

REVIVING MEDICAL EDUCATION AS SCIENCE AND ART: THE CASE OF LOST FACES

Zarrin S Siddiqui¹

It is almost two years since I visited my uncle at one of the leading private hospitals in Karachi, Pakistan. He had been critically ill with systematic infection after a minor eye surgery which was a bit unusual because this form of procedure is routinely done in hospitals. He has been under the care of a physician who holds fellowship in Medicine. There were only two patients in the ward because of impending Christmas and Eid holidays. The day I visited my uncle the consultant did not come to examine the patient. Why? Because he has only two patients and it was not worth visiting. There was no doctor in the ward not even at a resident medical officer level and as such there was no monitoring of his condition. Around 7pm in the evening a nurse aid came with medicines to be given and provided us with tablets. When I asked that how an unconscious person can take medicine orally the aide nurse glanced at the patient as if he is seeing him for the first time. Yet because no doctor was available he could not change the medications and insisted the tablets to be given orally. Of course it was difficult to give him the medicines so apparently he did not receive the right dose. The fever escalated. Next day my uncle was shifted to the intensive care unit. Again when I visited and asked the doctor on duty I was told that typhoid has been diagnosed but doctor thinks that it can be pneumonia, malaria and there is a possibility of meningitis so a lumbar puncture has been done as

well without informing any of the family members or taking consent. A chest X ray was unavailable till that time which should have been done by now.

Within fifteen minutes I left the ICU room, I was asked to return to ICU and was told that he just collapsed and that they are trying to revive. There were four persons around the patient and all they knew about resuscitation was to give cardiac compression. They had absolutely no clue about what guidelines are to be followed at that time. When I asked about Ambu bag or defibrillator I got to know that there is no defibrillator present yet the ambo bag was fetched afterwards which was still in its original packing and apparently has been never used. I was told that these procedures are all useless and will just inflict pain on patient as the time had come for my uncle to depart from us. There was no emergency trolley at that time which should have been routinely present in an ICU.

Another sad observation was that as an attendant I was required to observe so called infection control procedures which include wearing a cotton apron and shoes provided by the hospital; however to my surprise the consultants who were coming to see their patients in ICU observed no such precaution. Once again on inquiring I was told that they are CONSULTANTS and they are not required to do the same. Why? No one responded.

Medicine is a unique profession in the sense that it is not mere science but also an art. It deals not only with the knowledge and skills to treat the ones in distress but also has got a humane aspect attached to it which requires special attributes on part of the healing doctor. What I

Correspondence:

Dr. Zarrin S Siddiqui
Assistant Professor in Medical Education,
University of Western Australia,
Australia.
E-Mail: zarrin.siddiqui@uwa.edu.au

observed is pure lack of the guidelines for the management as well as lack of professionalism. Why on earth a doctor cannot follow infection control procedures which is a global issue for patient safety specially in developing countries.¹ Did the infection that my uncle got was hospital acquired when he came for a simple procedure, why they do not have competence to investigate a patient according to the guidelines. Resuscitation skills and Infection control are the foremost skills to learn for any health professional to enter this profession but unfortunately the health professional curricula are devoid of these in initial stages and so our health workforce does not appreciate their importance in the patient care. It has been generally recommended to have a robust approach to the teaching and learning of infection control issues and its preventative and control strategies within academic and practice environment². Similarly there is a general expectation that healthcare professionals should be able to treat a person in cardiac arrest in a manner consistent with established standards and guidelines³ and this again needs to be reflected in all health professional curricula at undergraduate and postgraduate level.

It is generally agreed that positive educational efforts that begin early and extend through medical school are needed to enhance humanistic skills of future physicians, however in the absence of positive role models it is very difficult to inculcate these skills among students if

they are not being practiced by seniors around them. Is there anything in the world that is precious than saving a human life then how can a person who has been trained for more than ten years to achieve the consultant status refuses to follow simple guidelines. If this has been the case in western world the consultant would have been sued by the patient for intentionally indulging in malpractice while hospital would be required to pay the compensation for not providing adequate equipment and trained staff and as such playing with the human lives.

We have number of organisations in Pakistan, why these organisations fail to protect the consumers? How long we will console the bereaved families by saying that the time has come. Yes, as Muslims we believe that there is a time for everything but there should be a difference in the care being provided at home and an ICU and that is why the families bring their loved ones to the hospital. The medical education has lost its face both as a science as well as art; who has got the responsibility to revive?

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