



FROM GENERAL PRACTICE

Door-handle symptoms

Chris Ellis

In family medicine teaching there are specific steps one should take for the closure of a consultation, such as summarising, follow-up arrangements and various reinforcement and reflective processes. Well, that is the theory, anyway. It is sometimes called 'methods of breaking rapport'. Yet somehow quite a few of my consultations don't seem to pan out in this way.

Take for instance, my Mrs McNaughton*. Trying to finish a consultation with her is an art form in itself. After the main business of the consultation has been completed and the blood pressure has been taken, the abdomen palpated and the prescription written, I rise with her folder in my hand. It is my first grand hint. As I head for the door she says 'but Doctor Chris that is not why I came in to see you ...'. It is like the false start for the 100 m when the chap fires the starting pistol twice and you have to return to the starting line. We then proceed back to the examination couch and examine the new complaint and return back to our original positions in our respective chairs. Having readjusted her prescription I resume my position under starter's orders, manage a fairly swift take-off and get to the consulting door while simultaneously engaging in 'closure' conversation to the effect that the consultation is now over.

She, on the other hand, is still firmly embedded in her chair and is craning her neck around to see where I have gone, quite oblivious to my behaving like a cat on a hot tin roof. I have now opened the door and am waving it gently in a beckoning rhythm which seems eventually to have the required effect. As she passes between me and the door she suddenly stops, and putting her hand into her bag, says 'oh, I nearly forgot, could you fill in these chronic medications forms for me ...?'. I find myself at this point gripping the door handle in a firmer way than is perhaps necessary and experiencing a form of air hunger where I hyperventilate with increasing inspiratory stridor.

I give this as an example of symptoms or requests, in this case of both the patient and the doctor, that can happen at the very end of a consultation.

* Mrs McNaughton is a pseudonymous composite figure.

Chris Ellis is a family physician in Pietermaritzburg, KwaZulu-Natal.

Patients may never reveal their real motive for coming to the doctor for several reasons such as shyness, perceiving that the doctor is too rushed, or because the doctor is on a different wave-length. This may lead, at the end, to patients mentioning their most pressing problem almost as an aside, as their hand is on the door handle.

My first experience of a significant door-handle symptom was when I had just qualified and was in practice in a small village on the west coast of Canada. I was looking after a Mennonite colony living up in the hills. The Mennonites are a fundamentalist religious sect rather like the Amish, who were made famous in Harrison Ford's film, *Witness*.

I was looking after a young married Mennonite woman and attended the delivery of her baby at our local hospital. In the following year she consulted me frequently for various complaints and one day I informed her, after we had completed the consultation, that I was leaving the village to go to Africa. She thanked me for looking after her; as she got to the door and with her hand on the door-handle, facing the door, she said 'I don't get orgasms'. I don't believe she would ever have mentioned it if I had not been leaving the practice. (I can't remember how I responded, as I was trained at medical school in the sixties when 'not getting orgasms' was not included in the curriculum. It was then the beginning of a wider sexual awakening in North America and Europe and orgasms were becoming compulsory. Of course now it is the first question I ask after 'are you on medical aid?'.)

Apart from sexual problems patients often leave unspoken many fears of dreaded diseases. A colleague of mine had a patient who consulted him for low lumbar back pain. He examined him thoroughly and explained with the aid of a diagram that the cause of his backache was a disc degeneration. He prescribed anti-inflammatories and asked the patient to contact him if the pain did not go away. The patient reached the door after the consultation and with his hand on the door-handle turned to my colleague and said 'so from what you have told me then I don't have cancer'. Conditions that may seem perfectly straightforward to the doctor may have a completely different significance for the patient.

Recently a man presented to me with symptoms of a kidney or urinary infection. He even suggested that he thought his problem was an infection in his kidneys. I tested the urine, which was clear, and reassured him that the symptoms might be caused by muscle spasm. I was aware that there might be



SAMJ FORUM

another agenda, but it was at the end of the day and my superbly tuned incisive diagnostic skills were not at their sharpest. We ended on that note and as he got to the door he said, as an aside, 'I believe there is a pill for it nowadays'. I knew intuitively exactly what he was talking about. He was referring to Viagra and we went on to raise the subject, so to speak.

My most recent door-handle symptom involved a man with sores on his arms and legs. I explained that they were Natal or

veld sores and were caused by bacteria. I prescribed antibiotics to take by mouth and a nasal cream, which I explained was to kill the reservoir of organisms in his nose. As he went out of the door he hesitated and said 'do you think I should have an AIDS test?'. I asked why he thought this was necessary. He replied that a worker in his factory had just died of AIDS and his symptoms had started with skin sores. I had treated his condition, but I had completely missed his reason for coming to see me.