Health and Medical case study

Student’s Name

Institutional affiliation

Health & Medical Case study

Case study: Narrative Medicine: A model for empathy, Reflection, Profession and Trust.

*What is particularly troubling you about this case?*

The case described highlights the wanting discrepancy within medical practice to relate a patient’s suffering to healthcare provision; serving to impair the efficacy of medical practice. Traditionally, the field of health and medical practice was connoted with detached caregiving – an approach which has since been refuted by scholarly research. Where healthcare practitioners fail to identify with the patient’s plight, the implications on quality of care given are profoundly negative. Such detachment in caregiving is a recipe for wrong diagnosis, shallow scope of intervention and non-compliance in medical practice (Charon, 2001). The absence of engaged caregiving in health practice is thus of concern.

*What ethical issues loom at large in the case?*

Among the grounding principles of healthcare practice is beneficence. This ethical standard defines and outlines a moral obligation for physicians to act in the best interest of their patients (Nandi, 2000). To this end, it becomes imperative that physicians relate intricately with their patient’s condition to ensure their interventions result in optimal benefits to patients. Detachment in caregiving incapacitates the physician from fully understanding the scope of ailment and resulting in poor healthcare interventions – negating the principle of beneficence. Autonomy is yet another critical ethical principle framing healthcare and medical practice. This establishes the need for treatment to prioritize the patient’s needs and preserve their privacy. Narrative medicine by involving the publicization of healthcare interventions by physicians on media columns and journal articles violates such privacy. The autonomy of the patient in narrative medicine is thus put on the line raising pertinent questions on the measures taken to preserve their autonomy.

*Who are the persons of interest featured in this case?*

The patient can be distinguished as the most important stakeholder within the case. The case reveals the depth that healthcare intervention should seek to acknowledge to successfully contribute to desired well-being of the patient. It identifies that patient treatment should not only encompass a physical and physiological dimension but rather a psychological one as well; offering emotional and mental support. The duty of physicians in providing effective healthcare interventions is addressed in detail within the case study amplifying their role in the subject matter. The case also explores the role of society in contributing to healthcare – making it an important interest group. For instance, Ms. Lambert’s sisters had wrongly invalidated her fears regarding the son’s health. The community thus can be addressed as an important interest group in improving therapeutic interventions for patients.

*What is the harm done? To whom?*

When healthcare intervention fails to address the context, patients are negatively impacted. Healthcare intervention devoid of the physician’s authentic concern fails to address critical issues rendering it ineffective. For instance, it may result in misinformed diagnosis. More so, it is shallow in focus failing to explore various alternatives and dimensions of care (Charon, 2001). While effective treatment should serve to offer the patient with hope and contain their anxiety and distress, this is often lacking where the physician is detached and the community alienated from the patient.

*What are the interests or preferences of the stakeholders?*

Three important stakeholders are identified within the case; the patient, physician and immediate community of the patient(society). The interests of the physician are enshrined in their duty of care to patients which seeks to contribute to meaningful healthcare and promote the health outcome of the patient. The patient’s interests revolve around containment of their anxiety resulting from the ailment and the assurance and hope of well-being. This is a duty placed majorly on the physician and the society. The community on the other hand seeks to ensure that healthcare practitioners provide quality care conveniently and affordably without taking advantage of patients to seek financial gains.

*Do you have any sympathy for any person or group featured in the case? Why? Why not?*

Yes-(The patients)Ms. Lambert and her son.

Ms. Lambert has for long grappled with fear of her son falling victim to Charcot-Marie-Tooth Disease. She herself has suffered the condition for her entire lifetime and understands the magnitude of uncertainty and agony her son is up against. The fact that her son had enjoyed good health for over seven years only serves to aggravate the situation. At full blown, the implication of the disease on the boy’s life will be profound since it will necessitate a great deal of change to his daily activities seeing that he might be incapacitated to carry out basic chores. This can be extremely hard for a patient to grapple with and could result in trauma and depression.

*What lessons can we learn from this case study at an individual level, institutional level and societal level?*

Healthcare intervention transcends the boundaries of patient-physician interaction. While the duty of physician in contributing to the well-being of patients is amplified, the community also plays an integral role to this end. Medical practice requires to cultivate constructive collaboration between physicians and individuals and the society at large. While there’s need to demand accountability of physicians to patients, mutual trust and alliance is requisite in framing such engagement between the community and physicians (Charon, 2001). More so, just as physicians, individuals and the society at large need to demonstrate empathy in engaging with patients providing them with mental and emotional support.

*Should the main situation your case study addresses be allowed to continue unabated? Why? Why not?*

No. Medicine as a practice is founded on the duty of care physicians are obligated to their patients. The aim of healthcare intervention should be to promote the well-being and general welfare of the patient. To this end, an authentic compassion and localized approach in defining the extent and implications of an illness is necessary (Charon, 2001). In its absence, the quality of care provided is bound to be deficient and ineffective. It is necessary that the physician fully understands the scope of illness, relate to the patient’s fears and most importantly, demonstrate empathy and offer hope of well-being to the patient. With current healthcare practice ailing from detached caregiving, it is of interest that feasible and practical solutions be devised to improve healthcare provision.

*What, if anything, would you like to be different if we were to prevent such unethical acts from happening again? What options do we have? What are the consequences of the options? What is/are the best option(s)?*

The practice of detached care giving is largely unethical and negates the principles of medical practice. Physicians need to be more engaged with patients forging an intimate connection that results in authentic concern and compassion for the patient’s plight. To this end, various alternatives may be explored. First, there is need to establish a sense of purpose in healthcare intervention (Cheney, 2019). This will help in drawing important interconnections between caregiving practices and their implications on healthcare outcomes. In so doing, a patient-centered approach to caregiving is made more feasible and practical. More so, there is need to eliminate systemic and structural barriers that plague care giving (Cheney, 2019). Eliminating such barriers forms a stable ground on which a new patient-centered model of caregiving can be founded upon. Toxic environments that impair physicians’ competency should also be addressed. While each of these alternatives has significant capacity in solving detached caregiving, an absolute solution to the practice is not existent. To realize the full scale of narrative medicine, an intersection of these solutions is necessary.

*Using ethical theories and principles we have discussed in class, justify this/these options?*

Medical practice emphasizes on the principle of beneficence; the obligation of physicians to provide the best care for patients. It is thus imperative that mechanisms to maximize the capacity of physicians to offer optimal care to patients be instituted. Non-maleficence; the clinical ethic that prohibits unnecessary harm; requires optimization of care and criminalizes harm to patients through omission. Detached caregiving is in essence an omission that may result in harm to the patient through shallow intervention. Maximization of efficiency of healthcare systems to support engaged caregiving is thus paramount. Autonomy as an ethical guideline to medical practice requires respect for individuals. While this is mostly applied in the interest of the patient, it should be extended to cover the physician from toxic work environments that derail caregiving.

# References

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