CORRESPONDENCE

Confidentiality and sensitive history-taking

Medical education in India lays a great deal of emphasis on textbooks. Assessments are made on written and oral examinations that are designed to test only knowledge and memory. Attributes such as compassion, confidentiality, ethics, and communication skills are completely ignored or even trivialised.

When I was doing my obstetric and gynaecology rotation several years ago in a rural hospital in India, I was assigned to a middle-grade doctor who had a diploma in the specialty. One day, a young lady came to the out-patient clinic accompanied by her husband. The two were married only a few weeks ago. I do not quite recall the clinical details, but all of a sudden the doctor asked the lady in a loud voice if she had multiple sexual partners prior to her marriage. She was completely shocked and close to tears. Her husband intervened and speaking in a soft and apologetic tone ruled out such a story on her behalf.

I was taken aback because there was no reason to ask the question in the first place, and second, the husband could have got a very wrong message. He would wonder why the doctor asked the question and whether the doctor had found something during the examination that prompted the question. The young lady could perhaps pay for the doctor's brashness all her life for no fault of hers. This is particularly true in the context of rural India where doctors are highly respected and the social setting is often cruel to women.

Such an insensitive and irresponsible manner of taking a patient's history could lead to a lifelong strained relationship between husband and wife. This is possibly an extraordinary and extreme case but it nevertheless reinforces the need to train doctors appropriately in how to deal with their patients in a sensitive, caring and confidential manner. The need to measure these attributes as part of assessment cannot be overemphasised.

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Disclosure of medical errors

The present letter is the author's reaction to the recent increase in incidents of public intolerance to negative outcomes in medical care that have been reported in the media and press from all over the country. On many occasions these have been followed by retaliatory strikes by health care workers resulting in suffering and even loss of human life in some cases.

To err is human and to forgive is divine. Since the inception of medical science, human error has been an irremediable truth of history. Medical slips have been reported across the world, but for every reported error there are several that go unreported. Increasing litigation rates have been reported from all over the world indicative of deteriorating doctor-patient bonds and decreasing patient forbearance towards an inexact science and uncertain practitioners. Although the litigation rates are not as striking in India, instances of patient-physician conflict coupled with public intolerance have been surfacing with alarming regularity in recent days, in forms of mob violence damaging public and private property. Disclosure is no more a matter of moral righteousness but a blame and shame game.

The multiple factors influencing disclosure make it a complex domain of human behaviour, rather than an issue governed by scientific guidelines taught in classrooms. Moreover, medicine being a vague science, it remains unclear when an adverse event becomes an error worth disclosure. Fear, guilt, risk of harm and retaliation, all depend on the outcome of error and peak when fatal (1,2,3). Many years ago, my friend's father succumbed to a nosocomial endocarditis, following catheterisation, and I have debated to this day if disclosure would serve any purpose beside rectitude, shifting the blame from the inadequacies of medicine to the hospital in question. I wonder if it is better not to know that a doctor's error killed my mother or to continue to feel focused guilt, anger and frustration thinking that my timely intervention could have saved her.

Although honest and able communication remains the cornerstone for reduction of controversies and allowing patients an opportunity to forgive and forget, yet scarcity of time coupled with fear of a backlash, not to mention poor communication skills, are common on the part of doctors as they struggle with the silent conflict to inform or hide actual details. Despite numerous simulation studies, it remains to be seen if the evidence generated from in vitro studies would hold in vivo practice where judgment is to be weighed not against the whole truth but against the patients' perception of the events (3, 4). Finally, although evidence indicates that candour reduces chances of litigation, as Gallagher et al have pointed out, yet the question remains, "How many of us believe it?" (5)

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