Disarming Dialogues
in Ethics and Professionalism

Actions speak louder than words

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Racing up and down the hospital stairs, the desperation showed on our faces - we were hoping to find a patient with cardiovascular pathology for our case presentation the following day, and feared we might have to end another week without having discussed any clinical case on the cardiovascular system. We hadn't had any patients get diagnosed with valvular heart diseases or get admitted because of an acute cardiac condition in the past couple of weeks. As fourth-year medical students, our ears longed to hear a murmur, our hands itched to feel a hyperdynamic pulse, and our eyes yearned to read an abnormal ECG. With barely two weeks left for our one-month rotation to end, how were we supposed to check-mark having seen the common heart diseases at bedside this semester when we hadn't?

'Perhaps we should discuss the respiratory system again tomorrow. I believe there is a patient who recently got admitted for a respiratory problem. Shall we go talk to him?' asked my batchmate. We went to the relevant general ward and located the patient and his wife. The couple was more than happy to have us speak with them. The patient answered all our questions, his wife showed us the medications he previously had been on, and they kindly allowed us to examine him. Throughout the conversation, I wondered about him denying having any previously diagnosed hypertension yet he had been on an antihypertensive. We'd just seen the particular medication. I reasoned with myself that the patient probably had a low health literacy given his poor socioeconomic background.

As my batchmate put the diaphragm of the stethoscope on the left side of our patient's chest to auscultate for any adventitious breath sounds, in the background of his ongoing cough with expectoration, her eyes widened. She looked at me and yelled, 'I think I hear a murmur'. She took out the ear-tips and extended them to me. I plugged in and listened closely; it was a murmur, indeed. I wasn't sure which one, but it definitely was a murmur.

It was a surprise for us on this warm, sunny evening, to have our wishes be heard. Something was certainly up with the patient's valves. I turned towards my batchmate and confirmed the presence of a murmur. With a huge grin on her face, she did a fist-pump

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to express her elation. The patient and his wife stared at her - they looked perplexed, probably failing to understand what we were saying since they did not understand the English language. I immediately felt my batch-mate's reaction did not suit the general ward background with our patient right in front of us.

'This doesn't look good at the bedside. Stop', I said. My batchmate immediately sensed my ethical worry. On realizing how her elation from an educational standpoint reflected badly on us, she sobered down and took a step back.

As medical students, we are hungry to learn to pick up clinical signs, sometimes at the expense of patient comfort. We focus on the disease and on the science behind it so much that we often forget there is a complete person in the examination room with us. In the heat of academic excitement and in our eagerness to work up a patient with a cardiovascular problem, my batchmate behaved in an unsuitable manner. Learning, definitely, is our goal and, thus, essential but as prospective medical professionals we are always walking the thin line between science and appropriate emotional response. Striking a balance in a profession like ours is paramount to avoiding failures in the physician's art. Even though I was just as thirsty to see cardiovascular clinical signs, my batchmate's response immediately reminded me of my mother's words: 'The basic ABC of a good doctor is - availability, behavior, and competence, in that order.'

After we finished speaking with our patient in great detail and completed the examination, we returned to the students' discussion room to organize and further discuss the case for our presentation the following day. I silently brooded over the uncomfortable encounter but soon realized that incidents like these should rather be openly discussed.

I expressed my concerns and to my surprise each of us in the batch had felt the same air of sudden embarrassment that I had. We discussed how our own anxiety about the next day's case presentation led to the sudden outburst of unseemly elation, which perhaps added to the patient's anxiety about his condition. As a team, we decided that we would be more watchful of our actions and body language hereon.

Hippocrates, the Father of Medicine, not only established medicine as a distinct field through his scientific contributions but called it a unique profession and stressed on moderation in a physician's behavior and keeping a calm attitude. Behavior and empathy have been key components in the practice of medicine, justifying the trust patients put in healthcare providers. Greeting patients with a gentle smile, or softly patting the shoulder of an extremely sick patient's relative to provide comfort are not just gestures. They are tools used to lay the foundation of a doctor-patient relationship, cemented in mutual trust. Perhaps the erosion of professionalism and of ethical considerations is the reason for increasing public cynicism towards the medical fraternity.

As medical students, we manage to learn the science, but often fail to practice the art of medicine. The disease is always remembered, the human is often forgotten. The treatment goal is met, patient expectations may not be. There has been so much emphasis on case presentations, their formats, and on knowledge, that effective communication, body language, and gestures in clinics often take a backseat during our medical school training.

Training in clinical rounds should not be limited to history taking and physical examination, rather students should be made to play a more pivotal role in conversations with patients. Disclosing the diagnosis, explaining treatment regimens, having difficult conversations, and providing comfort to patients while maintaining professionalism are skills that require much practice. Medical school is perhaps the best time to acquire such know-how. As learners, we can discuss with our superiors the flow of expected

communication and also get feedback later. Incorporation of medical humanities and reflective narratives as a part of the curriculum for developing soft skills seems like a feasible and valid solution.

That evening, I walked out of the hospital with a new awakening. To hone my interpersonal skills, to maintain professional decorum by correcting my body language, to balance out academic knowledge with empathetic values, to truly become a doctor - that is what I aim for. I now make it a point to pay closer attention to how my superiors interact with their patients, and how they build trusting physician-patient relationships, even as I strive to acquire competency in diagnostic and management skills.

This article has an associated commentary by Dr Ravi Vaswani and Dr Uma Kulkarni.