Diagnosis is never enough!

Author

Dr. William Wilson

Assistant Professor

Department of Emergency Medicine

Kasturba Medical College Manipal

Manipal Academy of Higher Education, Manipal

Karnataka 576104

[drwillwilson@gmail.com](mailto:drwillwilson@gmail.com)

9902526952

Competing interests and funding support - NIL

Submissions of very similar work, with references - NIL

Abstract

Medical schools train us to be brilliant academicians and diagnosticians. But as physicians, we must never belittle patient communication and not be inconsiderate in our approach to patient care. Communication as a skill gets neglected in post-graduate training as young doctors chase procedural and diagnostic excellence. It is high time we make amends.

“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). I always like to gauge the ER floor from the center, as I look around at the chaos, my mind slowly scans 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 fared me well.

A diagnosis is usually or should be followed by counseling of patients and attenders. “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 patient’s kin take time to comprehend and accept. The gravity of the situation usually takes time to set in and as an EP, 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 counselors or social workers helping families cope. With the requirement of prolonged ICU care and dismal outcome the families usually have some tough decisions to make. Most EDs are not equipped with counseling rooms either, so this emotionally charged conversation usually happens bedside or sometimes in the corridors and as I explain the dire circumstances, my eyes are always shifty, peeping at nearby monitors of another sick patient around or sometimes even making the next diagnosis.

Emergency Medicine is a time-based specialty where rapid decisions, often life-altering are made by a dozen. It requires an EP to be able to shift attention from one case to another swiftly and not get bogged down. Blood, vomit, death are routine and our training encompasses that, what gets overlooked are 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 prompt and precise diagnoses but often neglect to acknowledge what it does to patients and families. We seldom give them time to grasp the reality of the diagnosis and pressurize them to make even more critical decisions, all this knowing the financial burden healthcare can pose. *“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 pivot 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 any justice to patient communication nor have an empathetic approach to our patients and their families.

For long, the Indian Medical education system has ignored communication training in its curriculum, a skill that has been duly recognized in the West. The Association of American Medical Colleges (AAMC) Medical School Objectives Project urged faculties to teach interpersonal and communication skills.(1) The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) includes 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 USA felt that 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 expectantly grim in India as well. A survey done for surgical residents across 4 medical colleges reported that 81.7% did not receive any communication training, and in emergency surgeries, 32% of the residents spent less than 1 minute conversing with the patient. (3)

Another important aspect of communication often not considered is the quality of the dialogue. In an often-quoted study done in the 1980s, Beckmann 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 did not make pleasant reading either. They found patients' initial complaints were completed only 28% times 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 ER may have disastrous outcomes.

However, there is a silver lining to this. The Medical Council of India has introduced a structured program on attitude, ethics, and communication, namely the Attitude, Ethics and Communication Module (AETCOM) in the undergraduate curriculum. This is a case-based approach that is a framework of competency-based learning 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 with their core academic training. There is also a need for training of faculty, creation of resource materials, and standardized assessment to ensure the sustainability of the program.

Medical schools train us about the disease and not the patient. In the rat race of increasing our degrees and qualifications, our language dissolves the patient but emphasizes 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.” For us physicians, the diagnosis should never be enough!.

REFERENCES

1. Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R. Assessing competence in communication and interpersonal skills: the Kalamazoo II report. Academic Medicine. 2004 Jun 1;79(6):495-507.
2. Rising KL, Papanagnou D, McCarthy D, Gentsch A, Powell R. Emergency medicine resident perceptions about the need for increased training in communicating diagnostic uncertainty. Cureus. 2018 Jan;10(1).
3. Agarwal A, Agarwal A, Nag K, Chakraborty S, Ali K. Doctor patient communication—a vital yet neglected entity in Indian medical education system. Indian Journal of Surgery. 2011 Jun;73(3):184-6.
4. Beckman HB, Frankel RM. The effect of physician behavior on the collection of data. Annals of Internal medicine. 1984 Nov 1;101(5):692-6.
5. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved?. Jama. 1999 Jan 20;281(3):283-7.