The Patient is Dead: Continuing Medical Education and the Hidden Curriculum

Shaifali Bansal, People’s College of Medical Sciences and Research Centre, India

ABSTRACT

Most health professionals join their profession with an aim to do best for human suffering, fully understanding that reins of birth and death are not in their hands. It is possible that with time some begin to work mechanically and forget they are working with human lives. Then, one day a particular patient jolts a doctor from his or her slumber. This article follows a doctor/patient encounter and its attendant clinical complexity that is portrayed through a physician’s reflection, which examines if it is as simple as a patient dying.

Keywords: Death, Diabetes, Health Professional Education, Patient, Reflective Practice

INTRODUCTION

Following are the pages from a physician’s diary. The account illustrates how she grapples with organizational constraints, compartmentalization of medical knowledge, lack of integration in the care of the older person with complex needs and social constructs of the care of the older person. The author tries to analyze a particular patient situation in retrospect day by day and makes an attempt to express her feelings.

January 20

An elderly patient was brought to the medicine Out Patient Department (OPD) in a semi conscious state. Found to be diabetic 4 days back, he was profoundly dehydrated and in a state of Hyperglycemic Hyperosmolar Non-ketotic State (HHNS). His serum Osmolarity was 320 meq/L, pH 7.3, urine ketone negative and serum Creatinine 1.9 mg%. He had leucocytosis of 21,000 /cumm, but his Blood and Urine Cultures were sterile and fundus was normal. He was treated on lines of HHNS and after 48 hours his sugars were normal, dehydration was corrected and patient was afebrile.

January 23

Patient was switched over to Inj. Actrapid before breakfast & lunch and Inj. Mixtard 30/70 before dinner. I was on leave till January 26 during which time the patient continued to receive the same treatment.

January 27

It was my OPD day hence inpatient ward round was taken during lunch hours. During the round I observed that the patient had ptosis in right
eye. I asked for an ophthalmic opinion. For some reason not clear to me the opinion was not taken that day.

**January 28**

The following day I noticed that in addition to ptosis (III Nerve paralysis) IV & VI cranial nerves were also involved (Figure 1). On first thought it seemed to be cranial nerve involvement, common in diabetics, which generally recovers spontaneously and hence not always investigated further. But when my mentor asked, what is specific in diabetic III N palsy? I spontaneously replied theoretically - pupillary sparing. And as I simultaneously checked for pupillary sparing, I was shocked as it was not there.

So what are we dealing with?

Ophthalmologic reference was sent who said that there is no vision in the affected eye and further advised to get a neurologist opinion. I was not comfortable with the findings and on reading and searching found that Diabetic cranial neuropathy does not lead to loss of vision.

**January 29**

I was to be free today after ward rounds, free from OPD clinic and emergencies, free to ponder over this puzzle, read and make things clearer to myself. But that was not to be as I had to look after someone else’s OPD patients.

Anyway, neurological call was sent. I requested the consultant radiology for CT scan orbit and head.

That evening, before I left the hospital, I went to the CT room, “something in the maxillary sinus, swelling of superior rectus, medial rectus and some swelling of optic nerve sheath. Final report to be given tomorrow” I was told.

On my way home discussed with Consultant Ophthalmology. She said that they are building a case series on sinusitis leading to blindness and they probably got another case for the series.

**January 30**

Today is a round day of my unit head who feels I bore him on the rounds showing him dry, dull cases of endocrinology.

A teacher par excellence, he takes one look at the patient and asks me “are you dealing with mucormycosis?” I am stunned. It had not occurred to me till then, that this could be the reason behind his clinical signs. I rush with him to the CT scan room to ask the consultant Radiology if he feels there is some evidence of the deadly disease. “Not exactly” is the answer.

Till then Ophthalmologist has seen the patient. Asks for the CT films and Otorhinolaryngology review. My unit head asks me to get the patient transferred to Otorhinolaryngology/Ophthalmology. With the possibility of mucormycosis—I request Otorhinolaryngology consultant for urgent examination but am asked to send the patient post lunch. I send the patient to the ward for lunch. At 2:00 PM my ‘head of the department’ orders emergency meeting asking us to “Leave all ward work”.

Figure 1. Findings on examination of III, IV and VI cranial nerves
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