Doctor patient

Personal experiences of a doctor who became a hospital patient

— B Fehler

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Curriculum vitae

'Boz' Fehler is a Witwatersrand graduate, and also practised in the region for 30 years. Through his election as inaugural President of the SA Academy of Family Practice/Primary Care in 1980 he received recognition for his contribution to the cause of general practice over many years. He served on numerous committees relevant to general practice from 1965, and represented South Africa at the 5th to the 9th WONCA Conferences. When he and his wife Evette emigrated to be with their children in the UK in 1986, the Academy and South Africa lost an able and enthusiastic campaigner for general practice. We will continue to remember him each time the 'Boz' Fehler Award is made.

KEYWORDS: Patients; Hospitalisation; General practitioner; Emotions; Physician-patient relations

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Summary

The personal experiences and emotions of a GP who became a patient are described. The need for communication in the patient-doctor relationship, as well as a better hospital environment is emphasised.

Before discussing the 'Doctor Patient', I must give you insight into how this doctor became a patient.

About 2 years ago, as I was driving my car doing calls, I suddenly experienced a momentary loss of vision in my right eye, which was followed by dizziness and blurred vision.

As the blurring persisted, I consulted an opthalmologist on the same day (it is amazing how quickly specialists are able to see a colleague, if requested to do so). I, of course, made a diagnosis of a haemorrhage into my retina or lens, or possibly a detachment of the retina. However, the opthalmologist found my eyes to be normal, but referred me for fluoroscopy photos of the eye. This too was normal. At this stage all my symptoms had disappeared.

Then, about 3 days later, the blurred vision recurred. I then saw a neurologist who found no abnormality on examination. At my insistence, I was referred for a cat scan of my brain. As this was being performed, I lay alone on the scanning table, with the technician sitting outside listening to some very loud music. I was progressing through the scanner 3 mms at a time. Suddenly the music was switched off, the table on which I was lying was put into reverse and the whole procedure was restarted. I became most apprehensive and concerned as I realised that something had been detected. The neuro-radiologist then approached me and showed me the scan pictures. He stated that he thought it was a meningioma. He said I need not worry as it was situated in my occiput. No, I did not worry; I was absolutely petrified! Thankfully, being a member of the medical profession, a neurosurgeon then saw me immediately and suggested that it be removed.

However, I had to have an angiogram to determine its exact size and position. How I drove home from the nursing home that evening, is beyond me for I was in a state of terror. I could not come to terms with the fact that I, a fitness fanatic who had annual physical examinations with a physician, now had a medical problem. I realised, of course, the shortcomings of these executive annual check-ups.

As I was physically and mentally fit, I underwent surgery almost immediately. However, the stress

that my wife and I experienced at this time was immeasurable. To have all one's children overseas during this period was even more traumatic. Fortunately our sons flew out from London and Los Angeles to give us support.

After a 9-hour procedure by two neurosurgeons, I awoke in the intensive care unit (ICU) to the incessant bleeping of the monitor, not to mention the IV drips, catheter, ECG connections, nasogastric tube and drain from my now shaven scalp.

The shortcomings of executive annual check-ups became very clear

The mass, the size of a lemon, was removed and was histologically proven to be a benign meningioma. It had apparently been present for about 15 years. I was not satisfied with the diagnosis until it was proven histologically, and only then was my mind put at rest.

On the third day I was walking around and felt really well; not that I had felt ill before the operation. On the fifth night I suddenly developed chest pains, plus haemoptesis. Apparently I collapsed and was transferred to the Johannesburg Hospital ICU.

How typical this was for a doctor; to develop complications with an illness!

The pain I experienced in my chest was as though a double-edged bread knife was being pulled up and down. It was agony for me to breathe.

I was checked by the most caring houseman and registrar, but the senior consultant informed me and my family, "No case who commences his therapy in the private sector and develops complications, should ever be referred to the hospital for further care." I was in no state to argue with him. This prima donna had no concern that I was a desperately-ill colleague. Later, his registrars, housemen and sisters apologised for this individual's insensitive behaviour. Afterwards of course, his treatment was superb.

I spent a period of three weeks in the ward where I am a consultant, and then I returned home to recuperate.

Now, what does it mean being a "doctor patient"?

Firstly, you lose your customary responsibility for your own well-being. All decision-making processes are, quite correctly, taken out of your hands. You now experience what your patients have tolerated under your care for years.

Fellow-patients, on hearing that I was a medical practitioner, came to my bedside and informed me of many issues; they had become depersonalised since being hospitalised, their whole life story and illness was contained in a few pages, they had become a number, and were known by their diagnoses. Some were more fortunate than others, for they were also classified as being an 'interesting case and teaching material'. They had lost their dignity, were examined 4-5 times per day and during ward rounds medical terminology and technology were discussed which distressed and confused them. At no time did any doctor counsel these patients in regard to their illness. They left hospital as ill-informed about their complaints as the day they were admitted.

Being of the medical fraternity, I was protected from some of these problems, but others were created. For instance, when I asked for Stopayne capsules for my pleuritic pain, I was informed that medication can only be prescribed by the doctor on call. And besides, Stopayne was only used for terminal cancer, but I could have one paracetamol tablet! For being a 'doctor become patient' I was placed on the 'difficult' list in regard to medication.

The treatment I received at the nursing home and the hospital was magnificent and caring, particularly in the IC-units. The sisters who were employed there, have outstanding knowledge and ability in the handling of the acutely-ill patient.

All decision-making processes are suddenly taken out of your hands

The food in the nursing home was 5-star quality, but the hospital food was disgusting, to put it mildly. Meals are usually served cold, on TV-trays, and most of the time, are inedible.

Incidents always occur during one's hospitalisation which can only be seen in perspective afterwards. One night, when I was in a deep sleep (how difficult it is to sleep with tubes and drains in all orifices of one's body!) I was woken by the nurse saying, "Sorry to wake you, Doctor Fehler, but I forgot to give you your sleeping tablet." Needless to say, that was the end of my sleep!

On another occasion, after the pulmonary emboli episode, I awoke in terror, for I had had a dream that the heparin drip I was having, had caused a haemorrhage into the site where the meningioma had been removed. This was a most agonising and vivid thought; thankfully it was only a dream.

Temperature times, meal times and medicinal times mean very little in institutions. One is woken at 4 am to face the day, and breakfast is only served at 8 am. Why patients must be woken at this unearthly hour is beyond comprehension, for baths and bed-making are all over in 2 hours.

Of course, transport at the Johannesburg Hospital is an experience never to be forgotten. The porters use the corridors as their personal Kyalami circuit. They whizz you from one end of the hospital, down passages which must be over a kilometre in length, to the other. They appear to race with their colleagues. You, an anxious patient, with drips in your arm, mean little to them. They bump into the elevator doors and walls of the corridors as though

Hospitalisation can become a process of depersonalisation

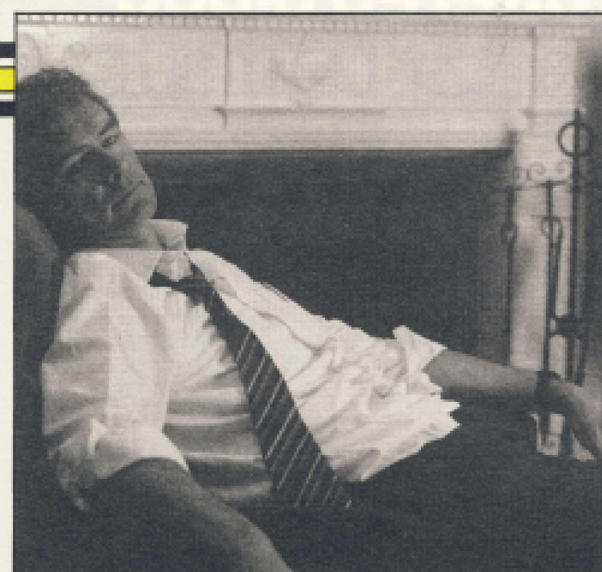
this was part of their daily duty. Frequently, during this most depersonalised form of transport, you invariably pass a colleague or two, who are shocked to see you as a 'doctor patient'. They make some inaudible remark, as though it is a normal daily greeting. The gentle greeting of concern for your ailment, which you expect, is not forthcoming from your colleagues. No doubt, embarrassment renders them speechless.

Patients and friends were wonderful. I received innumerable cards, books, chocolates and other delicacies from patients. No doubt, this was their way of demonstrating their empathy towards their doctor. Colleagues visited me and gave me tremendous moral support; visitors were always welcome, but at times it became overwhelming, particularly when they became engrossed in discussion, oblivious to my presence.

You are now known by your diagnosis!

The uncertainty of when I was to be discharged, what the results of the investigations were, waiting for my family to visit, all created anxious moments for me, the patient. Being a doctor caused caution in my therapy, so I was kept in hospital for a longer period than the average patient. How often did I hear "I'll be back in a minute with your results," but of course, this return visit never occurred.

After my experience in hospital, it is my belief that lengthy, unnecessary hospitalisation impedes the healing process of patients. Recovery from any ailment requires patients to understand the disease process and its problems. It must be communicated to the patient. Communication: how little of this ever takes place in the hospital situation!



PATIENT PERFORMANCE NEED NOT BE AFFECTED BY ANTI-HYPERTENSIVE THERAPY.

Thankfully, being a 'doctor patient', I was enlightened as to my problems, but I pity the average patient. Patients must be allowed to take a more active role in evaluating their illnesses, monitoring their symptoms, and developing their own treatment regimens under the guidance of their family practitioner. The attitude of the patient to his illness is more important than any doctor's treatment.

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In summary, hospitals are designed to minimise the efficacy of medical care for the acutely ill. However, by failing to meet the needs of the persons it claims to serve, certain aspects of the hospital environment may actually inhibit the curing process. If a new complaint in a patient disappears, and then returns a short time later, it warrants further investigation by the doctor - as was shown in my case.

I am grateful to all the innumerable doctors, paramedical and nursing staff who contributed to my recovery and enabled me to return to my daily life as a general practitioner. Once more I could attend meetings: I attended the WONCA meeting in London - my 7th WONCA conference! I play squash and jog, but perhaps not quite as well as I did before my experience as a doctor patient.

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