

Patients as friends - awkward or advantageous?

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Abstract

Rural General Practitioners often find themselves in a small community having patients as friends. This can lead to difficulty in the relationship. This is a reflection on family friends where I missed the youngest child's diagnosis of myoclonic epilepsy in the social context and which led to a crisis in the relationship. This led me to reflect on acknowledging my needs, defining the roles and relationships and being explicit and honest with the patient cum friend in the structuring of the dual relationship in various ways. I, as a doctor, have learnt to continuously reflect on objectivity and comfort in the care of the patient cum friend.

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BACKGROUND

Sammy was born uneventfully on 19th March 1997 to Andy and Kelly Bell.* Kelly was a good friend of my wife but was a very talkative person – something that did not go down well with me. They had 2 other children, Sandy and Sally. Sally was a very good friend of my daughter and was in the same class, although a very slow learner. Sandy was the elder but was suffering from learning problems and diagnosed as possibly dyslexic by a school psychologist. This was a source of great embarrassment to both Andy and Kelly as Sandy was put in remedial class after failing class 1 and class 2. They were taking it badly. They had had terrible experiences with Andy's adopted sister being mentally retarded and so difficult to handle. We were very close after they had helped my wife through an illness soon after they moved into town three years before. It had been a surprise when Kelly became pregnant with Sammy. She was just getting used to the freedom of a job that I helped her get and she agonised when she had to quit. I was their family doctor with the odd visit to *(Names are changed).

the rooms but I tended to deal with a fair number of their medical problems at social gatherings.

THE PROBLEM

Sammy seemed to be growing well. On one of her visits to our home in September 1997 Kelly broke off her conversation with my wife and mentioned that Sammy seemed to be getting occasional "head drops" when he sat up. He seemed completely normal while sitting in my lounge. Kelly insisted that he was growing completely normally. I dismissed the symptoms as part of growing up.

I overheard Kelly complaining to my wife about the head drops two weeks later. I was really in no mood to get engaged on a relaxed Saturday evening. I told her that I was sure it was just immaturity of his neck muscles. We were talking over a braai at our home a month later when Kelly repeated this complaint, adding that Sammy's head would drop 1-3 times a week and that he would start crying terribly after that. It was described as sudden single little drops of the head followed by fitful crying. He was now 6 months old. I kind of mumbled over a burning sausage that

it might be a form of epilepsy. As I watched Kelly's face respond to the word "epilepsy", I decided to shut up by reassuring her that Sammy would need to be referred to a paediatrician/neurologist in Durban for an EEG to confirm anything.

On cursory examination in my lounge Sammy was bright and had no focal signs. His systemic review seemed normal. Kelly had had no drugs during pregnancy. There had been no insults during pregnancy or labour. Sammy had been completely well since birth. His fevers had not been excessive and he did not suffer seizures related to the fevers. I told her I would arrange an appointment. I felt ashamed at having taken so long to pick up the problem and at my clumsiness in handling my relationship with Kelly and my management of the problem. My receptionist simply arranged the appointment with an attached letter. I did not see her further.

THE STORY GOES ON

Sammy finally visited the paediatrician in Durban in late November. He was getting 1-3 head drops a day. A diagnosis of *Myoclonic Seizures with*

Hyppsarhythmia was made on EEG. His CT scan was normal. Sammy, now 8 months old, was put on clonazepam (Rivotril®) 5 drops tds. His head drops recovered considerably but Sammy suffered extreme dullness from the Rivotril®. He would sit dazed all day. His ability to interact was extremely limited. Kelly was extremely concerned by this and was constantly worried about his future, so my wife told me. I tended to avoid them, as I was confused as to how to deal with the relationship.

It seemed simple enough to respond to my patients problems when we met so often but those were my times at relaxing and our interactions were becoming very unrelaxed with every social going into his progress. I felt weighted down considering the context of disability in their family and our friendship. This was despite reflecting that I could have done no better. I pushed my wife at the time not to invite them around often and when we were together I would deflect anything. "Check with the specialist the next time you are in Durban." was a standard response.

REFLECTION ON FRIENDS AS PATIENTS

I reflected on the issues thus far and realised that I needed to examine the difficulty I was having coping with my roles as friend and family doctor. I was managing a patient in a complex social environment. It was hardly professional family medicine. I did not feel good at it, yet it seemed simple enough socially to talk about it every time we met. I could not figure a way otherwise.

BEST QUALITY FAMILY CARE

There are four skills that underlie a doctor's ability to provide best quality family care.¹ They are:

- a. The solution of undifferentiated problems in the context of a continuing personal relationship with individuals and families.
- b. Preventive skills - the identification of risks and early departures from normality in patients known to the physician.
- c. Therapeutic skills - the use of doctor

- d. Resource management skills including skills of consultation and referral.

FRIENDS AND FAMILY BENEFIT? HONESTLY!

The issues of comprehensiveness of care, family care, bonding and cumulative knowledge of patients can all be advanced by a closer relationship. Family and friends are inevitable beneficiaries in such a scenario. Yet how often are they worse off? How often have wives complained about lack of care?

But doctors have their own needs. Doctors may often want to switch off in a social setting after spending the day with antennae up looking for signals of ill health. It becomes soul-destroying when I join a social group and the main reason anyone turns to me is to ask a medical question. Vigilance obviously drops in such a situation. We need our own space and we should not be afraid to claim it.

The relationship between healer and sufferer in such a social setting can only become meaningful if we, as physicians, are able to confront ourselves with complete honesty.¹ The longer one knows a person, the more difficult it becomes not to have critical opinions. How can we avoid judgement? We cannot. We can only remain consistently on guard against the subtle ways in which judgement can creep in destructively into our relationships. We must listen to ourselves, to what is going on within, as well as to what is taking place in the person we are hearing.¹

HONESTY TO OURSELVES

Self knowledge requires us face up to our faults and deal with them. This path does not come without mistakes and one grows through them. It does not come by keeping at arms length and developing distance between one's self and the patient, as seemed to be the case with the Bells and I. In fact it certainly does not help socially to do that especially when your status as doctor and healer is looked at with respect and awe. Part of effective listening is to

bring feelings into the open. Laying out the doctor's need - explicitly and constructively for a social setting and the boundaries of the relationship could easily meet with support from friends and family. In fact, understanding my social needs and its terrain, prerogatives and complexity and openly reconciling that with my normally-fewer-dimensional role as family physician was the crux of my problem.

NEGOTIATING THE RELATIONSHIP

Rourke, Smith and Brown² discuss various combinations of professional and friendly relationships that can exist between physicians and friends.

1. No relationship.
2. Physician and person are friends, friend is not a patient.
3. Physician and person are friends, friend is not a patient but tries to get advice at a social gathering.
4. Physician and patient have a strictly professional relationship e.g. anaesthetist.
5. Physician and person have a professional relationship but some degree of friendship exists within the professional relationship.
6. Physician and patient have two relationships - personal and professional but the two are totally separate.
7. Physician and patient have two relationships - professional and personal friendship and the two have some overlap.
8. Physician and patient have two relationships - professional and personal friendship and the two are meshed.

SETTING BOUNDARIES

Boundaries are required and these are based on the concept of multilevel relationships. These boundaries can be set in physical or in personal terms. One of the easiest is to deal with patient problems in the appropriate setting e.g. patient problems at the office. Patient and Physician have to learn not to practise medicine at the supermarket or at a social gathering except in emergencies. It is often difficult to decide where interpersonal boundaries should be set. Setting them towards the

personal end (with larger overlap) can risk enmeshing the two with loss of clinical objectivity whilst being set too close to the impersonal end (with little overlap) might make an inability to empathise or difficulty in communication.

Having personal friends as patients can obscure judgement and make us waver in our decision-making. If the doctor and his patients discuss and define their concurrent needs this can be lessened, if not eliminated. The patient's care can be improved with the relationship becoming more rewarding.²

JUDGING THE RELATIONSHIP

Rourke, Smith and Brown² go on further to say that there are three questions that need to be asked in order to judge whether caring for a close friend is helpful.

1. Am I too close to probe my friends' intimate history and physical being and to cope with bearing bad news if needed be? (e.g. perform a vaginal or rectal examination, care for terminal illness.)
2. Can I be objective enough not to give too much, too little or inappropriate care? (E.g. over investigate due to inappropriate anxiety)
3. Will my friend comply with my medical care as well as he or she would with the care of a physician who was not a friend? (e.g. familiarity might lead to non compliance).

MY RELATIONSHIP

When I examined my relationship with the Bells I tried to clarify my roles and needs and find ways to balance them knowing that both the friendship and

patient relationship would overlap. I had failed to think this through although I was in a good position as friend to support them as patients. Instead, I felt constrained by this and thus fled them in fear. It took me a few months while they were seeing the paediatrician to work my way through my anxieties. I broke the impasse with a discussion where I laid out my concerns and feelings, and my need for boundaries. They were most accommodating and non-judgemental. I have finally structured my relationship to a monthly visit at the surgery (after work - so as not to detract from the friendship and relaxed relationship) to discuss feedback from the paediatrician and progress.

MY PATIENTS AGAIN

I tended to look after them for colds and flu's but noticed that Kelly never came to me regarding her gynaecological problems. She was going to her Gynaecologist. I brought it up and we discussed that as being fine to keep our relationship uncomplicated. The easiest may have been to get the Bells to visit another GP considering our close relationship but they did not want that and I noticed that all three questions, as Rourke, Smith and Brown² suggested, had to be asked on every consultation. I also began to reflect more constructively on my SELF in my general practise and be less hard on myself – myoclonic seizures were after all a difficult problem to diagnose and manage.

PROGRESS

Sammy improved somewhat but suffered considerable sedation and a

few drop attacks per week despite increasing the dose of Clonazepam and the addition of Sodium Valproate (Epilim®). He would sit in a bundle staring for long periods.

A paediatric neurologist changed him to Vigabatrin (Sabril®) (one of the newer anti-epilepsy drugs and a choice in myoclonic seizures)³ with remarkable results. He is now fit free, with the sun shining as he develops and lets his sprightly personality show through those clouds. He is constantly on the move.

With a deliberate monthly consultation at my rooms to discuss their problems and concerns the pall of the anxiety and stigma has lifted from the family as I have supported them through his recovery. The effect socially is that there is much more closeness now between our families and I enjoy the social interaction much more with a lot less "medical talk". Even when it does occur it is no effort to steer it to a suitable conclusion – a consultation at my rooms. □

Acknowledgements

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