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REFLECTIONS

Just the diagnosis is never enough!

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Abstract

Medical schools train us to be brilliant academicians and diagnosticians. But as physicians, we must never belittle patient communication nor be inconsiderate in our approach to patient care. Communication as a skill gets neglected in postgraduate training as young doctors chase procedural and diagnostic excellence. It is high time we make amends.

Keywords: *Medical education, communication skills, empathy, emergency medicine*

"Fall from height with traumatic quadriplegia and type 1 respiratory failure", "spontaneous massive intracranial hemorrhage"," inferior wall myocardial infarction" were the first few diagnoses I made just 15 minutes into my shift. What may appear as pandemonium for some is nothing but routine for an emergency physician (EP). As I look around at the chaos, I always like to evaluate the Emergency department (ED) floor from the centre, my mind slowly scanning each face and their "diagnosis". "Corner bed acute gastroenteritis no warning signs, next, isolated limb trauma no vascular injury, repeat vitals soon" and so on, till I reach the last bed. I am content when I can picture each patient with a diagnosis and a plan of action. There is a method to the madness, at least this was mine, and in my short practice, this approach has served me well.

A diagnosis usually is, or should be, followed by counselling of patients and their relatives "Spontaneous massive intracranial hemorrhage" gets translated as a big bleed in the brain and, in general, a poor outcome. Often breaking a grave diagnosis would have to be reiterated multiple times as the patient's kin take time to comprehend and accept it. The gravity of the situation usually takes time to set in, and as EPs, we try to be direct with short, time-restricted conversations before we move on to the next patient. We do not have the luxury of counsellors or social workers helping families to cope. With the requirement of prolonged ICU care and dismal outcome, the families usually have some tough decisions to make. Most emergency departments are not equipped with counselling rooms, and hence, these emotionally charged conversations usually happen at the bedside or in the corridors. While I am explaining the dire circumstances to the families, my eyes are constantly shifting — peeping at nearby monitors of another sick patient or making the diagnosis of the next patient.

Emergency Medicine (EM) is a time-based specialty where rapid decisions, often life-altering, are made by the dozen. It requires an EP to be able to shift attention from one case to another swiftly and not get bogged down in the details. Blood, vomit, and death are routine and a part of our training encompasses that; what gets overlooked is communication skills and an empathetic approach. As medical students, we have heard ourselves exclaim *"Yaar, woh murmur waala case kahan hai ?"*, and as physicians, we pride ourselves on making a prompt and precise diagnosis; but often fail to acknowledge what it does to patients and families. We seldom give them time to grasp the reality of the diagnosis and pressurise them to make critical decisions, in spite of knowing the financial burden posed by healthcare. "Your son's scan shows a massive bleed and he will be comatose for life," is usually followed by "should we shift him to the ICU?" "Your father seems to have a brain tumor, we'll require more tests to confirm but it is not looking very good. You can speak to the oncologist for further details." We have all been guilty of being robotic many times while disclosing grave outcomes, exhibiting our detached and nonempathetic selves. As an EP, it would be careless of me to centre my attention on one narrative, while the other patients and their equally distressing stories pile up around me. However, sometimes I do wonder if we use our trademark excuses, such as lack of time and overcrowding, to not do justice to patient communication nor have an empathetic approach to our patients and their families.

The Indian medical education system has, for long, excluded communication training from its curriculum, a skill recognised in the West. The Medical School Objectives Project, an initiative of the Association of American Medical Colleges (AAMC) urged faculties to teach interpersonal and communication skills (1). The Accreditation Council for Graduate Medical Education (ACGME) and the American

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Board of Medical Specialties (ABMS) include communication and interpersonal skills as a benchmark for certification (1). Despite this, Rising et al demonstrated that a whopping 62% of EM residents in the United States felt that the medical school training had "not at all" prepared them for having conversations regarding diagnostic uncertainties and the majority of the training was described as "informal" (2). The situation is unsurprisingly grim in India as well. A survey of surgical residents across four medical colleges reported that 81.7% did not receive any training in communication skills, and in emergency surgeries, 32% of the residents spent less than one minute conversing with the patient (3).

Another important aspect of communication often not considered is the quality of the dialogue. In an oft-quoted study of the 1980s, Beckman and Frankel reported that, on being asked to share their complaints by a physician, patients were interrupted and redirected after a mean time of just 18 seconds (4). A similar study done by Marvel et al found that the patients' completed their initial complaints in only 28% of the interviews, and the physician redirected patients after a mean of 23.1 seconds; once redirected the description was seldom completed (5). The consequences of incomplete history, especially in the ED, may be disastrous.

However, a silver lining to this is the implementation of a structured programme named Attitude, Ethics and Communication Module (AETCOM) by the Medical Council of India in the undergraduate curriculum. This is a case-based approach offering a competency-based learning framework in the AETCOM domains that a medical graduate must possess. There is a glaring need for a similar module for postgraduate trainees, as they deal with patients and families daily and need adequate training in communication along with their core academic training. There is also a need for training of faculty, creation of resource materials, and standardised assessment to ensure the sustainability of the programme.

Medical schools teach us about the disease and not the patient. In the rat race to increase our degrees and qualifications, our language dissolves the patient and emphasises only the diagnosis. As Dr Nancy Angoff, Dean of Student Affairs at Yale Medical School puts it, "as medical students, we start our journey on one side of a bridge, with the patients, as we move through our training, halfway over the bridge we find our language changing to the language of medicine. Personal stories get replaced by medical jargon. And then you become a medical professional, the other side of the bridge; do not forget where you started – the side with patients and their language." (6) For us physicians, the diagnosis should never be enough!

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