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OUTSIDE THE SQUARE

These are a few of my favourite things: reflections on the doctor–doctor relationship

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Abstract

The doctor–patient relationship is often spoken about and is typically characterized by one of trust and compassion. However, the doctor–doctor relationship is rarely discussed openly as it is too hurtful to reveal the truth. Lack of compassion, competitiveness and even cruelty abounds in the opinion of the author who exemplifies this by some personal anecdotes and is based on 30 years as a physician. Unfortunately the lessons to be learned occur too late for most individuals. Selection of medical graduates may also play an important role in the whole malady. (Intern Med J 2005; 35: 65–66)

Key words: doctor–doctor relationship, compassion, competitiveness, neuroticism, aggression.

On the top of my book shelf in my study at home is a replica of a Portuguese caravel less than one foot long with a little dust in its intricate rigging, a survivor of the storms of many a house move, and the tempest of a divorce and property settlement. For over 20 years it has been my prized possession and were my house to burn down, I would be hard-pressed to think of anything more precious to rescue from the flames. It is before me as I write.

I remember the bleak Melbourne Saturday morning that two young girls of early primary-school age in their Sunday best, and with mum by their side, with their arms outstretched presented this little treasure to me. I was consulting for some extra income at that stage in rooms given to me free of charge by a senior consultant thoracic surgeon whose generosity I shall never forget. The girls' young father had been one of my first private patients. He had died of chronic respiratory failure while under my care and had managed to make the model during his long illness. It was his wish that I receive it after his death as a token of thanks. Those tears rolling down young cheeks epitomised the relationship between physician, patient and family. I tried to hold back my own tears and a lump welled up in my throat. I shall never forget that morning.

In the evening, when I drive out of the basement car park of the rooms where I consult, I pass the expensive stable of latest model European cars. I wonder what this is all about. Is this why we all did medicine? I hasten to add that my own car is 'elderly' according to my accountant, and Japanese. Let me share some reflections on the changes I have seen over 30 years of practising medicine.

As a first year intern in Brisbane, I worked in large medical units of 40 or more patients, understaffed by both doctors and nurses, and in antiquated conditions dating back to World War II. One day I was summonsed for an audience with the medical superintendent who told me I was under no circumstances to claim overtime. The reason for my long hours was my 'gross inefficiency'. I was spending too much time with my patients. What could a powerless intern say when faced by such an indictment from the high priest of this healing profession whose hallowed cloisters I had just joined? What is more, he told me, in his day, first-year interns were not paid at all. I had the status of an 18th century cabin boy and work habits had not progressed much since either.

As a registrar beginning my training for my medical fellowship exams, I often had to work all weekend after a week's work. To add to my woes, our unit always admitted new patients from the emergency room every Monday. That meant I worked usually with little sleep until Tuesday night and still had to work the rest of the week until the following Saturday morning. I was also studying for my fellowship, and to add to my sleep debt, it was the duty of the registrar of that unit to present cases at the review meeting on Tuesday mornings at 7 am. Mutiny was punished by an unfavourable report at the end of the term and meant certain death to any specialty aspirations. There was never an attempt to change the work practices or the time of the meeting let alone consider the nauseating fatigue we all felt by Tuesday morning. These arrangements suited both my consultant and the medical administration. Compassion for the suffering did not include doctors, particularly junior ones.

One day on a ward round in the thoracic unit on which I was working, I suffered a tension pneumothorax and came close to dying in the emergency room but for a hurried chest tube and a welcome gush of air. Ironically, I ended up in the same ward that I had worked that morning, only this time as a patient. As it was only a month away from my specialty written exams, my fellow registrars gloated over my good fortune to have some

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time off to study and brought me gifts of textbooks and study notes. Their eyes were not open to the absurdity of their actions such was their drivenness and anxiety. On the third day my chest tube was still bubbling furiously and I felt exhausted and disappointed. I was facing surgery. The third night, I was asked to review a problem respiratory patient of mine in the ward upstairs. In my dressing gown, pyjamas and *in situ* chest tube, carrying my bubbling drainage bottle in a string basket, I visited the bemused patient. Only in hindsight could I see the sheer madness of all this, but at the time I was powerless. No one cared. The next morning a chaplain visited me. He could see a young doctor on the verge of tears and utterly exhausted. He kindly rescued me by going to the medical superintendent's office and asking if I could be relieved of my pager. Until that day, the medical administration had provided no relief. I had inconvenienced the system.

As a young visiting consultant I was asked to see a very important patient while my boss was away on leave. The patient was a consultant physician for whom I had once trained and whom I knew had cancer. He elected to stay under my care, which suited my superior, and I visited him at his home at least weekly for many months until he died. Our relationship became very close and the experience was mutually enriching, if emotionally draining at times. I presented his eulogy and was rewarded by a charming watercolour he had painted several years before. Every day it faces me in my consulting room, reminding me of him. It, like the ship, is one of my favourite things. What disappointed us both was the incapacity of his medical colleagues to give of themselves through his final terrible illness. Like hail on the grass after a Brisbane summer storm, they all melted away.

As a thoracic physician I see the world of thoracic and sleep medicine changing for the worse in this country. It is now fractured into cartels of sleep and respiratory empires each vying for bigger pieces of the cake, another bit of territory, another post to 'pee' on, another new sleep laboratory and all to the tune of market forces, undercutting, price wars, and an entrepreneurial spirit more reminiscent of the East India Company. At conferences I feel the tension and neurotic competitiveness, beneath the superficiality of '*toujour la politesse*'. Conferences have become proving grounds for testosterone-driven young stags. I often wonder how many can see the emperor's new clothes. Drug companies with their well-preened 'reps' seduce us with their potions, offers and enticements, from the free pens to the expenses-paid symposia in places like Majorca, ostensibly to promote learning of diseases. From the solemn joss sticks bedecking the effigy of Mammon in the trade display auditorium waft the sweet incense, subliminal and not so subliminal which befuddles the minds and mores of the solemn congregation of the annual scientific *Missa Solemnis*. We all take it so seriously and regard one another as either friend or foe.

For the last year or so I have been staying at home while my wife goes to work one day a week. This has been good for our young pre-school children whom we felt needed a parent at home. We could have hired a nanny but chose not to. I also needed some time to catch up with medicolegal reports, other paperwork, domestic chores, banking and a whole range of other tasks most men take for granted. If I had inpatients I would see them later that evening when my wife came home. However, something unexpected occurred. Other doctors and particularly women resented my being at home while they were at work. It was usually subtle and probably unconsciously. My secretaries and I concocted various alibis for me to prove that I was still at work. We finally discovered the solution by telling them I was doing 'court work'. The subtle harassment ceased. I really was working after all.

How often are we requested to see inpatient referrals in the evening who have been in hospital for days or whose urgency is more imagined than real? We rarely consider one another let alone home life or mental health. How often do we see consultants wandering the wards well after dinnertime like zombies? Some thoracic physicians during the winter months even boast about how many inpatients they have at the time. There is never a thought about telling the emergency room doctors to call another consultant as they have enough inpatients to handle safely. This may invoke a referral-base crisis, or even worse, an acute anxiety state. The flow may dry up. Is it not better to respect a physician who rejects a referral at a certain time because of a safety issue? Who would fly with a pilot who had reached the limit of endurance or had a severe sleep debt?

The same applies to overbooked consulting session with squeezed-out lunch breaks, no room for personal time or relief for stressed staff. Mammon and the medical neurosis reign supreme. How many evening meals have been spoiled having been lovingly cooked by a neglected spouse? How many bedtime stories and bedtime prayers have gone unsaid to fretting children who have fallen asleep waiting up for doctor mum or dad? What is the cost? How many marriages have foundered under such lack of compassion and how many doctors have ended up with depression, a drinking problem or even committed suicide? We have little compassion for one another let alone for ourselves. Care and compassion occur only when the recipient is paying for it. It is a transaction, fair and square.

The first love of my father, who was a solo general practitioner all his life, was not his family but his patients. It is from this perspective that I write. Care and compassion for our patients are the quintessential virtues of the medical profession but may be rare birds when it comes to the doctor–doctor relationship and even to our own families. This is also often a problem when doctors become patients. Neuroticism, greed, the need to be in control, envy, drivenness, poor self-esteem and insecurity are but a few of the foibles well expressed after decades of the medical selection process. We should learn to extend to our families, our colleagues and ourselves the same care that we extend to our patients. The ultimate irony is that on our passage to the grave, eventually we all move from the doctor–doctor relationship to become patients ourselves. For many of us, the lesson comes too late or even worse, not at all.