CASE STUDY RESPONSE

The terminally ill are of no interest to doctors

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As a former MD resident in a teaching hospital in the late 1990s I have witnessed situations similar to the one described in this account (1). The responses of resident doctors today are clearly not too different from what ours were; they probably face the same pressures that we did, a decade ago.

For any resident doctor in those days, there were two types of "cases" – interesting and uninteresting. A case was interesting either because of its potential to be an MD exam question, or because it was a diagnostic conundrum or teaser for residents to apply their skills in medicine. Or it became interesting because of the satisfaction the resident doctor got when the patient made a complete recovery. Anything falling short of these criteria was uninteresting.

The 14-year-old girl in this narrative (1) fits very well the description of an "uninteresting case". The moment a diagnosis was made and the case declared chronic and terminal, there was little incentive for the residents to keep the patient in the ward. Efforts were made to encourage the family to take the patient home to "die in a home setting". If the family resisted, the doctor would shift the patient to a corner of the ward where he or she would be neglected by providers at all levels of the hierarchy. Neglect by resident doctors was surpassed by that of the nurses who in turn were topped by the hospital attendants.

As a resident doctor – especially as a junior resident doctor – I often found myself under pressure from my seniors to expedite the discharge of patients in my unit. Their unspoken directive was to release as many beds as possible on the day before the unit's "emergency day". If the ward was not cleared of "unnecessary" patients you were branded a poor clinician with bad ward management skills.

Fewer patients also meant that residents had less backbreaking ward work to do.

Chronically ill patients were least preferred, especially those with no lay attendants or "poorly compliant" ones – those who were seen to be slow in getting tests done from outside the hospital, who did not seem to show an interest in the patient's welfare, who did not attend to the patient's physical needs, etc. We also encountered "unknown patients", a term reserved for homeless people who were picked up by the police and dumped in the casualty wards of government teaching hospitals. They were, along with certain other categories of patients (the unkempt, the difficult-to-treat chronic cases), the untouchables of government hospitals, shunted from ward to ward on various pretexts. So a medicine resident would look for any signs of a problem that would be sufficient excuse to shift the patient to, say, the orthopaedic ward, or the surgery ward. When they failed to find a plausible reason to order such a transfer, they directed their efforts at finding out if the patient carried any old discharge cards of other medicine units that would give them an excuse to shift them there. On a few occasions residents even resorted to paying ward boys to physically remove patients – who were conscious but with chronic illnesses – from the ward by getting them a train ticket on long haul trains.

Despite these disturbing practices I always found resident doctors in government hospitals the most enthusiastic, energetic and sincere of all the staff, including support staff. This was perhaps because they knew they had to work there only for the limited period mandated for an MD degree. Also, they were young and more idealist than others in the hospitals. Finally, it was to their benefit to spend more time with patients; it was an educational opportunity which would help them in their practices, most often in the private sector.

Another factor that magnifies the problem highlighted in this example is the resource crunch – of both materials and humanpower – in these hospitals. All government teaching hospitals are stretched many times over the permissible limits. This affects the quality of care in these settings. This also often becomes a convincing excuse for many doctors to behave the way that they do.

This example also highlights the problem of communication between provider and patient. Most providers assume that patients will not understand medical information and do not need to be told about their illnesses. This can prove to be dangerous if patients and relatives feel let down and angry. It is interesting to note that the more educated patients and their relatives are, the better is the treatment they get from providers, even in public hospitals. The scenarios I have described here almost never involved this better-off group.

The situation has only worsened since my time. Doctors are rude, insensitive and coarse in their conduct with the patient. On a recent visit to a government teaching hospital as part of a research project I was struck by the obvious physical deterioration. Paint was peeling off the walls, the wards smelled unpleasant and the toilets stank. Surely patients deserve better.

Reference

1. Madhiwalla N. A terminally ill child in a public hospital. I*ndian J Med Ethics* 2007; 4: 184.