Intangible dimensions of medical practice

The work of medical professionals is perhaps even more intricate than that of many other professions. It is also more trying because the pain and suffering of ill people is visible and discomforting not only to the patient but to the people around. The physician or surgeon has a three-fold responsbility: to be well versed in the scientific aspects of medicine, to possess adequate clinical skills and, finally, to have an attitude that is ethical and humane. A deficiency in any of these three attributes should be considered a professional deficiency.

However, knowledge and skills are more easily measured by objective parameters than are intangibles like attitude. Is the doctor really listening to the patient's anxious recounting of aches and pains, or has s/he already made up her/his mind? Is 'informed consent' taken so that the patient undergoes a procedure voluntarily with complete knowledge of the risks and benefits — or to protect the doctor from legal liability? Such questions evaluate more than behaviour, they look at the doctor's attitude.

This is perhaps one reason doctors being evaluated for their proficiency are rarely, if ever, assessed for their humaneness. As a result, over time, they start ignoring the importance of patient empathy and communication. One often finds practitioners working hard to acquire the latest in medical knowledge, or honing their clinical skills. One rarely finds them working at developing and maintaining a humanitarian attitude. It is fair to say that such physicians are more inclined to be driven to prescribe drugs or therapies for reasons other than their patients' benefit.

In addition, increasingly dramatic and fascinating (to the surgeon) forms of therapy are being developed at a dizzy pace. This has led to their mindless application and to specialisation and superspecialisation as the route to acquiring deeper insight. The result is a focused pursuit of increasingly shrinking areas of work for the individual practitioner — pushing all other areas out of the scope of interest, including some vital (albeit intangible) aspects of medical practice

Yet it is obvious that medical practice cannot be meaningful unless it caters to the needs of the community within which it operates. A physician's worth depends on the relevance of his or her work to the people he or she serves. Physicians' concern for such relevance is, to a large extent, the outcome of their medical education and nurture. Sadly, it is quite apparent that such nurture is declining — to the peril of the community to which the physician caters.

Whilst behavioural changes can more easily be instilled through training programmes, attitudinal changes need persistent nurture in medical school as well as throughout professional practice. Unfortunately, barring a few exceptions, medical ethics has never been a serious subject in medical education sylabbi in our country. As medical education gets further commercialised, there is little hope for change in this area.

A few isolated efforts to institute hospital ethics committees and institutional review boards seek to make appropriate behavioral changes in medical practice. More, evidently, needs to be done to address the question of subtle positive attitudinal changes from the very beginning of medical education.

Such inputs are difficult to devise but not impossible, evidenced by the efforts of the St. John's Medical College in Bangalore, which includes ethics education as an essential component of its sylabbus. Likewise, the Halo Medical Foundation (a product of past students and staff of Aurangabad Medical College) sends its members to work with students in community work, where debates take place on ethics and social justice and the role of healthcare professionals and institutions. Working within communities helps strengthen empathy; break cultural barriers and build new relationships between students and the community. Meaningful medical practice necessitates an awareness of the ground realities of a community's needs.

I suggest that there are three types of doctors. The surgeon who boasts of his or her surgical skills in amputation, or holds that an electronic artificial foot is a significant achievement and represents the best that science has to offer, is misleading the community — and may even be called unethical. The procedure is expensive, of limited value, can even create its own disabilities, and is not an adequate response to the problems faced by the people the surgeon treats. The surgeon who offers the procedure believing that there is no other option — but acknowledging its limitations — can be called 'passively ethical'. But the surgeon who says, "Surely there must be a better solution, one which the people I treat can afford and use," and develops something like the Jaipur foot: that is a positively ethical doctor.

This subject is discussed from a number of different perspectives in this issue of the journal. In what is clearly a cry from the heart, Dr PK Sethi (1) describes the decline of truly innovative orthopaedics, and calls for action. This reflection on and assessment of the field of orthopaedics to the community of poor, rural Indians identifies numerous areas which specialists could work in to make useful contributions to their sociey.

In another essay, Sarita Agarwal (2) describes her own encounters with the medical profession and suggests that simple decency, consideration and empathy could make a world of a difference for people undergoing both physical and mental stress.

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