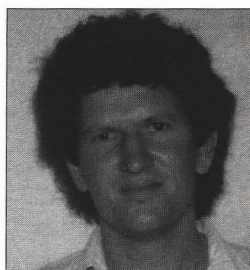


# Septicaemia and the doctor-patient

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## Curriculum Vitae

Ian was born and schooled in Port Elizabeth. He graduated in 1983 with a BA (distinction in Psychology) from the University of the Witwatersrand. He continued his studies and in 1987 graduated with a MBBCh from Wits Medical School. During this time he was student representative on the Medical Faculty Board and on the Professional and Ethical Standards Committee. Ian worked at Livingstone and Dora Nginza Hospitals in Port Elizabeth before going to Paraguay to work as a volunteer with the Anglican Church for one year. He returned in 1990 and after a locum at Boksburg-Benoni Hospital, started work at Manguzi Hospital in January 1991 where he is responsible for primary health care/community health services development. He has been acting Medical Superintendent since August 1993. He was submitted to alternative service as a conscientious objector and completed that service in September 1993. In 1991 he commenced at Medunsa with the M Fam Med programme. He is married to Jacqui, an occupational therapist, and they have a son, Timothy, 3 years old.

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## Summary

*A doctor who worked in a strange country for a year, became ill, became a patient. He describes how it happened, how he felt, how he was treated and what his reactions were. He then analyses these in the light of his attitude towards his own patients. He concluded that it is exceptionally difficult for a doctor to become a patient.*

## Introduction

In 1990 I spent a year working in Asuncion, the capital of Paraguay, South America, mainly doing non-clinical primary health care. At the time I lived in a poor neighbourhood on the outskirts of the city, where there were no doctors and a small clinic open only during weekday office hours. I relied on public transportation; there were 2 different buses in and out of the neighbourhood, but no buses after 10.30pm and though taxis could sometimes be caught into the area, they were not available to go out unless one happened to catch one dropping a passenger. As it was a poor neighbourhood, there were few private cars and only a handful of the 10 000 families had telephones; there was only one public telephone which was mostly out of order.

One Wednesday evening I developed a headache to the extent that I could hardly concentrate on the work that I was doing. Shortly thereafter I started to feel nauseous and feverish. I returned home, sweating and feeling

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very weak and went straight to bed. I had lost my appetite and I felt increasingly febrile. Simple analgesics failed to make any impression on my headache. My wife went to borrow a thermometer from a neighbour and found my temperature to be 40°C. Paracetamol, tepid sponging and a fan helped to bring it down a little.

After an unpleasant night my fever was down to 38°C, and I felt a little better, though I still felt nauseous and weak. I didn't manage to get up at all during the day and in the evening my temperature was again elevated, at 39.7°C. My headache had gone – I simply experienced general body malaise and nausea, and in fact vomited very small amounts a few times. I had had nothing, and wanted nothing, to eat. As there was no help to be obtained at night, I agreed that if I was not better in the morning, I should go to hospital.

On Friday morning I awoke feeling much the same; I wanted to let things ride and wait a bit longer, but my wife held me to my agreement and went to contact a missionary who lived in the area and who had a car, to ask if he could take me to the hospital which he duly did. I took nothing with me expecting to see the doctor and go. I went to the Baptist Hospital of Asuncion where I had been attending some clinical meetings and had got to know the consultant who ran the family practice residency programme, Dr S. He was not available due to some emergency, so I settled down to wait for him. I particularly wanted to see him because he spoke English. Although I could communicate in Spanish, I felt it would be easier to describe how I was feeling, in my home language.

After waiting about two hours I felt too ill to wait any more and nervously went along to the unfamiliar emergency room, where I discovered that one of the residents I knew, Dr N, was on call. I felt very unsure of myself in requesting that he be sent for, not knowing how the system worked or how he would feel seeing me. He was sent for, while a rather anxious nurse hastily got me on to a bed.

Dr N was very friendly, concerned and anxious to help. His questioning (all in Spanish) failed to elicit anything new: I hadn't eaten anything different, I was drinking from a good water supply, I hadn't been bitten by anything that I knew of, etc, except for the fact that I had made a trip to the south and the east of the country where there is a small amount of Vivax malaria, but that was some weeks before. On examination he found me to be hypotensive (BP 80/40) with a feeble rapid pulse (120/min), pyrexia (T 41°C) and peripheral cyanosis. General and systemic examination revealed nothing further.

The resident informed me I was suffering from septicaemic shock; he said I needed urgent investigation and treatment. I was too ill to argue, though I remember we did initially discuss the possibility of outpatient investigation. He was hesitant to make decisions without his consultant, probably because I was a doctor. An IV infusion was put up and bloods taken for FBC, U&E, Blood culture, Widal and serological screen for Trypanosomal antibodies (for Chaga's disease) and various other potential pathogens. I was admitted, due to my financial circumstances, to a general ward, and (with the approval of the consultant who had

My reluctance to go to consult another doctor

The corridor type of consultation is a recipe for disaster – especially as doctors tend to deny their own illnesses

Each doctor should have his own GP

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since arrived and had seen me very briefly) started on Ampicillin and Gentamicin IVI. In the ward there was one ceiling fan for a room with four patients, and the temperature outside was over 40°C. I became somewhat delirious and do not remember clearly what I said. I do remember reaching a point when I couldn't handle my fever any more and requested an anti-pyretic agent; I had trouble at this point making myself understood and heard, and felt embarrassed trying to get the attention of the nurse in front of the other patients and their families, although one of the visitors came to my rescue.

Another resident whom I didn't know came to see me and offered me a "Novalgina" injection, the active ingredient of which was, and still is, unfamiliar to me; I said yes, give me anything, I don't care, so a nurse administered an IV injection of the drug. Shortly afterwards I developed severe rigours to the extent that my whole bed was shaking; Dr N was called and, deciding it was a reaction to the Novalgina, gave me what I think was an antihistamine injection. I settled down after about half an hour, but my fever was running high again. The consultant was called and ordered immediate action. Overriding any financial concerns on my part, he ordered me moved to a private room with air-conditioning, as his private patient, saying that I couldn't cope with the heat the way the locals did, and while waiting, I was to have cold sponging of the whole body, both of which were then done.

This seemed to coincide with a crisis, as after this I started to feel somewhat better and although I did not have a good night's sleep, due to my drip and nursing activities, I was feeling

definitely stronger in the morning. Dr S then confided to me that he had been extremely concerned about me the previous afternoon. He gave me all the clinical facts he felt necessary in an empathic manner, obviously feeling I was recovered enough to hear them and discussed the blood results with me. The blood results were all essentially normal – no cause for the septicaemia was found. Interestingly, neither a urine nor a stool sample was taken, nor a CXR done. Meanwhile IV treatment was to continue and a repeat urea and electrolyte analysis to be done. The result of the latter showed signs of acute renal failure, presumably as a result of the gentamicin in the situation of septicaemic shock, so my dose of genta was reduced.

I felt quite lonely in my private room and I found the single visit of Dr S very short. It was only afterwards that I had a delayed reaction of fear for myself in view of my condition. I wondered and worried about unusual South American organisms and their consequences.

On Sunday I experienced general malaise again, though my fever did not return and my Urea and Creatinine were no longer rising (though not yet dropping). I saw Dr S once briefly, late on Sunday, and felt quite depressed; I did not feel I had the right to demand more of him as I was being treated *pro deo* by him, and felt uncomfortable to ask all of my question, probably because my pride sought to minimise any suggestion of ignorance.

On Monday I felt a little stronger, and my renal function was improving. Two sets of blood cultures had failed to grow anything after 72 hours. I was well enough to be getting bored, and it

Financial considerations interfere, one way or another

I was ready to suffer for lack of money; why am I cross with very poor people who cannot afford to come back to hospital for a check-up?

Too embarrassed to ask a doctor-patient about his social or sexual life style

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was an extremely long, tiresome day for me, made worse by my only visitor, my wife, arriving very late, because she had to catch 2 buses to reach me.

By Tuesday I was feeling much better; the IV antibiotics were stopped and, after ensuring that my Urea and Creat were continuing their downward trend, I was discharged home with five days worth of oral amoxicillin. I was told to return for a check-up in one week. I was not given any special instructions as to further precautions, possible side-effects of treatment, or recuperation; it was only my physical weakness which prevented me from full activity.

Further recovery was uneventful, though it was over 2 weeks before I was feeling completely strong again, and another month before I had regained my weight.

I still do not know exactly what had been wrong with me, though gram negative infection is the most likely. What I do know is that my attitude to being a patient was transformed.

## Discussion

Probably the clearest thing that stands out for me in the whole episode was my reluctance to consult another doctor. 'I wanted to let things ride and wait a bit longer.' Similarly, Ennis describes how he was willing to sacrifice (his) physical well-being to protect (his) reputation, and wonders, in the harsh light of hindsight, "how I can expect to develop a therapeutic physician-patient relationship with my own patients when I am willing to treat myself so callously."<sup>1</sup> I think part of this arose from denial; I denied the gravity of my own illness. 'I took nothing with me expecting to see the

doctor and go.' In a similar vein, Ennis states: "Until the point of hospitalisation, I denied the existence of the problem."<sup>1</sup> Such denial is very common amongst doctor-patients, who are reared on the myth of the immunity of physicians, which is subtly taught at medical school and in post-graduate training.<sup>1,2</sup> Very often we ignore the same warnings we give to patients.

Perhaps we focus too much on ourselves as supposedly different patients (the root of much of our trouble?) for this is not a characteristic of many of our patients who come from day to day, ie that they wait as long as possible. Certainly that is the case in my practice, and my own experience in Paraguay living in a situation where access to medical care was not so easy, has made me more understanding of this. The divide between the two types of people in the world, doctors and patients, them and us,<sup>3</sup> has to some extent been broken down. Does it mean I will consult more quickly next time? Possibly not, because of the other reason which was probably responsible for my delay, namely a sense of reluctance to impose on another colleague, especially where there is not going to be the same fee for service relationship.

The treating-doctor/patient-doctor relationship is at once more professional because of the people involved and at the same time less professional, because of the frequent lack of a formalised fee-for-service relationship. The more minor the complaint, the more likely the relationship is not to be formalised, but rather of the corridor consultation type – a recipe for disaster given our propensity towards denial. In a study amongst general practitioners,

A doctor is not usually allowed to be simply a patient – his opinion is always asked

My advise was asked when I was too ill to care

A lot of knowledge is assumed – and not given

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Furman found that 31% felt they get worse care than other patients, with one commenting that care is better if the sickness is serious, but worse if the ailments are relatively minor.<sup>4</sup> One solution is, of course, that each doctor should have his own general practitioner with whom there is such a formal relationship established, yet this is not common practice.

One way or another, financial considerations are likely to interfere, whether from the aspect of guilt mentioned above, or from the aspect of not being adequately covered by a medical aid (and losing income). I was admitted, due to my financial circumstances, to a general ward; later, 'overriding any financial concerns on my part, I was moved to a private ward.' I was ready to suffer for lack of money, yet how often do I not scold people far poorer than myself for not returning to hospital and using money as an excuse?

Where a doctor-patient often suffers is in the history taking and examination; these are just not as thorough as they should be, from assumptions made or from embarrassment.<sup>4,5</sup> No-one asked about my sexual and social history and background; neither a urine nor a stool sample was taken, which one would have thought essential for making an accurate diagnosis. My own assurances with respect to respiratory complaints seemingly made a CXR unnecessary, and HIV was never even considered. This is not as strange as it seems; I, like most doctors, have also seen colleagues to whom I have been quick to dispense advice and medication, but whose histories I have been too embarrassed to hear, and whose bodies I have been reluctant to touch beyond the boundaries they have implied. From the other side this

gives me a little sensitivity to the patient who feels the doctor has passed over him too quickly in making his magical decision. Sometimes of course the opposite is true in that the treating doctor, in his anxiety about caring for a colleague, does many more investigations than are necessary in order to rule out any possible source of error.

Along with the above goes the fact that a doctor is not usually allowed simply to be a patient but is continuously re-involved on the 'doctor' side. I was asked my opinion as to the diagnosis and way forward, and more significantly, asked about an appropriate anti-pyretic agent when I was both unfamiliar with what was available and too ill to care. ('Give me anything, I don't care.')

A lot of knowledge is assumed and not given. Dr S was very good at keeping me informed; he gave me all the clinical facts he felt necessary and discussed the blood results with me. Yet on discharge he released me into a vacuum. 'I was not given any special instructions.' Also there were many questions left unanswered. This often occurs because treating doctors assume their doctor-patients know all the information and do not wish to be patronising.<sup>4</sup>

One aspect that is certainly not unique to the doctor-patient is a great sense of vulnerability; the only difference is that as doctors we are not used to feeling vulnerable! How often have I ridden rough-shod over the feelings of my patients who are overwhelmed in my presence or by the very nature of a hospital. 'I felt very unsure of myself.' I think if anyone had shouted at me I would probably have burst into tears; I desperately needed to know people cared for me and were doing their

I was not given special or detailed instructions

A great sense of vulnerability

I needed to know that people cared for me and were doing their best

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best. Marzuk notes that some patient-doctors feel so vulnerable that they become demanding and attempt to control care excessively, or may show passive aggression.<sup>2</sup> The lack of emotional support is often the major problem the doctor-patient faces,<sup>1,2</sup> treating doctors assume their doctor-patients are very capable of dealing with sickness themselves, yet they often have a high degree of conflict over illness because it is socially unacceptable amongst doctors.<sup>2</sup> Many doctors feel anxious about all the usual procedures but are not able to express their vulnerability – an all-over cold wash down by a junior nurse stands out as one of my clearest memories in this regard!

Similarly there can be significant levels of frustration at being ill.<sup>6</sup> There is a loss of control which is extremely difficult for one who is used to being in control, especially in the area of health.<sup>4,5</sup> This is graphically portrayed in *The Doctor*, by Dr Edward E Rosenbaum (New York: Ivy Books, 1988), in which a very well-known physician describes becoming a patient in the very hospital in which he had been chief of medicine and president of staff; the loss of control he experienced was shattering and led to a totally changed outlook.

I discovered how important the daily visit of one's physician is.<sup>6</sup> It always seemed too short, too inadequate. I always tried to save up my questions for that special few minutes of attention, yet I always forgot some or felt unable to ask them.

Although Dr S dealt with me very well on an intellectual plane, and was empathic in his manner, I nevertheless did not feel able to share my feelings of depression, fear, loneliness, etc. I

suspect that I was assumed not to have those because of my medical knowledge; I, in turn, 'felt uncomfortable to ask all of my questions', for reasons of pride, a defect which I seem to share with other colleagues.<sup>2</sup> These feelings, of course, are not helped by being aware of errors of treatment, omissions in care, etc.<sup>6</sup>

I found myself anxious to be an exemplary patient. I 'felt embarrassed trying to get the attention of the nurse.' I was reluctant to make a fuss. Typically the ill doctor feels guilty because his treating doctor is almost doing him a favour.<sup>4</sup> 'I didn't feel I had the right to demand more of him'. Bowes' descriptions of her experience with having bloods taken,<sup>6</sup> reminded me of the excruciating experience of failed attempts at inserting a drip, because of incorrect procedure on the part of a junior nurse, through which I sat stoically.

It does seem that a hospital is not the place to go if one wants to get well, though I suppose it depends on one's home environment. Bowes felt that hospital personnel can be divided into those who cause pain and those who don't.<sup>6</sup> For my part 'I did *not* have a good night's sleep, due to my drip and nursing activities.' Nurses the world over insist on waking patients at 5am to make their beds! Visitors are very important, helping one to live vicariously.<sup>6</sup> I remember clearly how depressed I was on the day my wife arrived late due to bus problems.

How did my doctor feel about this? It is impossible to know, for he did not share any feelings with me. Very often a treating doctor feels under scrutiny and thence under pressure, with concomitant anxiety.<sup>4,2</sup> This may even lead to withdrawal of the treating doctor from his patient. The

We assume our doctor-patients are very capable of dealing with sickness

Socially unacceptable for doctors to become ill

An all over cold wash down by a junior nurse, made me feel very vulnerable

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resident did show hesitation 'to make decisions without his consultant, probably because I was a doctor'.

I never felt that my treatment was inadequate. Dr S was a competent and caring family physician. It is only with hindsight that I can see the gaps in the care of me as a person, gaps which we are all guilty of, and my own failings as a patient, which have indeed sensitised me to many of the same in my patients. These gaps arise from the fact that I and my doctor viewed my illness in very different ways – small issues for him were big for me and vice versa. Although this is probably inevitable in any doctor-patient interaction, it is important to be aware of it.

In trying to formulate my own approach to treating a doctor-patient, to try to avoid some of these problems, it would be easy to adopt high-sounding principles, such as doctors are human, the same as every other patient, and must be treated as such; which are true, but are divorced from the practical reality of how we often behave. I do, however, believe that a formalised relationship and a truly patient-centred consultation can make the difference.

Through this, the doctor-patient can be asked to state his agenda and express what he needs from the relationship, and can be given the opportunity to express his fears, feelings and doubts, recognising that it is never easy to be a patient.

To see whether this works in practice, I will have to wait for my next doctor-patient to come along – and struggle manfully through any corridor consultations I may be subjected to in the interim.

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How important a daily visit from the doctor was.

The doctor's visit always felt too short, too inadequate