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THE GREY MATTER

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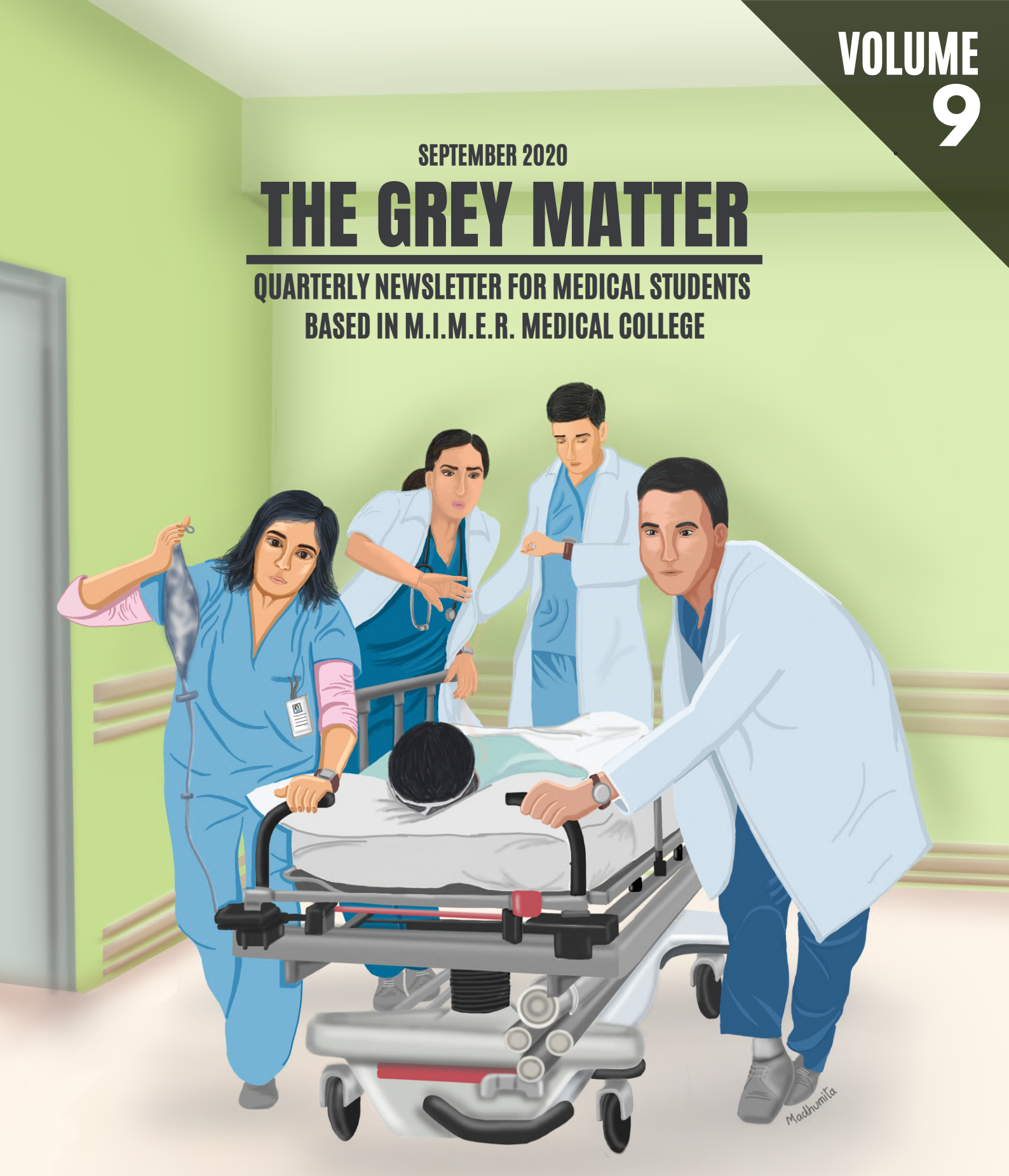
BASED IN M.I.M.E.R. MEDICAL COLLEGE



INDIAN HEALTHCARE SYSTEM
AN EMERGENCY

Healthcare in India : A glass half empty or a glass half full?

Healthcare is one of the largest service sectors in India. Over the years, our healthcare system has seen commendable progress being made, but it suffers some serious shortcomings in terms of health-care delivery. At one end of the spectrum are the impressive posh hospitals delivering health services to mostly the urban population. At the opposite end, there are facilities trying desperately to live up to their identity as health sub-centers.

As doctors of tomorrow, it is imperative for us to understand where our healthcare system is faltering so that we can collectively work towards our goal of providing better facilities to all, while also assuring better working conditions for doctors.

In the article 'Challenges to Healthcare in India' published in the Indian Community Medicine Journal, the author talks about the many challenges in our healthcare system in terms of the 5 A's:

- Awareness or the lack of it: How aware is the Indian population about important issues regarding their own health?
- Access or the lack of it: How accessible are healthcare services?
- Absence or the manpower crisis in healthcare: Do we have an adequate number of trained personnel?
- Affordability or the cost of healthcare: Can the average Indian afford quality healthcare?
- Accountability or the lack of it: Are the concerned authorities taking responsibility of their actions?

The future, at the moment, is brimming with both, probabilities and vulnerabilities.

We, at The Grey Matter, believe that even a small group of people can make a difference and this edition is our tiny contribution towards making our readers aware of the grim situation that our healthcare system finds itself in.

Dear readers, it's never too late to bring a change! Let's talk about the grey areas of the Indian healthcare system!

- Nupur Chaturvedi & Saneeka Vaidya, Co-Editors

Happy Reading

The Pandemic's Push For Technology- Is India Equipped for this Transition?

By Samira Davalbhakta, III/II M.B.B.S., B.J. Medical College & Sassoon General Hospitals, Pune.

Ophthalmology practice during the COVID-19 pandemic has changed significantly from what it was before. However, the question worth asking is, are these changes here to stay? For a speciality that was always equipped with the latest technology and gadgets, was the transition into an increasingly remote method of practice easy ?

The first question is a tricky one to answer, simply because there are so many variables involved. Although new and impressive technologies like the Digital Slit Lamp (or even our old 'WhatsApp® pictures') allow the ophthalmologists to effectively examine the eye, they lack the crucial elements of examination that are present when the doctors see the eye themselves. Nevertheless, teleophthalmology is a growing avenue where patients, many of those who were not even aware of a tele-option for eye care, have started to choose this, given the safety concerns of visiting a clinic. This has provided a push to an increase in the use of teleophthalmology.

Eye care can be divided into three broad sections: Initial assessment, follow-up and regular assessments, and surgical treatments. Visual acuity testing is often considered the backbone of initial vision evaluation. Numerous options are available for smart phone-based visual acuity measurement. One such application called the Peek (Portable Eye Examination Kit) Acuity App uses a tumbling E displayed in various orientations and requires an assistant to translate the motions of the patient to the phone. The smartphone is held at a distance of 2 meters while the examinee views the screen. The letter E is then displayed in various orientations and the patient is required to point towards the directions of the arms of the letter. The assistant then swipes the screen in that direction without actually looking at the screen (to avoid bias). Detailed instructions are available on the app, which also detects room lighting and self-adjusts the screen brightness or displays alerts when lighting is not optimum. Scientific studies comparing this app to standard charts have been conducted which show that the app accurately measures vision. Not only will apps such as these support patient care during this pandemic, but such technology can be used in remote places of India which provides a good reason for such a technology to stay.

Regular check-up of patients with eye conditions is an integral part of ophthalmology practice. To convert this into an online practice, however, has its pros and cons.

Video consultations will increase the level of safety with respect to the pandemic. Also, patient triage, treatment of basic symptomatology, and minor changes to drug treatment afforded to a follow-up patient are all possible and will decrease the number of patients wanting to visit the clinic.

However, skilled techniques like lacrimal syringing, slit lamp examination, or even simple intraocular pressure (IOP) monitoring require a doctor. Remote slit-lamp examination using robotic slit lamps do exist , but require a lot of technological up-gradation to qualify for the standards set by a regular slit lamp. The 'Glued intraocular lens smart phone microscope' is an interesting invention created by an Indian ophthalmologist that can be used to photograph the anterior segment of the eye. The innovator simply stuck a discarded polymethyl methacrylate (PMMA) intraocular lens to the back of a smartphone camera and with a few adjustments was able to get a clear image comparable to those attained via a slit lamp. Unfortunately, this technique has not been tested scientifically and evidence of its effective use in telemedicine is lacking. Additionally, such techniques will require patient education for it to be useful and cannot be implemented unless adequate preparation is present. As for IOP monitoring, technology like the iCare Tonometer is expensive, requires a lot of patient cooperation for effective functioning, and is thus unfeasible. Crude methods like digital examination by the patient and comparison to the consistency of a fruit can be used during emergency conditions, but cannot be compared to tonometry performed at a clinic. Although this shows the current irreplaceability of IOP measurement by remote technology, it also demonstrates room for innovation.

One aspect made clear, is that the technology exists but it requires further fine-tuning to become acceptable alternatives to the current standards of practice. However, due to the lockdown and social distancing norms, patients are more willing than before to avail for teleophthalmology services, which will create a demand, setting off chain reactions that will lead to new and improved technology.

How prepared is India for the implementation of this change in medical practice? With over 500 million smart phone users in the country , most using WhatsApp®, it is safe to say that the country is ready for this change, but only to a certain extent.

Patient education regarding tele-practice is essential not only for effective consultations but also for ensuring patient comfort and satisfaction, the ultimate aim of any physician. Such steps need to be taken before a pandemic hits.

Teleophthalmology is a regular practice in hospitals like the Aravind Eye Hospital. This system was launched way back in 2004 at Aravind Eye Hospital. It is now used regularly and extensively for patient care, linking the Primary care (vision) centers run by Aravind in rural areas to the specialists in the hospital.

On asking Dr. Kim Ramasamy, who heads the IT division at Aravind, whether the presence of this system made it easier to expand it to most patients, he answered that it was partially correct to think so- "We had our primary care clinics that use telemedicine to allow the patients to consult with the doctors. But we needed a quick fix video conferencing solution for all our patients to consult the doctors directly through their smart phone or computers sitting at their home". This process, he agreed, could have been much more difficult for smaller clinics and hospitals which had never invested in a telemedicine system. Aravind Eye Hospital is best known for its immense productivity and an assembly-line approach to the elimination of blindness. However, even this admirable hospital faced difficulties in maintaining its reach to the public. Used to seeing patients coming from all corners of the country, the number of visitors depleted owing to a lack of transport, and restricted mobility due to the requirement of an E-pass. Surgeries were shifted to an emergency-only basis, and elective surgeries were scheduled with caution. Their legendary and highly orchestrated system of cataract eye surgeries took a hit due to precautions needed, like one surgery per OT, and a gap between surgeries. Thus, the transition to an increasingly remote method of practice was not without its difficulties even for a set-up known world-wide for its efficiency.

Indian healthcare, like the rest of the world, received a shock when the pandemic hit. However, as always, we will manage to pick ourselves up and find newer ways and systems to circumvent the difficulties faced now. With more patients acquainting themselves with the idea of seeing their doctor online, this might become the new normal and might lead to increased use of the technology available to make this happen.

Thank you for the compliment, but I'm not a nurse!

By Dr Shivani Desai, Alumnus, M.I.M.E.R. Medical College, Pune

"*Sister, saline band kar do*"
"*Sister, BP normal aahe na?*"
"*Sister, sister,...*"
In one year of my internship, this was the second most frequently heard word after "*Aee Intaan*". On the first day, I did not even realize that the patients were addressing me as 'Sister'. It started irritating me as my male co-interns were addressed as 'doctor' and I along with the other female interns were addressed as 'Sister'.

During my first posting in the female Medicine ward, there was a cute old female patient in my unit who used to call me '*Sisterinbai*' very affectionately. Over two weeks of her admission I could finally get her to call me '*Doctorinbai*'. This was my first and last attempt at correcting my patients.
I used to wonder what makes these patients call the female interns 'sister'. Is it because of gender bias that they feel females cannot be doctors?

In my experience, I feel it is due to lack of primary education in the rural areas, where most of these patients come from. They don't know that the word 'Doctor' is a gender neutral noun used for both male as well as female doctors. They probably feel that the female doctors are called 'sisters' and so address us with the same respect.

Hence, eventually I started responding to them without any qualms. Also, throughout my internship, I realized through my internship that I was not half as practically qualified as our sisters. The brothers and sisters were the ones who taught me fluent intracath insertion, blood collection, i.v. injections, etc. They were always there to guide the interns.

So like turning lemons into lemonade, I took this as a compliment, because what else could be a mature defence, hence, this thing never irritated me again!

GUEST INTERVIEW

The hand that rocks the cradle

DR. MRS. KIRAN COELHO

In conversation with Nupur Chaturvedi, II/III M.B.B.S. &
Unnati Shukla, I M.B.B.S., M.I.M.E.R. Medical College, Pune

Dr. Kiran, MD, DGO, DFP is one of the leading Laparoscopic Surgeons of India. She is a renowned celebrity Obstetrician and Gynaecologist. She has been practicing Obstetrics and Gynaecology (ObGyn) for over three decades. She completed her MBBS training at Karnataka Medical College and MD from Grant Medical College, Mumbai University (1984). Her qualifications include advanced training and a Visiting Fellowship in ObGyn Ultrasound at Nassau County Medical Center, New York, USA (1988) as well as a Visiting Fellowship in In-Vitro Fertilization, Assisted Reproductive Technology and Minimally Invasive Surgery at Baylor College of Medicine, Houston, Texas, USA. She has performed more than 5,000 laparoscopic and hysteroscopic surgeries.

Dr. Coelho is professionally attached to the following hospitals in Mumbai :

- Lilavati Hospital & Research Centre, Bandra Reclamation
- Hinduja Healthcare Surgical, Khar West
- Breach Candy Hospital, Warden Road

Q. What made you choose Obstetrics and Gynaecology as a profession?

'The hand that rocks the cradle rules the world.' This age-old saying finds its true meaning in today's world where women have been successful at managing not only their household work but also their professional front. Women are the epitome of strength, love, sacrifice, selflessness and courage. A lot of women often tend to neglect their own health while trying to manage everything else. Health should be a primary concern for all.

I have always felt an urge to do something for women and Gynaecology was the perfect fit for me. It gave me the right platform to fulfil my dream of providing better healthcare to women. Secondly, my aunt, a Gynaecologist, has always been my role model. She has guided me at every step and I owe a lot of my success to her.

Besides this, bagging two Gold medals in Obstetrics and Gynaecology in my final year of MBBS gave me more clarity on what I wanted to pursue my post-graduation in. Another important reason why I chose to take up this profession is that I have always been passionate about treating patients. Being empathetic is of utmost importance for every healthcare worker.

Q. Where do you think we stand as a country when it comes to ART and some of the latest procedures in Obstetrics and Gynaecology?

I strongly believe that we're doing quite well in India in terms of newer techniques like Assisted Reproductive Technology, IVF, GIFT, etc. for the simple reason that in India, we have a greater patient inflow and hence, more opportunities to explore different avenues of healthcare. Being updated is the norm today. Western countries have made commendable progress in robotic surgeries. In India, Gynaecologists are more skilled than their western counterparts when it comes to endoscopic (key-hole), laparoscopic surgeries and high-risk obstetrics. Everything comes down to experience because experience is the best teacher. Learning and practising new techniques, attending and organising seminars is what has helped us stand at par with doctors across the globe. Obstetricians in India have greater credibility solely because having more patients to operate on has given us an edge over the doctors working abroad. At the same time, there is a lot that needs to be done and we've got a long road ahead.

Q. What do you think about the new bill regarding the change in gestational age for abortion?

The newly introduced bill was a much-needed amendment. All the Gynaecologists across the country had been petitioning for this for quite some time. The MTP Act that came into existence in 1971 talked about legal abortion until 20 weeks of gestation. Over the years, this field of Medicine has seen constant change and an update on this Act was long due.

A very common cause of terminating a pregnancy is malformations of the fetus. Cardiac and other congenital malformations are often detected between 20-24 weeks of gestation. According to the MTP Act 1971, aborting a child after 20 weeks in spite of him/her having malformations was considered illegal. This is one reason why this Act needed an update.

Secondly, a major part of our population stays in rural areas where they don't get their anomaly scans done at an earlier stage of pregnancy either due to inadequate facilities or a lack of awareness. Hence, it was imperative to make amends in the Act to give women the right to legally abort their child in cases of deformities even after 20 weeks (until 24 weeks).

Q. In this edition of The Grey Matter, we are talking about the Indian Healthcare System. Given your experience and so many years in this field, we would love to hear your views on the current Healthcare System and how is it different from a few years ago? What changes would you like to see in it?

Having worked in municipal as well as private hospitals, I can say that there is a stark difference between the standard of healthcare provided at the Public and Private Sectors. The budget provided by the Government to the healthcare sector is meagre. Government hospitals are ill-equipped and hence, are unable to provide enough medical facilities to those coming from a weaker financial background. Private hospitals, on the other hand, provide the best of facilities to their patients. It all comes down to the difference between the haves and the have-nots. Healthcare in our country is excellent, but it comes with a price.

Secondly, what we lack is the facility of maintaining electronic patient records with accurate statistics. Everything right from the patient history to the number of patient visits to the course of treatment should be a click away for all doctors and patients alike. This is one aspect where we lag behind western countries.

Our Public Healthcare sector also lacks standardisation of protocols. It is shocking to know that no two obstetricians follow the same protocol while performing surgeries like Caesarean sections or other high-risk surgeries. The need of the hour is to construct a well-rounded standard of protocol for all doctors.

The positive side is that the importance of being medically insured is gradually percolating down into the masses, people are becoming more aware of it. As a result, more Indians are taking up medical insurance to ensure a safer future. We're progressing with leaps and bounds, but there are still a lot of things that can be worked on. These are a few aspects where I believe we have great scope for improvement.

Q. Could you please tell us about your 'Save the Girl Child' initiative at the Lilavati Hospital and Research Centre?

This initiative was a fundraiser where we organised various events that were graced by celebrities.

This helped us raise money which was then invested in organising dental and eye checkups and immunisation programmes for girls coming from a weak financial background. We had our team of paediatricians and nutritionists who supported us throughout. Our healthcare workers and residents conducted awareness camps on menstrual hygiene and nutrition at municipality schools for underprivileged girls. We organised health camps in the periphery for general checkups that included haemoglobin estimation and stool examination. In addition to this, we had an outreach service called the Seva Ambulance Service.

This initiative was a resounding success because we managed to cover a large area in and around Bombay, spreading awareness to the underprivileged masses.

Q. We read on your website that you continue to work up to 16 hours a day, can you please share some tips for our young readers on how to maximize productivity in the time we get?

The key to a successful career is to love your job. Once you love your work it is not 'work', it's pleasure. For me, work has always been a pleasure. Even now I don't give up on Obstetrics because it gives me so much joy, be it treating infertility or bringing children into the world. Empathy towards your patients along with loving your work is extremely important.

Another very important thing is to keep abreast of the recent advances. One has to allocate some time every day to study. Even today I study every night because I have to give talks, lectures and be an examiner for DNB exams. One must train oneself with all the recent advances because if you don't, you'll be winnowed out. You must give your best to your profession.

Above everything, comes good support structure at home, especially for women. Juggling my busy career and bringing up two children would not have been possible without the support of my husband. I have reached where I am because of my spouse, whom I refer to as my 'Rock of Gibraltar'.

Last but definitely not the least, good health is also imperative. You must find time to exercise and eat well to maintain good health that lets you work those long hours.

Q. What kind of challenges did the pandemic pose when it came to practising Obstetrics and Gynaecology?

Some of the hospitals I work at are COVID hospitals and patients wouldn't want to be exposed by coming to the hospital for routine consultation. So the first challenge came in the form of contact with the patient and consultation. Fortunately, the government realized this, and video consultation has become legal which is so wonderful. I believe that this should be continued after the pandemic as well because the patient doesn't have to get dressed, travel miles together, wait in the doctor's waiting room all just for the 15-20 minutes of consultation. Now patients can do that from the comfort of their home where they have a fixed time to talk to the doctor, the reports can be sent through WhatsApp.

One can study them and send back the prescriptions. If and when the physical examination is required the patient can be called. For a pregnant patient, however, we can time the visits at the time of sonography. There are of course drawbacks. Apart from the fact that we cannot regularly examine the patient physically, there is also a restriction to perform elective surgeries during the time of the pandemic. I have patients who are bleeding heavily with large fibroids or tumours and we just have to wait until it is safe to perform the surgery. Of course, in emergencies like ovarian cysts, ectopic pregnancies, or cancer of uterus or ovary, surgeries are being performed.

Another challenge is that of operating on a COVID positive patient. Wearing the PPE and performing a normal delivery or C-section is very difficult. The long hours of work can be curtailed due to the personal protective equipment. Also, all the extra care that needs to be taken to not become carriers and bring the virus back home to our loved ones is another challenge. And we don't know how long it is going to last.

> "There are no shortcuts in medicine. It is 90% perspiration & 10% intelligence. Unless you have a passion & love for the subject you won't be happy."

Q. We hear that you sing and are also passionate about exercising. Do you think that has helped you in any way in your career? Is there anything else that you enjoy?

My best relaxation is undoubtedly my work. I hate taking holidays because there are always patients that you've looked after for 9 months and you cannot let them down. All the vacations my children have taken have always been with their father. What I do enjoy though is cooking, singing, and exercising. They're all my passions and help me relax. Besides, that one annual visit to my children in America is a must. I could never give enough time to my children, but now I go to the States for a month every year to spend time with my grandchildren.

Q. What would your advice be to the doctors of tomorrow?

They have a very difficult task ahead of them. First and foremost, do not choose this profession unless you're really passionate about it because it is a lot of hard work.

You have to be committed to working hard all your life because Medicine is always evolving. There are new inventions and new techniques every day, which is very exciting. Even in my practice of 38 years, there have been so many innovations that have revolutionised the practice of Obstetrics and Gynaecology. These advances in the field of Medicine will keep you engrossed your whole life if you're passionate.

Secondly, there are no shortcuts in Medicine. It is 90% perspiration and 10% intelligence. Unless you have a passion and love for the subject you won't be happy.

Most important is an ethical practice. Giving a 'cut' of whatever you earn from the patient to the General practitioner who refers the case to you is a practice that needs to end. It is the biggest block on the practice of Medicine. You must be ethical and charge the patient in accordance to the service that you're providing.

Always be compassionate towards the patients who cannot pay and never let money be the guide to your treatment of the patient.

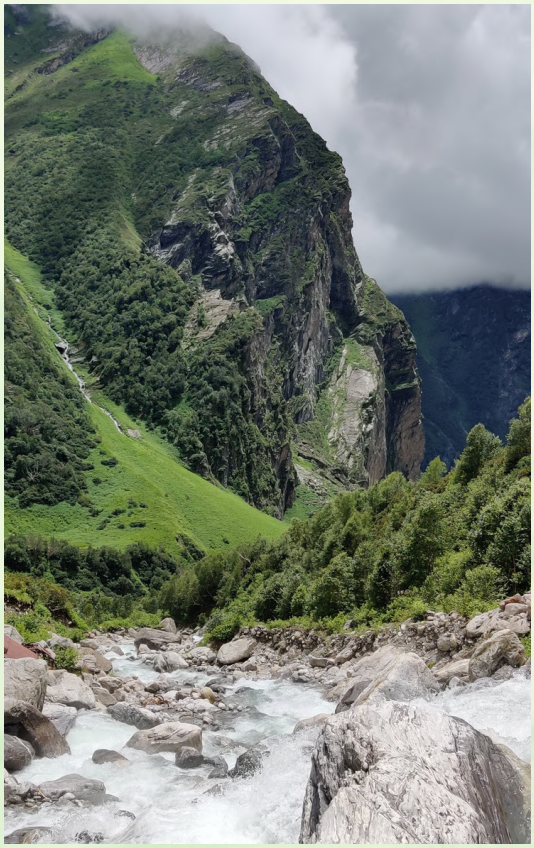
Your treatment should be for the love of treatment of the patient and to make him or her holistically better, the rest will all follow. Money will follow you if you're good at your craft.

Always be calm, collected and compassionate towards your patient because after all, they're coming to you with great faith. Your responsibility is tremendous. You should be mindful of that responsibility and deliver your treatment to the best of your ability.

Shutterbug

Revati Pathak
IV B.P.Th

VALLEY OF FLOWERS



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BALI

project you

Mental Healthcare amongst the healthcare providers

By Jubi Babu, II M.B.B.S., Dr. Vitthalrao Vikhe Patil Foundation's Medical College, Ahmednagar

With issues and concerns like increasing caseload, litigation, third party documentation, insurance companies and the struggles of their patients- which particularly hits hard when they don't do well, it comes as no surprise that there is an upward trend of doctors and physicians alike falling prey to mental health issues. In fact, according to some psychiatrists, the exceptional stress upon the shoulders of healthcare professionals is comparable to that experienced by a PTSD victim.

Here are some statistics that will drive the point home. The Indian Journal of Psychiatry concluded in a study that 30% of Indian doctors and physicians go through depression, while 17% have experienced thoughts about ending their life. Almost 80% of doctors, especially in earlier stages of their academics and career face the risk of burnout. Several studies have also suggested that doctors routinely experience work-related anxiety and then often succumb to alcohol abuse, drug abuse, become dependent on antidepressants, smoking and so on.

What are the causes of mental health issues among doctors?

The stressors for mental health issues among healthcare professionals are usually intrinsic to their job. These may include-

- Long working hours
- Negative patient related outcomes
- Adverse doctor-patient interactions such as verbal/ emotional, sometimes even physical abuse at the hands of patients or their caregivers.
- Interpersonal interactions among colleagues
- Patient demands
- Roles within the organization and relationships at work
- Career development
- Fear of making mistakes (especially in the case of interns and residents)
- Balancing work and personal responsibilities

What are the reasons behind stigma surrounding mental illnesses in healthcare professionals?

Times have changed and people around the world are now more willing than ever to discuss mental health issues. However, it is still considered a taboo in many settings and paradoxically, the healthcare workers are amongst one of them. The reasons for this include-

- Doctors often fear that if they disclose a mental illness, they might be deterred from continuing their job on the grounds of having an 'unstable mind'.
- Doctors sometimes feel ashamed that they need help from someone and are not able to 'fix themselves'.
- They also fear a loss of confidentiality- their personal details might be disclosed outside the consultation room and become a topic for gossip among their colleagues, or may even be brought to the attention of the employer.
- Sadly, patients do find it difficult to accept that doctors can be sick. Patients often place doctors on pedestals, thus rendering it almost impossible for the latter to come forward and acknowledge their vulnerabilities and disabilities like the rest of us.
- Doctors who are asked to treat other doctors are also sometimes embarrassed on seeing their colleagues in a second persona.

How can we, as students in the medical field, help to eradicate, or at the very least, allay this stigma?

Quoting Margaret Wheatley, "*All social change begins with a conversation*". Start a deliberation about the topic amongst your friends, peers, teachers and parents. Let people give their opinions and get to know yours. Let there be healthy discussions, because only when you start a conversation will there be any scope of change.

"*Words are singularly the most powerful force available to humanity. We can choose to use this force constructively with words of encouragement, or destructively by using words of despair. Words have energy and power with the ability to help, to heal, to hinder, to hurt, to harm, to humiliate and to humble*" -Yehuda Berg.

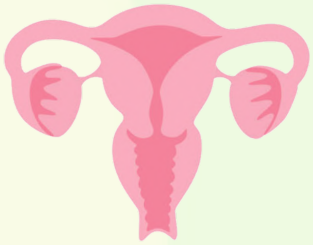
Remember and remind others, as well as yourselves, that the way we talk about issues matters more than we think it does. Often people think of 'mental illness' as a derogatory term. Instead of categorizing people as 'mentally ill' or 'mentally healthy', try to think of it as a continuum. People are bound to have good days and bad days. Try to look at it as a picture that's painted in different hues of grey instead of black and white. Offer to help others. Encourage others to offer help too. You never know, sometimes all a person might need is a shoulder to lean on.

Try to lend your ears and listen to their troubles. Assisting others can also help them recognize that they need to see a professional, as they struggle to realise that.

Discuss strategies for building mental health. Practice and educate about exercises that may help one deal better with negative emotions and experiences. Talk about resources. Online self help tips, support groups, etc. are free of charge and available to everyone.

We, at Project You, have come together to try and assist Healthcare Professionals deal better with their mental health. We have done our best to scrounge the internet and come up with some of the best resources and tips, all under a single roof, that can be used to help oneself manage mental health better, especially in tough times like the ongoing pandemic.

HYSTERO-LOGUE



By Riya Barar, III/II, M.B.B.S.,
M.I.M.E.R. Medical College, Pune

In the month of July, owing to the relative excess of time I attended an interesting online workshop for medical students. I found out something rather shocking about the history of the word 'hysteria'. 'Hysteria' in modern psychology and psychiatry refers to an excess of emotions and physical symptoms that have a psychological and not an organic cause. I realised that the origins of a word which was a medical diagnosis up until the 1980s and is still a symptom used routinely in medical practice is, in fact, downright sexist and misogynistic.

Here's why: Hystera; in Greek means uterus. Argonauto Melampus, one of the first people to propose a theory about "why women can be hysterical" suggested that women who refused to have sex or due to a lack of sexual satisfaction acted hysterical.

A bizarre theory suggested by Hippocrates, who is said to have coined the term 'hysteria' stated that due to lack of a male partner the uterus was sad and was now 'a wandering womb' that exerted pressure on the other organs and made women act 'hysterical'.

Both theories clearly show the reduction of women to reproductive objects. When words that have sexist origins are still routinely being used in practice, they remain a subtle reminder that women in the medical field are still 'the other sex'.

Some of the practices in our field in the more recent past could be regarded as questionable.

The MRFIT trial, one of the biggest trials contributing to current guidelines for the major risk factors for cardiovascular disorders, had a sample size consisting of men only.

The trouble with trials like these and the data they provide is that they assume the male body to be normal, and only assess the various factors possibly contributing to the development of cardiovascular disorders. This data is then taken into account in meta-analyses to decide the final guidelines for what are considered risk factors for CVDs for people across the globe. Would the results of this study have been different if female subjects were also included and how much would it have changed our current ideas of what are considered risk factors for CVDs? Even in some of the biggest clinical trials conducted by modern medicine researchers and practitioners, the female body's differences had not been acknowledged or accounted for.

In a study done recently, it was found that 1/3rd women undergoing a myocardial infarction do not present with the classical picture of retrosternal pain radiating to the back and jaw, but come in with general anxiety and palpitations.

I was shocked to find out this information and to imagine the morbidity and mortality that women across the world have been facing for years due to a delay in diagnosis. Any second year medical student will be able to tell you that a quick diagnosis in the case of a myocardial infarction can drastically change patient recovery and outcome. The line "time is equal to myocardium" from Robbins and Cotran's pathology textbook reiterates the same.

My own experiences with sexism and medicine started way before I entered medical college. They came in the form of 'friendly suggestions and kind advice'. As a teenager when I was asked what I wanted to take up as my career, I'd say rather confidently, medicine. After the affirming nod that every person in India gets when they say they want to be a doctor, there comes the follow up question, "Have you thought about how you will handle your own family and children while working as a doctor?"

"Have you decided what you want to take up as your specialisation?", was another common question I got after a couple of years of college. My response would be, "I'm not sure yet. Surgery and Obstetrics seem interesting to me so far."

The 'wise' advice I'd get in return was along the lines of how great Dermatology is. Especially, for a woman considering the less challenging hours.

While I hope to be someone who gives time to her family as well as her career, I can't help but wonder, why are these questions not asked to our male counterparts?

Why is it that it's so casual to hear comments like "career oriented woman". I never heard anyone call an ambitious boy a "career oriented boy," he's just a boy.

After I entered medical school, to say I was elated to finally be here is a serious understatement. Purchasing my first lab coat, bone set and the books I'd been dying to read.

My absolute love for what I study has never dwindled, but as I read my textbooks more closely, I was upset to see the non-inclusive language being used casually by renowned authors. Sexist language in books creates a generation of misinformed doctors. I cannot emphasize enough, the importance of creating and being a well informed healthcare provider for yourself, your patients and the future of medicine in this country.

As the next few years of medical school went by, I found myself arguing with colleagues and batchmates about practices that they engaged in that were blatantly sexist. Somehow, every discussion was covered up with blankets of defense, instead of acknowledging practices that could easily be replaced with more inclusive ones. I now know that conversations like these are teasers and reminders for the sexist speed breakers that lie on the road to becoming and working as a woman in medicine.

When I look back on those discussions a quote I heard recently comes to mind "When you're accustomed to privilege, equality feels like oppression"

These are my experiences with sexism, who is by all means a privileged citizen of this country. I can't begin to imagine what so many women might be experiencing on a daily basis, but I can definitely empathize. The objective of writing this article was very singular, to hope that you as a reader realise your fundamental role in changing the course of our future by simply questioning the norm.

We still have a long way to go in terms of truly understanding and accepting the equality of the sexes, how it affects each individual and how it can drastically change the trajectory of the progress of our society and I would even go on to say, the human race as a whole.

It's easy to look back on the history of medicine and notice its striking sexist practices and comment upon how atrocious they were. The past practices of medicine in no way shun the brilliant field of science that it is. However, what one might reflect upon is medical education and the practice of medicine around them now. Is it free from sexism? What are some practices that we see around us that future generations would look back upon in the way we look at the origins of the word 'hysteria'?

These are the cards we were dealt. Don't you think it's about damn time we change the whole deck?

MIMERSRC

by Dr. Oshin Behl, TEAM MIMERSRC

"The common facts of today are the products of yesterday's research."
Duncan MacDonald

Our textbooks are filled with chapters on research and yet our curriculum lacks it. This was motivation enough for starting the Student Research Council at our college, with the aim of bridging the gap between students and research. It started with a group of research-oriented students, who wanted to make Undergraduate research more feasible and accessible. Our 3-student core team, has now expanded to a 12 person core team, and I couldn't be prouder of how much we've achieved in our journey towards making research an integral part of every medical student's life.

Through workshops, seminars and webinars, the MIMERSRC teaches students about research methodology, scientific presentations, biostatistics and other vital topics that stand as challenges in the way of medical students interested in research. We have reached hundreds of students through our activity, under the able guidance of Dr. Derek D'Souza sir, our faculty advisor and the coveted Clinical Research Incubation centre.

We recently conducted our 1st Digital Healthcare Symposium, which saw 25 presenters from 4 countries, and 9 amazing judges from the Netherlands and India. The event truly highlighted how research can connect us, through borders and fields, even during a time when distance is the norm. The pandemic has also brought to light the giant gap that exists between clinical practice and research, especially in India. A quick search on PubMed shows that while many CoViD-19 related papers come from India, more experimental and groundbreaking research comes from countries which, not surprisingly, have a more integrated physician-researcher system. The latter has helped them in having a more sound exchange of knowledge and has facilitated more interventional research. While India is a hub for clinical knowledge and practical application, it is in dire need of good physician-researcher system.

Evidence based medicine is truly the need of the hour, with the world coming to realise that no Harrison can help us when the disease is 'out of syllabus'. We, as the new generation of doctors in India, must recognise this, and equip ourselves with a research based mindset, to be able to help our patients better and quicker.

Indian Healthcare System

By Riya Bharadwaj, II M.B.B.S.,
Dr. Vithalrao Vikhe Patil Foundation's Medical College & Hospital, Ahmednagar

The basic structural and functional unit of the human body is the cell. Our body is made up of a variety of cells and these cells grow, regenerate, respond to metabolically stressful conditions, adapt to their surroundings, and most importantly, are in a dynamic state. Similarly, our country is built upon numerous structural and functional units and strives for growth and development. One such basic unit is the *Indian Healthcare system*. Each and every one of us is linked to the healthcare system through one or more channels.

The Indian healthcare system is renowned for producing some of the finest doctors in the world. Yet, India's ranking on a global healthcare access and quality index continues to remain substandard.

But why do we lag behind with respect to healthcare? Who is responsible for improving the system? And finally, how exactly can we go about sustainably developing our healthcare system? The solutions to these questions are what stand between us and development of our healthcare system. In order to improve something, we must know its fundamentals.

INDIAN HEALTHCARE SYSTEM – LEVELS AND BRANCHES

The Indian constitution makes the provision of the healthcare in India, the responsibility of the state governments, rather than the central government. It makes every state responsible for raising the level of nutrition, the standard of living of its people and improvement of public health among its primary duties.

The Indian Healthcare system is broadly categorized into Public and Private Healthcare. One of the major shortcomings in this type of a setup is that the quality of healthcare provided is almost directly proportional to the amount of money paid. In spite of comparatively lower standards of healthcare being provided at the Public Healthcare sectors, a major chunk of the Indian population, especially those who are below the poverty line still depend solely upon this sector of healthcare.

The Indian Healthcare system provides services through five major branches, namely, Allopathy, Ayurveda, Homeopathy, Unani and Siddha, wherein Allopathy is modern medicine and is practiced throughout the country.

The burden of responsibilities on an individual can be reduced by lending a few helping hands, but on whom can the overburdened healthcare system rely upon, when all the preachers, promoters and practitioners are buried under stress and lack of relief?

'Less than one doctor for one thousand patients, but medical tourism booms', as rightfully mentioned in a news headline from the Economic Times, is one of the major paradoxes of the Indian Healthcare System.

Most hospitals in India are overburdened, understaffed and ill-equipped. There is a wide gap between rural and urban India with respect to technology, living conditions and economic empowerment. Moreover, around one third of India's population lives in these rural areas. Although the number of healthcare facilities in rural areas of India have increased during the past decade, convincing doctors to work in them still remains a major challenge.

How can the Indian Healthcare System become more welcoming and what improvements can be made with respect to the working conditions?

When you are a part of a system, your comfort level is determined not only by how well you absorb the system within you, but also by how well the system absorbs you. Countries like Australia and New Zealand have a good work-life balance, friendly workplace atmosphere, junior doctors are paid well and other such lucrative working conditions. European countries, in spite of providing an average amount of salary to healthcare providers, give them comfortable working surroundings and tolerable working hours.

India, being the second most populous country of the world, has numerous loopholes in its healthcare system. The healthcare professionals are a prey to long working hours, greater workload, poor salaries, especially for the junior doctors.

What need to change

One of the most important steps that should be taken is that the percentage of the G.D.P., that is reserved for healthcare can be increased so that the public as well as the private healthcare providers get better salaries which will ultimately result in good living conditions as seen in a lot of countries.

There should be regulation of shifts and provision of adequate breaks as well as leaves, in order to maintain a healthy work-life balance. The medical education should be made more student friendly and at par with the latest research so as to produce more balanced healthcare professionals. The number of institutions providing undergraduate as well as postgraduate medical education should be increased. There should be legal provisions protecting the rights of medical practitioners and safeguarding them physically, financially and mentally.

Regular counselling sessions should be provided to the healthcare professionals in order to allay stress and other negative emotions that come along with the profession. The cases of violence and sexual abuse at workplace should be acknowledged and stricter laws should be enforced in order to put an end to them. The responsibility of providing appropriate and sufficient equipment, personal protective equipment, staff, and intensive training programs should be taken up by the government. There should be a system rewarding good research development in the healthcare system as well as efforts to improve healthcare. This encourages hospitals to improve their performance and the quality of the healthcare they provide.

'Where there is a will, there is a way', and inculcating this into our healthcare practices, we can bring about necessary changes in the system, but we have a long road ahead.

the Mind-y project

By Aishwarya Puranik III/I M.B.B.S., M.I.M.E.R. Medical College

ARE WE COMFORTABLE WITH OUR OWN MINDSET?

Read it again, are we really?

No mindset is truly correct. It is all relative. However, having a strong conviction in our mindset, accepting and understanding ourselves brings us peace. Be open to changes, keep experimenting, make mistakes, try something new for a change, change your ideology if you feel something else resonates with you and ultimately find comfort in your basic principle. Your principles should make you feel good and comfortable in spite all the chaos.

Other's opinions should widen our thoughts, and not 'influence' them. Be you, do you. But finding too much comfort in your ideologies could be a red flag for a narrowed outlook.
So Keep believing! Keep discovering!

TAAZA KHABAR

By Rutuja Pawar, III/I M.B.B.S.,
M.I.M.E.R. Medical College, Pune

Duchenne: 'Crosstalk' between muscle and spleen

Duchenne Muscular Dystrophy (DMD) is the most common neuromuscular disorder in children and is passed on by X-linked recessive inheritance. It's a characteristic progressive muscular atrophy. The disease often results in death before the third decade of life. Researchers have found a connection between dystrophic muscles and the lymphatic system in mice with Duchenne disease.

The muscular atrophy in Duchenne disease is caused by a lack of dystrophin, a protein of the cytoskeleton. Although the disease is primarily neuromuscular, researchers from National University of Ireland, Maynooth, have used mass spectrometric protein analysis (proteomics) to show that Duchenne muscular dystrophy causes changes in certain proteins (proteome) in several organs including heart, brain, kidney and liver as well as in saliva, serum, and urine.

This proteomics shows how the skeletal muscles and the spleen influence each other because of the dystrophin deficiency. The spleen plays a key role in the immune response. Furthermore, the researchers have found for the first time a shorter form of dystrophin (DP71), which is synthesized as a protein in the spleen.

The 'crosstalk', meaning disruptive overlay of another conversation, is expressed especially by the fact that a large number of proteins in the spleen are drastically reduced due to the loss of the long-form of dystrophin. This includes proteins that are involved in lipid transport and metabolism, immune response and inflammatory processes. This research points out that the results of the study suggest that the mechanisms of the inflammatory processes which occur in the course of Duchenne muscular dystrophy merit special attention.

IT'S TIME FOR A TRANS-FORMATION

Damini Narkhede, III/II M.B.B.S.,
M.I.M.E.R. Medical College, Pune

Does International Classification of Diseases (ICD) affect medical practice?

WHO says, that good data helps health systems respond to disease trends, and allocate resources accordingly so that diseases can be prevented, detected and treated in the best way possible. They claim that the ICD helps countries do that.
I largely agree with this because health professionals in more than 150 countries of the world use this database. But the list isn't immune to change. With changes in the knowledge of diseases, the ICD has to be updated every few years.

The ICD-11 which will come into effect in 2022 has some interesting developments! It's electronic, easier to use and allows more details to be recorded. But what has gained widespread attention is the small but significant change of removing transgenderism from the classification of Mental Health Disorders.

Transgenderism was initially classified under Mental Disorders (Disorders of Adult personality and Behaviour) in ICD-10. Research has shown us that while transgender people are more susceptible to suffer from mental health problems due to dysphoria, societal stigma and other factors, it in itself is not a mental health disorder.

This seems like a huge victory. WHO predicts, assumes and hopes that gender non conformity and gender in-congruence being taken out of the list of Mental Health Disorders will help reduce stigma and push the world towards being more accepting of trans people.

This decision has been made with the help of an external advisory group and by relying on the feedback and advocacy of the affected community. People around the world have given varied opinions about this change.

The real question is, what about the implementation? Who makes sure that these changes are reflected upon people's views? Is it the government? The health sector? The education sector?

While this change is a welcomed one, it hardly parallels the reality of acceptance of transgender people in the world, and especially India. The entire lot of medical students in India is reading what some of their outdated textbooks are teaching them about trans persons. That includes PARK's PSM!

Social media is trying its best to raise awareness about these issues and educate people about sex education that they failed to receive growing up. But how many people are getting access to this information?

We have generations of doctors still believing that being a transgender is a mental disorder or some sort of anomaly. They are confused about basic terminologies associated with the Non Binary identifying population.

How many medical professionals and students know about the Transgender Persons Act, 2019? How many of us understand the fight of the trans community against this act?

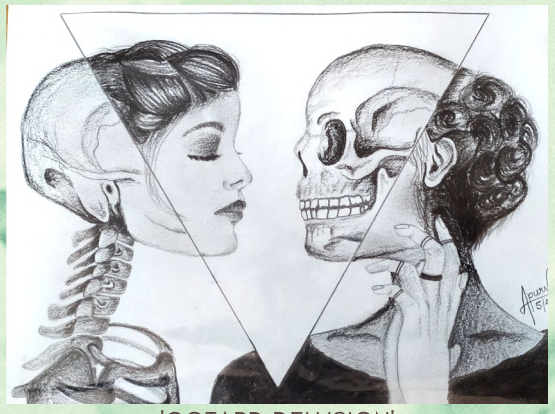
What we really need to ask ourselves is if this is how we want to continue? The simple truth is that the vast majority of the population seems to be misinformed about the trans community. If we don't understand the basics about transgenderism, how can we understand their problems?
This is one of the biggest reasons that prevents trans people from getting the medical care that they need and deserve. History has shown us the consequences faced by both doctors and patients due to lack of information or misinformation.

What is the solution then?
Should we be taught in greater detail about transgenderism and issues related to their health in our medical curriculum?

If you'd ask a transgender person, they'd most likely say yes. Who doesn't want a doctor that treats every patient kindly and makes a whole hearted effort to be understanding? The lack of solid data pertaining to the transgender community and the lack of awareness shown by doctors only increases the gap in making appropriate medical care accessible to the community.

If you ask me, a simple step of educating school going children about gender nonconformity and inclusivity can go a long way. Every person deserves to live their life with dignity, and a change in perception starts with each one of us. It is time for all of us to actively learn more about the transgender community. It is time to be an ally.

Pigment



'COTARD DELUSION'
Apurva Chaudhari
I M.B.B.S.

'BRUSHSTROKESINTIME'
Madhura Patil
I M.B.B.S.

'BUCK'
Mugdha Bichkar
II/III M.B.B.S.

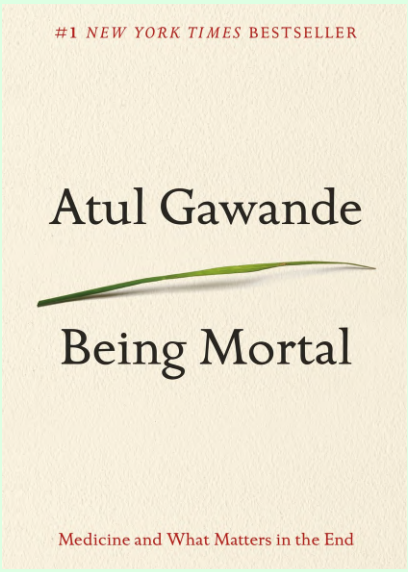
'INTO THE SEA'
Manasi Joshi
II/III M.B.B.S.

'HAND OF HOPE'
Sharvari Kulkarni
I M.B.B.S.

Being Mortal:

Medicine & What Matters In The End

Book Review by Anvesha Acharya, III/I M.B.B.S., B.J. Medical College & Sassoon General Hospitals, Pune



Dr. Atul Gawande's book is a reminder of our innate mortality and the frailty of human life.

An amalgamation of extensive research and poignant anecdotes, this book stays with you well after you've finished it. It begins with a brief history of nursing homes and living facilities for the aged and terminally ill. Describing the ghastly sights of old age nursing homes and their misplaced beliefs, he delves into the universe of an ever-evolving industry. As members of the medical field, our response is always to 'fix' what is wrong, to let science work its magic. Instead he asks us to look beyond geriatrics and gerontology, to look beyond what 'we' want and to shift our focus to the needs of the actual residents: the elderly. Through a series of interviews, we meet ordinary senior citizens to know their views, experiences, fears and attitudes. But this isn't your run-of-the-mill, matter-of-factly case history.

These are wholesome and heartfelt stories of the people around you- your parents, your grandparents, your neighbours. The ideology is simple- the failings of the various systems of your body should not dictate how you wish to end the story of your life.

Although the book is set in the USA, its values hold true here too. The author's grandfather was a centenarian who lived with his joint family in a village in Maharashtra. Today, as children migrate and families nuclearize, not many can dream for the same. Assisted living has found its footing in India. Top hospitals across the nation are preparing the next generation of doctors for elder care.

It is worthwhile to remember that the ultimate aim is not a good death, but rather a humane, dignified and fulfilling road till the very end.

The best kind of Salary

For a doctor, the most valuable payback for their work is patients' appreciation and their kind words of gratitude. Here's one such incident, **Dr Aizaz Khan** shared with us.

> In the initial days of my practice, I was building trust in my patients and they were just starting to rely on me for even itsy bitsy cases of cough and cold.
>
> A patient along with his wife came to me as a regular couple complaining of illnesses such as common cold. Eventually, when they found my treatment reliable, they opened up about not having a child even after trying for more than two years. The couple was concerned about the same and had completed previous treatments before but to no avail.
>
> I remember the time being important for a newly set doctor to build trust, suggest optimum treatment and continue further. I started their treatment and in a span of a couple of months, they conceived.
>
> The parents were happy after their baby was born and the first thing the father of the baby boy did was brought me a big box of sweets!
>
> The story didn't end here, he brought his wife and the baby to the clinic and invited me and my wife over to their house for dinner. That was the time I realized that even though I might have received a penny but to add to it, the love that I had received from the patient was unbelievable!
>
> Recently, they have been blessed with another daughter and this family of four has become my regular patient with both the kids still calling me 'Uncle'! This according to me is the best kind of salary!

Compiled by Shamama Khan, III/I M.B.B.S
Grant Medical College, Mumbai

If you have any such good appreciation notes or messages from your patients, please write to us about them at **thegreymatter.mimer@gmail.com**

Health Equity: A Basic Human Right

Vrushali Lahane, Final Year M.B.B.S.,
M.I.M.E.R. Medical College, Pune

Being a part of a medical college, almost everyone has had a glimpse of distress and anguish in the hospital wards. The frowned and dejected faces of kids visiting the hospital repeatedly for transfusions, a casualty patient dying on the stretcher because of late arrival owing to the remoteness of his village, the wretchedness of patient denying treatment; all this depicts the harsh and unjust reality of the Indian Health System.

Societal arrangements, economic structure, derogatory administration, defective management, depreciative principles are all contributing to the Emergent Situation of Indian Health Care. The doctor-patient ratio is decreasing at an alarming rate and to top it up the per capita expenditure of the Indian government is among the lowest in the South Asian region (1.4% of GDP). The 2002 National Health Policy recommends that public health investments and expenditures needed to be more than doubled in the next 5 years, but India has failed to come up with a proper plan of action for the same. The very essential priceless possession of Healthy Life has been turned into an economic commodity and basic needs turned into luxuries.

The National Health surveys show that the rate of hospitalization has very strong class gradients, near to about 10 fold. While the upper and most of the middle class can conveniently choose health services, the lower class doesn't even have access to basic health services. The 52nd round of NSS data shows 45% of the country's poor had to borrow money or sell their assets to meet the increasing cost of medical care. The major reasons being the sharp increase in the price of drugs and devices, consultation fees, hefty hospital accommodation bills, and sometimes precautionary medical tests. Every year nearly 4 crore Indians are pushed below the poverty line due to the expenditure on health care!

The majority of our population is being thrust into morbid conditions, disabilities, and even death due to curable yet untreated illnesses. This steep hike in health expenditure and health inequity is attributed to the ruthless privatization of health care over the years. It deepens the valley between the poorest and the richest worsening their miseries and hardships. Health inequity corresponds greatly to the social framework, geographic distribution, economical stratification, and at times political agendas.

The unequal geographical distribution of climate, disease prevalence, endemicity, working patterns posing different health hazards, and the unplanned distribution of services increase their hardships in access to care.

The Immunization coverage data holds 58% in urban and only 39% in rural areas. Besides, the physical distance, muddy unconnected roads, unavailability of safe potable water and sanitation gives the rural region a lower hand.

The public expenditure of the government also shows this disparity. Study shows that a number of the secondary level private institution were skewed in favour of the developed districts compared to the poorer ones. The control of disease and health coverage in urban slums has been the biggest challenge. The inclination of the rural population towards alternative care-seeking from quacks, magic, etc. makes the situation even worse!

Rural India has always been deprived of the appropriate health care over the decades. This attributes to our prime focus on big cities in the name of development and political manifestos being framed to please the upper and middle-class voters. This inequity spectrum varies according to the development status in states-economic, social, and educational strata. From a state struggling to provide access to nutritious food, water, and shelter to the majority, appropriate health care delivery is a challenge in itself.

Also, the miseries and hardships at Individual levels be it unemployment or social injustice makes the picture worse. Recurrent natural calamities also have a significant role in creating this disparity. A considerable bias is presently based on caste as well. Several studies suggest that health care utilization among Scheduled Tribes and Adivasi groups across states have been very low and immunization is a good indicator of such activities. The lack of connectivity, the gross difference in the cultures, diminished confidence in the government, negligence of authorities, unreformed systems, the prevalence of superstitions, quackery, and illiteracy put tribal populations in a place of inaccessibility for healthcare and other developments.

Health care is no exception for gender bias, with the majority of female illnesses going unnoticed and untreated. India accounts for 1/5th of maternal deaths in the world owing to perinatal diseases, nutritional deficiencies, and communicable diseases. The gender gap in healthcare access has widened over years from 2.6% to 3.8%. In many places, women tend to ignore their health and well being in the light of toxic Patriarchy. Domestic violence, lack of awareness about reproductive health, child marriages, lack of menstrual hygiene, and many such social norms push females to lead an unhealthy life.

The WHO, World Bank, Oxfam, government bodies, and social organizations need to work collaboratively for the equal, unbiased healthcare delivery across the country.

Encouraging and supporting the social sector interested in working for healthcare can turn out to be helpful. Fortunately, we have many NGOs and efficient doctors working for health provision in remote India.

Lastly, with wide and deep impact, we need systemic changes and a multi-sectorial approach. All the health care professionals need to participate actively in this fight against health inequity with the weapons of knowledge, empathy, and compassion! If patients can't afford to come to the hospitals, the health system should be able to reach their doorsteps! Public health institutions should be well equipped with dedicated staff. The emerging importance of people's participation has been highlighted in the current COVID scenario. Dr. Abhay Bang's concept of 'Health Independence' stands true, when people are empowered to manage their health, its delivery, and accessibility increases. Fairness, equality, and justice should hold the ground, turning the "Universal Health Coverage" goal in a reality!

PANDEMIC PREPAREDNESS

by Nishant Nagpal, III/II M.B.B.S.,
Dr. Vasantrao Pawar Medical College, Nashik

"By failing to prepare, you are preparing to fail."- Benjamin Franklin
In these unprecedented and testing times due to the COVID 19 pandemic, people have been obliged to stay home, avoid contact and isolate themselves. This has disrupted the normal functioning of the world, and has not spared the medical community.

When it comes to medical colleges, the pandemic has caused closing down of lecture halls, cessation of clinical rounds for students, shifting to a new online paradigm and halting of the timeline of the course by postponing exams. For medical students this situation has resulted in deterioration of an already low mental health. Lack of clinical exposure, loss of peer-to-peer learning, subpar outcome of online lectures has all added up to the ever increasing stress on the medical community.

For college professors, the sudden shift to a new dimension of teaching, using alien complex softwares and having to come up with a way to assess the students without face to face interaction has highlighted the weak areas of the Medical education system of India.

The fact that it is assumed that Medical students and professionals are available resources during a time of crisis like this, raises a few important questions. Are we prepared for a crisis situation like this ongoing Pandemic?

Do we have enough resources to train our medical students? Do we have efficient structure to provide such training? Does our curriculum cater to such special needs?

The answer to all of these questions is NO.

Our colleges are neither socially accountable to the community they serve to, nor does our curriculum acknowledge situations similar to the ongoing pandemic . Medical curriculum does not include public health emergency training. There is a distinct lack of community based services and awareness. The curriculum often does not address public health emergencies on a relevant scale to prepare the students enough. Yet they are often expected to volunteer considering they are the future healthcare professionals, which leaves them vulnerable to moral trauma and negative health outcomes.

Lack of a proper and tested communication model also reflects during online lectures with frequent interruptions and lack of interactiveness making them sparsely efficient.

All these problems can be solved by including Pandemic Preparedness, Global health crisis management and Communication skills across all grades in our curriculum. We as medical students need to advocate for these changes and evolution of the traditional methods.

The role of medical students as important stakeholders should be recognised by the authorities before planning out the curriculum and making changes at every level. Students should be involved in decision making as they are hit hardest. A baseline assessment should be done regarding knowledge and skills required during global health crisis. Proper analysis should be done of the data collected and then future changes should be planned accordingly.

As it is correctly said that an ounce of prevention is worth a pound of cure; such act of prevention will go a long way in benefiting medical students and the community that we cater to.

What Makes A Doctor!

by Pamposh Bazaz, II M.B.B.S., Raichur Institute of Medical Sciences

A lot of people, including me, were drawn to the profession of Medicine because of shows such as House M.D. Little did we know becoming a doctor is one of the hardest professions physically , emotionally and mentally, one can pursue. This maybe one of the most cliché lines you must've ever heard. Alas, it's true!

Just getting into medical school in India is rigorous. About a million appear for the entrance exam and only a few thousand are able to make it. The course puts you under a tremendous amount of stress and pressure causing a few students to drop out. The glamour of a successful practice tends to overshadow the overwhelming journey that every student agonises through.
So, if it is that hard, then why did I choose to pursue it? Why do thousands of us labour our way into Medical school? And to add insult to injury, why are millions willing to sacrifice their most youthful years to bury themselves under textbooks? In a country like India as a general rule, there are two possibilities. Either the individual's zeal overpowers the hardships or pressure of the society impels one through the course.

It's usually the former that counts for healthy motivation for one to make it through the entirety of the course relatively smoothly and they are the ones are truly happy with their professional lives. This marks the difference between a good doctor and an average one.
So, what essentially makes a doctor? Is it the ability to connect with people around you? Is it the ability to interpret situations and come up with the most ideal solutions? Or is it just to memorise things in a textbook and vomit it out in front of the examiner? In all honesty, everything I have mentioned above and a lot more.

I never really understood the meaning of empathy till I witnessed a doctor patient interaction. For a while I was under the impression that Dr. Gregory House's lack of empathy made him a better doctor but I couldn't have been more wrong. Calling empathy important is an understatement, it is imperative for doctors to be empathetic towards their patients so they can make decisions taking the patient's socio-economic standing, his/her mental and emotional state into consideration.

Every patient is unique and his case can come with its own set of challenges and it is doctor's responsibility to solve their problems. Herein, it is also important for a doctor to be stern with their patients. Empathy shouldn't turn into sympathy or it may cloud their judgement. I myself have witnessed patients and their relatives behaving recklessly risking the lives of the people involved and doctors being harsh, but fair, to make sure the patient lives to see another day.

When faced with adversity, time is of the essence, the quicker you solve the first problem the sooner you can move on to the second one, turn the blocks around enough times you might even end up solving the puzzle, but only if you make all the right moves, one haphazard turn and you might lose the patient. Hence, it is of utmost importance for a doctor to be able to perform under massive amounts of stress, performance anxiety should be left for the viva table and not the workplace. While trying to be quick on your feet, you must not turn reckless.

Everything that has been stated above are only worth something if the doctor is aware of what he's doing. I have sat for hours in the OPDs and followed senior doctors without having an iota of knowledge that they possess and yet I get treated by patients just as respectfully as they are. At times I feel a sense of impotence, and that feeling, I suppose, haunts every doctor at some or the other point in his/her career, to be incapable of helping someone who's in dire need of it. To avoid this nightmare turning into a reality you must have a thorough knowledge of what goes on inside the human body and what needs to be done when things go south, because when they do and you're inept to fulfil your duties, the patient dies.

Every doctor that I have come across has told me to study not because "you need to pass an exam" but because "you want to be able to save that one person in the OT. And the hundreds you see every single day." To become a doctor, one doesn't have to just dream it, one has to strive day and night towards achieving it.

Empathy, punctuality and efficiency are a few skills from a spectrum of qualities you have to imbibe in order to become a good doctor. Despite absence of certainty due to dynamic nature of the profession, you have to be certain about your expertise. The strength to accept things beyond your control and make the most out of every situation is going to set you apart.

Every day is a struggle, some days are better than others, but if you really want to know what it takes to become a doctor, just go to hospital and if you like the way it smells and the way it feels and if you crave the commotion; you'll surely persevere through it all.

> *"Medicine is where science marries art; where research marries creativity."*

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