The undesignated teacher

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This is a small but important part from my life story which I intended to share with others for quite some time. However, the correct opportunity didn't arise until now. Being invited to the inauguration ceremony of the Annual Academic Sessions of the Galle Medical Association (GMA) a few weeks ago rekindled this need. Having been connected with the GMA since it is inception and being very impressed with it is dynamism today. I decided that the *Galle Medical Journal* was the correct place to get it out. What I am going to relate is a very simple episode which one experiences all the time during the journey through medical school and later as a practicing doctor. Nevertheless, there is a side to it which needs to be seen with wider vision and understanding. For this I need to take you back forty-four years to the then General Hospital Colombo (GHC) now known as the NHSL.

It was January 1979. I had got through the second MB examination the year before and the clinical appointments were to commence. Leaving the formalin-smelling dissecting rooms and walking out of the medical faculty, crossing Kynsey Road and entering the GHC with our stethoscopes in hand was probably the most exalting experience to all of us at that time. Then the hospital did not have the modern buildings that one sees now. The wards were mostly open dormitories with half walls and reached by walking along open corridors. Each ward had about forty beds and each consultant had a full ward for male patients, and half of another ward for female patients, which was shared with another consultant of the same specialty. We had been assigned to ward 50 if my memory serves me right, which was a medical ward under a Consultant Physician whom I shall simply call the Boss; a tradition that had been coming down the generations.

Our Boss was a young energetic physician who had taken up the appointment at the GHC recently. He was very friendly and put us at ease very quickly. After the preliminaries our very first clinical training began. Each student in our group was assigned several patients in the ward and we had to take histories, examine them and follow up their management during our stay in the ward which was going to be two months. Our first Boss was a wonderful teacher, and I am still indebted to him for instilling in me the correct method of examining patients to get clinical signs easily and accurately. This was paramount at a time where laboratory support was quite basic, and imaging was practically X-rays only! The word "Scan" of any sort was unheard of. Therefore, it need not be elaborated how important clinical diagnosis was for a medical student. The only way this could be done was by using the patients who were admitted to the ward as the subjects for studying symptoms and eliciting signs. This is where my story begins.

The very first patient I was assigned to see was a middle aged tall lean and broad-shouldered man who was occupying a bed on the verandah side of the ward. This was a wide area outside the half wall of the main ward but still under the same roof. Dressed in a sarong and a sleeveless vest he was lying on his back and staring at the ceiling deep in thought. How deep these thoughts might

have been would become clear to me only later. The first thing I noticed was that he had an unusual ash-like colour to his skin. Standing on his side I looked into his eyes and in turn he looked at me. His expression was quite calm and serene, but his eyes conveyed a message of expectation which I couldn't comprehend at that time. However, even as a novice looking at his first patient, I felt that something was wrong with this man; very wrong. Still, I had absolutely no idea what it was.

I touched his arm gently. The skin felt quite dry and fragile. He had obviously lost weight recently. He did not appear to be in any pain. "Can you tell me your name?" I asked in Sinhala. He looked at me and softly said "Pemiyanu".[*] From there onwards, I started asking him the routine questions that one needs to ask to create a good history of his illness. He said he had been working mostly doing physical work until he had fallen ill several months earlier. Following the history taking I took out the book *Hutchison's Clinical Methods* which was the gold standard for clinical examination and started examining him to the best of my ability. At the end I still had no idea what disease he suffered from, but I had noticed that a peculiar fishy smell came from him every time he spoke with me. He was also quite pale indicating anaemia. It would be a while later that I would realize how important that smell was, and how ill Pemiyanu had been when he gave his history and allowed me to examine him for a length of time.

The next day during the ward rounds, the Boss stopped at Pemiyanu's bed and turned towards our group and asked, "Whose patient is this?". I held up my hand and he told me to present my history and findings to him. As I started reading the history of Pemiyanu's illness, which later I realized was very rudimentary indeed, the Boss guided the whole group through the process of diagnosing his condition. Pemiyanu had chronic renal failure. In 1979 it meant virtually no cure. Pemiyanu's kidneys had packed up well and good. He was unable to excrete waste products via his urine, and they were accumulating in is body. He was not producing enough red blood cells, explaining why he was pale. The fishy smell emanating from him was from ammonia-related compounds, which got retained in his body. He was passing urine in quantities but alas it was not carrying any toxins out of him. Pemiyanu was dying and there was nothing anyone could do to stop the process.

At that time dialysis and kidney transplantation was not available in the government hospitals. Pemiyanu was therefore managed conservatively. He was on a strict diet, and other conditions that could have aggravated his illness were controlled as much as possible. I talked with him daily when we visited the wards. His mood and health varied from day to day. Some days were good days when he would smile and talk freely. Sometimes he would be sleeping or simply too depressed to talk at all. Every day when I visited him and went through his management and observed his symptoms and signs, I learnt something new. Some of these were related to his illness and some were in relation to his general condition. Sometimes he would tell me about his family. This opened my eyes to the fact that behind every patient was a family faced with concern and uncertainty. Pemiyanu was not simply a "case" in a ward. He was a father, a husband, a brother and a son. Looking back, I am fortunate that I learnt this reality from the very first patient I had encountered. Almost every student in our group of ten would have examined him at some point during our stay in the ward. Pemiyanu allowed everyone to listen to his chest, poke and prod him all over his body, turn him from side to side and so on without any sign of resistance. Even at the end of our two months appointment when we changed wards Pemiyanu was still there on the same bed, hanging on to his life which he did graciously right to the end.

Pemiyanu died a few weeks later. Even though I had left the ward and moved onto a surgical unit I used to get news of him through the subsequent group of students who replaced us in that ward. Due to his condition, he was remembered by everyone who had come across him. His death was something that I had anticipated all the time but also wished would never happen. Pemiyanu showed me the uncertainty of life, and how an illness can cut short the hopes and aspirations of anyone of us and our loved ones. He taught me the fundamentals of clinical medicine through his illness, which I am

sure helped me to acquire the skills and knowledge I would have used to treat other patients throughout my life as a doctor. His courage and determination and the graciousness in his own humble way allowing so many to learn from his dying body showed the greatness of this simple man. I am at least consoled that the last few weeks of his life were spent with dignity and amongst us who cared and consoled him in the limited way we could.

Pemiyanu is not alone. The hundreds of thousands of patients who have died after illnesses in hospitals would have imparted an unmeasurable amount of knowledge to the budding doctors all over the world. When we doctors remember our teachers let's not forget these *Undesignated Teachers* who would have played probably the biggest role in the process of moulding us into what we are today. As medical students, and later as practicing doctors the more we appreciate this, the stronger would be our compassion and empathy towards the patients who seek our help every day. After all these are the two vital requisites that need to be developed if we are to truly call ourselves *The Healers of the Sick.*

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[*] *Pemiyanu is a pseudonym to protect the identity of the patient.*

Editorial Comment:

This letter brings many key facts in related to medical humanities. The author emphasizes on the central position of the patient in the learning process in clinical education. This is an aspect sometimes neglected by medical students. Patients have more in their background - suffering, hardships and families. It also highlights limitations in managing end stage renal disease in the absence of dialysis and renal transplantation at that point of time, where such patients had to dejectedly look at a blank wall without cure and a certain death. Considering the importance of the issues raised in this letter, we invited three senior clinicians to comment on the issues raised in this letter and we publish them below. This will be the start of a Medical Humanities Forum in the Galle Medical Journal. *We look forward to your comments and proposals very much.*

Editors, GMJ

Sarath Gamini De Silva

Senior Consultant Physician:

I read with much interest the clinician's comments on the clinical training he had as a medical student starting in 1979. We had our own clinical training at the General Hospital, Colombo (GHC) presently the NHSL, exactly ten years earlier in 1969, beginning just two months after passing the second MB examination. The general format of two medical and two surgical appointments of two months each was the same. We had two weeks each of introductory appointments in medicine and surgery beforehand. It appears that the availability of various diagnostic investigations was also about the same.

The consultants who trained us were considered the most experienced in the country, GHC being the "end station" for them. They were only a few in number and as such household names. I was awestruck the way they were treated with almost divine respect by the more junior doctors, the nursing and other healthcare staff and the patients. They were walking around with much authority in full European attire. The medical students were always at a loss to finding out how we should behave with them. However, students in the senior batches had warned us about various idiosyncrasies of the consultants and how to please them with our work. While the morning sessions were spent in the wards, afternoons were in the lecture theatres in the medical school. We were told to spend as much time as possible with patients in the wards even in the evenings. This made us became aware at the very beginning that practicing medicine is a 24-hour job.

With about twelve to fifteen of us in a group, each one had five or six patients allocated for clerking. It was impressed upon us that a detailed history will give the likely diagnosis even before clinical examination in about 75% of the cases. The validity of this fact became increasingly evident to me as I progressed through my career later, I stressed on the importance of a detailed history as a clinical teacher for 25 years later on. One has to have an open mind like a detective, with every answer given by the patient leading to another question.

The clinical examination should be thorough guided by the history of the illness. *Hutchison's Clinical Methods* was the bible (as much as the *Cunningham's Manual of Practical Anatomy* was in anatomy dissections). Every fact mentioned in that book, being looked for in the patient. Listening to murmurs, looking for palpable livers and spleens, eliciting exaggerated reflexes gave us much fun as experience.

Detailed clinical examination was considered important in an era where ultrasound scans, fibreoptic endoscopies, various cardiac investigations and CT scans *etc.* were not in the scene. We had to do with plain x-rays, ECGs, IVPs etc. Every patient admitted to the ward had the urine tested for sugar by the Benedict's test. A student failing to do that was treated almost like a delinquent. One may wonder how much time a clinician should spend on looking for difficult to find physical signs like murmurs etc. when such could be easily unearthed with readily available extensive investigations. But then, to request an ultrasound examination by the radiologist without palpating the abdomen beforehand by the clinician is unacceptable. It is the clinical findings that should be the guide to what investigations are to be done. Overloading the laboratories and other units with unnecessary investigatio is self-defeating as the reports and results thus produced hastily may not be accurate.

With information shared with other groups we used to go from ward to ward looking for interesting patients. Patients' comfort was often ignored in the process. The teachers impressed upon us that the patients' wellbeing should take precedence over everything else. Waking patients up from an afternoon nap, several students poking the abdomen of a patient were often met with an angry response, although most of the time they treated us "budding doctors" who might help them in recovery. However, their compliance should not be taken for granted. The "vising hour" meant for meeting the family members is very important for the patient. I have seen even that short period being used by some students to take histories or by doctors to conduct various procedures. The description of the patient with chronic renal failure with a hopeless situation in 1979, described as an "undesignated teacher" amply displays the concerns of a patient which students as well as doctors tend to ignore during busy ward work. His hopeless situation is further aggravated by being dumped on a bed on the corridor/open verandah outside the main section of the ward. the fact that every patient has a caring family or a family to be cared for is often forgotten. The letter describes how the patient became more responsive and content as at least the medical student had an ongoing conversation with him over several days. One can imagine the misery of a patient with an incurable illness, dumped in the corridors, being summarily dealt with by all concerned!

I congratulate the writer of the *"undesignated teacher"* or highlighting an aspect often ignored by the medical student, doctors and the healthcare staff.

Ranil Fernando

Emeritus *Professor of Surgery, University of Kelaniya;*
Dean, Faculty of Medicine, University of Moratuwa:

The author must be commended for highlighting an important aspect in medical education which does not receive the due recognition in the normal course of events in the career of a medical student. The value of the contribution made by patients to the education of an aspiring doctor is immeasurable, with very little or no benefit to the patient. If emphasis is given to this fact and it is likely to instill in a sense of gratitude and obligation in the minds of the young graduands which is likely to generate a more compassionate attitude towards patients in young doctors.

M K Ragunathan
Senior Consultant Physician:

Thank you so much for publishing this fantastic letter by a senior clinician in the *Galle Medical Journal*. Story telling had been widely accepted as part of undergraduate teaching and postgraduate and in fact it has been happening all over the world in medical schools and medical practice. Though recognition as storytelling may be a new thing but the practice has been lifelong in history of medicine.

Medical humanities have been incorporated in medical curriculum at least in a few medical schools in Sri Lanka.

All what this clinician has put it down on a well thought of a well-articulated article is telling a story of a patient how it has made a lifelong impression into his medical career. But what is astonishing here is as early as in the initial first medical appointment the learning he had achieved using a single patient. Every one of us would have done it and will be using stories of the patients they see to subconsciously use as a tool to impart knowledge and attitude in developing empathy which is a core requirement to become a healer in the true sense. Again, what is praiseworthy is sharing this story to a wider circle who is fortunate to read this article. May I humbly suggest to the editors to use this article as a nucleus to an ongoing discussion or rather story telling by whoever read this from their clinical experience. If senior clinicians or even a junior medical students can respond by writing his or her experience with a single patient how that exposure has moulded his or her empathy. And if the editors agree can title the series as the *Undesignated teacher* to draw interest for readers as well as future contributors.