HOSPITALity: clinical detachment and Eastern hospitality

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There is something removed and distant about the practice of medicine, it's felt most in the word "clinical". We use 'clinical' to describe thought or behaviour which is very logical and does not involve any emotion, strictly objective. Plain. Simple. Even unattractive - like in the example of 'clinical furniture'. Cold and detached - like a if a mother had a 'clinical' attitude towards her children. Yet clinical is also meant to refer to the work done with real patients or the medical treatment given to patients in hospitals. Real patients with real emotions and incredible vulnerabilities who turn to public health with credulous trust are met with this cold clinical course.

The moment I stepped into the clinical space, bold Arab-Muslim presence and a slight western-Sydney twang to my accent, I felt the beginning of what would be a career of pressure to withstand a western-medicine meets eastern-hospitality contention. I first noticed this during a rehab ward placement as a student in Wyong, a region with a reputably and substantially high rate of alcohol misuse presentations compared to the national rate. Coming from a home of a strictly practicing Muslim family where alcohol use is forbidden, in a community with predominantly other Muslim families, with friends and neighbours who were also Muslim - I had never previously been exposed to alcohol consumption, let alone the devastating social consequences of its severe misuse. My first university "medball" was the first time I smelt alcohol, I remember this distinct sharp vinegary smell, the sticky bathroom floors and losing a peer to a drunken toilet stall nap mid-event. After that culturally immersive experience, I'd decided that scenes with clinking glasses and flowing bubbles were not suited to me and I abstained mostly from the sights of young adult binge drinking lore.

Avoiding confrontation with alcohol did not last long when I landed onto the Drug and Alcohol ward. I remember a particular patient, 40-something, mother, who was bouncing in and out of the rehab unit with voluntary admissions prompted by her partner leaving her at the wards entry and driving away to drop their two young children to school. I felt her isolation. This was a young woman in need of dire help, and she was met with this rotating roster of junior doctors, jaded rehabilitation nurses and an understandably worn-down husband. At this point, all the disulfiram (an alcohol dependance medication with the trade name 'Antabuse' that makes you feel ill when you drink alcohol) in the world, all the clinical protocols, policies and guidelines were not enough. Notwithstanding my limited scope and understanding as a student, and acknowledging that I had and still haver a very superficial understanding of this case and its load on a multidisciplinary level,

I still believe the clinical nature of Western medicine and the lack of hospitality in practice contributed to this woman's outcomes.

Hospitality in Middle Eastern culture is a not just a social norm - it's a moral obligation. It's deeply established roots are reflected in medicine and it's practice. When I learnt I loved general practice and family medicine, it was because I was seeing eastern hospitality in medical practice. In a clinic older than I am, run by a Lebanese-born, Crimea-trained General Practitioner, I was overwhelmed with the human emotion and level of connection this single doctor was able to establish with his hundreds of patients.

Medicine is a product of culture and power.

While there is plenty of literature on "eastern medicine" (referring to mostly Chinese medicine and predominantly funded by the capitalist mass interest of Western health insurers in high marginal profits), there isn't a lot to say for how Middle Eastern medicine is a representation of identity and collective emotion. Here's what I gathered from 18 months of junior doctor-ing in South West Sydney at the very hospital I was born in:

RHAZES AND ARABIC MEDICINE

HEALING AND FOOD

Saturday shifts at my base hospital are notorious for a huge influx of family and friends circling the carpark looking to take role in a crucial component to patient recovery - community healing, its strongest vessel being the home cooked meal or the tray of syrup drenched sweets. Food and healing are well connected. Even in a Western clinical sense, we know that the sooner patients can eat post operatively the better their outcomes and recovery. I'd like to humbly think that best practice of the hospital food service model originated from Arab and South Asian patient families bringing in plates of food, bags of locally grown fruit and cellophane wrapped baklava and the renowned effect it had on the patient and all the ward staff - but I acknowledge this anecdotal evidence is limited.
The most beautiful impact this culture around healing and food has, is on its local, born and bred staff. I will never forget the moment my registrar came to me wide-eyed from the tea room and stuffed a piece of cake in my mouth with "please, please, try my mother in law's namoora".

SPIRITUALITY

In a catchment of ethno-religious patients, it was not unexpected to find patients using hymns, Quran recitations, hanging images of holy fathers and saints in the rooms to instil a sense of home and safety in the unprecedented uncertainty of acute illness. What was unexpected was how much patients were willing to share that vulnerability and extend their prayers on to me - when I knew it was them who felt the most in need of prayers. When I walk into a room with a Muslim patient, I like to greet them with the familiarity they know best:
As-saalamu alaykum (Arabic: اَلسَّلَامُ عَلَيْكُمْ, as-salāmu ʿalaykum) - 'Peace be upon you'
There's a palpable sense of relief when they instinctively send peace upon me too, before even looking up and seeing someone who could very well be their neighbour or pray next to them at the mosque or know their grandchild from when we attended school together. I've left many a grandmother's bedside after a brief review or a task as simple as collecting their blood, for them to send blessings my way, praying to God that I stay safe, that I am blessed and prosperous whatever I do - and that of course, I'm blessed with children! It might just be the eloquence and beauty of the Arabic language, but it never fails to make me smile.

While the bonds of spirituality in medicine are fortified in communities where doctors and patients can share a common ground - it has been to me as equally moving in all faiths. A long-stay patient on paediatrics with a terrible pneumonia spent most nights miserable with worsening shortness of breath every time he tried to lay to sleep. In the early weeks of his admission, I recall him using his headphones at night in what I assumed was some sort of insular activity of sensory overload to drown out the beeping of cardiac monitoring and distract himself from the pain. One night he became so anxious he didn't plug in the headphones and sung the hymns out loud. He was an alter boy, and the hymns were his prescription anxiolytic.

COMMUNAL CARE

The enlightenment of Western medicine saw the development of medical ethics and the codification of medical practice, with an emphasis on the doctor-patient relationship, informed consent and autonomy, and professional standards. Autonomy in my patient encounters, is a communal experience (as bizarrely contradicting that sounds). Family updates and family meetings quickly became the crux of my geriatrics rotation of my internship. I distinctively remember the internal conflict brewing within me, learning of patients with frequent presentations linked to a families dwindling capabilities to deal with the demands of dementia and florid delirium but steadfast in their attitude to continue to try to care for them from home and outright refuse external care. It was frustrating and inspiring at the same time. I could see how dementia chipped at the person inside the patient, and at the bonds and connections with their family.
In some cases, communal autonomy comes a patient centred approach and a family obligation to honour that autonomy, even in circumstances where those interests are at odds. There was something very rewarding about building a patient back to a point where they felt powerful enough to fulfil that autonomy. Sometimes the endgame wasn't the cure or even finding an answer, but my registrars quickly taught me it was the advocacy on behalf of a patient to get them where they wanted to be.

CONCLUSION

I'd like to think the intersection of my identity and culture with medical practice has lead to a wholesome experience in my early career. I am still affronted by situations where the sterility of Western medicine challenges the over-familiarity of my upbringing, but I see a future for Middle Eastern medicine - if not in this district, then just in the humble walls of my own practice some day. Inshallah (if God wills) says grandma in Bed 7B!

RELATED LITERATURE

Alcohol attributable hospitalisations by sex, HNECC PHN, NSW 2001-02 to 2014-15; alcohol attributable deaths by PHN, NSW, 2012-13 (Centre of Epidemiology and Evidence NSW Health.
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