

**View Point**

# MEDICAL EDUCATION, TRAINING AND PATIENT CARE FROM THE LENS OF RESIDENT

Ruchi Sachdeva<sup>1</sup>, Sandeep Sachdeva<sup>2</sup>

**Author's Affiliation:** <sup>1</sup>Dept. of TB and Respiratory Medicine; <sup>2</sup>Dept. of Community Medicine, PGIMS, Rohtak, India

**Correspondence:** Dr. Ruchi Sachdeva, Email: drsachdeva@hotmail.com

It was a jubilant moment to receive the news that I got through all-India competitive entrance exam for pre-medical test. The fruits of hard work, perspiration and sacrifice had come through but with a pinch of salt, as my rank was lower-down in the merit list. It was a challenge to convince my family till I proceeded to enroll for MBBS course in a medical college from the state very different from my native in all perspective-geographical, socio-demographical and linguistic. Anatomy was real terror that disciplined us for rest of our lives. Pathology led me to believe that I was also suffering from some disease for which I had to receive counseling. Educational visits to understand living condition and health care structure in slums and rural area under community medicine was eye opening. Bed side medicine and surgery were stimulating, engaging & learning was exhaustive. During OBG posting, assisting delivery & holding newborn was moment that led to feeling of accomplishment and thanks giving to natures divine.

The persona of our teachers were captivating and were mesmerized by volume of information retained by them but use of only chalk & board during teaching was boring. All through-out degree course we kept on cramming with little inter subject linking, critical and/or out-of-box thinking but over time-frame subject alignment now appears to be perfect. Best part was patient examination, evaluation, interaction and management during internship along with junior faculty. Healthy moments of ragging made seniors our best friends but alas this magic has lost its effervescence in the current context.

During this professional growth, many new dimensions were being added at personal front also as I had to learn local language to communicate with patients, people and friends; learnt and adapt to local cuisines, culture, and

customs. Our parents and relatives visited us on many occasions, stayed in local hotels, travelled to tourist and archeological spots, did lot of shopping and carried home little mementos thereby contributing substantially in economy at micro-level. Some of my native peers happily married local residents thereby adding a new dimension of experience and enrichment in life. Today, I understand the vision of policy makers and one of the objectives of all India competitive exams be it medical or engineering is to foster Indianness (a feeling of unity in diversity) amongst its citizens! Now let me share my humble views as a chest resident.

Poverty, illiteracy, unhealthy practices and compliance issues is rampant among masses (especially when 70% are residing in rural areas) in any developing society with limited access to competent health system and personnel leading to in-appropriate care. In contrast, urban class is more aware, demanding and assertive on patient's rights, treatment risk benefit, clinical practices & negligence leading to increase hopping for advise, personalized care, litigation and/or attack on medical personnel.

In India, according to Global Adult Tobacco Survey (GATS), around one-third (35%) adults use tobacco in some form and 52% are exposed to second-hand smoke (SHS) at home with rural area accounting for 58% and urban (39%) respectively.<sup>1</sup> According to NSSO survey based on information collected during 2009-10 from 100,794 households in 7428 villages and 5263 urban blocks spread over the entire country, the percentage of households in India reporting use of firewood and chips was 87% in rural areas and 25% in urban areas.<sup>2</sup> Taking the example of Haryana state, nearly 61.8% [76.6% (rural) and 22% (urban)] household used fuel other than (LPG, electricity, or kerosene) suggesting dung/crop/fiber residue while 11% used woods

for cooking.<sup>3</sup> Some serious efforts to control tobacco menace in the country were undertaken during last decade and notification for ban on tobacco product by ministry of health in 2011 only therefore its positive impact would be visible only in next two decades. With increase in longevity [avg. age 32 years (1947) to current, 66.8 years] and simultaneous exposure to smoke/tobacco & other risk factors for last 60 years sizeable population is now and will continue to manifest in large volume at health facilities with chest, cardiac, cancer and/or associated diseases. Under these circumstances with concomitant acute shortage of ICU beds, government institutions are 'negatively' labeled in community as centres of mortality and entrusted with the task of issue of DC (death-certificates) only.

Influenza pandemic provided ample opportunity to inform/sensitize communities towards improving personal hygiene and cough etiquettes but administrators failed to interject new practices. In the backdrop of rising cost of care, alcohol abuse, propelling graph of non-communicable disease burden, obesity, HIV/AIDS and environmental hazards it is mammoth task to drive the issue across the minds of patients & other stakeholders that health is an individual responsibility also with key principle of prevention is better than cure and to attempt for positive health behaviour is a still an impossible task.

To dissect, look into microscope or take up knife as a carrier option following graduation, personal traits, motives, hard work or merit plays the trick. Residents in clinical departments especially in government institutions are apparently overworked with little time for introspecting on clinical decisions, improving patient care or communication. Inadequate logistics, casual approach, high turnover of patients and poor infection control practices are detrimental in controlling the menace of nosocomial infection. On many occasions we fail to understand the basics of quality, effectiveness, efficiency and competence of care in an environment of limited resources but still master many skills by multi-tasking, trial and error. Team work, motivation, and respect for others are becoming dwindling entities in society including our profession. At times due to in-adequate institutional & departmental protocol for case management and lack of secretarial assistance, confusion reigns high, anger spreads like wild fire, nurses skip

consultants round and 'poor' resident ends up bearing the brunt.

There may be lot of CTVS surgeons in the cities but only few with inclination for thoracic in-comparison to more glamorous cardiac surgery. Multi-organ disease patients in-particular abdominal Koch's and infertility cases keep shunting between departments and surprisingly some 'experts' recommend ATT only on the basis of positive tuberculin test. TB with a propensity for multisystem involvement continues to play havoc in population and it's a pity to observe sufferings & poor quality of life practiced by young patients with MDR-TB and their family members. Truly, nature has its strange blue-print of handling humans but the struggle of science to conquer diseases continues unabated. In this difficult but scary real life situation, health personnel including 'other' specialty & super-specialty physicians also require continued medical education on changing dynamics and reinforcing the basics of primary care and RNTCP.

Gaining education (knowledge, psychomotor and attitude) on various aspect of pulmonology related to patho-physiological & clinical spectrum of diseases & management; concept of continuum of care; intensive care; modern imaging technique; therapeutic procedures; interventional bronchoscopy; allergy testing; oxygen/aerosol therapy; sleep management; respiratory rehabilitation; adverse effects of drugs; CPR; cancer; pulmonary hypertension; lung transplant; occupational care; chest physiotherapy; pediatric pulmonology; conduct & interpretation of PFT/ABG; preventing & diagnosing sudden death due to pulmonary embolism; smoking cessation; genetic therapy; molecular biology; stem cell; clinical trial; telemedicine;<sup>4-10</sup> pulmonary manifestation of different systemic diseases, public health including research methodology, biostatistics, behaviour change communication, documentation, administration, financial, conflict, time and self management to name a few needs sincere efforts from residents, constructive criticism & supervision [normative (administrative), formative (educational), restorative (supportive)] from our seniors and functional linkages with other departments.

Internally it is satisfying to be a physician but system expects us to undertake many divergent roles and responsibility including research. However, in the backdrop of intense compulsion

for publications, originality is losing charisma with the evolving cut/copy/paste phenomenon. The sorry state of affairs is being driven even into the minds of very young school children as they are required to execute projects through use of internet. On the corollary they tend to 'speak' less but 'share' more on internet and the day is not far when these kids would be living in virtual world who are 'socially isolated' and still 'net-connected'. Communication is an art with fewer medicos having a flair for it for which they were neither trained nor shown the path. However with rising trend of medical tourism<sup>11</sup>, maturing of local media (print/electronic), research and publishing of new journals from India, writing makes a business sense too in addition to professional growth and personal satisfaction.

With the exponential rise in technological modalities, health insurance (proportion of Indians having any health insurance is less than 15%), unethical referral, practice of defensive medicine in the era of consumer awareness & protection, there is higher tendency among professionals to investigate first and may be examine latter. It may lead to higher cost but at the same time some new diseases/disorders are also detected during this process for which we never comprehended. However, similar practice is unwillingly being transferred to younger generation as a result they do not intend to 'touch' or 'observe' patient for learning. Stethoscope as an element of show-piece will be found only on pictures in archives of library books or models in university museum. With changing life equation and dynamics students are apparently smarter and want results in short period of time; interested in learning theory with simultaneous declining trend of physical fitness during under-graduation and postponing practical learning for post-graduation period thus aiding the path of growth for water-tight compartment of numerous specialist and super specialist.

Instilling belief that medical profession is a life-long learning is a challenge but we hang our boots in despair after exams 'enough is enough'. A person can be directed to a pond but not necessarily be lead to drink too and on the same but critical note inspiring teacher can make a difference in the of life of students and residents. In this era, such selfless mentors are also becoming hard to find.<sup>12,13</sup> To teach or train requires time, energy and efforts from learner as-well as guide. Our peers in developed

nations<sup>14</sup> probably also passed (or still passing!) through these developmental changes however interlinked global economy can shorten the trajectory of system experimentation and learning. Thus we can suitably adapt & adopt the global best practices for pulmonology and sub-specialty development in India and still not lose the subtle relationship chord of being considered as family-physician.

There is overall shortage of health human resource be it medical, nursing or allied paramedic (respiratory therapist etc) considering population or geographical parameters but assumes critical proportion for specialist. Taking the example of chest medicine, current (2010) estimated need of 1010 postgraduate (PG) seats fall short of 660 as actual is only 350 seats. Further estimate for the year 2021 & 2031, the requirement for PG seats are 2020 and 4039 respectively. India has largest number (330) of medical colleges (e.g. China has 188) in the world with annual production of 30,000 doctors and 18,000 specialist. High level expert group of planning commission on universal health coverage has further proposed for creation of 187 new medical colleges in a phase manner and target of one doctor per 1,000 will be achieved by 2028.<sup>15</sup>

On an encouraging and positive note, Government of India, Medical Council of India (MCI), National Board of Examination (NBE), Indian Council of Medical Research (ICMR), Quality Council of India (QCI) and specialty association are engaging themselves and other partners for enhancing production, management, regulation & retention of human resource, enactment of legislation, conduct of standard entrance & exit exams, curriculum development, registration/certification/accreditation, revamping education, streamlining training, providing funds for infrastructure development/innovation/technology transfer/patent, promoting alternative system of medicine (AYUSH), institutionalizing capacity building for research & knowledge transfer through international collaboration.

With the epidemiological, economical and demographical transition being observed in the country and concomitant rise of mobile/internet based technology health communication with patient has deteriorated further. Do we need to re-align with the changing technology with focus on evidence based medicine (EBM) or hold

on to historical concepts? Medical and social paradigm is being re-structured and can legislation play a protective and deterrent role is to be seen during coming years. On a parallel note, considering future chronic respiratory disease burden<sup>16</sup> will it be premature to call for an urgent national movement to combat respiratory diseases other than TB also is a matter for introspection, debate & discussion.

Nature preserves only the fittest and the current competitive era has further propounded this phenomenon to an extent, perform or perish. These thoughts could have projected a confusing, gloomy and/or depressing scenario. However on the face of development we are evolving, hopefully for a better future and everything may not look as dismal as it may sound. Flexibility in approach, overall enthusiasm in life, positive attitude, hard work and patience along with value for tradition could be possible answers. But how much we promote, practice and sustain the core principles is a matter of personal choices!

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