Dr.Richard Henderson Smith. / 11th August 2006.

International Association of Medicine of the Person, 58th Meeting .

Motivation in the Doctor-Patient Relationship.

I have been asked to speak within our conference theme about motivation in the context of the Doctor/Patient relationship.

Let me begin by thanking you for the huge honour and privilege of being invited to lead our thinking on this subject.

I speak from the standpoint of a general practitioner with more than 30 years of practice, not as an academic nor an expert in motivation. I have been the senior doctor in my own practice for 20 years so my observations come from my clinical experience and ongoing personal study only. My thoughts are therefore anecdotal. I am a generalist and along the way I spent four years as surgeon/ anaesthetist as well as physician and leprosy doctor in Bangladesh. My principal concern as a doctor is to stimulate and encourage my patients to cope with acute illness, to find the courage to face chronic and terminal illness or to change their behaviour for their own long-term good.

“Motivation is an inherent and central part of the professional’s task.”[1]

I take ‘Motivation’, for our purposes, to be the drive towards meeting a need or achieving an intention, energising and directing behaviour towards a goal. Intention is the springboard of conduct, organising life’s patterns towards readiness for the drive to action. Motivation has been defined as the ‘go’ of mental life[2]. It pushes a person into adaptive behaviour whenever the appropriate stimulus or associations are present. Notwithstanding the classical ***primary*** hierarchy of needs [3], I think human motivation goes further. Of course these primitive drives to survive and thrive and the associated desire to avoid pain and fear of pain, disease and death will always be involved and often motivate our patients to attend us. However the psychological motivation to achieve a proposed course of action is, I think, a higher purpose since it takes into account our social context and therefore involves conscious decision which is at times counter-intuitive.

Within my title I shall be particularly concerned with the encouragement of a state of readiness to consider change by my patient, but later I do intend briefly to discuss the doctor's own motivation.

My patient and I are "joint adventurers in a common cause"[4]. By the very nature of our ethical standards as doctors we have a ***covenant*** [5] relationship with our patients. It is the commitment to the relationship itself which lies at the heart of our work with people, whom we promise to serve with faithfulness and confidentiality. We promise to do our best for them, to try to avoid causing them harm and to be fair and just in relation to the rest of our patients. The patient in turn voluntarily offers something of him or herself to us and so the *trust* at the heart of the doctor/patient relationship is established. Paul Tournier, of course, wrote about this in a chapter significantly entitled "To live is to choose". This is what he says: "Trust is a matter of prime importance; we must trust absolutely [the patient's] responsible choice, even if it seems to us to be questionable…The task of a doctor is to help each of his patients to become a person, to assume his proper responsibilities." [6] Together we react to an environment which shows signs of disorderliness, to re-impose order and predictability. So we embark upon a *mutual* search for meaning within the universe of which we feel the centre, knowing that it is not THE universe; recognising also that we do indeed have choices, albeit perhaps limited ones. Carl Jung wrote: "Meaning makes a great many things endurable – perhaps everything. Through the creation of meaning…a new cosmos arises".

Motivation depends upon a relationship. "The point of contact between doctor and patient…is probably the most powerful therapeutic agent in existence."[7] At the outset I have to win my patient's attention and trust. He requires me to take him/her seriously, to be accepted as a person, with all the complexity and life experience of which I know but a tiny fraction. I must look him/her in the eye, look beyond wants to the clinical need as courteously and efficiently as possible. [I hope you will forgive me if henceforth in this talk I speak of he, him or himself to INCLUDE she, her or herself]. Together we must recognise an issue or problem and eventually explore the possible necessity for change. This is where I seek to facilitate motivation but I must remain available to him when the decision is *not* to change. The process requires

commitment, mutual respect and acceptance thus allowing my patient to comprehend and be empowered to comply with any *agreed* actions or processes. An example where I and our team abjectly failed in this was with a patient, AG. He refused to engage positively, eye contact when it occurred was confrontational; he had his own agenda. He and I failed to agree that he needed any help. He insisted only upon his desire to escape into internal oblivion. He refused to acknowledge that his drug habit brought him into conflict with the child-protection authorities. He would not agree to work within boundaries, constantly trying to get his own way with requests for prescriptions of benzodiazepines to supplement his daily cannabis use. Ultimately this led to a crisis where he came close to physically assaulting me and my few female staff thus forcing his expulsion to a so-called secure setting.

Our consultations need to be open-ended, empathic and undefined until a diagnosis is arrived at. We must never lose "the ability to see the wholeness and vulnerability of the person…to see beyond the specific focus of the problem" to the real person[8]. Within the constraints of contemporary practice somehow we need to allow ourselves time and emotional space to make a connection and establish a rapport, whilst at the same time offering our expertise. By contrast, our management must aim to be clear, goal-orientated and definite since, as doctors, our ambition is to help our patients achieve something, whether to change in some way or simply to persevere with a chronic condition as it unfolds. We need to give our patients as much time as possible as often as possible. Time is becoming increasingly stretched these days and time constraints put pressure on the essence of good doctor/patient relationships. People need time to express themselves especially if emotional or psychiatric problems are present. I need time to understand my patient and arrive at a proper diagnosis and continue to help him. There are occasions when we work with our patients in a fraternal way and other times in a patronising way and we must carefully discern the appropriate stance for each occasion. Our approach may vary with the same patient on differing occasions. In short we need to facilitate a close, but not too close, relationship; intimacy, but clearly not too much. We need to develop intuition but avoid the risk of over-identification, to guard our emotions and aim to retain objectivity. Before long we must clinically examine our patient and, I believe, this is a crucial motivational tool. When we "lay hands on him" and make physical contact in some way, we communicate our common humanity and mutual trust. If nothing else I

almost always check my patient's pulse as an excuse to hold his hand. Touch is essential for health and well-being[9]. When caregivers have the intention to 'connect-with' rather than to 'do-to' a person, the communication can have a healing effect [Montgomery, p45].

Motivation depends upon communication. I have an 85 year old friend, who often reads the Bible lesson in Church with great clarity and emphasis. After the service one day she asked me whether she should start to have Influenza inoculations. Of course I encouraged her to do so but, being cautious, I asked her whether she was allergic to eggs since the vaccine is cultured in hen's eggs. A couple of weeks later I met her and she told me that she had indeed had the injection without mishap but that she was sad that she could no longer eat eggs! My powers of persuasion had proved strong but communication far from perfect!

-We must therefore be a ***credible*** source of information and motivation;

- we have to win our patient's ***attention***;

- to communicate our message ***effectively*** (translating medical jargon to narrow the gap between technical terminology and everyday speech).

-Our patient may then ***accept*** our message,

- ***continue*** to follow it and understand its importance,

- and comply with what we are ***confident*** is current best practice.

In addition, the greater the doctor's knowledge of the psychological, social and physical aspects of the problem, the better the sense of well-being and health of patients.[10]

Sometimes there may not seem to be much need for change (in contrast to the aims of counselling or psychotherapy). We may be required only to encourage our patient to keep going, to remain faithful to the impulses of life. We must calm fears and smooth anxieties even, for example within so simple a task as measuring Blood Pressure. I have noticed that *my own* state of mind and the pressures of the day can affect a patient's Blood Pressure. One day I was called out of the consulting room to assist with the resuscitation of an elderly lady, not one of my own patients, who had collapsed on the road-crossing nearby. She had been a family neighbour for some eighteen years, an immigrant in her eighties; she had had a hard life and was a lovely

Christian lady. The situation was hopeless and when the ambulance arrived she was clearly dead. I had to return immediately to the interrupted consultation and found that my measurements of Blood Pressure for the rest of the morning were all rather high. Blood Pressure readings seemed to depend as much on the emotion of the observer as on the patient's own state of mind. Short-term hormonal changes are influenced by relational factors. If I am hard-pressed and impatient then *my* negative state creates anxiety in my patient and raises *his* corticosteroid levels and blood pressure. Perhaps there is something here about loving ourselves before we can effectively love others! Emotions, experiences and attitudes are psychological factors which can even affect the immune system, feeding back to physiological changes[11], [12].

Motivation goes further than a vague internal state of readiness; it must lead to the faithful attempt to follow advice or a therapeutic plan. The emotions are engaged so, for example, a patient's reactions to a serious diagnosis often mirror the stages of grief since there is a perception of the loss of opportunities. So there can be an initial denial, wishing things were other than they are. Anger and resentment follow, then a sense of resignation. Finally we hope for acceptance and the establishment of positive attitudes to the new state.

Miller[13] lists a number of general motivational strategies. Effective approaches typically combine *several* of the following:
i] Giving ***advice.*** Having clearly identified a problem and explained why change is important, we advocate specific change, but rather that giving orders, make offers of help. The physician must be an educator and any complaint, however trivial gives an opportunity for instruction, as any general practitioner knows from his dealings with the parents of young children. Education connects the patient's consciousness with his physiology, reducing fear, and this more positive attitude aids healing if not cure.
The truism of the 'Doctor as drug' is so easily overlooked in the constant drive for greater efficiency in contemporary health services. Miller writes "It appears that the primary impact of brief interventions is *motivational*. Their effect, we believe, is to trigger a decision and commitment to change". Famously the likelihood that patients will quit smoking has been found to follow physician's advice[14].

ii] Removing ***barriers.*** This includes practical questions of access or opportunities for review. But, more important, we have to put aside doubts about our patient's ability to change since the therapist's belief in the client's ability to change can be a significant determinant of outcome[15]. There is then the possibility of ***balance*** between the patient's own concept of his disease and the doctor's professional concepts allowing successful negotiation and the creation of consensus[16].

iii] Providing ***choices,*** to maintain a sense of independence and freedom and encourage our patient's self-responsibility. Motivation may be either ***intrinsic*** in terms of the patient's *own* desires, decisions and drives or ***extrinsic*** in terms of incentives or pressures felt from outside. Intrinsic or Inner motivation is far stronger than the influence of Extrinsic or External forces and this confirms the importance of ***autonomy*** and the individual's own drive to achieve some kind of control in his life rather than to be controlled *by* events. But as doctors we spend our time preparing for and recognising events as early as possible and then helping our patients to process these for themselves. They will use physiological, psychological and spiritual means to attempt to overcome the perceived external pressures be they patho-physiological, psychological or indeed spiritual. Our task is to assist this struggle for personal liberation, to empower him to remain or become autonomous. He must be allowed to make and to take ownership of his own judgements, under our guidance, and to make mistakes, even as we urge otherwise. We must discourage dependence because "ultimately … health lies in the integrity or oneness of the whole"[17].

Internal, intrinsic strategies require personal investment and mental effort and so reap a higher reward in motivational terms. It is these upon which we mostly try to build in our work. Within the consultation Intrinsic, internal motivations may be derived from the patient's own ***rational choices*** and self-challenges, for example towards better general health or to cope with the news of a serious diagnosis. Working with our patient we attempt to turn negative emotions such as dread into positive, forward looking hopeful feelings.

iv] Decreasing the ***desirability*** of former behaviour by exploring a cost/benefit equation. Again we clarify why *change is desirable*, and perhaps this is one of those occasions when we should patronise our patient, that is to act as a father-figure to

him. “A source is increasingly persuasive as his message increases in confidence…”[18] Change must be shown to be a challenge rather than a threat, inevitable and normal because stability is an illusion in human lives. In the face of uncertainty we need to help our patient welcome change as an opportunity for growth and self-development, to see that there is ***purpose*** in dealing with life’s problems. He need not be overwhelmed by a sense of powerlessness, threat and anxiety because a time of flux is not only a universal experience but can be shared with others within a community. Alienation is unnecessary and support is available.

v] Practicing ***empathy*** involving respect, supportiveness, concern, sympathetic understanding and active interest. This is not identification; rather it is compassionate regard and reflective listening. In order to properly serve our patients we have to say to each one, in some way, “Come with me, I am going that way too.” So we can discover that we can be agents of cure when possible, bring healing often, but comfort always.

vi] Providing ***feedback*** and positive re-inforcement, helping our patient reflect upon self-monitoring. Initial motivations need to be nurtured and encouraged in order for drives to flourish for the patient’s long term good.

Lastly [vii] Clarifying ***goals***, comparing achievement with an agreed plan, linked with self evaluation. General practice is primarily solution-focussed and *motivation depends upon a goal*, whether to change and reap the reward of a longer or, at any rate, a better life. We wish to help our patients to set their own goals. This can be helped if there is some immediate pay-off. For example, in Britain patients newly diagnosed with Hypothyroidism or Diabetes Mellitus have, for many years, immediately been awarded all prescriptions free-of-charge, for the remainder of their lives. This greatly facilitates compliance with medication and acceptance of the life-change. By contrast Asthma patients without other reasons for free prescriptions are forced to pay for each item, and it is well recognised that compliance in these cases is often patchy.
We must take into account our patient’s *ability to set realistic objectives* (this may entail breaking up the goals into smaller, sequential entities). It is a privilege to share the experience of coping with complex issues over a long period of time. It was

wonderful and moving one day to share the happiness of a 63 year old lady [MMB] that her psychotic son, who had served a long prison sentence, was at last being rehabilitated in a near-by city, settling into a supervised flat, learning to repair musical instruments and rebuilding relationships with his family. My patient is herself schizophrenic, still receiving treatment for breast cancer and has heart failure and is obese. Her husband has multiple and serious diagnoses but is emotionally the stronger. Talking of her son she said "I didn't think he had a future but he has", her joy had changed her. No longer was she the apathetic person with whom we have worked to bring all these issues under some kind of control, little by little, over the past 16 years.

Motivation depends upon purpose, regardless of whether it is to change or continue a course. As doctors we need to attempt, by educating our patient, to facilitate the conversion of Extrinsic drives, which we may ourselves initiate, into Intrinsic motivation, purposeful and owned by the patient himself. One motivational model[19] describes a cyclical movement from

- ***subconscious pre-contemplation*** (the seed is sown, the patient is not yet aware of the possibility of change) which develops into
- conscious ***contemplation*** of the reasons for change through to
- a ***determination*** to change. This is translated into
- ***action*** (and engagement with therapy) and
- possible ***maintenance***. At this point there may be
- ***relapse*** (major or minor) and reversion to ***contemplation*** and a reprise of the cycle.
- Relapse must be accepted as a ***normal stage***. Eventually there may be a
- ***permanent exit*** from the cycle to a new way of living. We may have to watch our patient travel around this cycle several times before he finally achieves change. For example smokers have been found to make the cycle between 3 and 7 times before quitting.

As I write this I watch a patient [JW, aged 45] accompany her 6 year old daughter home from school. Some three and a half years ago her son aged 8 died of a malignant brain tumour within 9 months of the onset of symptoms and diagnosis. She suffers

from pathological grief and neither my partner nor I have been able to help. After a couple of years she did agree to counselling, but after twelve sessions the counsellor wrote to confirm what we already suspected, she does not *wish* to be released from her almost overwhelming sadness. It feels to her to be the only remaining link to her son. She has quit her executive job, concentrates on her daughter but relies hugely on the emotional support of her husband. She does not want her doctors to bring change for her; she seems to wish to share her son's state through a kind of living death. She remains in the Pre-contemplation phase.

Extrinsic/ external incentives whether exerted by the Doctor's words or family pressures reap lower psychological rewards for the individual, tending to minimise an individual's preparedness for effort. Such motivation needs tangible rewards in order to prevent its dissipation. A recent trend by health authorities keen to foster payments by results has been to formalise parts of individual health care within itemised contracts. For example we have a smoking cessation scheme within which a patient actually signs an agreement to quit smoking on a particular date and to follow a specified schedule of "treatment" and also attend for review. In my experience patients are willing enough to sign papers and accept cheaper prescriptions but some failed to comply because they were not fully and *internally* committed to quit smoking in the first place.

The faith, hope or optimism of the patient that some kind of healing is possible is a powerful determinant of outcome. A dramatic New Testament story illustrates this. It is the account in Mark's Gospel [5:24-34] of the woman with the haemorrhage. The point of this story is that she was healed because of her faithfulness *without* Jesus' conscious involvement until *after* the moment of change and healing.

"We can be transformed from victims to heroes depending on how we respond to crisis"[20].

Within our relationship we are often required to attempt to change the attitudes of the patient towards himself and towards the disease or disability which confronts him. It seems to me that, on many occasions, ***attitude*** is crucially important in determining how the patient copes with the illness or crisis as well as having an influence on the outcome of the disease itself. We are only too well aware that a patient with Acute Asthma is at more danger if he is in a state of panic than if he is as calm as possible and trustful of his carers and the treatment they offer. "A clear correlation … between

mental attitude and length of survival [of cancer]"[21] has been demonstrated. And "studies of cancer patients have suggested that attitude is vitally important in determining the outcome of illness. Those with spontaneous remission … have been found to be positive in attitude"[22].

The Doctor has to affect the patient's motivation taking into account, not only his overall outlook but also his ***personality***. For our purposes we may divide these into four types:

[i] The ***Activist*** who will look forward and engage in a campaign. I recall misreading one patient [GE] who had aggressive, metastatic prostate cancer. He came to the consulting room armed with a thick folder containing all the letters and details from his consultant, the internet and many newspaper articles. Actually he rapidly became

[ii] a ***Theorist*** who cogitates & dwells on theory finding it difficult to act. He becomes overwhelmed by worries about his illness to the exclusion of all other aspects of his life. My patient [GE] took to his bed. After several weeks of support from both a skilled palliative-care nurse and me he was again able to comply with treatment, resume his activities including limited rounds of golf and began once more to spend time with his grandchildren. He died peacefully at home some nine months later.

Another type of personality is

[iii] the ***Pragmatist*** who will take on 'the reality' of his situation, however grave, and cope in a stoical and practical way often with apparent good humour.

And lastly we have

[iv] the ***Reflector*** who will think deeply about his situation and therefore may procrastinate for a very long time. An 88 year old widow [PO] consults me often about her Chronic Obstructive Pulmonary Disease and Gastro-Oesophageal Reflux Disease. However she will never comply with a prescription for more than a day or two for fear of side-effects. She therefore always develops new symptoms after any attempt at treatment and discontinues it. We have to make the attempt to give our patients our full attention on each occasion *implicitly* asking them to trust our judgement, knowledge and experience. With this lady I have more than once actually asked her *explicitly* to trust me and my medicines, but to no avail!

If I am to succeed in helping my patient I must listen carefully, candidly opening myself to his ***needs*** (essential requirements) which are not the same as his *wants*. Wants are perceived desires, more superficial and may actually be a distraction from his real need. DF is a 39 year old self-employed builder with all the stresses of looking for and then fulfilling his business commitments. He complained of increasing difficulty in swallowing both liquids and solids for several months. However he told me that he had always had a tendency since childhood to gag under stress. He is a conscientious and slightly anxious, lean 'young' man with no other physical symptoms. I have known his family well ever since I was appointed to the practice 20 years ago. My patient and his wife had two children, the elder of whom was then aged 10 years of age, suffering from Hurler's syndrome (congenital mucopolysaccharidosis or 'gargoylism'). After her diagnosis at the age of nearly two she was given the prognosis of only 8 more years. She had been cherished by her family but now at 11 years old she was blind, almost deaf, profoundly developmentally delayed, housebound and largely confined to bed in the terminal stages of her illness. Clearly it seemed probable that her father's condition reflected his emotional and mental anguish. My task, however, was to exclude significant physical illness and provide a means for him to come to terms and deal with his tensions. In the course of the consultation he said "I guess my problem is to do with my daughter's illness". He was thus seeking reassurance that the symptoms which he had heard might represent a serious threat to his own life were indeed a reflection of the difficulty he had in "swallowing the bitter pill" of his elder child's dreadful condition and dying state. He wanted her health, knowing that was impossible, needing support for himself.

We must take into account our patient's ***environment***; it should be conducive to health improvement. One of our tasks is to create an accepting therapeutic environment by adopting a genuine interest in our patient as a person.
One ten year prospective study showed that breast cancer patients who received group therapy to improve social communication and lessons in self-hypnosis for pain control with the aim of living as *fully* as possible, on average survived *twice* as long as those given only traditional medical treatment [23].

We should at this point remember the family unit. I recall a 20 month old child, brought by his mother with a history of a viral cough. I could find nothing on examination except that he was fractious, though was clearly thriving and secure. However he became distressed during my examination and began calling out for his father. Clearly fathers and the stability of relationships are most important for the well-balanced environment required for the nurturing of children and it is necessary for us to encourage couples to ‘stick it out’, to remain faithfully together, learning to forgive each other for their own sake as a couple, for the sake of their children’s health, that of their extended family and, ultimately, of their community. Tragically often parents split in our society today because of an inability to compromise, communicate and work together. Older children, in particular teenagers and young adults suffer, lose direction and, sadly, often subside into substance abuse and crime. One study demonstrated that married *cancer* patients survive significantly longer than the unmarried.[24]

Ideally the doctor should be a role model for a healthy life-style, with a positive attitude towards his own troubles and future. I believe that motivation takes place in *any* encounter, however informal. Implicit messages can have significant effects within the ongoing relationship at the heart of general practice. For example we frequently enquire about smoking habits but there is often little time to pursue this. In these circumstances I always ask of smokers, almost as an aside, “Do you think it’s good for you?” – aiming to stimulate reflection and sow the seeds of resolve.
As motivators we need to enhance ‘feel-good’ factors, encourage the development of the patient’s autonomous responsibility for his choices and steer him towards a realistic long-term goal.

But we need to be aware of DE-MOTIVATORS such as

- a sense of hopelessness [eg GE & JW above]
- unsatisfactory relationship with the Doctor [eg AG, who in the end actually required a strong Extrinsic, external Contract containing the threat of legal sanction, to control his aggressive desire for tranquilising drugs]

- if the doctor is too controlling then autonomy may be stifled
- low self-esteem which may, or may not, reflect psychological illness
- stress within the context of a perceived life-threatening disease or its management. “Stress is not ‘out there’…but is determined by how people interpret and relate to the events and circumstances of their world” [Graham, p249].

“Medicine is a delicate balance of art, science and communication”[25].
As for ***doctors’ motivation*** within their business of caring for others, I think that the *intention* of most is to connect with the patient in a way that is helpful [Montgomery, p44]. This may be driven by scientific curiosity, the desire to better understand the nature of human life and death. We require humility and a preparedness to be open and listen to the other with honesty, integrity, and compassion. These values encourage a relationship where a healing effect can arrive. “Successful caregivers possess a philosophical view that recognises the wholeness and integrity of that which is human and of the fragility of this human factor in the technological environment of healthcare” writes Montgomery [p43]. We have to “develop some sort of philosophical or spiritual understanding that enables [us] to *tolerate* and *accept* a wide variety of human experience” which transcends moral judgement. We learn not to communicate our disgust at that which transgresses our own values and discover how to accept and nurture ‘the sinner’, forbearing to cast the first stone. Rightly we should be non-judgemental but our core-values should not, indeed they cannot, be hidden. We must care and connect even with those whose intentions are contrary to our own, for example those seeking abortion where the mother’s life is not apparently at risk. (Ironically the very first patient I saw after receiving the invitation to deliver this lecture was one such!) We have to develop ways to talk about issues that disturb us, to explore with patients questions which they would prefer to ignore or whose existence they deny. We must accept each person as they are at the time of the encounter and attempt to connect with the fellow-human within.
For my own part the values and motivation to offer help comes from my Christian faithfulness and the support of the Christian community, the Visible Body which

shares my burdens, and enables me to continue working at the pace and intensity required. I draw my own paradigm of care from Jesus Christ whose responsiveness to his patients invited a reciprocating trust. Simply being present for his patients he created a space full of positive meaning and hope. In attempting to follow this example I need confidence in my competence, but must avoid arrogance, building a mature self-awareness and recognition of both my own and Medicine's limitations. A connection, an emotional bond within our common humanity becomes possible, even a kind of professional intimacy which enables me to give something of myself to my patient with loving kindness. Of course within the pressure of modern practice I often fail to achieve this ideal. "The pressure …to do more and more tasks…tends to create an atmosphere of dehumanisation of patients". [Montgomery,p43]

When the doctor-patient relationship is right there is a flow, harmony and ease of communication. This is evidenced by relaxed humour or, on rare occasions a convivial silence. The reciprocated acceptance leads to what Tournier called "a true meeting between persons". My patient and I together become part of something greater and experiencing that reinforces the desire to repeat the experience with others.

My brother is an artist, a professional painter, and I am tempted to envy his creativity. But I have come to the conclusion that the practice of medicine is more of an art than a science, requiring a special kind of creativity in human relationships which, in the end, may be just as profound and enduring as an oil painting. The effects of the work may be less tangible but nevertheless as deep. We are fortunate in having a captive audience who actually queues to commune with us!

Approaching her finals in Occupational Therapy this year, one of my daughters had to critically evaluate the following statement: "The Therapeutic use of self is arguably the most important skill a therapist has" – yes indeed!

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