A Patient Talks to the Doctor - Russell Farley

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Curriculum vitae

Russell Farley graduated from Rhodes University in 1967 with BCom with CTA. He achieved his CA(SA) with honours and was appointed Partner with Byrd & Whittle which later progressed to Ernst & Young. Russell has held various positions, culminating in Manager of the Natal Region and National Executive of Ernst and Whinney. He is currently Client Services Partner of Ernst & Young. Russell married Margie, who later died of cancer following three years of illness, and leaving two children aged 16 and 12. Russell enjoys tennis, mountain rambling, literature and music, and is aspiring to become a golfer.

Note:
Russell Farley was one of six patients who addressed the 7th GP Congress in June 1990 at its first plenary session. Russell stayed the week with us at the Wild Coast Sun, attending talks and workshops. This talk represents his conclusions presented to the final plenary session.

Summary

On behalf of many patients, the author explained to a large group of GPs, what they experienced as their patients. They were quite satisfied with the technical expertise of their doctors, but identified 3 areas where they felt doctors had failed them: (i) they tend to treat the disease and forget the person behind it with his emotions and his fears, (ii) they do not discuss the problem and the treatment with their patients - patients want to talk more about it, understand it better, (iii) the GP must stay in touch, remain the facilitator to whom the sick patient can return after specialist treatment, to help him sum up the whole situation and decide on the next step.

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The Patient's ideal

I thank you, the general practitioners, for your invitation to address you at this congress. It has been a great privilege and honour for me and also a great learning experience. I have learned that you are great fun to be with. I have made many friends and we have laughed together at Derek van Deventers' hairy legs and admired your beautiful wives in beautiful clothes. In fact, I so admired your wives that I have decided to give up Hansa and take up women again.

I have learned that you are dedicated and competent professionals determined to do your utmost and to give your all for the good of your patients. I have learned that your commitment to your patients can wring you dry emotionally at great cost to your personal and family relationships, and sometimes your health and your very lives.

You have listened with patience and fortitude as five of your patients analysed your services to them and the interesting thing that came from these discussions was that there was no serious criticism of your technical expertise and handling of the basic illnesses, even in the case where you were unable to find the causes. In fact, you are doing a vital job and doing it well and I salute you!

But...you are falling down in three essential areas.

1. The overview of the patient and his medical history.
2. The discussion of the treatment of the problem with the patient and keeping him informed.
3. The personal aspect of the patient (and his family) who has a serious condition that will affect the rest of his life, or terminate it.

You have debated the points and criticisms of your patients with great interest and enthusiasm but not always with acceptance. I heard some of you say that counselling is not your job, that you have no time, that the cases you heard were extreme and not representative of the vast majority of patients who cope with and accept the communication and current service of the doctor.

I can assure you, if you think that, you are your own worst enemy and you are doing your profession a great disservice.

That the criticism is widespread can be shown by the fact that almost without exception, when I shared with friends and acquaintances that I was coming here to address you, each one had a horror story to tell and all these horror stories could be classified into one of these three categories. They told me to "go sock it to them!"

I can say, without any fear of being disproved, that you are suffering from an *expectation gap* between yourselves and your patients.

This expectation gap even extends to you when you become patients. Several of you shared with me your own experiences when a loved one had been sick or had died. How you wished someone had facilitated an open discussion in your family so that you could tell a dying parent, brother or child that you loved them, and would miss them and forgave them, and ask for their forgiveness.

As to the question of time, I think you are so busy with the lesser routine matters that you are indeed

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No criticism on your technical expertise, but...

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bogged down. You need to create time by delegating some of these duties to trained paramedics in your rooms. Time cannot be an acceptable excuse to the patient who has to come to grips with a child with no arms. You seldom have more than a few patients with major problems at any one time. These people need all the time you can give them.

You need to come to grips with the fact that you are human and not gods. Leave the miraculous healings as described by Chrissie Briscoe, to God. You cannot call them on at will, but appreciate them when they happen. Simply do your best and

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Don't think counselling is not your job

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remember, it is not your fault Margie died, that Kerry Lee had no arms, that the child had cancer. Get rid of your guilt feelings. All the patient requires is that you tried your best. From time to time you will even make mistakes and cause a patient danger or harm. This is terrible but it is an occupational hazard. Learn from these experiences but do not become so cautious that you wear belt and braces thereafter.

To those of you who say that counselling is not your job, I say that you are on the hook, you cannot escape. You cannot in all conscience deliver a death sentence to someone and simply walk away.

This reminds me of the story of the pig and the chicken who were walking down the street and came across a restaurant advertising ham and eggs. "Oh look" said the chicken. "We are involved". "Oh no" said the pig, "You are involved, I am committed". You doctors are the chickens, the patients are the pigs.

To return to my three areas of weakness in the medical profession of which you are part:

1. Overview of the patient and his medical history

Prof Nigel Stott outlined the case of the plasterer who died unexpectedly, who had worries. I will use two illustrations of my own.

When I returned to Durban on Tuesday, I went to visit a friend who was in hospital with a heart attack. She told me that she had always been healthy but a year ago she underwent an examination for an insurance policy. The insurance was turned down because of her ECG which showed that she had suffered several heart attacks. She went to her GP who simply dismissed it as being attributable to a tonic she was taking.

Ten years ago my own mother became ill and died of renal failure. When I took her to the hospital I packed her clothes and I came across the pills and medicines she was currently taking. I packed them to show the doctor and they filled a

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The Expectation Gap between GP and Patient

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large shoe box. No wonder her kidneys failed! The true fact was she was lonely and needed friends, not pills at all!

Be sure that you are understanding the evidence and interpreting it correctly. Again I can best illustrate this with a story.

An executive visited his doctor for his annual checkup. The doctor asked the usual questions about smoking, drinking and exercise. Eventually he

. . . A Patient Talks

asked, "How often do you have sex?" "Infrequently" came the reply. The doctor, being cautious, asked "Is that one word or two?"

One of you learned gentlemen showed me what seemed to be a very well thought out paper showing that the changed sleeping habits I experienced was due to my eating habits which included an increased intake of sugar through my food and also increased alcohol intake combined with adrenalin. I am sure he is completely correct, but at the same time he is completely wrong. My sleeping habits were changed by stress which changed my eating habits. If he treated my blood sugars alone he would not solve the problem.

2. Discuss the treatment and the problem with the patient

During discussions some of your expressed frustration and annoyance were if your directions are not followed. You felt it was the patient's own fault if he did not get well.

In my profession we realize that the best way to get our staff motivated to

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Bad service is unacceptable at any price!

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do their sometimes boring tasks, is to explain to them, and make sure that they understand, what they are doing and why it is necessary. We also explain to them what can go wrong if they foul up.

A patient is vitally interested in his body and his ailment. He also wants a balanced view of the prognosis, risks and side effects of the treatment. If he knows what to expect it will not seem so bad when it does happen.

The patient wants informed reassurance. False confidence from the doctor or even worse, silence, leaves the patient with nameless fears. Many patients will make their own enquiries as to their condition from encyclopedia, medical books and friends. If they catch you out in a lie their future confidence in you is impaired.

Misunderstanding can have disastrous results. Witness the man who came to his doctor and asked to be castrated. "Are you sure?" asked the doctor. "Definite", said the patient, so the deed was done. In the

... A Patient Talks

recovery ward the patient asked the fellow in the next bed what he was in for. "Circumcision," answered his companion. "Dammit!" exclaimed the patient, "I knew it was something with a C!"

Some of you have indicated that the patient has the duty to enquire if he wishes to know more. This may be so but often the patient is somewhat overawed by the situation. He is scared of what he may find out. Being

You are human beings, not gods

unsure he follows the lead of the doctor. If the doctor maintains silence the patient thinks that the doctor judges this to be the best for him and so he sits quietly and worries.

All this explanation must of course be kept in lay language and while it is desirable to show what can go wrong, don't lay it on so thick that you medicalise the worried well. If you are going to undertake further tests, be at pains to explain it to the patient and then to report back. The suspense is terrible. Two of your patients touched on this. Jenny Crouch's pediatrician adopted the no-news-is-good-news approach while Ann Shelton proved that this was unreliable as the records were mislaid.

In my office I demand a report back every time I delegate, to ensure all is well.

3. The Terminal Patient

Another of my friends' horror stories was the one of the doctor, having done a biopsy came rushing into the ward and told his patient "The sample shows cancer, I can't talk to you now, I'm in a hurry. I'll explain it to you tomorrow". He actually returned two days later.

In my professional role it is one of my less pleasant duties to dismiss people who are not performing properly. We never fire people – we counsel them into another career – I have taught myself to do this task so well that at the end of almost every interview the ex employee smiles, shakes my hand and thanks me for doing him a favour. I allocate plenty of time, make an appointment, lead a discussion which gets the employee to assess his own performance. Then I tell him he is falling short of our standards and we believe in his interests that he should seek a different environment which suits him better.

They go through the whole Khubler Ross pattern: denial, anger, bargaining, depression, acceptance. But they know that I am right at the end. Many of these people come and visit us as friends. Surely a doctor can

Remember, it's not your fault that Margie died

do at least this for a dying patient or one whose life is going to change dramatically through a damaged child?

In your sessions you had much discussion of how far the doctor should go in counselling and for how long.

I do not believe it is your duty to hold people's hands forever. I do believe however that you should receive training in basic counselling so that the first bombshell is given in a firm but caring and gentle way. Ideally you should have a trained counsellor or psychologist on hand at that session or arrange for the patient and the family to receive counselling

I do not believe you are paid enough!

at an early time. This will prevent major emotional problems later and give the patient a contact for later counselling, if necessary.

When you refer a patient, do not lose touch. Stay in contact, whether with a counsellor or a specialist medical person. It is you, the GP, to whom the patient looks for management of his case. You must be the facilitator who uses specialist technical skills as necessary, sums up the whole situation and decides the next step.

You may find that at times the patient rejects your kindness and advances. Be tolerant and forgiving. The patient may be behaving irrationally through emotion and distress. He may lash out at those around him in his anger and give vent to destructive behaviour.

Give him a broad shoulder to lean on. Later he will say "I knew there was a rock I could hold on to".

Get your secretary to phone occasionally to enquire as to progress both for the patient and family. You

. . . A Patient Talks

have no idea how this interest will be appreciated.

Finance

Being an accountant I cannot leave this subject without touching on finance.

I do not believe you are paid enough!

There was a time when the doctor had the best house and best car in town. This is not so any more! I think it was Gerhard Reyneke in the wee hours of Tuesday morning who told me his father's consultation fee was equal to the price of a sheep. A visit to the patient involved the whole day, a tour around the farm and a slice of Sannie van der Spuy's melktert.

People/patients like to deal with successful advisers

And that is the time we hark back to, and remember the excellent service of the family doctor.

What has gone wrong? The medical aid societies have their own pressures to keep subscriptions to members down. Has this been done at the expense of the general practitioner? Are people now taking every cough to the doctor and bogging you down with minor ailments at a very low rate per hour?

Your keynote speaker spoke of people-centred service. It is my experience in business that for excellent service you can name your price! Bad service is unacceptable at any price.

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Although you may not see yourselves in this way, you are actually in business. The product you supply is a medical service. That this requires a caring and loving attitude, does not alter that fact.

People (and patients are people) like to deal with successful advisers. It gives them confidence if they are receiving good advice. This successful image of course, must never reach excess and ostentation.

I recommend that you review your fee structures and charge a differential rate according to the skill and responsibility required. Negotiate with medical aids for new structures which will allow you fair compensation.

The Patient's Ideal

So what then is the Patient's ideal GP?

1. That you are a fundamentally caring person; and that you are technically competent and up to date, is taken as a given.
2. Build a personal relationship with the patient in the good times. Be open and honest and develop mutual trust.
3. Treat the person as a medical entirety, be diplomatic but firm if lifestyle errors are showing in medical complaints.
4. Be the patient's manager if you refer the patient to specialists. You be the bearer of bad news if there is such.
5. Be human; not remote. Cry with us if that is the way you feel. That is a display of strength, not weakness.
6. Discuss openly the patient's condition and prognosis. Do not look away and avoid the subject if Kerry Lee comes to see you. Ask her how she brushes her teeth with no arms.
7. Be kind and open when you impart the dreaded news. Arrange counselling if you cannot do it yourself. Facilitate open discussion among family members.
8. Do not take tasks you are not qualified for. Use social services, nurses and laymen. Appoint mentors from your old boy network. (Your patients, who have themselves experienced the problem that this patient is suffering. Most would welcome the opportunity to help).
9. Come to terms with your own mortality and death. None of us are immune. If you are comfortable in the presence of tragedy, it will rub off on the patient.
10. Show confidence but be sincere. A patient can see through false promises of recovery.
11. Listen! Empathise, but don't sympathise. The latter will drag you into the abyss too.
12. Make time for your patients who need it. Learn to identify them.

Finally, I have listened to Professor Nigel Stott on the podium, in discussion groups, and in private conversation. He and your other academics and leaders know what is the patients' ideal. Listen to them - and do what they say.

May God Bless you all!!