

medical school training had “not at all” prepared them for having conversations regarding diagnostic uncertainties and the majority of the training was described as “informal” (2). The situation is unsurprisingly grim in India as well. A survey of surgical residents across four medical colleges reported that 81.7% did not receive any training in communication skills, and in emergency surgeries, 32% of the residents spent less than one minute conversing with the patient (3).

Another important aspect of communication often not considered is the quality of the dialogue. In an oft-quoted study of the 1980s, Beckman and Frankel reported that, on being asked to share their complaints by a physician, patients were interrupted and redirected after a mean time of just 18 seconds (4). A similar study done by Marvel et al found that the patients' completed their initial complaints in only 28% of the interviews, and the physician redirected patients after a mean of 23.1 seconds; once redirected the description was seldom completed (5). The consequences of incomplete history, especially in the ED, may be disastrous.

However, a silver lining to this is the implementation of a structured programme named Attitude, Ethics and Communication Module (AETCOM) by the Medical Council of India in the undergraduate curriculum. This is a case-based approach offering a competency-based learning framework in the AETCOM domains that a medical graduate must possess. There is a glaring need for a similar module for postgraduate trainees, as they deal with patients and families daily and need adequate training in communication along with their core academic training. There is also a need for training of faculty, creation of resource materials, and standardised assessment to

ensure the sustainability of the programme.

Medical schools teach us about the disease and not the patient. In the rat race to increase our degrees and qualifications, our language dissolves the patient and emphasises only the diagnosis. As Dr Nancy Angoff, Dean of Student Affairs at Yale Medical School puts it, “as medical students, we start our journey on one side of a bridge, with the patients, as we move through our training, halfway over the bridge we find our language changing to the language of medicine. Personal stories get replaced by medical jargon. And then you become a medical professional, the other side of the bridge; do not forget where you started – the side with patients and their language.” (6) For us physicians, the diagnosis should never be enough!

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REFLECTIONS

Ethical dilemmas of a freshly graduated rural clinician in Kerala, India: a personal reflection

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Abstract

Freshly graduated doctors are the lesser-known workhorses of the rural healthcare system in India. These rural clinicians confront

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numerous ethical dilemmas in their day-to-day life, which are quite different from the ethical issues they may have encountered during their medical training and internship at a tertiary care hospital. These include taking end of life decisions, breaking bad news, conflicts in the doctor-patient relationship, declaration of death, and counselling of patients or family attendants of terminally ill patients. Yet, the decisions they make during such challenging situations are often influenced by their undergraduate training and limited clinical exposure. This is a personal reflection on the ethical dilemmas that I faced as a young medical graduate, appointed as the resident medical officer of a rural hospital in Kerala, and how they influenced me in my early stages of clinical practice.

Keywords: Ethics, rural service, healthcare, doctor, curriculum.

Introduction

This paper is a reflection of the challenges and ethical dilemmas that I encountered during my two years of rural service at Karuna Bhavan Medical Centre (run by a congregation of religious nuns), in Koruthodu village, in the foothills of the Western Ghats in Kerala, soon after completing my MBBS and internship at St. John's Medical College, Bangalore. Koruthodu is a mini hill station with a cluster of forest ranges all around, teeming with a variety of flora and fauna. Karuna Bhavan serves more than 16,000 people, mostly labourers on daily wages and tribals, residing in an area of 33 square kilometers. The nearest referral hospital with basic sonological facilities is 25 kms away, while the closest tertiary care centre is around 70 kms away. There is no public transport to these hospitals after 6.45 pm.

Issues with patients

Affordability and access to healthcare were key challenges. It was almost inconceivable to expect patients to pay for treatment if the costs were three digits or more. I treated patients with chest pain, who were carried uphill and downhill on their shoulders by family members, through the forests, with a Rs 50 note in hand. We had to manage such patients with our limited facilities, knowing that bringing the patient to the hospital itself was a monumental task for the patients' attendants. They clearly could not afford to go to any other private hospitals, which were also distant. Other patients included chronically catheterised patients with severe urinary tract infections due to faulty and unsterile methods of catheterisation. Elderly patients, living alone, were brought in with severe dehydration from chronic diarrhoea. Some patients, severely handicapped by chronic rheumatoid arthritis, osteoarthritis and gout, asked only for pain relief. Others presented with long-standing uncontrolled diabetes and varicose veins with large, infected, diabetic ulcers and multiple varicose ulcers. Infants with untreated epilepsy, children with delayed developmental milestones. Teenagers with deafness, due to untreated chronic inflammation of the middle ear, regularly walked into my OPD. Delayed treatment leading to avoidable complications, even life-threatening ones, was very evident in such patients. I had to reduce costs with the hospital's help, while not compromising on patient care – simple measures like breaking “adult” tablets to treat children, since paediatric formulations often cost more – and sourcing and stocking low-cost medications.

Most patients, especially those in the working age group, avoided hospital visits in the early stages of their illness. Patients who had suffered a minor injury came into hospital weeks later, when it had become a large, infected wound requiring removal of a lot of dead tissue and a long course of antibiotics. However, despite the frustration of these avoidable problems, it was hard to ignore that they were often breadwinners who could not afford to lose a day's wages for a hospital visit. These experiences made me more considerate and open minded and less judgmental. Of course, I had come across many such patients in my undergraduate and

internship period; but then, I was within the protective arms of my parent institution, backed by institutional policies and charitable funds to decide the further care of such patients and at times, to waive their charges. It was very different being the sole person responsible for the patient.

The lack of affordability of healthcare manifested itself in other ways. Sometimes, the attendants absconded leaving behind a very sick patient. If transfer to a bigger hospital was necessary, the problem became more acute. Once, a young tribal man experiencing chest pain was brought in by his relative. The ECG was suggestive of a damaged heart muscle which required specialised care at a referral centre after the initial treatment. On being told this, the attendant absconded, leaving the patient behind. The patient was finally shifted to a referral hospital with the help of panchayat and forest officials. The immediate issue was resolved but I wondered what would have happened if the patient had deteriorated in our care and what community backlash we would have had to face.

Often when a patient was referred to a tertiary care center for further evaluation or treatment, the attenders took them home instead, as they could not afford the expenses at a bigger hospital. The very next day, they would bring the patient back in a worse condition. Treatment of such patients was clearly a challenge and for me an ethical dilemma – treating them with the available care when there was better (but unaffordable) care elsewhere which would allow for better outcomes. I wondered how self-financing, not-for-profit healthcare institutions such as ours could be economically viable in situations where public healthcare does not reach disadvantaged and poor populations. Despite having an in-house doctor, nurse, pharmacist, lab technician and accountant from their own religious congregation – who did not receive salaries – the hospital found it hard to break even. When equipment was damaged beyond repair, replacing it was out of the question. We had a major setback when the equipment for checking serum electrolytes went out of order – we resorted to a thorough evaluation of the patients' signs and symptoms and an evaluation of the ECG variations. Nevertheless, many patients had to be referred to a higher centre after initial management.

Patients with terminal illnesses such as end-stage malignancies (which they were largely unaware of), liver cirrhosis and bed-ridden elderly were often admitted as in-patients for palliative care. Therefore, breaking bad news and certification of death was something that I had to do frequently. Even though we were trained to break bad news as undergraduates, doing it alone as the solitary doctor in charge of the patient was not easy. Often the patient's relatives had requested me not to communicate “bad news” to the patient as they felt it would negatively influence the patient's hope for survival. Wouldn't I be colluding with the family? What about truth telling, while still ensuring sensitivity to the patient and family needs? In such a

scenario, I had to have a one-on-one conversation with the patient to assess his or her mental and emotional state, weigh the risks and benefits of breaking bad news, and make a decision that I thought was in the patient's best interest.

Issues with the community

Every rural community has unique social, religious, cultural, geographical and economic characteristics. For instance, young girls and women were uncomfortable discussing their menstrual and sexual history with a male doctor, even in the presence of a female nurse. Patients and family members often concealed histories of seizure disorders and mental health diseases, as they were stigmatised. Therefore, I had to maintain a delicate balance while choosing my words to ensure the patient was not offended while obtaining a thorough history.

I had to deal with the many myths and local practices pertaining to medicine. These included the popular understanding about vaccination, keeping burns open till the wound healed irrespective of the degree of burn, nebulisation as a universal cure for all respiratory diseases, cow dung and coffee powder as "first aid" for open wounds, and massaging following a fracture to hasten bone healing, among others.

A significant number of patients initially used domestic and indigenous cures for their ailments and were very apprehensive about allopathic medicines, associating them with harmful side effects. They only visited a doctor as a last resort after trying everything else advised by their relatives, neighbours or a local *vaidyan* (unqualified practitioner of indigenous medicine). Many considered injections and intravenous fluids the ultimate treatment for all diseases and demanded injections for simple ailments. On top of that, unqualified or self-proclaimed practitioners of indigenous medicine also spread false propaganda against modern medicine. This resulted in delays and non-compliance with treatment advice. It was hard to reach out to these "healers" as most of them were respected elders in the community who were unwilling to give up traditional practices. To make things worse, local pharmacies liberally dispensed allopathic prescription drugs over-the-counter.

In rural areas, it is nearly impossible for a doctor to maintain a low profile. The entire village gets to know you in a matter of weeks; they look up to you and have high expectations of you. Therefore, doctors working in rural areas should be aware of their social and ethical obligations, apart from their professional responsibilities. I knew that people constantly watched me, as they recognised me even when I was spending time somewhere outside the village, like a restaurant or a movie theatre in the nearby town.

Issues within myself

As a fresh graduate, working alone in a rural hospital with minimal facilities compared to the tertiary care centre of my internship, I faced challenges, which appeared unimaginably daunting. I had to rely on my limited work experience and

constant self-learning without the direct supervision of a senior doctor. Being short and slim added to my woes as the villagers had a very different image of a doctor. What I lacked in physique, I had to make up for with good rapport and patient management, and as time passed, people got used to their "young doctor".

Chronic sleep deprivation due to prolonged working hours, lack of a social life outside the hospital environment, and constant pressure to prepare for the post-graduate entrance examination often took its toll on my peace of mind.

Handling irate and offended relatives when patients died or worsened, and the possibility of violence, was another issue I had to face. Once, a 65-year-old man who had never ever had a medical checkup in his life, collapsed at the entrance of the hospital following a massive cardiac arrest. His superstitious wife was overwhelmed with grief and blamed the hospital for bringing bad luck, as she said, "My husband was a healthy man, all his life, until he stepped into this hospital." Despite our best efforts, the patient unfortunately succumbed. As soon as his wife heard about the inevitable autopsy, she began to recount his past history of neglected episodes of chest pain, to avoid a post-mortem examination. Soon the situation got worse as the relatives of the deceased and a few opportunistic local politicians gathered a mob who surrounded the healthcare professionals to protest against the decision to conduct an autopsy. Finally, the police had to intervene.

Discussion

The training that I had received to handle such situations during my undergraduate course was quite substantial. At the time, I hardly appreciated this. In the first year, we had a whole week dedicated to a 'Rural Orientation Programme (ROP)' conducted by the department of Community Medicine, and interacted with the local communities, did surveys, conducted health education programmes, visited schools, peripheral health centres, and anganwadis. A similar programme called 'Community Health Accreditation Program (CHAP)' was conducted during the third year MBBS with an extra week of Urban CHAP, apart from a week of Rural CHAP, where we visited various factories, government hospitals, old age homes, the Spastics Society, orphanages and a few NGOs. We also took part in surveys in urban slums and nearby localities, seminars, presentations and awareness drives. St. John's is the first medical college in India to introduce a stipulated Medical Ethics curriculum in the MBBS course. We were taught, through lectures and interactive sessions, to handle common ethical dilemmas such as taking end-of-life decisions, breaking bad news, conflicts in the doctor-patient relationship, declaration of death, counselling of patients or attendants of terminally ill patients, and how to coexist and deal with practitioners of other branches of medicine with mutual respect. We also had the opportunity to go in for a "mini internship" after our final year at a rural hospital in North India, where we would meet and treat a completely

different demography of people. Events conducted by the students such as 'Autumn Muse' – a national level inter-collegiate festival, traditionally have students donating the profits to a charitable fund, and also conducting outreach programmes such as medical camps, blood donation camps and awareness programmes.

Despite this unique training, my rural service taught me that nothing could completely prepare us for the actual eventualities we face. In my opinion, attempts to help doctors working in rural areas to overcome the challenges and ethical dilemmas should have two components. The first is structural; governmental efforts must ensure allotment and efficient utilisation of funds and sound policy making to improve the function of rural hospitals in order to bridge the gap between the rural and urban healthcare sectors. The second component is the preparation of young undergraduate doctors with holistic training for work in challenging situations. The enhancement of bioethics in the medical curriculum and the integration of the medical humanities into the MBBS course would go a long way. More than a century since the introduction of the Indian Medical Degrees Act, medical ethics

has finally found a place in the Indian medical curriculum as a distinct teaching module which addresses Attitudes, Ethics and Communication (AETCOM) competencies. This is indeed a reassuring first step towards achieving the holistic education of medical graduates. As always, the proof will be in the details and the implementation of the programme.

Conclusion

Rural service is something that most doctors try to avoid at all costs, as it is largely considered a waste of their time, money and effort. My own bittersweet experience of two years has shown me that it can be truly enriching. I would like to believe that I have emerged a better doctor and a better human being.

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