

## **THE ROLE AND ROAD AHEAD**

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Esteemed Guests, Dear Friends !

At the outset let me thank the fellows of the IPS for having given me the honour of being your President in the dawn of the Millennium. Down the memory line, I recall my having enrolled as a student member of the IPS in 1973, when the organisation was just one tenth of what it is now. I have had my humble share of efforts and excitement in the growth of the Society and the pleasure and the privilege of sharing these with many of the elders and peers. After nearly three decades when the Society has grown in membership, stature and activities, it gives me immense joy to recall all these and assume this august chair with your blessings and good wishes.

It is customary to deliver a scholarly oration on a personally preferred theme as the Presidential Address. From Aggression to Zest or Antisocial Personality to Zoophobia I could see alphabets of topics and themes, but rolling over them it occurred to me, shouldn't I rather convey to my professional brethren the feel of the road I laid and travelled - a road that has not been well - lit or well - laid, nevertheless a road, I feel every psychiatrist, true to his profession would care to travel.

There was an incident near my home town some time back that disturbed me as a Clinician. A boy who was to be operated for a lump in a limb was subjected to a circumcision operation in a nearby Government Hospital by mistake. This created a hue and cry and the concerned surgeon and the nurse were charge-sheeted. The plea of the nurse was that it was the duty of the surgeon

to identify the patient he had to operate; even if the nurse had placed the wrong patient on the table had he done it, the mistake would not have occurred. The explanation of the surgeon was that it was a very busy surgical day in the hospital with too many patients, a long operation list had to be covered within the limited table - time available and there were frequent power - cuts. Then there was the indiscipline of the patients and the relatives, who would crowd in front of the theatre door and push in each time, irrespective of whose name is being called for admittance. Whether this line of argument would ultimately help the doctor to defend himself is not clear; probably not. Whether the combination of lack of facilities, surgeon's work overload, indiscipline of patients and power-cuts is sufficient and necessary to cause a mishap in a hospital? The former are stark realities in our hospitals and the latter, admittedly is infrequent. With more of facilities, professionals and resources are we sure, we can avoid such mishaps in our hospitals?

You may recall another incident, few years back in which the mother of a famous Indian film actress was taken to a reputed Neuro-surgical Centre in the United States to get a brain tumour operated. Unbelievable it sounds, the Neuro-surgeon operated on the normal side of the brain leaving the tumour on the other side. It is not clear from the news report whether he had extirpated the normal brain tissue on the normal side. Obviously, lack of facilities, tight working hours, long operation list, indiscipline of the patients and crowding of people at the theatre door - none of these

could be accounted for this ghastly mistake in that setting.

The existence of a Clinician with this mindset in the medical profession is a matter of concern to all of us. Albeit infrequent, it is a disaster. The medical profession in general and medical teacher in particular, can not but be deeply distressed. Hurt and haunted with each such instance, I yearned for a solution.

Admittedly, zero-error Medicine is an ideal and an occasional lapse does not merit an over-reaction or generalization. However, it is not the occurrence of a technical error, deficiency of skill, or dearth of man and material resources that causes most of these disasters in clinical care. Clinical activity is becoming merely routine and more ritualised. The surgeon sees the contours of the lump in the limb, the redundant prepuce or inflamed appendix, but not the person who comes or is brought with it. Procedure-orientation takes its toll on the clinician and the person-oriented Medicine recedes. The communication with the patient and the family members recedes and Doctor-Patient Relationship suffers. Communication with nurses and paramedical staff recedes and the essential team-work in medical care suffers. If that happens even in the well equipped resourceful clinical settings of the advanced countries where standards of care are monitored and upgraded by vigorous medical audit and legal surveillance systems, what about our country lacking such amenities and corrective mechanisms?

Whether a similar incident can occur in a psychiatric clinic i.e., whether a wrong patient be administered Electro-Convulsive Therapy, for instance? The answer, all of us prefer, is in the negative. We feel Psychiatry has an in-built immunity against such a clinical disaster.

If so, isn't there something in Psychiatry that gives us the potential and the mandate to help our medical colleagues to find a solution to the fragmentation and dehumanisation of patient care?

Stated simple, the answer I gained from my work and intend to share with you, is that the

psychiatrist is essentially the best teacher and guide to his medical colleagues in the pursuit of a holistic, humanistic clinical approach. Even when he is not occupying a formal teaching position or not able to conduct systematic training programmes, his clinical profile would serve as a role model for clinicians in other disciplines. The role a psychiatrist takes and the road he lays and travels have immense learning values for them as they liaise with him. To maintain that role model and to lay and travel that road, the psychiatrist, however, needs to address many issues, harness resources, modulate and mould his social and academic interfaces and groom himself.

### **Teaching Communication**

Communication in clinical settings and Doctor-Patient Relationships are emphasised in the context of undergraduate medical training, and continuing in-service training of doctors and other care-givers. The WHO enlists this as an important component of undergraduate medical training, but not many medical colleges in India impart it effectively to their undergraduates or postgraduates. The CME programmes organised by professional associations also do not usually take care of this training component. To a large extent, the satisfaction/dissatisfaction of patients and their families in hospital services depends on Doctor-Patient Relationship. Bad skills and bad clinical outcome result in medical malpractice or compensatory litigation, mostly when it is combined with bad feelings, originating from problems in communication and Doctor-Patient Relationship. With the spectre of consumer protection litigation looming large in the medical care field, Medical Profession in our Country is learning, the hard way up, the importance of attending to communication and behavioural aspects of Doctor-Patient Relationship.

Over the last few years in my institution I have been engaged in organising brief Training Workshops on Communication and Counselling for surgeons, obstetricians and emergency-care physicians. Important aspects of clinical communication and counselling have been covered with case studies in an interactive group-

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learning format. There may be other psychiatrists also who are carrying out similar exercises in their institutions/localities. But none of us have so far succeeded in mainstreaming this essential training for medical and paramedical personnel. In many corporate hospitals training courses for the staff on clinical communication are usually conducted by non-medical experts on communication. Granted their expertise in the concepts and skills of communication, my own feeling is, this training would be more effective if imparted by clinician-teachers with first person experience of clinical situations.

Though communication skills form an essential part of a psychiatrist's armamentarium, a systematic instruction on communication skills is not given to postgraduates in psychiatry in most training centres and some of us learn it out of personal interest and efforts. This lacuna can be corrected at the initiative of the Indian Psychiatric Society and postgraduate training departments. A psychiatrist well trained in communication skills and who keeps himself in touch with Internal Medicine and other specialities will be the ideal resource person for imparting this training to clinicians in these disciplines. The Indian Psychiatric Society can evolve a module and link up with the Indian Medical Association to develop an effective instructional programme on communication and behavioural aspects of patient care at the national level. It can be carried out with active co-operation of State Branches of Indian Psychiatric Society and the Indian Medical Association. In the formal Medical Education sector, the IPS can take it up with Medical Council of India and through Departments of Psychiatry of Medical Colleges the training can be carried out. The Department of Psychiatry should take interest in Behaviour Medicine and develop active clinical liaison with Departments of Internal Medicine, Surgery, Obstetrics & Gynaecology, and basic Specialities. To reflect the interest in Behaviour Medicine, it would be appropriate if all Departments of Psychiatry are designated as Departments of Psychiatry and Behavioural Sciences. The role of a specialist in Behaviour

Medicine would enable the psychiatrist to sensitise other physicians on the importance of communication and impart essential skills of communication that can be applied in the day-to-day clinical work. Helping to attenuate the estrangement and mistrust unfortunately growing wide between the disheartened medical profession and the frustrated ailing population through such an effort, this would help the psychiatrist to serve a great public cause in our health care system.

### **Training Clinical Counsellors**

Counselling and Psychotherapy are gaining wide currency in our country, thanks to the mental health education through the mass media. Psychologicalisation of all psychiatric and psychosomatic disorders builds up a set of new superstitions on the omnipotence of Psychotherapists and Counsellors and tantalize the public and general medical practitioners. This untoward effect notwithstanding, there is a genuine strong felt-need for Counsellors within the medical care services. Training courses on counselling are conducted by several institutions to capitalize on this. These courses, including many of the ones conducted by University Departments consist of didactic theoretical instruction combined with just a few clinic visits. Lacking participatory clinic-based practical training of any significant duration, the candidates coming out of these courses do not develop the competence to do proper clinical counselling. Irrespective of whether they are termed Student Counsellors, Family Counsellors or Addiction Counsellors, often they are projected as Clinical Counsellors and Psychotherapists and, unfortunately are perceived as such by the public; worse still by other clinicians. This is an unhealthy development in our present health care scene that is harmful to the public. Clinical Psychologists, Psychiatric Social Workers and Psychiatrists should come together to counter this menace. Postgraduate Departments of Psychiatry can take up the task of training Clinical Psychologists and Psychiatric Social Workers, if they have faculty members from these disciplines. In the institution where I work, Post Graduate courses have been

started for training Clinical Psychologists and Psychiatric Social Workers. Despite many difficulties and lack of resources the experience of running these courses has been encouraging. The best part of it was that the intractional in-patient and outpatient work widens the clinical vision of postgraduates in Psychiatry. I feel such training initiatives need to be taken in Postgraduate Training Departments all over the Country; so that properly trained Clinical Counsellors are available in medical care settings; where their need is increasingly felt.

### **Long Term Perspective in Medical Care**

Medical students in our country are largely drawn from youth who are insulated in their childhood and adolescence from any situation of pain and helplessness, including that caused by diseases and disabilities. Understandably, most of them come to study Medicine, lacking the empathy to understand and handle pain and suffering and the sensitivity to perceive the psychological and socio-cultural aspects of life. Undergraduate Medical Education in our country does not include any content or mechanism to impart to the student such a sensitivity and empathy. Without these they go out into the community to practice the healing profession. Our efforts to improve the undergraduate psychiatric training to correct this lacuna has not met with any significant success, thanks to the lethargy and inertia of the Medical Education Establishment at every level. In this situation, initiatives and efforts at the individual teacher and individual institution level seem to be the only workable programme. A Psychiatrists in the Faculty can effectively use his clinical rapport and liaison with other medical teachers to develop instructional collaboration and integrative teaching to remedy this serious lacuna in the training of our undergraduates.

The clinical spectrum of many medical diseases and the nature of medical burden of society is also fast changing. The over bearing reality of many medical afflictions, including trauma, for the sick person, his family and society is what it holds in the long term. i.e., Disability Adjusted Life Years (DALY). The importance of

psychological, behavioural, socio-economic and cultural factors in DALY cannot be over-emphasised. Our medical training that has all along been oriented to cross-sectional evaluation and one-time management of clinical situations has become insufficient for training clinicians with appropriate orientation and sufficient competence to practice Medicine with a longitudinal perspective of illnesses and disabilities.

The pursuit of a profession in Medicine destines its practitioner to be with and take care of the sick, weak and helpless, when the rest of the society channelises its energy and efforts in the pursuit of progress, prosperity, pleasure and happiness. The allowances and consideration given to the sick person in the acute stage of an illness drain away over a period of time, but the clinician and care-giver cannot disown and discard the patients, clustering and lingering in the clinical services with chronic disabling diseases. A philosophy and commitment to take care of these individuals is precisely the essence of long term care and rehabilitation. The traditional Indian has the time and mental space to take up the task, but the wave of socio-economic changes and the dearth of resources are bound to render these insufficient or even irrelevant. Rehabilitation programmes all over the world are suffering as much from lack of an intrinsic source of enduring commitment and energy as the dearth of extrinsic resources without either of which no caring system can sustain itself for long.

India has witnessed how the disability of an oppressed and deprived people was galvanized into a vibrant socio-political movement for Independence by the Father of the Nation. The Gandhian social reconstruction model of decentralized local self-governance provides the best strategy for disability care and rehabilitation. Through Panchayatiraj Programmes and People's Planning Scheme self-governance is being implemented in various States of the Country. The thrust in these programmes is mainly in the development of essential physical infrastructure and providing essential living amenities to people. As part of the People's Plan Campaign in Kerala

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we have been trying to initiate Psycho-social Rehabilitation Units with modest institutional and complementary community programmes, termed Sradha Bhavan Project. However, to educate the people's representatives and to motivate them to include Psycho-social Rehabilitation as a component of People's Plan Projects has not been an easy task. But, such projects seem to offer the best prospect for the care of the mentally ill, possibly feasible as the Panchayati Raj institutions gain strength in the Country.

### **Technology at Optimum**

Technological advances that enrich clinical and therapeutic intervention have empowered the practising clinician in every branch of medicine, including psychiatry. The biological substrate of major psychiatric disorders are being delineated and new generation psychotropic medicines that are more user-friendly are bringing up the Quality of Life of our recovered and remitted patients. Over the two decades the psychiatrist has emerged as a Clinician with a therapeutic power and precision that match well with his colleagues in other disciplines. However the convenience, halo and hangover of this empowerment, over a period of time, may cause some clinicians to be indifferent to the psychological and socio-cultural antecedents and determinants of morbidity and disability.

Psycho-social and ethno-cultural factors are not abstractions in psychiatric work. They are essential ingredients of a good quality clinical approach in any branch of Medicine, but more so in the Medicine of mind. It is possible that sometimes these are likely to get relegated into the background, in the wave of psychopharmacological and imageological advances and consequent empowerment of the Clinician. It would be quite unfortunate if this happens.

Evidently every clinic needs a window into the socio-cultural realities of the outside world, and every clinician the sensitivity and ability to maintain the glimpse through this window. The Siberia of our times, spelt different i.e., Cyberia, is a cause for concern or educanists, mental

health professionals and social scientists. From Cyberophilia to Cyberomania, a full glossary of Cyberopathy is probably awaiting the psychiatrists. Among other factors of the evergrowing tide of Cyber-medicine may catch a clinician also on the wrong and obliterate his vision of the society. The window in the clinic wall may get eclipsed by windows in the monitor; data bases may replace the clinician's direct perception of the dynamics of individual and social living. If a dense cyber-interface descends between the client and clinician and hinders the essential human transaction in the clinic, Medicine would become sub-fertile and Psychiatry sterile. Not that it happens or bound to happen in a large scale, but a note of caution may not be out of place.

### **Holistic Clinical Approach**

There is much talk and some efforts for integrating the Indian system of Medicine (Ayurveda) with Modern Medicine. Much of this is rhetoric, though there has been some genuine efforts; but very few ones with enduring results. Operational difficulties in integrating these systems and the mutual antipathy notwithstanding, some conceptual aspects of Indian System of Medicine need to be made familiar to the students and practitioners of Modern Medicine. The emphasis on Health as much as on disease, attention to preventive and promotive facets of Health Care and the framework of an interactional therapeutic process-in short a broad Bio-psycho-social concept has been contemplated in Ayurveda, centuries back.

Ayurveda conceives the treatment process as having Four Limbs ('chathushpada') viz : the physician, the drug, the care-giver and the patient. All these four limbs are to be united constructively for an optimum therapeutic outcome. The physician designs the treatment regime and unites the other three in the treatment process. The qualities of a good physician are narrated at length in the text, so also are the qualities of a good patient, good care-giver and good medication.

Psychiatric clinical practice by its very nature often takes care of these four factors. In sense, in Psychiatry we have a real interactive

substrate in its day-to-day practice. Any psychiatrist who does justice to his training and discipline is bound to keep such a framework in his routine clinical service, whether he is aware of it or not.

It is notable that this model of clinical care contemplates a dynamic operational framed work for an interactive therapeutic alliance, not just between the patient and the physician, but includes other care-givers also.

The model of Doctor-Patient Relationship and clinical team work predominately practiced in Medicine has been the activity-passivity hierarchical model. In this, the physician is active and the patient is passive; the physician decides and dictates, and other care-givers obey. While this is acceptable and, may be unavoidable in the acute stages of illnesses, during the follow-up and maintenance stages, since it fosters feelings of helplessness, passivity, dependence, apathy and amotivation it is ineffective. In most of the psychiatric, psycho-somatic and chronic medical diseases a dynamic interactive therapeutic alliance involving the care-givers, the patient and the family members in a long term perspective would not only be effective, but essential too. The patient and the care-giver need to work together under the guidance of the physician rather than remain a passive object and a nursing aide respectively, in the treatment process. The dependence, alienation and dehumanization that are bound to occur in the patient during prolonged treatment with activity-passivity model would be minimized or eliminated by this participatory interactive treatment process. The preventive and promotive aspects of health care also would be best served in the latter model.

'Holistic Medicine' is a gaining wide currency and gathering momentum. At times, it originates from a genuine wish on the part of a well-trained, committed clinician to transcend the barriers of his techniques and reach out to his client as a human being. Often times, it is a populist tactic, resorted to by charlatans and manipulative practitioners to tantalize the public and expand their clientele for professional

prosperity. In any case, the movement is gaining ground as an alternative to modern medical care. What draws people to this could well be, among other reasons, the alienation and frustration they had experienced at the circumscribed, symptom-bound, non-participatory, mechanistic medical care in most of the conventional clinics of Modern Medicine. Though this drift satisfies their psychological needs for some time, in the long run it does not serve them well as relapses are recognised and handled late. What is desired is to evolve mechanism in the practice of Modern Medicine itself to incorporate holistic principles effectively. Much of what people appreciate in the so called 'Holistic Medicine', is the psychosocial and ethnocultural sensitivity and approach that they miss in the conventional medical clinic. This forms an essential ingredient of clinical approach in Psychiatry. Similarly, the participatory dynamic model of therapeutic relationship conceived in Ayurveda and perceived positively by the people of this country, more or less exists in psychiatric practice. In conceptual and operational aspects psychiatry cannot but be holistic. The primary physician and specialist in Modern Medicine would succeed in gaining the confidence of their long term clients if they seek the role model of a balanced psychiatrist and incorporate holistic principles practiced in the psychiatric clinic. The psychiatrist, in his turn, stands to gain by integrating the basic concepts and life - style approach of patient care in the Indian System of Medicine, Ayurveda so as to live up that model role.

#### **Ray of Hope and Sustenance**

The intrinsic spirituality of the Indian mind finds expression in many clinical situations. The rituals, festivals and offerings apart, there is something in the Indian Mind that accepts the Providence with grace and humility, and accepts the clinician as the gift or agent of that Providence with trust and gratitude. In every family we find care-givers who understand, accept and even help the clinician in times of his uncertainty. Situations abound in clinical work when we realize that the Receptors of Love, on which our Self acts, are as important as the receptors in brain synapses, on

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which our drugs act.

Long back we have been made aware of the 'Politics of Experience'. It seems Economics of Experience is probably what concerns Psychiatrists most. Psychiatrist has the necessary and sufficient material to learn the Economics of Experience which essentially is Economics of Emotions. Given the importance of emotions in Medicine, the Psychiatrist who deals with Economics of Emotions and the Receptors of Love, all along his professional pursuit, emerges as a natural guide and teacher to a modern clinician who is discovering the closeness of relationship between Love and Survival.

### **Summary**

Much of the contemporary stresses and

crises in the practice of Modern Medicine arises from the inability or failure of the clinician to maintain the psychological and behavioural dimension and the long term and life-style perspective in clinical care. The Psychiatrist, if he moulds himself with regard to the different facets of clinical role indicated above, would emerge as a Teacher and Guide to his clinician-colleagues. Grooming the facets of this clinical role, drawing from the resources of the society, culture and his own Self, the Psychiatrist can lay the road through which he can lead his professional brethren in other clinical disciplines to a genuine Humanistic Holistic Medicine. This is precisely the Need of the Hour in the practice of Modern Medicine.

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