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Taking humanity out of the medical humanities: Doctors and Death amidst Covid-19 | Migita D'cruz

The physician's prayer goes:

From inability to let well alone, from too much zeal for the new and contempt for what is old, from putting knowledge before wisdom, science before art and cleverness before common sense, from treating patients as cases and from making the cure of the disease more grievous than the endurance of the *same, good Lord deliver us.*

Sir Robert Hutchison (1871-1960)

These are fine words indeed. But what do these words mean for us, as physicians, while we weather the novel coronavirus pandemic? And what do they signify for the medical humanities in these troubled times as patients and patient deaths are increasingly becoming numbers? And the single-minded focus has become to decrease the numbers from Covid-19.

Delaying life-saving treatment

A young man who had grappled, often successfully, with a mental health illness, over his lifespan, was singularly unfortunate to suffer a sudden and idiosyncratic toxic reaction to a drug he had tolerated well in the past. He was doubly unfortunate to suffer from the reaction, which evolved into a multi-organ dysfunction, during the lockdown period.

What this meant for him and his mother was that they had to spend days on the road, from their hometown to reach the state capital and our hospital. During this period, a wholly treatable adverse effect devolved into a life-threatening condition. He developed multi-organ failure and was struggling to breathe by the time he reached our psychiatric emergency services in a speciality institute in a metropolitan city. A long struggle ensued as I, and the other psychiatry residents in the emergency services, tried to keep him alive and breathing as we tried, desperately, to arrange for him the life support and dialysis services he required. It was unfortunate that he was sick at a time and place when the health care system had no extra resources to spare. Even as he struggled to survive, he did not develop the coronavirus infection at any point.

We had life support, but no facilities for dialysis, at our hospital. We tried, frantically, to contact our colleagues in other institutes, across the city, to arrange for him the support he required. Nearly all of the half dozen hospitals contacted refused him, as their services were either completely consumed by, or on standby for, patients suffering from the pandemic. Our patient's crisis of survival was clearly not a priority. The last hospital agreed to take him in and provide facilities for a dialysis.

The unfortunate man and his family had, by then, spent five days waiting for care that was absolutely essential to his survival. He received it, finally, only to linger for two more days and then die. He left behind a bereft mother grappling with the loss and with little resources available for his interment or, even, for taking his mortal remains home.

Ceasing "non-essential" care

I remembered the physician's prayer today, after over a decade, during our struggle to help our patient get the treatment he needed. He did not die of the coronavirus. All other things being equal, he might have had a better chance at treatment if he did indeed have the virus. He might, then, have merited more attention from a health care system that cannot seem to see beyond the coronavirus, just now. It made me wonder, is this justified; prioritising coronavirus patients in order to contain and deal with the pandemic, over any other health crisis in patients? How does one balance the needs of both?

The lockdown, and the other myriad barriers in the pathway to care that the global response to the pandemic has brought, means that patients who do not have the coronavirus infection often slip between the cracks of the healthcare systems.

Not only do patients with an immediate health emergencies require medical care, but even patients with chronic conditions such as mental illnesses require access to healthcare facilities forlong term treatment and regular monitoring. They are, however, now confined to their homes due to the shelter-in-place directive, since several weeks. They are unable to reach hospitals to renew their prescription, and this affects those below the poverty line the most as they are the most reliant on government hospitals for free medication. Indiscriminate travel restrictions and physical distancing mean that negotiating the journey from home to hospital is long and arduous. Physical distancing norms also mean that those who wish to travel have to stand for long hours in lines, several feet apart, to obtain travel passes from public administrative service officials, for scarce transport services, that seat fewer persons, to reach nodal centres, where the wait starts all over again.

Hospitals in most large cities lie in red zones and health care workers have been deployed to address the pandemic, even directly within communities creating an acute shortage of staff and resources of an already strained system. We, as physicians, have also been asked to cease non-essential services, which include the kind of therapeutic drug monitoring that might have been life-saving in this young man's case and helped several others in preventing them from reaching a crisis. Is this justified?

Counting losses

These successive lockdowns were planned with little planning of contingencies, and little regard for those suffering from non-covid ailments. Tele-consultations cannot replace hands on treatment. Did the government and public health authorities think that the country could be divided into only COVID-19 patients and the healthy? If so, then we have indeed succeeded in taking "humanity" out of the medical humanities.

Our patient was not just a victim of multiple organ failure, but a failure of a lopsided health crisis management. He and his family took half a month to navigate and access the required care what would have been otherwise a one-day bus journey. That he did receive dialysis,

finally, was due to concerted efforts to persuade our colleagues in other specialities. His struggle, and his death, served as a bitter reminder of how impotent we physicians often are, in negotiating the travails of the health care system. It was never a wholly friendly place before, and has become less so now, as we grapple with a novel infection. What the pandemic seems to have done is it has unmasked the field’s latent Darwinian and utilitarian leanings.

Seven months into the pandemic, I have, as a psychiatrist (a relatively low risk profession in times such as these) lost my first patient to the pandemic. It was, however, not in a manner or form that I expected. And now, I must deal with my guilt as best as I can. I look back and see nothing that I could have done differently for this young man. But I am part of the system that failed him. Perhaps what I can do, is talk so that others hear. In death then, may he have the justice that he did not in life.

In our response to the pandemic, as we enforce social distancing and a lockdown (such ugly words, these are now), have we, then, too much zeal for what is new and contempt for what is old? Have we put knowledge before wisdom, science before art and cleverness before wisdom? Have we forgotten about the well-being of our patients, while we scramble to control the number of cases? Does controlling the pandemic imply a Darwinian and Utilitarian approach? Does this not compromise the rights of the non – covid 19 patients? Are such approaches justified for the larger good? Is the larger good even benefitted? Have the processes to deal with the pandemic more grievous than the disease itself? And in the process, have the medical sciences set themselves apart from humanities and humaneness? The good Lord forgive us, it would appear that it sometimes is so.

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