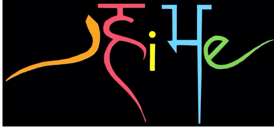

Narrative Medicine

Our patients, our 'cases'

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Abstract

In busy teaching hospitals, patients are often regarded as 'cases' and the human dimensions are sometimes neglected. In this article, I describe a few of my experiences at the Government Medical College, Thrissur, during my undergraduate medical education days. Patients were examined repeatedly, and many were very uncomfortable with this. During those days there were no facilities for simulation and even procedures were 'learnt' on patients. The hospital environment did not provide enough space and privacy to patients and was confusing and bureaucratic. We were not explicitly taught communication skills and how to understand the patient perspective. This paper suggests that the health humanities can play an important role in understanding the patient perspective.

Keywords: Communication skills; Empathy; Health humanities; Narrative medicine; Provider-patient relationship; Undergraduate medical education.

As a health professions educator with a keen interest in the health humanities, I read with great interest the article by Sood S titled 'Actions speak louder than words'.[1] The author poignantly describes her encounter with a patient and his wife and how clinical learning and the desire to see new cases triumphed over gaining an understanding of the human condition. Patients are regarded as 'cases' with diseases and the human condition loses its importance. I believe the word 'case' dehumanizes the patient. More than a century ago, the great clinician and educator, Sir Robert Hutchison, cautioned against treating patients as 'cases'; however, in busy teaching hospitals like the one where I completed my undergraduate medical education, this advice was not always followed.[2]

My Undergraduate Years at Thrissur, Kerala, India

The article transported me back in space and time to my undergraduate medical years at Thrissur, Kerala. We were a hundred students in the batch and our teachers taught us well. During those days the institution had no postgraduate seats. The system was highly competitive, and we were

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driven to excel. The concept of group work and a cooperative learning environment did not exist formally though, as students, we developed informal support mechanisms.

The college was not a referral institution and many patients came with ordinary fevers, aches, and pains. The competition to find and review exam-pertinent cases like valvular heart disease, lung collapse, consolidation, and abdominal tumours, among others, was cutthroat. These patients were repeatedly examined by students often without much concern for their comfort and safety. Unfortunately, I was also among such students.

We were under tremendous pressure. We had very little idea about the process of the examination and what constituted an adequate physical examination or a clinical presentation in the eyes of the examiner. The long cases dominated the clinical examination and our performance depended to a large extent on luck, in addition to our clinical skills and acumen.

A Few Examples of Patients and 'Cases'

I still remember a lady whose husband was suffering from stomach cancer and had pyloric stenosis. He was examined repeatedly and the next day his wife was angry and upset and bluntly refused to answer any of our questions. Her husband had spent the night in agony, presumably due to the repeated examinations.

We used to occasionally get patients suffering from thromboangitis obliterans. Cigarette smoking is quite common in Kerala, and among the working class 'beedis' are commonly smoked. We used to make these patients walk in the wards to measure their claudication distance. Different groups of students used to do this throughout the day, and I believe it must have been painful to the patients. Quite likely, the pain may have continued through the evening and the night.

During our surgery posting we were in the operation theatre and the patient was being given spinal anaesthesia for an abdominal surgery. Due to some reason the house officer was not able to do the procedure correctly and no cerebrospinal fluid was seen dripping through the cannula. It was after three attempts that the anaesthesiology faculty decided to take over the anesthesia procedure. We had no simulation laboratories and we learned our techniques on patients. I often felt guilty to be practising on the economically disadvantaged, but it seemed at the time that we had no other choice if we wanted to learn.

My classmates and I had a similar experience in the Paediatrics ward when we had to start an intravenous line in a child. The child was held down by the burly attendant and was scolded by all of us to lie still. We sometimes ended up with a counter puncture and had to do the procedure again. The patient's family members would be waiting outside, and they would get understandably upset with all the shouting, crying, and screaming going on. Again, prior practice on a simulator would have improved our skills and made the process smoother and less painful, but simulators were not available to us then.

Patients and the Hospital Environment

We learned that patients would exchange notes about how to stay safe from the hordes of medical students. Some went to the rest rooms and waited out the students while others went out to the hospital canteen if they could escape the watchful eyes of the security personnel. The bed-ridden ones did not have these options available and they must have felt beseiged.

I believe we were not entirely to blame. The hospital was a foreign land for most patients and not a very welcoming one – everything is unfamiliar.[3] In those days, the hospital did not have personnel appointed to help

patients navigate the complex hospital structure and bureaucracy. There was one volunteer but he was quickly overwhelmed. I do understand there are several issues involved but patient privacy and comfort did not receive the attention it required. There were no separate rooms where students could examine patients. Wards did not have separate examination rooms. The government only provided subsidised treatment and food twice a day. The hospital was not built to create a patient-friendly environment. Even as students we felt it was utilitarian, and unwelcoming. The wards were crowded and those in the district hospital were not well maintained. Finding space and privacy in the crowded wards and outpatient departments was impossible.

We were in a tough, competitive program of study, with one-hundred students admitted in each batch, and the hospital environment was crowded and chaotic. Added to that, we were under constant academic pressure to do well in our examinations and wanted to gain all the clinical experience we could.

How We Helped Our Patients

Our approach to our patients was not all negative. Kerala has a more egalitarian social structure compared to many other Indian states and we had a sense of responsibility toward society and the more disadvantaged sections of the population. We had a 'poor patient fund' in the institution and all of us contributed regularly as per our means. The temple town of Thrissur organizes a temple festival every year in April-May. As part of the celebrations an exhibition with different stalls and attractions was organized. The medical college stall was very popular and the entrance fee collected was an important source of support to the fund. We also donated blood as and when required and volunteered at blood grouping and donation camps organized by the Kerala blood donor's society. An active network of voluntary blood donors was created, and the hospital did not suffer from blood shortages.

What We Were Not Explicitly Taught

Some of my batch mates and seniors were more competitive and spent a greater amount of time and effort examining patients. How empathetically they did this is a moot point, since the skills of showing empathy, comforting a patient, showing concern, talking to the family were not discussed and taught. These were assumed to be skills we would pick up on our own though watching our faculty demonstrate these during their patient interactions.

Another challenge for us was carrying out breast and reproductive system examinations on female patients. The hospital was crowded and privacy difficult. The students and the patient were both shy and we had not been explicitly taught how to obtain permission to carry out these examinations. The resulting conversations were awkward and sometimes patients and their families believed we may have behaved inappropriately. Female patients were often reluctant to be examined by male medical students and had to be repeatedly coaxed by faculty members. In those days, more medical students were men than women. In our batch the ratio was around 65 men to 35 women. In any case, having a single patient examined by scores of students did not help matters.

The Scenario Today

Today, the pendulum may have swung the other way and students may not be spending enough time with patients. The skills of talking to patients, obtaining a proper history, and doing a physical examination are becoming less commonly practiced. Doctors and medical students spend more time today looking at patient lab reports and investigations on a computer than in directly interacting with a patient.

Today, the number of medical schools in India has dramatically increased and India has the largest number of allopathic medical colleges globally. As of 21st May 2020, the number of medical colleges was 542, and

there were 64 standalone postgraduate medical institutes.[4] These admit over 80000 students. Medical education in India has become increasingly privatized and these private medical colleges may have reduced number of patients due to lack of paying capacity of patients. On top of that, patients who do manage to pay heavy sums of money for their treatment do not want to be examined by students.[5]

All of these factors lead to increased student pressure on economically disadvantaged patients admitted in teaching hospitals. An article published in 2016 had examined problems of medical education in India.[6] Among these were rapid and uneven growth of colleges, regional imbalance, accreditation standards, selection of medical students, shortage of teachers, poor supervision during internship, poor faculty development, outdated curriculum, shortage of clinical material, and lack of emphasis on research.

The Value of the Health Humanities

I enjoyed reading this beautiful piece of writing by a medical student.[1] The skills of communication, empathy, breaking bad news and putting the patient perspective first should be explicitly taught to students and narratives such as those published in health humanities journals can be useful tools to learn skills beyond the technical. Being technically competent is only one aspect of being a doctor. The health humanities could be effective in facilitating student learning of all other skills that contribute to understanding the human experience of illness.[7]

I realized the value of role-plays, literature, movies, and the arts in the education of medical students only after I got involved with the medical humanities module. Incorporating the health humanities into the formal curriculum, abetment of learning in simulation laboratories, and actively experiencing effective communication, teamwork, and professionalism are important for today's learner. With an increase in the privatization and commercialization of education, ethics education should be strengthened and the patient perspective emphasized during undergraduate medical education.

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