One flu over the doctor's nest

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I visited the doc, was feeling quite ill…
Hoping for comfort or maybe a pill
Was taken by surprise when he barely did glance,
To explain my ailment, hardly gave me a chance!

Papers in a sheaf were handed to me
Blood tests and a scan, even a CT!
For over a day I ran from pillar to pole
The bills in my pocket – they burnt a hole.

The reports he scanned and shook his head
"Hmmm…let's try a new drug instead."
Each pill from which, I was to learn,
Pharma and doc, more cash would earn.

For a 'second opinion' to a friend he sent
Upon meeting whom, I was quick to repent.
Merit aside, a degree he'd bought.
Of medical ken, he knowledge had not!

"Our system is foul!" I winced in pain.
'It's no wonder we face a brain drain.
Diligently those who honour their seat
Earn barely enough to make ends meet

With generous compensation, the corporates entice
For questionable ethics – humanity pays the price.
I had reckoned this to be a noble profession.
It's become a business is my honest confession.

Of medical men, if this be the plight
An ignorant man would be a doctor's delight!
For, when I sought treatment for a simple flu,
Was he too busy to realise…
I was a doctor too?

An undergraduate student's view of the medical humanities

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For the new medical student, admission into medical college marks the culmination of years of study and effort, and the beginning of a new era in his life. He is on course to becoming a doctor. There is enthusiasm as well as expectation. There are dreams which await fulfilment.

But this excitement does not last long, as he starts experiencing challenges and stresses that he had not foreseen. These problems can be listed under two broad categories – scholastic and personal. Scholastic problems include the sudden transition from the study pattern of 10+2 and CET, to the vast and complex one of the MBBS; the fear of failing for the first time; and the pressure to secure a post-graduate seat. Personal and interpersonal issues include adapting to hostel life, the trauma of studying in a language in which one is not fluent; and peer pressure and groupism based on class, regional, or scholastic differences.

My observations as a student

As an undergraduate, I have observed that the nature of these challenges and tensions varies as the student goes through the different years of his education.

The first year is generally spent in becoming acclimatised to the new environment. Most of the students get to know each other in the course of the year and segregate themselves into groups, mainly based on regions. Interpersonal conflicts are minimal, but personal, linguistic and scholastic difficulties are dominant.

In the second year there is a lighter syllabus and relatively more time, opening up opportunities for various extracurricular activities. However, group dynamics are at their peak, with each group trying to dominate the others, and this adds to existing stressors. Lack of confidence, inadequate communication skills and insufficient orientation towards procedures and practices all deter students from going to the wards.

In the third year, the additional stress is that of scholastic performance, even as economic stress may become prominent for some.

Senior students can provide appropriate guidance to junior students. However, seniors invariably end up transferring their prejudices and tensions to the juniors, and these only get more acute over the years.

As students learn to cope with these tensions, and manage academics, they are left with hardly any time or inclination to spare a thought for the hardships of others. When passing an exam and scoring is the chief aim, the patient is bound to get relegated to being "just a case". The habits formed during these undergraduate years continue into residency and become the guiding principles of practice thereafter. One can expect students to be sensitive to their patient only when they are at ease with themselves.

Suggestions for reform

The roots of most of these stresses can be traced back to the lack of dialogue between students during the first year. Dialogue alone can help sensitise students towards each other, clear many prejudices and prevent the snowballing of stress. Some of the following programmes could help achieve these changes:

- Basic training programmes in English and regional languages.
- Workshops on coping skills
- Random allocation of students to small groups for various activities.
- Introduction of compulsory reading hours in the first year, ensuring that every student reads a specified amount of regional and English texts, followed by group discussions.
- Promoting regular performances of small skits and plays depicting local customs and traditions to improve general knowledge.
- Proper orientation in the principles of epidemiology and ward practices before the commencement of clinical postings.
- Workshops and simulations on communication skills and patient management.

Once we have a class of students who have experienced such programmes, they can be a positive influence on their juniors.

Conclusion

These programmes and activities must be introduced in the first year, building up to advanced training in the later years. Whether we name these programmes "medical humanities" or something else, they need to be relevant and useful to the student, helping him address the problems which he faces every day, during his undergraduate years. Only then will he develop an interest in the medical humanities. And only then will he be in a frame of mind to learn to be a good doctor.

Medical humanities: a resident doctor's perspective

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Abstract

The barrage of competitive examinations, overwork, sleep deprivation, and the pressure of expectations all combine to destroy the dreams that resident doctors have when they start medical school. The empathy they had before entering this field fades away, and they eventually become insensitive to their patients.

Medical humanities may be the means to halt this trend. Sensitising young minds, using the arts, literature, history and lessons on social issues, may bring about a paradigm shift in these doctors' outlook towards their patients.

However, for the humanities to be integrated into medical education, the current curriculum must be modified and made more clinically and socially relevant. Further, the humanities cannot be taught in lecture halls; they need to be integrated into all aspects of medical school. For this, the medical school faculty should be sensitised to, and trained in, humanities education.

Background: the problem

The unending corridors and wards of a government hospital can confuse any first-time visitor. I remember on my first day at my department, I could not find the Doppler room though it was just around the corner from where I stood. So surely it is too much to expect an illiterate old man with his frail wife to find their way from casualty to x-ray to the ward on their first visit. Yet many of us would not bother to stop and help such a person in distress.

As medical students, and then as doctors, we fail to read the anxiety and apprehension on our patients' faces as they approach us. We are ruthless in the way we rush to finish with the long queue of patients. We are mechanical in inserting catheters, lines and tubes. We do not consider it necessary to explain procedures in detail, to calm the patient on the table. It is true that we are overworked and sleep-deprived, live in inhuman conditions, and must survive the taunts and tantrums