Learning 'on' patients

Medical education cannot be at the patient's expense

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The process of learning involves an 'other'. The other could be a person like a teacher or fellow student, or it could be a thing like a book or computer. Learning medicine inevitably involves the patients whom we treat. The question is: when a junior doctor is operating for the very first time is he 'learning from' the patient or 'on' the patient? Do we always learn from our patients or do we sometimes learn on them, and at their expense?

Unsupervised operations

I have seen doctors perform complicated surgical procedures for the first time — unsupervised and guided only by a book by their side. However, we all know that surgical skill cannot be taught by a book; no book can take the first-timer safely through every surgical eventuality. While such situations can conceivably arise rarely when a minimally equipped facility is forced to provide emergency care, it should never happen in hospitals which offer the treatment routinely. It is therefore essential that in hospitals which offer surgical treatment, a senior doctor guides juniors doing an operation for the first few times. If juniors are left to do such operations alone then they are 'learning on' their patients.

The same criticism is also applicable to junior radiologists who are asked to interprete ultrasonographies or to junior residents who are forced to take major decisions in medical intensive care units. Such situations arise because our hospitals have not laid down proper guidelines in this regard. Senior doctors with attachments to many hospitals and nursing homes find it difficult to be present to supervise their juniors.

The Italian medical education system takes this caution to the other extreme, in the process slowing the learning experience. In Italy doctors are never allowed to do anything — even with adequate supervision — until they are fully qualified. There are no resident doctors, and senior consultants — many over 50 years of age — do overnight emergency and casualty duties while their trainees work eight-hour days. Even simple operations like hernias and circumcisions are done by older surgeons — while trainees get their degrees without having performed a single operation.

The United Kingdom has recently laid down guidelines which address the ethical duties to one's patients while meeting the requirements of learning. Consultants must be present for almost all operations. The law even specifies which procedures within an operation may be left to the junior doctor; 'skin-closure' may be left to the junior but the senior must be physically present in the theatre during the entire operation, including skin closure. Also, two operations may not be performed simultaneously under the guidance of one senior surgeon - even if it is in one operating theatre block.

Testing procedures on poor patients

In at least one hospital, I have personally witnessed doctors make systematic use of their poor patients to test equipment and hone their skills. One illustration is laparoscopic surgery, a lucrative business for those who promote themselves as laparoscopic surgeons. Very few of these doctors spend adequate time (and money) to learn the techniques with an experienced surgeon or centre. They usually attend a 'crash course' or 'workshop', buy the equipment and start doing laparoscopic surgery on their own.

For such doctors, the actual training is almost always conducted on poor patients in public hospitals. These surgeons usually make such investments in equipment shortly before quitting their jobs in public hospitals and beginning private practice. Before they leave they do 'haath-safai' on their poor patients. While it may seem as if these patients are benefitting from free high-tech surgery using expensive equipment, at no cost to the public hospital, in fact this practice amounts to training on patients without their informed consent, and misusing the hospital as

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a personal training facility. Interestingly, this practice does not seem to attract the attention of public hospital managements.

Unqualified but doing specialised procedures

Many surgeons take pride in saying that they can do all types of surgery, even if the operation might best be done by a person specially trained and experienced in the procedure. Paediatric surgeons repair cleft lips and palates. Urologists do bladder exstrophies. General surgeons do hypospadias and even neonatal intestinal obstructions! This too is a way of learning 'on' the patient, improving one's skills at the patient's expense.

Such 'general surgery' may make sense in a rural area where there is a shortage of trained specialists and the surgeon is forced to be a 'jack of all trades'. It can also happen in short-staffed, resource -poor public hospitals. However, in private practice, particularly in a city like in Mumbai, the reason is more simple: to make money and keep the patient. Surgeons may hesitate to lose a customer and refer their patients to a specialist who will have better results for a particular procedure. This is unethical, because the patient's benefit is clearly secondary. Likewise, it is unethical for a surgeon to perform major neonatal operations outside a proper neonatal surgical department; many neonatal conditions require the inputs of an trained, experienced team, and access to a range of back-up facilities. Unfortunately, some peripheral hospitals and .nursing homes perform specialised neonatal surgical procedures which should be done in one of the many full fledged departments of paediatric (including neonatal) surgery that exist in the city.

No informed consent

In many public hospitals, clinical trials of drugs and techniques are performed without proper scrutiny and the sanction of an ethics committee or other professional organisation, and without the patient's informed consent. Most trials are instituted at the behest of pharmaceutical or medical instrument manufacturing companies.

Unethical learning on patients can and does happen. It is more likely to happen when we treat our patients as just 'something' and not as 'someone', as a learning tool rather than the reason for our work.

Suggested guidelines

Each hospital must lay down detailed guidelines about presence of seniors for particular procedures. For example, a senior qualified person must be available in the operating theatre for any procedure performed on any infant under anaesthesia. The number of hospital attachments that one person may have should be strictly restricted.

Permission to do new procedures should be restricted to adequately trained persons supervised by experienced seniors. Anyone permitted to start a new procedure in a public institution must be asked to sign a bond for a stipulated period depending on the type of expertise and expenditure required for the new technique/procedure.

Professional bodies should lay down guidelines about the surgeries which their speciality is capable of handling well and the standards for the settings in which various procedures can be performed.