Rural and Remote Health
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy
ISSN 1445-6354

PERSONAL VIEW

Communication with patient, family and community in the rural world

RR Gracia Ballarin
Amurrio Health Centre, Oskidetza, Comarca Interior, Spain

Submitted: *27 March 2005;* ***Resubmitted:*** *29 September 2005;* ***Published:*** *22 December 2005*

Gracia Ballarin RR
Communication with patient, family and community in the rural world
Rural and Remote Health **5: 424. (Online), 2005**

Available from: http://rrh.deakin.edu.au

A B S T R A C T

The rural world and its population have their own characteristics, different from the urban world, which contribute to creating a unique framework for physician-patient communication and relationship. On most occasions the physician arrives in the village from some other setting and must adapt. He or she must make a good first impression on the neighbours, and learn the language they use to describe the most common illnesses and symptoms (sickness, indigestion, faintness, lack of appetite…), because the doctor must use the patients' language. Moreover, the doctor has to accept being permanently observed and identified. Thus, this Spanish personal view takes the reader into the world of the rural doctor.

Key words: rural doctor, Spain.

Introduction

The rural world and its population have their own characteristics[1], different from the urban world, which contribute to creating a unique framework for physician-patient communication and relationship. On most occasions the physician arrives in the village from some other setting and must adapt. He or she must make a good first impression on the neighbours, and learn the language they use to describe the most common illnesses and symptoms (sickness, indigestion, faintness, lack of appetite...), because the doctor must use the patients' language[2]. Moreover, the doctor has to accept being permanently observed and identified.

© RR Gracia Ballarin, 2005. A licence to publish this material has been given to ARHEN http://rrh.deakin.edu.au/

Integration into the community entails accepting, with all the advantages and disadvantages, four aspects that characterize, from my point of view, the physician who lives in the village in which he or she works: accessibility, closeness, trust and presence in the community.

The rural physician usually has a large geographical area to look after but within this a smaller population is assigned. This enables the physician to spend more time caring for each patient, which contributes to great mutual satisfaction[3].

Background

The organization of a village was historically defined in relation to its authorities. First, the wealthiest person in the village; next, other people who held some type of authority: the mayor, the police, the school teacher, the priest and the physician as an expert in health matters.

Opinions, judgements or measures dictated by the physician were not questioned and the simple 'because I said so' was of enough weight. This facilitated a paternalistic model of relationship in times when the illness itself, rather than the preoccupation with it, was what brought people to the physician. This model enabled a balance between the needs and expectations of the patients.

In today's urban society, only a minimum of authority is granted to a doctor and professionals in general. Moreover people frequently go to the doctor's office more for their worries than because of diseases, and they question the opinions, diagnostic means and therapeutic choices of the physician.

However, in the rural setting today these two models coexist. There is the old vertical relationship of mainly elderly people and those who live in families with stronger bonds and with fewer vital connections with the outside. Nowadays there is also a horizontal relationship adopted by young adults, who have seen all voices of authority progressively fade away.

Thus, trust becomes something that the doctor has to obtain by demonstrating knowledge, skill and a certain attitude but, above all, by being a good communicator who accepts the challenges of today and the beliefs of different groups of people who include those who:

- still believe what the physician says is always true
- believe that the wisest physician is the one in the hospital
- believe that any opinion on health matters has the same value
- do not recognise any type of authority in anybody.

Dealing with the patient and family

Accessibility has traditionally been a characteristic that permeates human relations in the rural setting. This can be the source of great satisfaction for the physician (as it makes it possible to be in the right place at the right time). However, the professional who is unable to place limits on this accessibility can become the slave of it[4], if patients become accustomed to being assisted in any circumstances.

Accessibility, together with trust and continuity, give the patient satisfaction[5] and the rural physician an in-depth knowledge[6] of the patient and his or her family, allowing knowledge of those family secrets that frequently are the origin of symptoms of somatization that are difficult to care for.

Accessibility also enables access to beliefs about health and illness and about natural remedies. With the invasion of the modern, urban world, through immigration and television, ancestral beliefs about health and natural remedies have gradually been lost or at least undervalued by the possessors themselves who, in general, tend to conceal them because of various fears.

In general, all these aspects become increasingly manifest the more sociologically rural[7] is a family. That supposes maintenance of an extended family, with three generations living together. They preserve a certain family intimacy and

© RR Gracia Ballarin, 2005. A licence to publish this material has been given to ARHEN http://rrh.deakin.edu.au/

some isolation, while at the same time there may be a strong interrelationship among families of the same village. This situation enables the elderly to live at home to the end of their days and family beliefs, biographies and experiences to survive with them. These families tend to prefer elderly persons to die at home, allowing the physician to care for them in the last moments of their life. This creates strong links between family and doctor and, at the same time, it allows the doctor to help the spouse and relatives develop a healthy mourning.

Dealing with the community: observer and observed

Observer: doctor and citizen

The doctor who lives in the rural community where he works, knows the environment - the smaller, the better - the health of the community and other circumstances, such as the social, economic, employment, family, psychological, or historical factors, that influence the population[8]. The doctor has this knowledge not only as a doctor, but also as a citizen. He/she knows what happens in the village: a company that doesn't work well, meningitis in a school in the town, the excursion day when elderly people go to the beach, or when a dispute arises among relatives or neighbours.

Little by little, the doctor learns about the rituals that the population use for healing. Sometimes such rituals are of religious origin or they may derive from white magic. For example, Saint Blas, tradition says, cured throat infections[9]. In the days followings his festival, people in some countries wear a cord around the neck, trying to avoid such diseases. In a similar way, physicians must know the alternative therapies their patients use to improve their health. The doctor must, at least, be aware of the local traditional faith healers, homeopathic remedies or other well intentioned people who compete with the health practices that occur in the doctor's office.

The doctor who knows what is happening in the community may find an explanation for such things as epidemics of migraines, increases in the number of requests for sickness certificates for work absences, depressive syndromes or any number of somatic disorders the genesis of which is in some crisis through which the community is going.

Another difference in the life and practice of the rural doctor is the doctor's involvement in farewell rituals following a death in the community. Such a death is usually more apparent in the rural world. The announcement of the death is publicised throughout the town by notices in appropriate places, sometimes accompanied by an old picture of the deceased person. In some towns (M. Comesaña, pers. comm. to http://www.rediris.es/list/info/medfam-aps.html, 24 October 2003) when someone dies a car with speakers announces it in the streets of the village, saying: 'Gentlemen neighbours, we communicate to you that Mr So-and-so has died. He was affectionately known as…[and they give the person's nick-name] and his family and relatives invite…' Everybody takes part in the funeral because of his relationship with the deceased person, or because of family, friendship, work or neighbourhood reasons.

Taking part in the religious funeral services of the town may be as useful for the doctor as for the patient's family. The family of the dead patient usually values the presence of the person who was caring for their relative until the end. This allows the doctor to make his own farewell if he needs to do so. Nevertheless, the attendance of the doctor at the funeral is not common. This may be out of diffidence, or because of that strange sensation of failure that accompanies the doctor in the face of the death of a patient. Or it may be because the doctor has lost connection with his own spirituality or, simply, because he considers that a funeral isn't the place for a doctor.

Observed: he or she continues being the doctor

A doctor leaves his office at the end of the day without the white coat that differentiates him externally from the other villagers. Maybe he is trying to pass unobserved in the community, maybe trying not to receive more hints to guide him in the diagnosis of his patients' problems. But in the town, people continue to identify him as 'the doctor' and he

© RR Gracia Ballarin, 2005. A licence to publish this material has been given to ARHEN http://rrh.deakin.edu.au/

unavoidably continues his 'mission', exercising influence as the 'policeman' of healthy habits. For instance, he may meet a patient with emphysema smoking a cigar in the street, or a person who has received an hepatic transplant as a consequence alcoholic cirrhosis, drinking a liquor. This is not a pleasant experience for the patient, although the doctor is off duty and, naturally, doesn't comment. Perhaps patients have different expectations, for it is not strange to discover a patient who has been recommended not to smoke, hiding the cigarette when he/she sees the doctor approaching.

When the doctor goes for a walk in the street or in a town park he greets those he meets as neighbours, not as patients. The doctor doesn't usually recall the professional reasons for their consultations. Everyday he sees many patients, but the patient sees only one doctor. When they meet outside the consulting room, the patient remembers why he consulted the doctor, the nature of the problem or what part of his body was shown to the doctor. Likewise, intimate information revealed in a moment of worry, prompted by a good clinic interview, or at a moment of relaxed relationship, may weigh heavily on the patient when he/she meets the doctor in the street. In this case, the patient doesn't see a neighbour, he sees the person whom, once, he spoke to about his marriage, or his family, or his work or some secret affair.

There is another sense in which doctors feel an emotional burden on their shoulders due to their compatriots. The rural doctor's visible attitudes are sometimes social or political behaviours that the professional develops as citizen, to encourage pre-determined activities or ideals. In this case their behaviour isn't determined by their role, but local citizens don't see a private citizen there. For them, it is the doctor who supports a political party or takes part on a demonstration.

For similar reasons, doctors also contribute to community health by keeping healthy habits and behaviours - it would probably be very uncomfortable for them not to do this. Fortunately, we doctors usually recommend sensible things and behaviours that we believe in. Consequently, it is not difficult to obey ourselves!

However, there is a certain additional 'neighbourhood relationship' pressure that the doctor feels when meeting his patients in the street. Patients may make a request on the spot for unnecessary medication, a certificate for non-appearance at their job, or request unnecessary tests. Those requests, based on an understanding of the friendship, compromise the justice principle[10]. In order to avoid some of these pitfalls it is very important that the doctor defines his ethical standpoint from the beginning and accustoms his patients to respect it, because it is much more difficult to change a way of relating to patients later.

In Spain, patients are assigned doctors by the National Health Service in each town. A patient may change doctor if there is another available in the same town, but that change isn't so easy to make from the relationship point of view. If the doctor lives in the town, they will meet again in the supermarket or at the children's school. It is even possible that after giving up a doctor's services it may be necessary to request professional care from him in a moment of emergency or because that doctor is substituting the other doctor. For these reasons patients prefer not to change doctors and to develop a good relationship instead.

For identical reasons, and for the sake of his own mental health, and out of consideration for his patients and neighbours, it is necessary for the doctor to cultivate a tolerant attitude, without abandoning his personal ethics. This was summarized very well by Juan Gérvas in a recent article in which he explained his new situation as the solitary doctor in Canencia of the Sierra, a village near Madrid: 'I am more tolerant with my patients because there is not another doctor and we have to get on well with each other'[11].

Similarly, the doctor suffers more than other citizens from a lack of privacy. Because tales of events and opinions move very fast in the rural setting, the professional can't avoid being a victim of gossip and rumours. A lack of discretion accompanied by the doctor's great visibility is especially painful when an error or misunderstanding has occurred. A clinical error, which is practically inevitable in exercising medicine, produces huge suffering in any setting. In the rural

© RR Gracia Ballarin, 2005. A licence to publish this material has been given to ARHEN http://rrh.deakin.edu.au/

setting, everybody knows and comments on even a small mistake, and, little by little, the truth is enlarged and distorted. This is, possibly, the most serious side-effect of living in a rural town. In such cases, the very difficult task of asking for forgiveness for an error is the best tactic to avoid personal wounds that may otherwise heal badly[12]. Fortunately a doctor's successes are magnified and chattered about in the same way!

The family doctor and the family, and the doctor's friendships

In small towns the doctor's wife used to be considered another doctor. When the doctor was out people requested advice or attendance from her. She usually deputized very well, being able to excuse the absence of her husband or to respect her partner's nap.

This is not so nowadays, but frequently the distinction is still blurred between the person and the professional couple. The patient may suppose that the doctor's wife knows, at least, if the patient has consulted with the doctor. The patient may not understand the professional boundary between the doctor and his spouse and, in some situations, the patient may still ask the doctor's spouse for an opinion. In other cases, the patient may feel embarrassed because he/she supposes that the doctor's spouse knows something that, of course, she does not. How this relationship affects the doctor's son and daughter is difficult to know but, once again, the patient knows who the doctor's son is, especially if he is a classmate. This creates some difficulty when the doctor attempts to research health risks in a patient, as is frequently necessary with the adolescent population in attendance. These young people may not understand that confidentiality is the basic pillar of trust, and when the doctor asks if the patient consumes drugs or practices sex, he won't divulge that information to anybody, the doctor's children included.

A final comment about a difficulty which rural doctors have to face when they live where they work: the problem of merging personal friendships with professional relationships. The doctor who attends in the consultation of their friends (a very frequent situation where there is a single doctor in the community) has to be, first and foremost, professional and, after that, the friend of his friends. During the consultation he should choose the professional role before the emotional one. That is not usually difficult with the daily problems seen in the surgery, but it can be problematic in the case of health problems not usually disclosed to friends. These are problems such as impotence, depression, fear of death, couple problems and so on, which are less often presented directly and more often presented as somatization disorders. Moreover, some of these topics are linked to beliefs, fears and expectations related to those ideas that the binomial health illness plays in each person. These topics are so individual and intimate that it is very easy to feel hurt and ashamed if they aren't approached properly.

The doctor who wants to maintain such friendships should learn how to be a skilled communicator and then take extreme measures of care to explain the position of the relationship. At the same time, he has to detect signs of embarrassment and inform the patient clearly about the plan of care. We mustn't forget to remind the patient that the professional secret is obligatory in spite of friendship. In the end, the doctor must be allowed to express emotions both with the patient and him/herself - if possible with a degree of humour[13].

Conclusion

The human experience of being integrated into a rural community and learning how to communicate with that community is very satisfying. It is a challenge to exercise the profession with pleasure. It requires time, tolerance and a good disposition to leave one's mark in the community and, at the same time, the doctor must accept being a model of health and behaviour. The doctor tries to make a place in the community for Balint's apostolic function[14]. That is the practice of medicine he/she considers right.

In the same way, the doctor has to be grateful for those details which have more a symbolic value than others, which

© RR Gracia Ballarin, 2005. A licence to publish this material has been given to ARHEN http://rrh.deakin.edu.au/

are offered to him by the most sensitive community members. This is an old habit that, little by little, is being lost. Patients bring to the doctor garden products like lettuces, tomatoes or peppers. Others bring cakes or eggs but, unfortunately, these are being substituted by the urban candies, chocolates and sweets.

Acknowledgement

I thank Amy who has taught me all the English I know.

References

1. Wynn-Jones J. *Rural Health: Is there a role for Europe?*. Proceedings, 16ª Congreso semFYC, 13–16 November 1996, Granada; 45.

2. Neighbour R. *The Inner Consultation*. London: Kluwer Academic Publishers, 1988; 151.

3. Gross DA, Zyzanski SJ, Borawski EA, Cebul RD, Stange KC. Patient satisfaction with time spent with their physician. *The Journal of Family Practice* 1998; **47:** 133-137.

4. McWhinney I. *A textbook of family medicine*. Spanish edn: Doyma Libros SA. Barcelona: Oxford University Press, 1995; 17.

5. Steward M. Continuity, care, and commitment: the course of patient-clinician relationships. *Annals of Family Medicine* 2004; **2:** 388-390.

6. Starfield,B. *Primary care: balancing health needs, services, and technology*. New York: Oxford University Press, 1998; 154.

7. Grupo de trabajo de Medicina Rural de semFYC. *El medio rural: una visión mirando al futuro*. Barcelona: Documentos semFYC nº 11, Semfyc ediciones, 1999; 8-11.

8. Galán Sánchez B. Pasado, presente y futuro del médico rural. Procedings, 16ª *Congreso de la semFYC*, 13–16 November 1996, Granada: 46-49.

9. Carril A: Etnomedicina. *Colección nueva castilla*. Valladolid: Castilla Ediciones, 1991.

10. Costa A, Almendro C. *Mñdicos de Familia*. (Online) 2005. www.fisterra.com/formacion/bioetica/justicia.asp (Accessed 3 November 2005)

11. Gérvas J. Contraste médico rural, desde un punto de vista personal. *Semergen* 2004; **30:** 90 93.

12. Borrell F. Quñ fem quan ens equivoquem? Reaccions emocionals davant els errors mñdics.- *Butlletí SCMFiC* 2004; **22:** 3-4.

13. Borrell, F. *Entrevista clínica. Manual de estrategias prácticas*. Barcelona: Semfyc Ediciones, 2004.

14. Balint M. *El medico, el paciente y la enfermedad*. Buenos Aires: Libros básicos, 1961; 273-302.

© RR Gracia Ballarin, 2005. A licence to publish this material has been given to ARHEN http://rrh.deakin.edu.au/