Crises in the family and health team – the doctor's role

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All people play games with themselves, each other, within families and in their daily social and business circles.

These games consist of selfrighteousness, arrogance, superior attitudes, inferiority, guilt, remoteness, helplessness, invasion of each other's space, avoidance of the truth and fact, pretences, pretending not to see or know things that are not easy to face, or accept, suppression and a host of others.

When a crisis occurs in a family and one is consulted or invited to interfere, it is sometimes difficult to see through the smokescreen and cut through the layers of fantasy, fiction and mist with which a member or members of the family have surrounded themselves.

To get to the core of the problem, a doctor may have to uncover a lot of sensitive areas and, in doing so even upset the current family dynamics.

This may lead to resentment and aggression, but it is no substitute for accepting responsibilities and the truth.

There are however cases where the play acting has been in action for so long, that the intervention or involvement in a crisis will lead to such chaos within the family, that one can only give support, direction, be a good listener and help to carry the burden.

I will present two cases – the first of which was an ongoing process which was very taxing to all concerned, and the second one an incident which became a process and involved the whole family.

Factors dictating the doctor's role

- Ability and desire of the doctor to help the family and become involved.
- Status of the doctor in the family.
- Interpersonal relationship between the doctor and the family.
- Cohesiveness of the family and its ability to react under duress.
- Presence of a leader in the family to take charge, direct and keep the cohesion,
  (a) vulnerability of the family – if the "kingpin" is affected.
  (b) invulnerability – where the leadership is shared ie. a second leader has always been present and groomed or a leader emerges and takes over the reins in distress.
- Tensile strength and flexibility of the family to cope with stress.
- Strength of each individual to function personally and to lend strength to the family.
- Social attitudes of the family.
- Spiritual strength and cohesion of the family.

Crises disturbing family dynamics

- Illness, injury, assault, rape or accident.
- Alcohol and drugs.
- Divorce, separation or marital disturbance, such as a third party.
- Unwanted, undesirable, inopportune pregnancy in mother or children.
- Loss of livelihood, bankruptcy, financial crisis or ruin.
- Sexual embarrassment – third party.
- Legal crisis – arrest, rape by a member of the family or of a member of the family.
- Involvement of a member of family in a political or other crisis or confrontation with the police.
- Physical or mental or emotional handicap or crisis of an adult or child.

Case No. 1

The first case involved a family friend aged 60.

He had a recurrent D.U. for 15 years and did not have much faith in conventional medicine but occasionally consulted practitioners of alternative medicine.

I was most surprised when he arrived at my rooms to consult me professionally – he was full of apologies for bothering me.

His symptoms were pain in the epigastrium, loins and thoracic spine. He had always had a pallor, was always lean and was a pipe smoker.

Examination and later radiology showed secondary malignant deposits in T.10 and 11, and suspicious shadows in the right lung. The ESR was markedly raised.

Further investigation by a thoracic surgeon demonstrated an inoperable Ca bronchus.

This man, who was an atheist, handled the situation very well and bravely from the beginning. He was neither overdramatic nor demanding but he was shaken by the turn of events and insisted on knowing all the facts, the prognosis

and asked how long the process was likely to take.

He insisted that this wife be spared the anguish of knowing the prognosis.

She similarly wanted to know the diagnosis and prognosis and asked me to save him from the diagnosis.

I had a long discussion with them and told them the truth as I knew it. I also held out some hope by telling them that although we knew the truth, that occasionally the condition could halt itself, remain static or recede.

They were now thrown together to face this new reality and they clung to this "hope".

Unfortunately their three children – two sons and a daughter worked in London where they were born and therefore all communication was by telephone and, obviously due to the expense, there were limitations to this too. However, they phoned me often. They needed to know. They had received a dreadful shock. Their emotions had been stirred up. They needed to talk to someone at source, who would give the plain ungarnished facts.

How long would it be? Should they come immediately? Would it upset or frighten him? Was there nothing that could be done? Maybe a senior thoracic surgeon in London; maybe a famous radiotherapy clinic in England or a chemotherapy centre, could help?

They needed to talk to someone at source who would give the plain ungarnished facts

I realised their utter frustration in being so far away. They wanted to be with their parents – even just to be together to talk and close their ranks.

I told them that they should not hurry to come out immediately.

This would only have an alarming effect on their father – and then there would be a long vacuum with no one around.

It would be wiser if they would stagger the visits to cover a longer period. This would also give the parents more to look forward to – especially as the illness would probably be a protracted one.

The wife is a pleasant lady, who has a little business of her own. I could forsee problems here, as not having a large staff it would be difficult for her to be away from this business which needed her attention to prosper and more importantly – to survive.

Severe unrelenting and interminable pain in the right chest wall necessitated a short period in hospital where the thoracic surgeon introduced mustine into pleural cavity to control local pleurocostal spread. This was a painful procedure which eventually settled the pain.

Unfortunately this flared up again a month later and a further installation of mustine into the pleural cavity was required. This turned out to be a very unpleasant experience – painful with a bad reaction to the mustine.

Unfortunately, the thoracic surgeon seemed to have problems of his own at this time and was most unsympathetic and almost aggressive.

Both husband and wife were appalled by this experience and were adamant that there would be no further hospitalisation.

Another surgical opinion was obtained and although a kinder approach was encountered, obviously no change in prognosis or treatment could be offered.

This consequently put the whole problem of management into my lap.

My patient now looked forward to the visits of his children who came out individually and stayed three weeks each.

He continued to work most of the day and I would see him once, twice or three times a week as he felt necessary.

The wife, elder son and I discussed the future and obviously a matter of great concern was the attitude of the organisation by whom he was employed at a later stage.

We decided that the son should speak to the Managing Director who would then be asked to contact me.

When he phoned, he was aware of the medical condition and it was my task to persuade him to keep the patient on as an employee, in order to qualify for medical aid, but mostly for pension and death benefits which would amount to three years' salary. I also asked for him to be allowed to leave for home when he was tired.

We spent some considerable time in the discussion and finally he told me that this would be put to the board.

Eventually he phoned to tell me that this had been accepted. This was a great relief to the family.

When the daughter came out on a visit she was a real tonic to the family during her stay but one could sense the tension rising as her departure drew near – there were tears when she left.

I felt that this was a good release valve as the situation had become somewhat unreal – almost like a celebration.

I encouraged them to plan a holiday in Cape Town at the end of the year. Fortunately, accomodation was acquired.

In the meantime the younger son arrived to visit.

As this was the third and last of the children it seemed to evoke a feeling of desperation. My patient began to reject the diagnosis and looked forward to his visit to the Cape where he had a friend who was a thoracic surgeon.

It is amazing how the play acting carries on

I prepared copies of all reports and sent them and the X-rays to Cape Town – where he was seen on a few occasions by his friend who confirmed the diagnosis.

On their return I knew that the coming months would be a great strain to all.

He became more frail and dyspnoeic and his visits to his office trailed off. He spent most of his time sitting or lying propped up on the settee in the lounge. It was necessary to acquire a sheepskin for his sacroiliac region as he had lost weight.

I visited him three times a week at home, examined him each time, marvelling at the very slow spread of the disease.

I introduced him, his wife, the brother-in-law and sister-in-law to the T M technique through my son who although a medical student was a trained teacher of T M.

This seemed to give them something to hold on to as they were all able to meditate together each evening.

My wife and I joined then on quite a few occasions. This seemed to have a remarkably soothing effect on the whole family.

It is at a time like this that a doctor finds himself doing a great deal of talking, and philosophising, in this case to the patient, wife and to the sons and daughter overseas, it was continued support and communication.

A glimmer of hope appeared here, an imagined improvement there, a morsel that had been grasped here, a joke and some laughter there.

It is amazing how the play acting carries on, with everybody present as participants and how the doctor can keep up the fami-

ly's spirits under these circumstances but often under the great stress of interference and suggestions by the many honorary doctors among friends and acquaintances who make their appearance at these times.

His management had become difficult and he finally agreed to accept a nursing sister to ease the daytime burden.

I particularly welcomed this as tensions were mounting with the increasing pain and with the greater use of analgesics and hypnotics until narcotics were used and given by the sister who was an absolute gem — firm but kind.

Financial doubts

During this time, financial doubts and problems began to arise. We talked to the accountant and planned for the future with the assurance that I had been given by the MD. Thus the financial picture was taken care of.

Each of the children returned on a second visit, while the second son returned permanently. This was a great help to the wife and to the patient but their position was difficult as their time in Johannesburg was limited. I was present at two very sad scenes when they took leave of their father. The nursing sister had become an integral part of the family and was loved and respected by them all.

The liver was now the obvious seat of secondary spread and then the brain.

Jaundice inevitably appeared but my patient was never aware of it. It disturbed the family a great deal but they accepted the explanation.

Acceptance

The cerebral involvement was evident by occasional outbursts and memory lapses interspersed with amazing lucidity. Acceptance was appearing.

His gratitude to me was embarassing and repeated daily as he clasped my hand and thanked me for all my help and care until he finally sank into a coma before his end.

He indeed died with dignity.

As this family had never had any religious affiliation but were of the same faith as I, the wife and children had asked me some time previously, whether I could arrange for a cremation.

All the arrangements were duly made and carried out.

After the many months of involvement with this sad illness, I too felt a void and needed a little time to mourn the loss of a friend.

Case No. 2

The second case was of a different calibre and certainly did not start off in a dramatic fashion.

A mother brought along her daughter whom I had brought into the world 15 years previously.

She was a shy girl who had not menstruated for three months. The mother wisely left us alone.

Questioning elicited nothing until finally with almost a sense of relief she told me that on Christmas eve, while mother and father were out, elder brother "came home drunk and jumped on me".

Examination elicited an enlarged uterus of 12 - 14 weeks size. All other symptoms of pregnancy were present and confirmed by blood and urine tests.

> ... one is conscious of the tremendous privilege which is accorded our profession — to be of service to our fellow-man

Mother was remorseful but father had murder in his heart when I told him of the pregnancy.

I contacted a social worker for referral to T.O.P. clinic at the hospital and she was very encouraging. I also contacted a senior psychiatrist at the hospital — an old classmate — to enlist his support for T.O.P.

In the meantime the elder brother had moved in with the elder sister and brother in law — so he was out of the way and remained remote.

For some unaccountable reason the gynaecologist of T.O.P. clinic was reluctant to evacuate the uterus and the unfortunate girl was subjected to much discussion, tests and procrastination.

Much counselling was needed for the girl, mother and father during this trying period.

Guilt, remorse, fury and regret was experienced by each one in turn.

The hospital took over and did not always include the General Practitioner. It was rather dehumanising for the young girl — who had been taken out of school.

Finally a hysteroctomy was done at 22/52.

The Social Worker and psychiatrist devoted a great deal of time to the family and when this young lady returned home a great deal of rehabilitation and adjustment was required to restore the family to any semblance of normality or reality.

The family was in chaos.

It took many months for the family to settle down and to this day the equilibrium is easily upset.

This could not have happened to a family with greater problems.

Mother has L.E. which is well controlled. Father had an aneurysm of the circle of Willis which leaked and was tied off ± two years previously.

Subsequent to this he entered a phase in which he exposed himself to schoolgirls, with inevitable arrest and court appearances.

The neurologist and I appeared in court on his behalf and managed to squash the case.

He developed another aneurysm on the other side but fortunately investigation showed that it had sealed itself off by a clot which obliterated it.

A setback

Unfortunately, further exposure to schoolgirls recurred. This was a difficult and very heavy burden to carry — as it involved police, irate parents and again an appearance in court with the neurologist and psychiatrist — again successful.

With this latest debacle with the young daughter, the Sword of Damocles which had hung precariously for all these years began to sway but fortunately father's equanimity was restored as he was persuaded that all that really mattered was the daughter's future.

I told him that I hadn't let him down over the past 20 years and I wouldn't let him down now.

In all my years in medicine I have known many crises in families.

I like to think that I may have been of some help and that I was not found wanting in their moment of trial and that I may have made their burden a little easier to bear: for what is our purpose if not to use our knowledge, experience, know how, contacts, strength, wisdom and consciousness to good purpose for others?

It is when one has been through the trials and misfortunes of others that one is conscious of the tremendous privilege which is accorded to our profession — to be of service to our fellow man. ☐