’s major medical text, Peabody states:

One of the essential qualities of the clinician is interest in humanity ... for the secret of the care for the patient is in caring for the patient.8

Novack et al,9 using Balint’s methods recognize; while working with physicians and general practitioners, that improving the practitioner’s personal awareness not only leads to greater satisfaction in the work and the relationships associated with the work, but also enhances clinical practice to improve the quality of medical care. Self-awareness generates adaptive behaviours, for in a state of self-awareness there is a deeper and more sophisticated understanding of the emotional responses of both the clinicians and the patients. The importance for the practitioner is in the recognition and understanding of intersubjectivity and therefore, the ability to contain and minimize emotional disturbance for both.10 This management enhances the practitioner’s capacity to cope with the pain and fear and minimises a splitting and denial that potentially results in anger and distrust for the patient. The approaches are discussed from a basis of ideological practice.

To cure sometimes, to relieve often, to comfort always.11

9.2 Who makes the decisions and to whose benefit?
What focus of praxis would best serve (i) the patient, (ii) the care of the person, (iii) the management of the disease or (iv) the achievement of a performance objective to meet fiscal policy?12
What model or what mixture of the models would best serve society, patient, practitioner and the doctor-patient relationship: the cost-containment, cure or care model? Do medical schools collude with the contextual need to generate graduates with appropriate social defences? As one general practitioner said:

As a young GP my primary task was to help and to care for the patient. This care implied cure because it involved solving the problems and producing the answers. I am now able to say to the patient, I do not know, and observe the look of horror on the face of the patient. There is the expectation of knowing; now we explore the answer together. I care about the outcome of the patient and feel terribly guilty if it goes wrong. I am always worried about them. [I:8]

I believe the task taken up by the health worker depends upon his or her ability to contain the vulnerability in the transitional space of the doctor-patient relationship. As a result the primary task aligns with the societal, cultural and psychic context of the practitioner. Which serves the well-being of the patient and fulfils the task of the RACGP, *Care, Cure or Cost-Containment*?

For the *Cost-Containment* model, the primary task could be conceived as maintaining and managing the budget set by government, by meeting patient throughput and specific diagnostic entities without impacting negatively on the quality of the healthcare intervention.

For the *Cure* model, the primary task could be conceived as achieving evidenced-based practice for patient cure through research and development.

For the *Care* model, the primary task could be conceived as providing medical care for the person through all health-care related processes.

These approaches to the practice of medicine convey the primary relatedness of the practitioner to the patient either by economics, by disease or by person.

Yet Gordon who communicates a need for an humanitarian approach to the practice of medicine emphasizes ‘the body, [as] the very object of its focus’, rather than the person. Humanity is lost in the pathophysiology or the economy.
The disciplines of medicine and the humanities sometimes demonstrate diametrically opposed modes of thinking, they share a focus on the human. The separation of clinical care from the 'human sciences' is a professional and social mistake, and the growth of medicine as an economic and rational profession has paradoxically contributed to the social diminution of the body, the very object of its focus.¹³

The three models drawn depict the focus constructed for the primary task and emphasize the stakeholders involved in achieving the task. Are the tasks performed normative, existential or phenomenal considering the RACGP statement? How are the deeper psychic needs of the general practitioner's community addressed?

Krantz and Maltz recognize that the preferred medical work paradigm chosen by contemporary society is Cost-Containment.¹⁴ Isn't quality more than just cost-containment?

In this post-modern world of turbulence and active adaptation... more attention has been directed toward process variables such as work flow, quality management, and concurrency.¹⁵

9.3 Working Hypothesis
End-of-life planning can only be approached in the care paradigm because the process depends upon the capacity of the practitioner to contain emotional vulnerability.¹⁶

The primary task of General Practice is defined by the RACGP (See Chapter 5: End of Life Planning in Primary Task). The task performed is dependent upon the meanings derived by the individuals in their roles, the defensive mechanisms deployed to contain anxiety, and, the ego maturity of the practitioner fulfilling the task.¹⁷ The approach of the model of practice hinges upon the ego maturity and ability of the
general practitioner to recognize and manage the feelings present in the consulting work. In containing the emotional impingements present the general practitioner integrates the conceptualization of role-idea and the associated societal expectations. The conscious and unconscious defensive behaviours deployed minimize the anxiety experienced by the general practitioner and enable the contextual task to be performed. To take up the task of end-of-life planning the person in role 'requires an extremely high level of consciousness' and containment recognizing the internal and external dynamics present. Armstrong could have been speaking of end-of-life planning while talking about the containing of vulnerability, for this indeed is the challenge in end-of-life planning.

The challenge [is] to contain the vulnerability, not to control it or project it. But to contain it, it had to be acknowledged not as a hazard but as an occasion: the occasion for real work - the proof of being in touch and the means of keeping in touch.
In this era of entrepreneurial medicine, business principles are applied. Medicine and government together focus on productivity and 'units of service'. Rationing, benefit plan, and cost containment have taken center stage in the public arena.\textsuperscript{21}
9.4.1 Description of the Model

In the Cost-Containment model, the primary task could be conceived as managing the budget. This task is achieved through the practitioners meeting pre-determined patient numbers and specific diagnostic entities without in principle effecting the quality of the intervention. The model of Cost-Containment demonstrates that the central focus of the approach to healthcare is related to productivity with the quantitative key performance indicators at the centre of the model. Every component of the model is focussed on performance objectives for the model of practice is structured and funded to achieve these objectives. As depicted in the model it is centred on performance. All of the stakeholders, the Acute and Primary Health Sectors with the guidance of the Federal and State Governments work together to develop objectives associated with their responsibilities to healthcare within each sector. A budget is calculated in an attempt to correlate with the responsibilities. In the Primary Health Sector, it is necessary for general practitioners and their Practice Managers to adhere to set performance indicators to achieve the objectives of the funding budget. The recipients of healthcare, the patients are far removed from the focus in the model. To an observer this is a 'phenomenal' task. To the Federal Government funding Primary Health and Aged Care nationally, the overriding emphasis is to ensure the appropriate use of funds to cater for the system's needs. To practitioners, this means the adherence to administrative requirements set by the Federal Government which do not seem to be congruent with the task definition of the RACGP which is inclusive of the social, psychological and emotional healthcare to patients. General practitioners assume their work will be monitored; they must meet the performance criteria associated with throughput, costings and billings. As a consequence of the increasing administrative demands of the government, practice managers are often employed to complete the stipulated documentation for practitioners to demonstrate adherence to key performance indicators and complete the administrative requirements to validate workload.
9.4.2 Characteristics of the model

But there is dissonance in this complex system. The community demands an ever higher standard of healthcare to be provided by the Government and general practitioners. The expectation is that general practitioners will be available for routine and out-of-hours work and that schedules for work will meet the needs of society. From the perspective of the general practitioner, the demands continue to escalate with a requirement for 24-hour availability and an increasing complexity of work in an aging demographic. For some general practitioners these demands have brought about disincentives that impact directly on the healthcare of patients. These quotations emphasize the pressure of change.

It is a hell of a problem. Primary care is changing; there are changes in work practice, increasing feminization of the workforce, and unwillingness of the current generation to take responsibility for after hours work, they have 0900-1700 schedules. [I:6]

and

The problem is time. In our system you can not run a small business and survive unless you see patient numbers and this does not leave a lot of time for issues that need a lot of counselling to fit into a busy days’ schedule. The palliative care patient, the elderly patient and the chronic medical patient have multiple complex problems. All need time. [I:11]

and

In the next ten years there will be no phone calls, no home calls, and Nursing Homes will probably have to pay someone to call. [I:8]

and

The health care system is now economically driven. The rebate system means I can not allow myself a lot of time to talk with people. I employ a Counsellor to fulfil that role, and then I pay the counsellor more than the consultation rebate. The rebate needs to be increased, but the Federal Government is not going to do this. [I:11]
The AHS in Victoria is funded by the State Government, which produces an inducement for the general practitioner to off-load out-of-hours work and complex care issues to the acute sector, assisting him/her in maintaining an economically viable small business.

In the Cost-Containment model of economic rationalism (See page 304 of this thesis); the patient, palliative care, aged care and research are removed from centre stage of the system to the periphery. Cost constraints and productivity with key performance indicators are the focus and fundamental to the model of practice. Time consuming components of healthcare management are unproductive to the economic business model. The measures rarely have a qualitative function. The outcome is the creation of an illusory central controlling agent, a persecutory totalitarian authority which requires accountability from general practitioners to the financial denominator.24 Defensive mechanisms with a paranoid-schizoid stance are created against the internal fear and uncertainty of the demands of the external authority.

The emphasis is on fiscal policy; nurses are much cheaper. But who attends the patient at three o’clock in the morning? I am always so conscious of Medicare and like big brother watching for over-servicing. [I:8]

The core business involves efficiency and the effective use of the budget.25 As in the model, the interfacing organizations and groups are involved in the conception of budget requirements, its consequent provision, allocation, and appropriate distribution. The medicine practised becomes equally as prescriptive, with time constraints, government rebate for the service provided, the concern about over-servicing and the additional fear of litigation in the changing community.26 This general practitioner’s perspective reflects the changes.

Medicare does not fund in-depth or long term work with patients or their families. The Health System is resourced and funded for short interventions, documentation, and prescription writing. This is a systemic framework with the emphasis on documentation and medico-legal constraints. [I:2]
These changes emphasize how Cost-Containment invites the focus of general practitioners to move from the doctor-patient relationship.

9.4.3 The defensive patterns of the model

The model creates an interaction of consumer-provider with a rationalized business-management approach seemingly supplanting emotion and uncertainty with order and stability. The economic rationalist philosophy would enable practitioners to use the focus of cost-containment as a defensive technique with persecutory splitting, automation, and depersonalization; an unconscious attempt to avoid the emotional aspects of medical management. The funding model is deemed to provide structure and surety as general practitioners fulfil the regulatory requirements.

I do not know that the welfare of the patient is really the focus of any healthcare planning in Australia. It is the budget. [I:10]

The practice for the doctor becomes mechanized, with a process perspective of a critical appraisal of the presenting requirements, ordering diagnostic tests, providing prescriptions and arranging specialty referral. The consequence of this style of practice is a continuation of through-put to maintain the budget and the survival of the small business. In this stance the defensive manoeuvre demonstrates a resistance to linking; the emotional experience of the doctor-patient relationship is avoided and the interaction is devoid of informative intersubjectivity.

By replacing other understandings ... with a pervasive 'provider-customer relationship, people often lose contact with the deeper meanings, and hence sources of satisfaction and purpose, connected to their work.28

The cost-containment model in removing the doctor-patient relationship from the centre of the scheme encourages a paranoid-schizoid stance. Both society and General Practice decry the lack of resources and responsiveness to pursue what is
deemed as an appropriate level of medical care. The practice portrays that the emphasis is no longer patient-care but the budget and the performance indicators. The general practitioner, with a defensive manoeuvre, complies. The defensive functioning of the group is fight/flight, $baF$, where the doctor is perpetually in persecutory fight mode against the economic rationalists who limit the patient-care profile. The practice depends upon the budget allocation.

Another basic assumption activity, me-ness, $baM$, is operative. In this setting the doctor does not acknowledge the presence of the dyad in relationship but operates in a depersonalized fashion as customer-provider. Each individual attempts to divest him/herself of emotional connectedness with the internal and external realities to maintain a sense of self which is not threatened. These defensive strategies of professionalism and intellectualism assist in limiting the emotional involvement of general practitioners, but maintain their psychic status. Tasks that require psychological, emotional and spiritual role-relatedness like end-of-life planning rarely occur in this approach. The practitioner in retaining an intellectualized, technical stance is able to remove him/herself emotionally from the distress of the individuals involved and ritualize the process.

The silo structure in the Acute and Primary Health Sectors is another manifestation of the Cost-Containment model. Each sector (AHS & PHS) persecutes the other for poor patient management and blames the other for poor communication; a destructive splitting and blaming of the other for irresponsible patient-care.

Distrust of the institution grows out of the reality of repeated unproductive interactions with hospitals. [I:2]

and

We as GPs often need to take on the responsibility of failed discharge planning, or no discharge planning, for the public system. The system should not require so much rescuing. [I:4]
We could reduce this fragmentation of healthcare by improving communication and sharing resources within the healthcare system. It would involve the patient, rather than interventions or healthcare practitioners, becoming the centre of care.\textsuperscript{32}

In most settings, this model ensures that end-of-life planning does not occur in the doctor-patient relationship. Both parties withdraw from the patient’s reality. The medical practice focus of the \textit{Cost-Containment} model is of short interventions and symptom control which encourages dehumanization and separation. Professionalism minimizes the emotional contact.

If I go to a home and have a discussion with a patient who is nauseated and vomiting, it is much easier to deal with the physical conditions, their diagnosis, management, therapeutics and counselling, rather than have a conversation with someone who is dying as a result of a terminal illness. This is a different form of counselling that does not fit into things. I would find it hard to initiate this conversation and then charge for it. [I:3]

The engagement with a person dying from a terminal illness requires presence, empathy, and connectedness. It ‘does not fit in’ the \textit{Cost-Containment} mode of operating. \textit{Cost-Containment} allows ritualized functioning associated with diagnosis, management, therapeutics and counselling associated with a defined medical condition. Dying and death are not manageable! In line with patient-care being at the periphery of the \textit{Cost-Containment} model; the defensive techniques involved in the paradigm invites avoidance of the anxieties and fears of performing stressful intersubjective work with the patient. Accordingly the task to fulfil the performance indicators and manage the budget creates defensive strategies with persecutory anxieties that relate to the perceived presence of a authoritarian state, of being observed, of over-servicing and abusing the system and of mis-managing the budget.
She cried when she told me about calling her surgeon, a friend of twenty years, only to be informed by his nurse that there were to be no further appointments because the doctor had nothing more to offer. 'What is wrong with doctors? Why don’t they understand the importance of sheer presence? ... Why can’t they realize that the very moment they have nothing to offer is the moment they are most needed?'³³
9.5.1 Description of the Model
For the Cure model, the primary task could be conceived as achieving evidence-based practice for disease cure through research and development. The Cure model has the disease as the central focus. The energies of all the participants involved in the model focus upon cure. In the Cure model all interested stakeholders, Government and philanthropic funding of Research Institutes, and the Acute Health Sector, encourage the focus of developing research projects to cure disease. Terminal patients within this mindset are also focused on the cure of their disease. Society also embraces this collective illusion. The Primary Health Sector, the general practitioner and the family, a little removed from this focus of activity, support the pursuit of cure. Death cannot be countenanced in the Cure model. There is a culture of silence with disconnection between cognitive and emotional capacities. The hope for omniscience and therefore grandiosity about the ability to cure leads to expectations of overcoming death. To achieve the task focus, the emphasis of the practitioner, through the AHS, society and the research facilities, is to attract government or philanthropic dollars for research to cure life-defying diseases.

The medically based model ... has so steadfastly chosen cure over care. Cure encourages no self-reflection, only evaluation as to outward success or failure. If to 'cure' is the goal, death is our enemy until death is inevitable and the quality of life so miserable ... death becomes the new cure.

9.5.2 Characteristics of the model
9.5.2.1 The Myth of Cure
Modern medicine has accepted the paradigm and myth of cure. As a collective illusion it resists any passage through consciousness and as a consequence dying and death can be denied. The myth allows general practitioners and specialists to remain detached in the doctor-patient relationship; for the primary task is cure. All energies
are focused and required for the processes of fighting the disease. It is not possible to acknowledge that a disease may be incurable: reality cannot be faced. All live in the hope of cure.

A myth is constructed from an old reality, whether it existed or was invented. It is concerned more with a collective group than with an isolated individual.38

General practitioners have frequently referred patients for specialty management. During the time of the treatment of the disease general practitioners are frequently left out of the loop of the cure-treatment model. It is only when the disease, the reality of incurable cancer needs to be addressed that general practitioners are required to continue the care. The specialist in the AHS flees from no cure. As this general practitioner points out:

We get a lot of the end-of-life planning taken out of our hands especially by the Oncology people. They take over, and the patient disappears into the hospital system. They throw them out when they are about to die; if they need a bed. This is a bit awkward. They only recognize the role of the GP when they have done all they can for the disease. But it is the patient who has the disease who is told to go home. They deal with the treatment and cure issues. They don’t deal with the death or continued caring issues. [I:11]

In the setting of the Cure model the defensive processes for all participants, doctors and patients, involves the fighting of the disease (baF). The assumption is the disease is curable. The defensive behaviours focus the fears on the dynamics of the disease with a disposition to attack and defeat it. The demeanour is fight with a paranoid-schizoid quality. As stated by one general practitioner, the energies are directed to this fight.

The obituaries say, and he fought to the bitter end. It is like a battle, the approach to death, fighting death, fighting a terminal illness. [I:8]
In the process of cure, the patient relies implicitly upon the leader. The leader of the group is the person taking responsibility for the management of the disease. The expert has specialist knowledge, expertise and the probability of bringing about cure. No other options are posited at any phase during the disease trajectory. In an unconscious defensive activity, the medical process of planning and pursuing treatment options to cure the disease absorbs the consultation time. No time is available to discuss the disease trajectory, treatment options or emotional and psychological issues. The disease is only considered from the perspective of cure. Treatment options are discussed as part of the process of intervention and cure. The patient and his/her family often not involved in decision-making about treatment options. Questions of benefit and burden of an aggressive treatment option are rarely considered.\(^{39}\)

A characteristic feature of the consultation in which patients [are] told they [have] cancer [is] a rapid transition from the provision of bad news to a discussion about what could be done about it. By far the most time and energy was spent on ‘treatment’ options.\(^{40}\)

The development of a care plan, which would be consistent with the normative task of patient-care, rarely occurs; for the doctor is unable communicate futility. Futility acknowledges medical failure and the limiting feelings of guilt.\(^{41}\) Dying and death are denied. The patient and family could be overwhelmed by the fear and dread associated with a diagnosis of terminal disease so take-up the specialist’ leadership, who mitigates against dying and death.

9.5.3 The defensive patterns of the model

By separating the disease from the person the practitioner maintains a focus on curing the disease; a defensive mechanism: a phenomenal task. Dependency is absorbed in cure. For the practitioner disconnection occurs between his/her cognitive capacity and emotional experience with a resulting detachment and professionalism.
Whatever feelings are present in the space, the patient is unable to enquire. The fear is that questioning could be perceived as doubting the specialist’s expertise, prompting the anxiety of alienating the doctor and being abandoned.42 A collusive interdependence is maintained by all parties.43 The basic assumption activity rapidly moves from mode to mode taking up intuitively the feelings of the leader, who is accepted as the curer.

In retaining the hope to cure, the specialist within the AHS is able to resolutely continue to treat, perhaps using another trial drug, as though the disease is curable. In this state, death is split off and denied. Life continues as the only outcome. The patient remains dependent upon the specialist, and the omniscience and omnipotence of the research team. This illusion aids in the maintenance of hope. The patient and the specialist team, together conquer the disease and in doing so conquer death through a miraculous cure. This collusion between the patient and the medical team in the expectation of an improbable, even miraculous cure, is illustrative of Bion’s basic assumption pairing, baP.

The defensive behaviours do not cater for the establishment of a doctor-patient relationship that links cognitive, volitional and emotional experience. The distressing and painful is split off, emotionally and physically. The acceptance of a relationship that explores the capacity be with the pain and distress of the patient cannot be conceived. The issues of separation and loss are avoided.44 The idea of death does not only concern our biological destiny, but pervades our relationships, all of which are marked by issues of separation and mourning.45

9.5.3.1 The Politics of Salvation or Medical Rescue
Lawrence could have been speaking for the medical fraternity when writing of the politics of salvation.46 Modern medicine has moved with society’s collusion into the
realm of omnipotence and omniscience fostering the societal desire to eliminate death. As a consequence of this posturing, cure has become mandated. The medical expert because of his/her perceived omniscience is encouraged by members of society to use this expertise to make decisions, depending upon this expertise, to bring about cure. With this expert posturing there is grandiosity and pleasure associated with specialist knowledge. Professionalism enables the specialist to maintain the depersonalized, dehumanized posturing as expert, remaining aloof, protected by his/her analytical and technical proficiency to rescue the patient from the disease.\textsuperscript{47} The AHS exhorts this stance as a defining aspect of its technological, clinical and research competence as an organization. But such a stance is problematic.

\textquote{The heroic use of science technology have become prominent forces that shape daily life ... In this environment of self-glification, material gratification, and extraordinary technological achievement, suffering, dying, and death are pushed to the periphery of cultural experience.}\textsuperscript{48}

Basic assumption behaviours of dependency and me-ness can be operative in this sophisticated environment where the patient with their family collaborates with the medical team and the AHS to avoid death.

\textbf{9.5.3.2 Emphasize the Disease}

The focus of communication in this cure model is the disease. Group members communicate with each other about the disease; the task is curing the disease. A comment from a general practitioner,

\textquote{When there is a disease to attack the purpose is clear. Once this is removed the meaning has been lost. There is stress amongst the family and the overarching health systems. [I:2]}

The dynamics of the relationships developing in the Cure model are often defensive and collusive maintaining unrealistic hope.\textsuperscript{49} It is often only the positive aspiration, the myth of cure, which can be present in the consciousness of the group. Cure
creates hope for all involved in the management of 'a' disease. The assumptions are positive, constructive and supportive. The unity of the group pursues this function. Anything outside this functioning is counterproductive to the group’s togetherness, \textit{baO}. Individual relationships are secondary to the task of cure. To acknowledge a reality which involves uncertainty and the potential of chaos would be destructive to the construction of hope for the group and is avoided. Therefore addressing an alternative outcome of a critical or terminal disease would create conflict and be negative, destructive and ruthless. Both cannot be present.

Bitter experience has taught us that resistance against the unconscious can be so subtle that it may distort the analytical findings and reinterpret them in support of some personal defence.\textsuperscript{50}

The dynamics of splitting, a paranoid-schizoid stance is evident in the \textit{Cure} paradigm. Who deals with the issues that arise in the setting of failure? Where does ineffectiveness, hopelessness, and helplessness reside for each of the roles? The role-holders are isolated in the process with little communication about progress or prognosis. Where are hope, anger, fear, despair, and denial located? Where is the containment for the patient? Perhaps general practitioners feel like this? At the periphery of the model general practitioners take up the projections from the patient and the AHS, they take up the anger, the sense of helplessness and hopelessness in the healthcare systems! (See Chapter 6: System Psychodynamics)

Dying patients need more than prescriptions for narcotics or referrals to hospice programs from their physicians ... someone who will unflinchingly help them face both the medical and the personal aspects of dying ... Physician’s commitment not to abandon their patients is of paramount importance.\textsuperscript{51}
The care-centred approach of openness, empathy, conscious speaking, eliciting, and sincere listening ... are not just attitudes and practices we adopt when sitting with the dying. These are practices for our whole lives, for us to use everyday.52
9.6.1 Description of the Model

The central focus of the Care model is the person. The model of practice is inclusive of the organizations that are responsible for funding and providing the care. It draws on the government funding bodies, healthcare sectors with the Research Institutes, as well as the groups and individuals intimately involved in caring for the person, the general practitioner, the family and friends. In the Care model, the primary task is conceived as providing medical care for the person through all health-care related processes. This concept of care is all inclusive, from the ethical and moral attitude to the economies of healthcare, from the scientific interventions with attention to research and development, to the humanities of healthcare. The ultimate focus of General Practice is the health care of the nation through the care of the individual patient. With the person at the centre of the model, the contributors to his/her health management profile provide comprehensive support fulfilling the normative task. For the general practitioner the model of Care is ongoing, it does not begin at a time of a crisis. The approach of General Practice management is the care of the individual who attends. In managing in role, general practitioners give themself to the care of the patient, to listen, problem-solve, and decision make with them.

A morality centred on care and concern can potentially serve health care in a constructive and balanced way, because it is close to the processes of decision-making and feeling exhibited in clinical contexts.53

9.6.2 Characteristics of the model

In this model of practice all aspects of the person’s wellbeing can be taken into consideration including the medical component from cure to care. As stated succinctly by this general practitioner caring for a patient is inclusive, their medical issues, social issues, psychological, and emotional issues.

I have an elderly population that I care for: over 80 years of age. A lot of them will ask me about forms to donate my body to the University. I discuss EPOA(medical)
with them, with the spouse present. A lot of people want to know things like: will you look after me, what happens if I get ill and have to go to a Nursing Home? It comes up quite frequently, they are probably all thinking about it and they discuss it as a part of the consultation. I do not have a formal approach with each person; it occurs as it flows. Some want to discuss it and some do not want a part of it. If someone lives alone I chase up the next of kin so that I have it documented, who ... to contact and sometimes [I] even ask or get a feeling of what they would like for themselves. Some patients give me a form to say they do not wish to be on life support. I discuss with them and then discuss it with their family so everybody knows. I become proactive if the patient lives alone or if the illness is becoming significant, or those who have an emotional illness or dementia and are not going to be able to look after themselves. I get a bit more active and involved with the family. [I:11]

The emphasis is the health of the person who attends the general practitioner for a consultation, review or continuing care. It remains a collaborative effort with continued personal responsibility for individuals to fulfil their personal healthcare role. As the model illustrates, general practitioners work with the patient to achieve health and well-being through the support of stakeholders. At a time of crisis, the general practitioner is usually the 'deliverer of bad news' and could maintain involvement in the ongoing care of the patient with the resources of the AHS and the community, including Allied Health workers. The primary task remains to care for the individual. This is holistic in its nature. The care is ongoing for many practitioners are involved in the care of the person. Open and honest communication between the role-holders is important. It is envisaged in the Care model that role-holders be open to the emotional experience of the patient to assist the patient.

In caring, we will encounter our own feelings of pain and often helplessness; we will encounter the sacred paradox of human impermanence. It's no surprise ... the medically based model ... has so steadfastly chosen cure over care.\textsuperscript{54}
The disclosure of a diagnosis of a terminal disease is associated with extreme fear, uncertainty and vulnerability for the patient and the doctor. The environment for communicating this information and the timing of the communication is significant. The acknowledgement of support for the patient and sensitivity in the disclosure of the diagnosis by a trusted practitioner are of paramount importance to providing containment at a stressful time. Quill writes,

> Care is a far cry from 'not doing anything'. It is completely analogous to intensive medical care, only in this the care is directed toward the person and his or her suffering, not the disease. Dying patients need our commitment to creatively problem-solve and support them no matter where their illness may go.\(^{55}\)

### 9.6.3 The defensive patterns of the model

With care focused on the person, the role-holders are able to communicate and develop relationships with each other. Maintaining a depressive stance is integral to these relationships; it contains the praxis. The involvement of the family completes the loop for the continuity of care. Beauchamp and Childress recognize the ethical nature of involvement.

> The ethics of care seems particularly well-suited to disclosures, discussions, and decision-making in healthcare, which typically become a family affair, with support from a healthcare team.

The ethics of care fits this context of relationships.\(^{56}\)

Care has a cognitive and intersubjective dimension, because it involves insight into and understanding of another’s circumstances, needs, and feelings. The recognition of individuals as persons generates respect and the ability to work with them to their benefit. This framework of care can provide the containment for the individual with the disease as well as containment for the role-holders, who each have their defined primary task within the therapeutic and/or the support role.
9.6.3.1 Being-with the Patient

The significance of the doctor-patient relationship is built upon the ability of the doctor to make himself/herself available in the 'here and now' to listen, and to be with the patient, in a state of concern in order to develop a greater understanding of the patient. In the sophisticated work group, the dyad, there is presence and the ability for each to participate and cooperate as they explore to achieve understanding that seems to fit the circumstances. Both can work and learn together, with respect and dignity, honouring the purpose of the consultation. The doctor and the patient in creating a shared task together contain the uncertainty and anxiety of the encounter.

In this way the general practitioner rediscovers his own humanity and mediates between his patient and ... dehumanized medical techniques and attitudes of his training.  

In managing himself/herself with the authority of the role, the general practitioner creates a transitional space for the patient, family, and himself/herself to work. In this space of exploring and listening there is freedom for the patient to develop a sense of himself/herself which creates greater personal awareness and understanding.

By a certain way of listening, the consultant can lead his client, an individual or a group, into a state of self-attention and self-awareness.

At times of extreme stress in association with a significant disease diagnosis, basic assumption activity unconsciously occurs during the consultation. The expression of the activity is commonly of dependency and with a desire for the expert to take control of the circumstances. This gives a sense of containing the fears and anxieties present for the patient and family, and by providing a sense of security, enable them to continue to work through the next phase of the process. This can occur
constructively as basic assumption activity can also facilitate group work. Menzies Lyth recognizes that,

What gives people self-respect and a feeling of status and reward ... is actually having control in the small part in which they are closely involved.\(^6^0\)

Because of the long-term nature of the doctor-patient relationship, baP, in a sophisticated form may also be at play. This activity may enable the doctor and the patient to explore the future. The outcome pursued may be fantastic, for baP may be present in its aberrancy,\(^6^1\) in a setting of a family member and the doctor colluding to deny the patient appropriate information, or avoiding the truth rather than seeking it together. Or baP may enable both, doctor and patient, to face the reality of the disease process. The \textit{sine qua non} of a facilitating environment as for the infant's development is for 'good-enough' mothering or care in an environment of containment.\(^6^2\) In the development of 'depressive' functioning individuals can move from dependency to pairing and on to achieve interdependency; mature egos with self-awareness. With this care and containment individuals learn to progressively integrate into the family group, the work group and then into society as a whole.

\textbf{9.6.3.2 The patient-care paradigm}

Through creating an environment of containment with openness and empathy general practitioners demonstrate their aim to be with the patient during the time of transition. End-of-life planning, respects the patient, their context, needs and choices, and in doing so acknowledges their autonomy. Winnicott in acknowledging the individual says,

When one speaks of a man, one speaks of him \textit{along with} the summation of his cultural experience. The whole forms a unit.\(^6^3\)

Within the patient-care paradigm, the doctor engages with the patient and also creates connections with relatives and support staff. S/he is able to engage with the patient and relatives, whose reality may include pain, loss and impending death.
The patient as a person is not disenfranchised but within the developed transitional space, is enabled with the assistance of the general practitioner and others to explore and understand the nature of the disease process. This exploration may encourage the patient to attain self-awareness to acknowledge and value his/her own humanity. Such realisation may enable him/her to exercise autonomy and personal authority with respect to living, dying and death. As Elieli states,

This is how the [patient] will be able to make sense of his own experiences, emotional and others, in order to regain his sense of destination.64

The next task, end-of-life planning for the patient, involves the consideration of therapeutic options and interventions which s/he is able to consider with the doctor and the family. For the patient, an autonomous being, has the right to make choices about his/her own death and to do this in a supportive, containing space in an environment of care. This process is participative, cooperative and collaborative. Nietzsche would recommend that the individual has the need to know about his/her impending death and as a consequence,

Each person owns his own death. And each should enact it in his own way ... Yes, he must decide how to face death: to talk to others, to give advice, to say things he has been saving to say before his death, to take leave of others, to be alone to weep, to defy death, to curse it , to be thankful to it.65

For (See Chapter 8: Education) if general practitioners are able to recognize and work through their own fears related to dying and death they would be more able to recognize and contain these fears and anxieties present for the other; intersubjectivity.66 Then, in taking up the responsibility and authority in role and learning task-appropriate skills the doctor can assist patients and their families to end-of-life plan.67 I quote Levy again:
Death, grief, and the prospect of loss remain issues that raise the same anxiety and discomfort for caregivers as for patients and their families.\textsuperscript{68}

Defensive behaviours can be mobilized in any anxiety provoking setting. The ability to recognize and contain the emotional experience enables the practitioner and patient to create a transitional space to acknowledge and work with the intensity of the experience.

\section*{Conclusion}

What in reality is practised is a mixture of the three models. For all models are relevant to the care of the patient. For medical praxis is required to serve: (i) the patient, (ii) the care of the person, (iii) the management of the disease and (iv) to achieve performance objectives to meet fiscal policy. All aspects are relevant to attaining a quality care health system. It is my hope that during undergraduate and postgraduate medical education the humanitarian focus of medicine can be enhanced. In doing so the requirement of interpersonal and communication skills would be acknowledged and addressed.

As caregivers we can learn to be comfortable with the intensity of those feelings and try not to cover them up or make them go away.\textsuperscript{69}

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10. Can DEATH be ACKNOWLEDGED?

The aim of the research described in this thesis is to develop an understanding of the psychodynamic processes that limit general practitioners' involvement in the groundwork of end-of-life planning with their patients.

The development of the thesis is shaped through phases of appreciation of the context of the work of general practitioners whose practice is influenced by personal, professional, cultural, societal and ideological attitudes. The resulting thesis is a formulation derived from an analysis of the collected data. This final discussion collates aspects of the research findings that seem pertinent in constraining the involvement of the general practitioners in the task of end-of-life planning. It also outlines possible approaches to address these limitations. Sackner-Berstein acknowledges the difficulty while recognising its relevance.

One question for which we know the answer is that of when to start the discussion about end-of-life care: it is never too early, and rarely easy.¹

In the final section of this thesis, I have chosen the working hypotheses that I believe represent the salient aspects from the research findings that are pertinent to the progression of the process of end-of-life planning in society today.

The section commences with a summary of the general practitioners' observations of society's attitude to dying and death. The associated working hypothesis is basic to the arena of work for general practitioners that significantly influence their capacity to take up the task of end-of-life planning. Potential programmes for public education are then considered. The following section summarizes the perceived deficiencies of undergraduate and postgraduate medical education in skills related to the communication of bad news and difficult issues. Practitioners' recommendations and those from specific clinical articles are reviewed. Subsequent sections examine
crucial aspects of the praxis of general practitioners as they relate to task and role. Specific learning to enhance their capacity to take up the task of end-of-life planning in role is considered. The final section discusses the potential of Bridger's transitional change model as a theoretical platform for general practitioners working with end-of-life planning. The development of a transitional object, a designed process as a basic tool for discussion and documentation is examined.

10.1 Working Hypothesis I: Society's Focus
Generally speaking there is a fear of death in Australian society. The general practitioner, being a member of this society, is consciously and unconsciously influenced by that attitude. Because s/he lives in this same fear, s/he wants to avoid and deny death and as a consequence does not take up role and its attendant authority to end-of-life plan with patients. [Chapter 4: Society's Focus]

It is argued in Chapter 4 that general practitioners as members of society express the values and traditions of the culture and also collude with its unconscious defensive attitudes. But the same general practitioners need to take up the authority in role to end-of-life plan with patients in their care and support their relatives during the process.

The role of the medical professional to diagnose and treat illness has not changed. However tasks as recommended by the task definition of the RACGP, should change depending upon society's requirements. Moreover, as stated by Beauchamp and Childress in their text on biomedical ethics, the awareness for change is based on emotional experience, associated with dying and death in this case.
Insight into the needs of others and considerate attentiveness to their circumstances often come from the emotions more than reason.²

Even so, a rational acknowledgment of the relevance and purpose of end-of-life planning flies in the face of the medical myth to cure illness and to prevent death. Members of society including its medical practitioners collude in order to defend against death anxieties. Lang states,

The conscious system strives mightily to deny and shut out death-related thoughts, images and events.³

The doctor's role defensively becomes: to protect society from death and to eliminate his/her own sense of failure in the face of death.⁴

The public's exposure to the acknowledgement of death as inevitable and the process of end-of-life planning has the potential to allow the doctor and the patient to address relevant planning requirements. This permits the doctor, especially in association with chronic disease and aging, to involve the patient in decision-making and to pursue treatment choices with the patient and their surrogate. Introduction to discussions about dying and death allow individuals in their own emotional context to discuss pertinent value choices prior to a medical crisis. These discussions allow the patient to develop a greater understanding of their medical condition and consider treatment choices appropriate to their needs, as well as inform and include their surrogate. For:

Decisions about life-sustaining therapies are moral choices, not simply medical decisions. Hence, we seek intimates from our moral communities who share our values, perhaps our history, to speak for us.⁵

In such a setting the individual patient, with the assistance of the practitioner, has the option to assess the benefits or burdens for treatment selection. For in accordance with the Medical Treatment Act of Victoria 1988, it is the prerogative of
the capable individual to withdraw from treatment or refuse treatment. Openness in
the face of catastrophe requires containment, but gives permission for honesty.
Nietzsche in discussion with Breuer states:

‘Yes. he must decide how to face death: to talk to others, to
give advice, to say things he has been saving to say before his
death, to take leave of others, to be alone, to weep, to defy
death, to curse it, to be thankful to it.’

It is essential for this personal communication to occur prior to the development of
incapacity and inability, so that individual needs and expectations can be addressed.
As well, part of assisting individuals in their self-determination in end-of-life planning
includes the appointing of an Enduring Power of Attorney (medical) for the setting of
diminished capacity. The name of the individuals Enduring Power of Attorney
(medical), EPOA, should be documented as part of the basic medical information. This
is especially pertinent both in the setting of an aging population with the
unpredictable onset of dementia, and for a young population indulging in extreme
sports.

All healthcare facilities could assist in the education of staff and the public by
providing the details of the Medical Treatment Act for the relevant State. A
brochure could be devised to communicate the relevant aspects of the Act and the
role of the EPOA(medical).

Educational summits could assist in informing members of society about the roles
relevant to end-of-life planning, for the individual, the chosen surrogate, family and
friends and the doctor. Public education forums or optimizing media conversations
and editorials through the Public Advocate and knowledgeable practitioners assist in
this function. These could enhance the public’s knowledge and recognition for self-
determination and willingness to end-of-life plan.
This public education and the public’s expectation of a process to address end-of-life decisions would ultimately assist general practitioners in taking their authority in role and developing an approach to end-of-life plan with their patients.

While focussing on public education, there is also a requirement for the practitioner to focus on personal educational needs to facilitate communication.

10.2 Working Hypothesis II: Educating the Doctor

Because the course of undergraduate medical education and postgraduate placement does not adequately prepare general practitioners with interpersonal and communication skills, emotional issues like end-of-life planning may not be addressed.

[Chapter 8: Education]

The general practitioners interviewed emphasize the limited opportunity to learn skills involved in complex interpersonal communication with patients during their undergraduate and postgraduate education. They state that medical communication is usually diagnostically posed, problem-based and solution driven with negligible emphasis on interpersonal skills and the recognition of the social or emotional impact of illness. Also, there is limited awareness of the valuable information available by being with and exploring the emotional experience present in the doctor-patient relationship. Personal values of empathy, compassion, respect and honesty are consciously acknowledged by the general practitioners interviewed. But the emotional experience present in the transitional space is not consciously acknowledged. There seems to be limited conscious recognition by practitioners that in managing in role they utilize their emotional resources and life-experience in engaging with the patient. It is often the tacit information that influences the doctor-patient relationship. This includes the communication and decision-making and consequently
the medical care provided. A practitioners' self-awareness and emotional maturity will influence and contribute to the effectiveness of patient-care. Several of the female practitioners interviewed, recognize and acknowledge the importance of the ability to work with 'feelings' and their effect on the quality of the doctor-patient relationship and the quality of the work performed. As a consequence these practitioners have sought further personal education and incorporated counselling as a component of their practice. But a sophisticated use of emotions in counselling requires sophisticated training. It is difficult even for the professional to understand why one feels as one does. As Armstrong states:

What is it I am feeling here-and-now to 'why am I feeling it?'

From a psychodynamic perspective, medical education offers little systematic attention to many critical aspects of the doctor-patient relationship. These include; the importance of self-awareness, interpersonal and communication skills, and the psychological ramifications involved when handling complex information across emotional and cultural divides. Other aspects include: the recognition by the medical practitioner of the relevance of one's personal attitudes in taking up the role, the role-idea; the effect and affect of the emotional implications of caring for the severely ill, and the complexity of end-of-life care issues. Moreover, projective identification while caring for the dying patient also has the potential to affect the practitioner's own well-being, ability and capacity to respond in a patient focused manner. This is acknowledged by Meier et al who state:

Because feelings influence behaviour and decisions, it is necessary for physicians to learn to identify and assess their feelings consciously.

In the medical setting there is limited attention to and interpretation of the emotional experience within self and within the workplace and its impact on patient and personal care. Managing these anxieties involves recognizing the transferential
projections of the patient and containing one’s own and the patient’s vulnerabilities while attending to their requirements. This is a form of learning not currently undertaken by the medical faculty as part of the training for general practitioners, or of other specialties who consult with patients in existential distress. Reflective action involves acknowledgement of the dynamic internal and external complexities of the individual and the system. These attributes contribute to the competency of the clinician in all forms of decision-making and in end-of-life planning. The development of intrapsychic integration enables the practitioner to work with the emotional experience while being cognisant and thoughtfully creative in caring for the patient.

The RACGP establishes, promotes and maintains the standards for clinical practice, education, training and research for high quality General Practice in Australia, and, as the regulatory body it accredits individuals to practice within the specialty. It also upholds and maintains the standards of conduct within the specialty. As a means of maintaining these standards the College could provide the resources to determine and understand the needs of the faculty members to assist in addressing specific educational needs, through the Regional Divisions of General Practice. During the immediate postgraduate specialty training years, a general practitioner found that role-play in the forum of group work, assisted in recognizing and working with the emotional response in complex clinical scenarios. In this training, facilitated by clinicians and psychologists, the role is to explore with the trainees the emotional experience in the here and now.

This education could include Balint-type groups. Balint designed seminars to enhance the therapeutic role of the general practitioner. The intent of the course being to develop the capacity of the practitioner to work with transference and countertransference issues while gaining insight and enhancing empathic connection and communication with their patient.
Meier and her associates acknowledge the vulnerability of both the doctor and the patient when working together and the importance for the doctor to develop the capacity to recognize and work with the emotions present.\textsuperscript{22}

**Physician Feelings influencing Patient Care**  

<table>
<thead>
<tr>
<th>Warning Signs (behaviours)</th>
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<tbody>
<tr>
<td>Avoiding the patient</td>
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<tr>
<td>Avoiding the family</td>
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<tr>
<td>Failing to communicate effectively with other professionals about the patient</td>
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<tr>
<td>Dismissive or belittling remarks about patients to colleagues</td>
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<td>Failure to attend to details about patient care</td>
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<tr>
<td>Physical signs of stress or tension when seeing the patient or family</td>
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<td>Contact with patient more often than medically necessary</td>
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<tr>
<th>Warning Symptoms (emotions)</th>
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<tr>
<td>Anger at the patient or family</td>
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<td>Feeling imposed upon or harassed by patient or family</td>
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<tr>
<td>Feeling of contempt for patient or family</td>
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<tr>
<td>Intrusive thoughts about patient or family</td>
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<tr>
<td>Sense of failure or self-blame, guilt</td>
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<tr>
<td>Feeling of personal obligation to save the patient</td>
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<tr>
<td>Belief that complains of distress are manipulative efforts to seek attention</td>
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<tr>
<td>Frequently feeling victimized by the demands of the practice of medicine</td>
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In Table 1, Meier et al. identify the potential for rescue or disengagement as possible defensive behaviours and the importance of developing self-awareness. Emotional awareness enables a practitioner, during the consultation process, to recognize personal feelings and behaviours. A capacity to attend to the transference or countertransference present provides ‘good-enough’ patient-care.\textsuperscript{24} If the practitioner has limited self-awareness their feelings may not be contained but may be acted out. For example, a practitioner in recognizing and acknowledging the impending death of a patient may feel overwhelmed by a personal failure to cure and its associated guilt. A sense of hopelessness and helplessness overflows and the
practitioner avoids consulting to the patient and the family. Or the practitioner may be experiencing an extremely busy day and not have time to consult to the patient and the family who require counselling for future plans. As a consequence s/he feels angry at the patient, the family and the system, 'it's all too hard'. As Novack et al write:

Unrecognized feelings and attitudes can adversely affect physician-patient communication: they may interfere with physician's abilities to experience and convey accurate empathy; may preclude or distort meaningful discussions with patients about dying, sexuality and other difficult topics; or lead to underinvolvement or overinvolvement with certain patients.25

In recognizing and managing the conscious and unconscious processes the practitioner remains able to provide 'good-enough' patient-care.

Have medical personnel been trained to fulfil this task? Has s/he the capacity or the willingness, in the setting of dying and death, to acknowledge the emotional experience and work with the shared reality of the inevitability of death? Or in the face of the death, does the discomfort ensure that emotional connectedness is avoided? Does grief silence, at a time when the practitioner's presence is prescient?

Levy, an intensivist believes the capacity to deal with such anxieties can be learned through acknowledging death.

The ability to deal with uncertainty without resorting to avoidance is a skill that can be learned. For caregivers, it is a matter of appreciating the importance of developing a comfortable relationship with death.26

There is a requirement that medical education involve communication skills. In relating to the care of the dying this includes attending to the emotional, spiritual
and psychological aspects of care for the dying patient and their relatives, as well as the physical aspects of pain and symptom management.

The lecture or didactic setting is not the vehicle to engage in this education. These skills involve the ability to work with personal emotional connectedness as well as to be with the patient and work with the emotional experience. Levy writes:

> What does compassionate end-of-life care look like? First, a caregiver does not avoid the discomfort and uncertainty of dealing with death, and talks honestly with patients.²⁷

This style of education may assist general practitioners and other specialty personnel to take up the task of end-of-life planning. The final construction of the task performed is dependent upon the meanings derived by the individual in role and their ego maturity.²⁸ At this time, the professional body for General Practice needs to assist the speciality by clarifying the need of fulfilling the task of end-of-life planning, as a component of continuing care. When end-of-life planning is authorized as a task, an educational programme involving the exploration of capacity and containment in role can be introduced to assist in its fulfilment.

### 10.3 Working Hypothesis III: The 'TASK' clarified

The Royal Australian College of General Practitioners in defining the primary task for General Practice makes a general statement which lacks clarity for its implementation. Specific issues and processes are not defined, so the practitioner takes an individual stance and may not view end-of-life planning as a component of his work - as part of the primary task. [Chapter 5: End-of-Life Planning in Primary Task]
The lack of clarity of primary task leads general practitioners to carry out an existential primary task, which reflects personal values and life experience. Although the primary task is defined by the RACGP, what is enacted or in-acted is unconsciously conceived by the individual and influenced by his/her role-idea. It is important that the primary task is identified and uppermost in the minds of the practitioners especially when the task involves an emotionally demanding commitment, for not knowing induces further anxiety in the task performance.

The principle of end-of-life planning for the patient is based on personal autonomy, decision-making, individual choice and culminating in death with dignity. As in many settings associated with emotional intensity, the task becomes moderated by the anxiety, uncertainty and ambiguity generated through its communication; this impacts on care. Limiting the conversation denies both parties the ability to engage in end-of-life planning. The timing may also be critical for the decision-making for the patient and his relatives.

The physician's failure to inform the patient of his prognosis took from him a genuine choice about how to spend his last weeks.34

Guidelines for end-of-life planning would complement the work of general practitioners. There have been some developments that might aid the process of clarification of primary task; at least in the area of end-of-life planning. In August 2006, the Australasian Medical Association produced a national position statement recommending the role of the medical practitioner in advance care planning for patient self-determination. The position paper encourages all states and territories to 'enact legislation that establishes advance directives as legally enforceable, while ensuring that the same legislation provides statutory protection for doctors'.35 Through this further credence is given to the doctor in-role to take up the task of end-of-life planning. The process ratifies the role of the doctor in the doctor-patient
relationship, and the space for the competent patient to discuss and document their goals and wishes with regard to their end-of-life plan. The acknowledgement and development of a national process enables general practitioners to focus care for the patient within the overarching medical systems to which they belong. The Australian Medical Association recognizes that there is a requirement for the task of advanced care planning and for Australasian medical colleges to formalize a process nationally which establishes a clear role for the medical practitioner. The proposal recognizes the need for an ethical and legal process to assist doctors and to enable patients to make future health care choices. The purpose of the process is to safeguard the patient’s rights and protect the clinical independence of the medical practitioner.

Because the end-of-life plan is an important conversation it is imperative that such documentation is distributed to all personnel involved in the care of the patient. The systems requiring immediate access to the document include the patient, the General Practice, the EPOA (medical), family members, specialists, the residential care facility, and the Acute Health System.

10.4 Working Hypothesis IV: MANAGING in ROLE

The general practitioner does not take up the authority in role to fulfil the task of end-of-life planning because the emotional experience present in the encounter creates intense anxiety and his/her fear of being unable to contain the vulnerability.

[Chapter 7: The Role of the General Practitioner]

As stated in the section on the Role of the General Practitioner [Chapter 7] what general practitioners bring to role is determined by theoretical learning and skills, experiential learning contexts, technical application and personality. Overall the integrating capacity of the doctor shapes how the role is taken up. Hence, for the
general practitioner management of him/herself in role is influenced by several actors. First is the ability to take up the authority of the role as given in the primary task. Second, is the ability to use their medical expertise. Third is the capacity work with the emotional experience of the moment while consulting with the patient. Finally, how general practitioners take up their role influences primary care and the delineation of that care for the individual. As previously documented [Chapter 4: Society's Focus] members in society avoid thinking about death and dying or project the fear associated with their thoughts. General practitioners are utilitarian recipients for these projections. General practitioners raised in this society collude with society to deny or avoid thoughts or discussions about death. As well, the general practitioner experiences personal existential death anxiety. To take up the role of end-of-life planning with the individual patient, Miller would acknowledge that general practitioners need to recognize, work with and understand the processes occurring in the society in which they live. This would enable better management of personal existential death anxieties and facilitate the task for end-of-life planning.

If the individual citizen has a fuller understanding of the processes operating in society of which he is a part then he will learn to manage himself in his own roles with greater maturity.

Through managing in role and containing the vulnerability of the emotional experience, the general practitioner enables role-to-role engagement: hence, making it possible for the patient to take up the patient role in the doctor-patient relationship with the personal autonomy and authority respected in this role. With communication the doctor-to-patient relatedness brings medical, emotional, psychological and spiritual integration to the task. The trust and openness in the transitional space of the relationship makes possible end-of-life planning for the patient with the doctor. The general practitioner in focussing on the task, the role and the boundary is able to work on an important emotional edge. Communicating about a life transition with a
patient may involve a conversation about a terminal illness like cancer, or the inability to cure a chronic illness which has an extremely poor prognosis or the recognition of the need for residential care for the elderly patient. In each of these circumstances general practitioners are confronted with extreme anxiety, their own and that projected by the patient.

If we're to keep working together, you may have to face a lot of anxiety. You'll not only face my approaching death, but you may be confronted with your own.40

This is the space of end-of-life planning.

The question remains: how to handle this most sensitive information and work with the patient?41 There is a need to consider a way of assisting practitioners to feel contained to do this work.

### 10.4.1 A Transition to End-of-Life Planning

Bridger created a model termed the transitional approach with facilitating features to support change.42 The concept of transitional change allows participants to explore subjective experience in an environment that is open, collaborative and containing. Ambrose in describing the transitional model makes explicit the characteristics and the qualities emphasizing:

- An open system,
- A collaborative approach,
- In a holding environment,
- Problem toleration,
- Potential space and playing,
- 'Double task',
- Developmental potential,
- Transitional object, and
- Transitional space.43
An open system perspective involves the recognition of the interdependence of the individuals and groups involved in a process. With a collaborative approach there is a sense of responsibility for the sharing of relevant information and important knowledge between all members of the team with individuals having tasks and roles to fulfil for the system. A holding environment relates to how a setting is structured emotionally to create relative safety with understanding and respect that contains the emotional intensity related to the problem-solving task; in this context: end-of-life planning. Problem toleration is a critical component of the model and is associated with tolerating the complexities and ambiguities within the systems while working together to elucidate a needs-based plan. Potential space defines the capacity of the individual to be creative, innovative and unrestricted in play, to perceive new possibilities in the development of effective outcomes. The focus of transitional change is of a 'double task' which involves both the design of the process, in this setting end-of-life planning, and the awareness of working with the psychosocial components of the task. Developmental potential is the recognition of a need for innovation and change; to create a plan that responds to a challenge. It requires an acknowledgement of the external reality, an acceptance of risk, a capacity to work with anxiety and an awareness of the significance of role and the requirement to drive change. Transitional objects and situations facilitate change. Transitional space is an external condition which allows individuals and/or personnel the space; in the everyday pressures of work, to engage in learning.

It is in the context of end-of-life planning that a transformative process is useful. These qualities in a supportive doctor-patient relationship could facilitate change. For the patient, the time of transition from wellness to illness, cure of a disease to control of the disease, means that personal identity, cognitive, volition and emotional schema are upturned and become uncertain, unpredictable and unknown. It is at this time that interdependence of individuals involved in the care and concern for the
patient is crucial for a beneficial outcome. The framework of the transitional model to approaching change could aid general practitioners in creating a facilitating environment in which to end-of-life plan. The model can assist the practitioner to develop a transitional situation which allows the participants to work towards reconciling the tensions of the inner and the outer world. It requires the presence of a holding environment for the containment of the emotional anxieties and the development of a transitional object. That is, guidelines to facilitate the process for medical staff, to aid the process. It is important for the doctor in arranging to communicate with a patient, family and/or friends about the transition from curative to palliative care that those involved in the transition are prepared and available for the conversation. Understanding the necessity for the meeting is relevant for all participants, because the discussion requires that all involved are able to share openly and honestly relevant information crucial to any planning endeavours.

For general practitioners taking up their role they are acknowledging the purpose of the role for the patient. An open space represents and respects a collaborative approach with diagnostic, emotional and existential issues of equal tenor. Containment involves acceptance, understanding and a sense of relative safety in a fraught conversation. For Shapiro and Carr:

The containing and interpreting that occurs in the holding environment provides individuals with the opportunity to become aware of their projections and reinternalize them.

It is beneficial to both parties, for general practitioners in working with patients and their families at times of critical and protracted illness examine and reflect upon their own emotional vulnerability. The ability to contain emotional stress requires the general practitioner, in role, to use his/her experience and emotional resources. The recognition of transferential projections, the acknowledgement of the patient’s and family’s anger, the fears, their sense of helplessness, and hopelessness, assists in the
maintenance of an understanding and caring relationship. Being empathic while focusing on task, the practitioner is cognisant of the stressors associated with the task and may contain the projected fears without resorting to primitive defence mechanisms, or stepping aside from these fears and out of role. Novack with his colleagues emphasises the dilemmas when the doctor moves out of role.

Unrecognized feelings and attitudes can adversely affect physician-patient communication: they may interfere with physician's abilities to experience and convey accurate empathy; may preclude or distort meaningful discussions with patients about dying, sexuality and other difficult topics; or lead to underinvolvement or overinvolvement with certain patients.55

In recognizing the importance of the task of end-of-life planning, each participant brings their understanding of reality to enable learning and work in the group. End-of-life planning induces significant insecurity and anxiety with the potential for resistance and significant distress in the space. The ability to hold the space without rescuing or fleeing is relevant to the capacity and courage required by the practitioner in managing in role.

[Individuals] must expand their consciousnesses and become aware both of the whole range of realities that are impinging on the system ... They have to live with the realities, however disturbing they be, and to tolerate them, not step aside from them.56

Under many circumstances the doctor, the patient and the family involved are terrified of the task of end-of-life planning for it invokes personal fear of dying and death, the incomprehensible and its unknowableness, so avoiding the task and side-stepping the responsibility is preferred. It is important that the focus remains the patient. Unless the task is conceived as relevant and useful to the patient and their family it is unlikely that a general practitioner will initiate a conversation about
planning. It requires the acknowledgement of reality and acceptance of risk. The development of trust in the doctor-patient relationship is relevant to creating a transitional space for reflection and problem-solving in the task of end-of-life planning. The development and 'funding of a legitimate planning tool': a transitional object in the process, would allow the patient and the doctor to sit together to begin to end-of-life plan.\textsuperscript{57} As a bureaucratic document, the transitional object would facilitate the discussion of end-of-life planning, as a timely process, in collaboration with the family or surrogate.\textsuperscript{58}

Aspects of the process include assessment of cognitive competence and capacity. The appointment of an EPOA (medical) is recommended with this person being involved in future discussions. It is important for all involved to understand the disease, its progress and prognosis, to ascertain the goals and needs of the patient, the burdens and benefits of treatment regimes and choices as they related to personal, religious and cultural beliefs. This plan is always open to respecting the wishes of the patient; not to continue, to change its emphasis, and to regular review. For as Ambrose states:

\begin{quote}
Attempting to impose change on groups of people within an organization or communities who are either unprepared for it or who show no spontaneous inclination themselves to have change brought about is usually counterproductive.\textsuperscript{59}
\end{quote}

\subsection*{10.5 Working Hypothesis V: Whose ROLE?}
End-of-life planning can only be approached in the care paradigm because the process is dependant upon the capacity of the practitioner to contain emotional vulnerability.\textsuperscript{60}

\[\text{Chapter 9: Care, Cure and Cost-Containment}\]

As has been argued, for the person in-role to take up the dynamics and emotional demands of end-of-life planning an extremely high level of emotional consciousness
and containment is required. As already quoted, Armstrong could have been speaking of end-of-life planning while talking about the containing of vulnerability; for this indeed is the challenge in end-of-life planning. In creating an environment of containment with openness and empathy a general practitioner demonstrates his/her aim to be with the patient during the time of transition, to respect the patient’s needs and choices and to acknowledge personal autonomy. Taking up the task of end-of-life planning is a demanding process for both the patient and the doctor. Choices need to apply for both individuals.

First, is for the general practitioner to recognize the relevance and importance of the task of end-of-life planning for the patient. Next is the decision by the general practitioner as to how best accommodate and fulfil the task of end-of-life planning while retaining the fundamental focus of patient-care? In this process the general practitioner may also enlist the assistance of a therapist, social worker or psychologist to support this work of end-of-life planning with the patient and family especially if the practitioner feels disturbed by the prospect of the task.

Managing “boundary conditions” is critically important to managing all aspects of the professional-patient relationship. It allows real human emotions to be present and experienced without them becoming an obstruction to or intrusion on the patient.

The capacity to manage in role while performing this task is crucial, for empathic containment of emotional vulnerability is central for all present to fulfilling the task. The doctor works with the emotional intensity of the experience of the patient while containing the space, to enable exploration of the wishes of the patient, while being mindful of the requirement for clarity to ensure understanding by all involved.

The awareness of the end of life is always present in us, and it faces us all the time with anxieties, which change in intensity.
and become more acute when we go through particular moments of crisis.\textsuperscript{65}

It is the core issue, isn't it! It's making me feel uncomfortable, facing their death before its time. I feel the discomfort and let the time go by. If they have not expressed a need for that sort of discussion for me to raise it is presumptuous. There are many ways to dodge this discussion. [I:2]

The practitioners involved in end-of-life planning need to recognize the communication skills, continued education and support required. This could be achieved through Balint-type groups as this would also facilitate personal development. As recommended by Balint:

\begin{quote}
Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously in the patient's mind when doctor and patient are together.\textsuperscript{66}
\end{quote}

\section*{10.6 Summary of the Research}

\subsection*{10.6.1 Who is performing end-of-life planning?}

Within the research community it appears that very few are attending to the task of end-of-life planning. The initial quantitative study based in the Emergency Department supports this assumption (Chapter 1: Background). The majority of adult patients of the community attending the Emergency Department, in May 2002, were not engaged in end-of-life planning with their general practitioners.

The research demonstrates that end-of-life planning does not occur because:

- The contextual and societal fears associated with dying and death unconsciously remove these thoughts from the minds of the society members so that end-of-life planning is not conceived as a task for most members in the community. Moreover the myth of cure promulgated by the media for the medical profession is accepted as the desired outcome by society, further removing the link of life from death.
The personal and societal avoidance of thinking about death and dying inhibit the task of end-of-life-planning. Rather than acknowledging that death is a natural event, society generally perceives death as a medical problem.67

The majority of general practitioners, as members of society, do not conceive that the task of end-of-life planning is part of their role. They do not take up the authority and responsibility to end-of-life plan with patients because they collude with society to keep death out of mind.

10.6.2 Who ought to end-of-life plan with patients?
Ideally, the logical and practical person to attend to the task of end-of-life planning with a patient is his/her general practitioner with whom he has developed a trusting relationship.

The purpose of General Practice is to provide the day-to-day health care for individuals within the community. The general practitioner in this role offers whole person medical care to the individual focusing on continued health and well-being. The care provided is comprehensive and provides continuity.

While acknowledging the importance of confidentiality in all conversations; the significance of the transfer of clinical, social and emotional information is important to the well-being of the patient. The general practitioner provides this role-to-role liaison for the patient with the specialist and other allied healthcare professionals, as required during the life cycle of the patient. These liaisons provide an opportunity for the healthcare system to integrate and work together for the purpose of the patient. This communication within the systems not only improves role-to-role relatedness with the specialist and allied healthcare professionals but also further enriches and develops the general practitioner-patient relationship encouraging trust, which enables openness and honesty in communicating.
The doctor-patient relationship also facilitates, where appropriate, the development of relationships with family and friends; the individuals important to the understanding of purpose and meaning in the patient’s life. This inter-relatedness and collaboration is especially significant at the time of end-of-life planning, so that at a time of crisis the group, with the chosen surrogate, is able to work together to the benefit of the patient.

The research indicates that general practitioners believe they are the most appropriately placed members within the healthcare system to initiate the task of end-of-life planning. Even so, they do not believe that they are currently equipped to perform the task requiring authorization by their medical faculty, endorsement by society and improved communication skills in their medical education.

10.6.3 What are the limiting factors?
From the data analyses the perceived limiting factors to the provision of end-of-life planning by general practitioners are:

- General practitioners do not assume the authority in role to perform end-of-life planning for patients as part of continuity in care. This aspect of patient-care is not documented within the framework of tasks in General Practice and the practitioner does not assume authority to perform the task. The RACGP needs to endorse the task, provide guidelines and education to go towards enabling practitioners to take up the task as part of their role.68

Recently the Australasian Medical Association produced a national position statement recommending the performance of the task advance care planning to encourage patient self-determination.69 The paper encourages all states and territories to ‘enact legislation that establishes advance directives as legally enforceable, while ensuring that the same legislation provides statutory protection for doctors’.70
Initially general practitioners, as a group, do not identify end-of-life planning as a component of the primary task and therefore do not take up the task as part of their continuity of care for a patient. Even the assessment for residential care of the elderly debilitated patient is removed from the mind of general practitioners, the patient and their family until a crisis occurs.

Because of the medical myth of cure the practitioner experiences failure to cure as a personal and medical failure with the consequent guilt disabling the practitioner from addressing the transition from cure to care.

General practitioners recognize that undergraduate and postgraduate medical education does not provide them, in role, with a secure and safe framework for the initiation of emotionally intense communication. These educational limitations need to be addressed before General practitioners would feel capable of end-of-life planning with their patients.

10.6.4 Who could support the general practitioner in-role?
General practitioners require the support of the RACGP, medical bodies, government authorities, allied healthcare and society to take-up the task of end-of-life planning with their patients.

The task of end-of-life planning requires authorization and endorsement by the RACGP so that the general practitioner is able to accept their professional authority in role to fulfil the task of end-of-life planning.  

This task could also be supported with medical education by providing specialist educationalists in both undergraduate and postgraduate training to support the role. This education as an experiential model would assist the general practitioner and other specialty faculties to deal with the emotional intensity of end-of-life planning which involves the capacity to manage in role.
Managing in role recognizes and works towards understanding the processes occurring for the patient in the society. This education would also enable general practitioners to better manage their personal existential anxiety. It would involve aiding the recognition and capacity to understand the psychic and contextual dynamics of society and to integrate these with personal dynamics. That is, the unravelling of the internal and external realities of clinical work and working with both.

- Education of society is gradually occurring as the media promulgates well-being, quality of life and self-determination. This education and acknowledgement by individual members of society will support general practitioners in fulfilling the task of end-of-life planning as individuals take on the personal authority and responsibility for their own end-of-life care.

- Another area that needs review is the funding of a process model, to adequately acknowledge the time required to fulfil the task of end-of-life planning. The media, especially at times like the Schiavo case report, promulgates the values of end-of-life planning and the appointment of a surrogate. But taking up of the task end-of-life planning for the profession and for members of society is slow to occur. As medical practice becomes more complex, in a changing demographic, further research into education and delivery of services should review the practice as well as the funding models required to fulfil the practice. This process of end-of-life planning also needs to be supported by the medical fraternity.

- The general practitioner in the community could also enlist the assistance of a therapist or psychologist to support this work of end-of-life planning with the patient and family. These healthcare practitioners have the technical skills to
support and assist general practitioners to manage in role; to share the task of end-of-life planning.

Our aim is to help the doctors to become more sensitive to what is going on, consciously or unconsciously in the patient's mind when doctor and patient are together.74

**Critique & Suggestions for further research**

**10.7.1 Is end-of-life planning supported?**

Discussion of the process of end-of-life planning is beginning to occur in the current medical literature. The Medical Journal of Australia (MJA) recently published a positional paper by the Australian Medical Association recommending the practice of end-of-life planning.75 Specialty areas particularly palliative care and oncology are recognized the limitations to end-of-life planning and are initiating research with recommendations to address undergraduate and postgraduate education. The educational recommendations involve reform enabling the profession to develop communication skills that will assist the practitioner in being with and supporting seriously ill patients and their families.76

Clinical practice guidelines, developed through the funding of a strategic research grant by the National Health and Medical Research Council have been published by the MJA to assist healthcare workers prepared to take up communicating end-of-life issues.77

**10.7.2 Who else could take-up the role to end-of-life plan?**

As stated in the research data, the people most appropriately placed to do this work are the general practitioners; but the task is enormous and their time is often limited. A 'Respecting Patient Choices' model devised by an American Medical Foundation is being adopted in areas of my community hospital, this model, funded by the Federal Government, employs allied health professionals to fulfil the task within the hospital environment.78 This model is in the process of being taken into local
Nursing Homes. With the support of RACGP and Divisions of General Practice the project could be based within community practices to assist in educating general practitioners’ involvement by supporting the development of a team approach.

10.7.3 Other professionals to research
Most of the fields of medicine have associated chronic debilitating disease. For example; Renal Medicine has dialysis, Endocrinology has chronic cardiac, renal and vascular disease, Respiratory Medicine has chronic obstructive and restrictive lung disease, Neurology has conditions like multiple sclerosis, motor neurone disease and recurrent cerebro-vascular diseases, as well as Geriatric Medicine having dementia and debility. Research could explore the capacity of these specialty areas to develop guidelines and a programme to educate patients about the chronicity of their disease processes and their ability to maintain quality in life with symptom management. Currently fields like Oncology, Haematology, Surgery and Palliative Care tend to deal with more rapidly progressive disease processes, but these specialties rarely address the issues of quality, symptom management and end-of-life planning. What would aid these practitioners in the work with their staff, the patient and their family? What would patients think? Research projects to explore how to introduce a similar process for the patient could be advantageous.

10.7.4 Difficulties in gaining authority to end-of-life plan
The most critical phase of end-of-life planning is its introduction to the patient. For the practitioner to ascertain the timing to introduce a conversation of end-of-life planning with a patient and their family is difficult and the process introduces an extremely, emotionally distressing period. Schofield et al, report that a quarter of the Oncologists administered treatment; that would be of no benefit, to maintain hope and avoid the conversation.79 Currently it appears that practitioners; instead of pursuing personal authority in their roles, are relying upon the authorization from government, legal and medical establishments to begin to practise end-of-life
planning. But the most salient authorizing agents are the individuals involved in the process itself, the doctor and the patient. It is in the setting of the doctor-patient relationship where respect and trust are born that permission is granted and doing no harm lives.

Within this context, at times the patient may not wish to hear. But the availability of the choice should be paramount. Respect, personal choice and self-determination are critical values. As Amado and Ambrose suggest:

You cannot make people change their long-established ways of perceiving, thinking, and framing problems. What you can do, however, is to provide conditions that enable people to see things in a new light, to extend their perspectives, to look at the consequences of their actions, to question the validity relevance of their existing ideas, beliefs, and attitudes that underlie their actions, and to entertain different ones that are more relevant to their new perspectives.80

10.8 Conclusion

It is important that the practitioner is able to acknowledge the inevitability of death and not disguise the outcome by evasion and continued treatment activity.81,82 The potential prognosis of terminal or critical disease is understood by the practitioner and this knowledge should be shared to allow the patient and/or surrogate access to the decision making process.83 The emotions associated with the uncertainty, the sadness, the pain and distress involved in end-of-life planning are very human attributes, they can be accepted, rather than suppressed or denied.84 This is the phase of care that benefits from a humane, open approach, where support and understanding are prerequisites while engaging with the patient and relatives.
Despite the findings of the research performed, as researcher I believe that the task of end-of-life planning is an important process to perform for patients, their families and the medical profession. Knowledge of the choices for interventions and management of a person with a chronic or acutely debilitating terminal illness allows patient and/or their surrogate to facilitate the treatment choices and fulfil the personal wishes of the involved person. Personal autonomy, freedom of choice and self-determination in the setting of knowledge, legal frameworks and informed consent enable those participating in the care of the person to knowingly support and accomplish the wishes of a loved one.

A fundamental commitment of the practitioner is to care for and support the patient and their relatives during health and disease transitions. This was recognized by Braumwald and his co-authors when writing:

However much the knowledge base of medicine has expanded and will continue to expand, the fundamental commitment of the physician to the care for the patient remains unaltered.\(^8^5\)

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13 Billings A, Block S. Palliative care in Undergraduate Education. JAMA, 1997;278:733-738.
29 Lawrence WG. Management Development...some ideals, images and realities. In: A.D. Coleman & M. H. Geller, eds. USA: A.K Rice Institute, Group Relations Reader 2, 1985: p. 236.


57 Interview 3.


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Appendix 1

DEMOGRAPHIC QUESTIONS

Age

Sex   F    M

Ethnicity

Religion

Practice specialty

Yrs of practice

Personal contact with dying or death of an elderly relative?

What is the role of the GP?

What do you bring to the Dr - Patient relationship?

Preparation in medical learning for communicating issues of significance?

Do you end-of-life plan with your patients?

The name of a patient / family from your practice who may be prepared to be involved in this research?

Appendix 2
MEDICAL ?s (2)

1. How does the Australian society deal with death and dying?

2. What are the social issues that influence your attitude to death and dying?

3. What do you think are the cultural features to the viewpoint or what is the cultural basis for these concepts of death?

4. What religious beliefs do you think influence decision making?

5. What influences your own practice?

6. Are there other fears or anxieties for society, for you?

7. What ethical or legal implications do you think are relevant to ACP, or end of life decision-making?

8. How do you think all these issues influence the Australian attitude to end-of-life plan, ACP?

9. Do you believe your patients have any knowledge or understanding of ACP?
MEDICAL ?s (2) cont

10. Have any of your patients discussed ACP with you?

11. Have you been involved in ACP with any of your patients?

12. Who do you believe should initiate the discussion about end of life planning /AHCP?

13. What for you, are the important issues for end of life planning?

14. When should people begin to have this type of discussion?

15. Have you discussed the purpose of EPOA (medical treatment) with any of your patients or their relatives?

16. Do you ponder these types of issues for yourself and members of your family?

17. Do you believe there are any components in the relationship which enable or disable this conversation?

18. How would you describe the doctor-patient relationship?

19. Is there any thing else that you believe is important and relevant to this discussion?

THANK YOU
Appendix 3
For Aged Care Facility staff, patients and relatives, the project plans to:

- enable individual healthcare plans to be formulated
- enable end of life discussions to occur with carers, family and the patient if capable
- allow individual' choices to be explored
- explore quality and quantity of life issues
- explore cure and care issues
- regularly review individual' plans with the patient and their family
- develop a system wherein plans will be known, communicated and observed
- work sensitively with patients and family at the end of life
- encourage the implicit fears of death and dying to be explicit
- communicate clearly so that the individual patient needs and expectations can be made explicit
- develop a greater understanding and acceptance of difference and diversity in individual, religious and cultural values
- develop a greater knowledge of 'carer roles' and their impact on patient care
- emotionally care for and support patients and their family
- develop a collaborative working environment
- develop change processes through action research
- aid patients and staff to develop a reflective capacity in their life journey.
Appendix 3 (cont)

General Benefits
The general benefits of the research may provide a basis for the community to review its current practice of acute intervention, resuscitation and prolongation of life without questioning quality and quantity of life decisions and aspects of individual choice, so that:

- Advanced healthcare planning will be considered as an integrated part of the individuals’ goals for medical care and the continuum of care for the elderly dependent and the young disabled individual in the community.

- The psycho-social dynamics of decision-making around end of life issues are articulated and examined.

- A greater understanding of the psycho-social dynamic needs and expectations of individuals around quality of life issues will be gained.

- The research will stand as a model for change in the broader medical community.

- An enhanced ability for all involved parties to communicate about end of life issues with patients, relatives, medical and para-medical personnel will be fostered.

- An increased capacity will be developed within the health sector for developing change through action research.
Appendix 4

ADVANCED CARE PLANNING Date: MAY 2002

PATIENT: (ADULTS >20 years)

please circle relevant data

Patient LABEL

From: home supported accom retire/village hostel n/home

Referral letter: Yes No

Referral LMO: usual locum

Referral Carer: usual agency

Born in: Australia Elsewhere_________________

Cultural origins: Anglo-Irish Greek Italian Indian Lebanese Turkish East-European Chinese Vietnamese Other_________________

Religion: Nil Buddhist Catholic Greek Orthox Hindu Islam Protestant Other________

Reason for ED presentation: CNS Resp CVS Orth FALL Debility Ca Confusion Infection Other_________________

Reason for Admission: CNS Resp CVS Orth FALL Debility Ca Confusion Infection Other_________________

Advanced Care Planning: Yes No

Healthcare Planning Process: Family GP ACAS Hosp None

Power of Attorney Yes No

Enduring Power of Attorney (medical): Yes No

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Appendix 4 (cont)

ADVANCED CARE PLANNING PROJECT  (ADULTS)

Date:  MAY  2002

The Emergency Department of the XXXX in May 2002 is performing a study and all
adults who attend in May are invited to participate. The plan of this research is to
determine if advanced care planning is occurring in the adult population who attend
the Emergency Department. These questions are not personal and bear no
relationship to the illness for which you have presented to the Emergency
Department for treatment today.

The data sheets collected will be held within safe storage for a period of 7 years,
the questions will be statistically represented; your confidentiality will be assured.

Advanced Care Planning enables individuals in discussion with their family and local
doctor to determine their healthcare choices in the setting of severe disability,
chronic illness or terminal disease.

Have you heard the phrase advanced Care planning?

POSSIBLES ???s: WONDERING ABOUT YOUR THOUGHTS OR PLANS

If under circumstances of an accident or severe illness wherein you were unable
speak or make decisions for yourself have you appointed someone to make
treatment decisions for you?

or

I wonder if you have thought about what your Rx plans would be if you developed a
significant illness or had a severe injury with significant disability and have you
made this known?

or

If under circumstances of chronic illness you wished to (or did not wish to) undergo
continued resuscitation efforts &/or have major surgery, have you discussed and
documented any plans for this type of circumstance?

or

Have you thought about at what stage in an illness enough would be enough, no more
treatment please and made these thoughts known, documented?

or

Would you wish for medical personnel to make all of your treatment plans and
therefore would not wish to have an advanced care plan?
Appendix 5

END-of-LIFE PLANNING

Project Description and Aim

End-of-life planning is a process that enables an individual to develop an understanding of their medical condition and then explore their own healthcare wishes with the intent that their medical care reflects their personal values, objectives, religious and cultural needs. The discussions that occur can involve family and healthcare providers so that the decision-making and choices about treatment and care, take place in an environment of openness with respect and comply with the legal requirements of the Victorian Guardianship and Administration Board Act 1986.

As a legal document an individual’s healthcare plan, should be made explicit respecting the autonomy of the individual, for this will honour this individual’s choice within ethical and legal guidelines.

The absence of discussion and decision-making with patients, family and carers about end of life care means that the management choices are diminished at the time of a crisis. The default position, especially for the frail elderly patient is transportation to a hospital emergency department for medical intervention. A medical approach may focus on ‘cure’ at all costs and quantity of life, rather than ‘care’, with the focus on quality of life and dignity at the time of death.

The aim of the research is; to explore the complexity of the social, cultural, religious, ethical, legal and emotional concerns which operate in the process of developing advanced healthcare plans and to identify the perceived roles and responsibilities in initiating discussions with the patient or their family about healthcare planning. The research model will use a psycho-dynamic approach in a framework of action research.

Outcome

End-of-life planning enables competent people to maintain a sense of personal control over their healthcare, to make the treatment choices that validate their sense of being, so that, at the time of a crisis or if they become incompetent to make these decisions, a plan is available for family and medical staff to heed.

Summary 16th May 2003
Appendix 5 (cont)

Benefits of the research:
A greater understanding of the psycho-dynamic needs and expectations of patients, family and carers around quality of life issues.

An enhanced ability for all parties involved to communicate about end of life issues with patients, relatives, medical and para-medical personnel.

An increased capacity, within the health sector, for developing change through action research.

Advanced healthcare planning will become an integrated part of the continuum of care for the elderly dependent and the young disabled individual in the community.

The research will stand as a model for change in the broader medical community.

The psycho-dynamics of decision-making around quality of life issues are articulated and explored.

Participation:
Participation is by individual choice; this consent can be withdrawn at any time, without prejudice. All data collected for this project will be anonymous. It will be stored in a private office in a locked cabinet. Selected items of the research will be published in medical peer review journals. The entire document of research findings will be published as a post-graduate doctoral thesis. If requested confidential information will not be included.

Any questions regarding the project can be directed to:

Professor Susan Long  
Australian Graduate School of Entrepreneurship  
Swinburne University of Technology  
Telephone: (03) 9214-8145

Complaint procedure:
Any complaints relating to the project are addressed to:

Head of Australian Graduate School of Entrepreneurship  
Professor Adolph Hanich  
Swinburne University of Technology  
Telephone: (03) 9214-5249

or

The Chair: Human Research Ethics Committee  
Swinburne University of Technology  
PO Box 218 Hawthorn Victoria 3122  
Telephone: (03) 9214-5223
Appendix 6

END-of-LIFE PLANNING PROJECT

Consent by Medical Practitioner to Participate

I have read and understood the information provided. Any questions I have asked have been answered to my satisfaction. I agree to participate in this project, realising that I may withdraw at any time without prejudice.

I shall participate in an:

Individual interview (45-60) mins yes no

I agree that the research data collected for the study may be presented, published or provided to other researchers on the condition that anonymity is preserved and that I cannot be identified.

Anonymity will be ensured in all printed material.

Name of Participant ------------------------------------------

Signature -------------------------------------Date----------------

Principal Investigator:

Signature-------------------Date--------

Consent Form for Medical Practitioners: 16/5/2003
Appendix 7

THEMES

Container / Containment / Boundaries:    2:2

Primary task:                     6:2

Role:                             1:4

Human attributes, integrity      1:5

Relationships                    9:11

Space                             7:3

Assumptions
   baF (4.9), baD (8.1), baP(13:4), baO(7:5), baM(12.3)

Education                        5:3

Meaning, purpose, being valued, independence       5:9

Personal authority, Choice        2:2

Systems                           2:7

Time                              11:2

Ethical issues                    3:2

Quality of life                   4:7

Shame                             11:9

The Unknown                       11:6
Appendix 8

DEMOGRAPHICS of the General Practitioners

Removed to retain confidentiality.