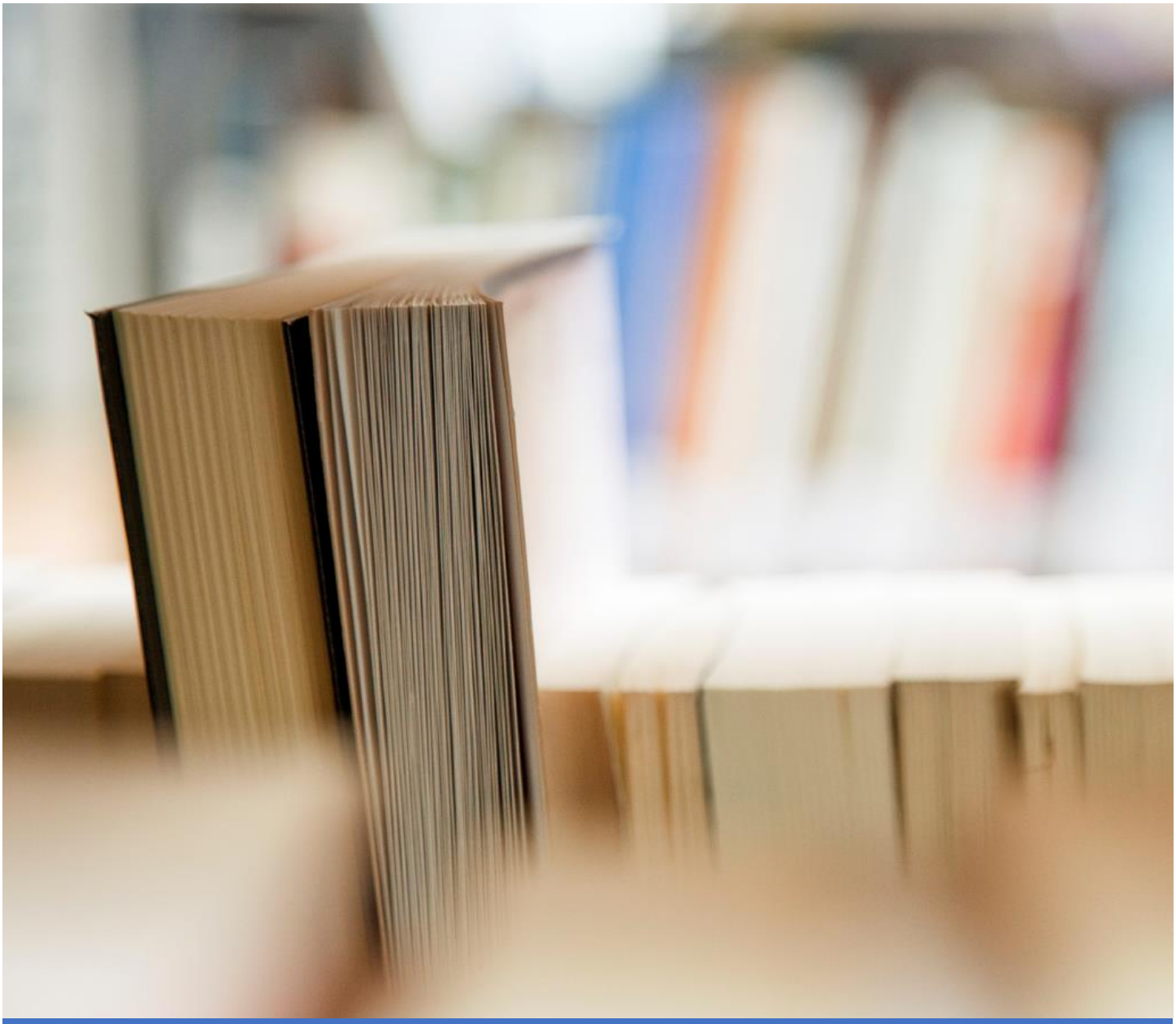

# AETCOM PREPARATORY MANUAL FOR SECOND MBBS

FIRST EDITION: FEBRUARY 2022

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# PREFACE

The Medical Council of India (MCI) prepared and introduced the Competency based Medical Education (CBME) curriculum for MBBS undergraduate medical education in 2017. It was implemented from the MBBS batch of 2019. As a part of the CBME curriculum, Attitudes, Ethics and Communication has been introduced in regular teaching and assessment process. According to Dr. Vedprakash Mishra (Chairman, Academic committee, MCI), “The entire concept of AETCOM module lies on the fundamental principle that changing a person's attitude can change his or her behavior. The Cognitive components of attitudes are more fundamental and constant over time and more closely connected to basic values. Behavioural attitudes are manifestations of underlying cognitive and affective attitudes. Ethical dimensions play a crucial role in behavioral evolution and the basic building block of good communication is the feeling that every human being is unique and of value.” Thus, AETCOM serves as an important way to foster important skills in medical students.

In the view of this, Maharashtra University of Health Sciences (MUHS) has incorporated AETCOM-based questions in the assessment exams of all subjects of MBBS students. While this question is a 5 marks optional question in the first-year subjects (paper 1), it is a compulsory non-optional question for 7 marks in all second-year subjects (paper 1). In accordance with this, many academicians have prepared preparatory manuals or books for the first-year modules. However, there is paucity of resources for the second-year students. Hence, we, a group of second year students, have developed and compiled this booklet for all second years as a reference as we believe that ‘knowledge increases by sharing’. We have developed this booklet after extensive study and literature review from multiple sources putting in a lot of time and efforts in it. Although we might not be experts in the fields, we hope that this book serves as an important tool for the preparation of exams for second-year students. While we are positive that most questions in the MUHS exams might come from this question bank, we do not give any assurances for the same; and we are not legally liable in the occurrence of the same. We thank and acknowledge all those who have helped us in the process, a list of which has been given at the end of the booklet.

# SECTION 1: PHARMACOLOGY

Sherwin Carvalho, Pauras Mhatre

## Modules:

2.1. The foundations of communication – 2

2.2. The foundations of bioethics

2.3. Healthcare as a right

# Module 2.1: The foundations of communication - 2

## Background

Communication is a fundamental prerequisite of the medical profession and beside skills is crucial in ensuring professional success for doctors. This module continues to provide an emphasis on effective communication skills. During professional year II, the emphasis is on active listening and data gathering.

## Competency addressed

| The student should be able to: | Level |
|---|---|
| Demonstrate ability to communicate to patients in a patient, respectful, non-threatening, non-judgmental and empathetic manner | SH |

## Learning Experience:

**Year of study:** Professional year 2

**Hours:** 5 (1 + 2 +1+1)

i. Introductory small group session - 1 hour
ii. Focused small group session - 2 hours
iii. Skills lab session – 1 hour
iv. Discussion and closure – 1 hour

### Contents:

This module includes 2 interdependent learning sessions:

1. Introductory small group session on the principles of communication with focus on opening the discussion, listening and gathering data.
2. Focused small group session with role play or videos where the students have an opportunity to observe, criticise and discuss common mistakes in opening the discussion, listening and data gathering.
3. Skills lab sessions where students can perform tasks on standardised or regular patients with opportunity for self critique, critique by patient and by the facilitator.

## Assessment

1. Formative: Participation in session 2 and performance in session 3 may be used as part of formative assessment.
2. Summative: may be deferred.

## Resources:

1. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Acad Med. 2001; Apr; 76(4): 390-3.
2. Hausberg M. Enhancing medical students' communication skills: development and evaluation of an undergraduate training program. BMC Medical Education 2012; 12:16.

# Module 2.2 The foundations of bioethics

## Background

An introductory session in a large group that provides an overview of the evolution and the fundamental principles of bioethics including the cardinal pillars of ethics viz., autonomy, beneficence, non-maleficence and justice.

## Competencies addressed

| The student should be able to: | Level |
|---|---|
| 1. Describe and discuss the role of non-maleficence as a guiding principle in patient care | KH |
| 2. Describe and discuss the role of autonomy and shared responsibility as a guiding principle in patient care | KH |
| 3. Describe and discuss the role of beneficence of a guiding principle in patient care | KH |
| 4. Describe and discuss the role of a physician in health care system | KH |
| 5. Describe and discuss the role of justice as a guiding principle in patient care | KH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 2 large group session - 2 hours

**Contents:**

This module is a large group learning session that can be made interactive by illustrative examples.

## Assessment

**Summative:** Short notes on a) Autonomy b) Beneficence c) Non-maleficence

## Resource:

A review of the four principles of bioethics is found here:
http://archive.journalchirohumanities.com/Vol%2014/JChiroprHumanit 2007 v14_34- 40.pdf

# Module 2.3: Health care as a right

## Background

This session is aimed at introducing students to health care systems, their access, equity in access, the impact of socio-economic situations in determining health care access and the role of doctors as key players in the health care system.

## Competency addressed

| The student should be able to: | Level |
|---|---|
| Describe and discuss the role of justice as a guiding principle in patient care | KH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 2

i. Participatory student seminar - 2 hours

**Contents:**

This module may be done as a participatory student seminar with debates on the more controversial issues to increase a reflective process.

Focus may be on:

1. Is health care a right?

2. What are the implications of health care as a right?

3. What are the social and economic implications of health care as a right?

4. What are the missing links? (see resource 2 for a brief overview) and

5. What are the implications for doctors?

## Assessment

**Summative:** Short note on barriers to implementation of health care as a universal right.

## Resources

1. The Universal Declaration of Human Rights. http://www.un.org/en/documents/udhr/
2. Missing links in universal health care. http://www.thehindu.com/opinion/lead/missing-links-in-universal-health-care/article6618667.ece

# Questions and Answers

Module 2.1 The foundations of communication - 2

**Q. State few essential elements of communication in medical encounters in accordance to the Kalamazoo consensus statement**

Communications in medical encounters involves building a relationship with the patient. A strong, therapeutic, and effective relationship is absolutely necessary for effective physician - patient communication.

Essential elements according to the Kalamazoo consensus statement involves:

I. Opening the Discussion-

- Allow the patient to complete his or her opening statement.
- Establish a personal connection.

II. Gathering information-

- Use open-ended and closed-ended questions appropriately
- Actively listen using nonverbal (e.g. eye contact) and verbal (e.g., words of encouragement) techniques

III. Understanding the patient's perspective-

- Explore contextual factors (e.g., family, culture, gender, age, socioeconomic status, spirituality)
- Explore beliefs, concerns, and expectations about health and illness

IV. Sharing information-

- Use language the patient can understand
- Check for understanding
- Encourage questions

V. Reaching an agreement on problems and plans-

- Encourage the patient to participate in decisions to the extent he or she desires
- Check the patient's willingness and ability to follow the plan

VI. Providing closure-

- Summarize and affirm agreement with the plan of action
- Discuss follow-up (e.g., next visit, plan for unexpected outcomes)

**Q. What is communication? What are the types of communication? Discuss the importance of efficient communication in healthcare settings.**

Communication: A process by which information and understanding is exchanged between individuals, by any effective means.

Types:

I. Verbal-
   - It involves the use of spoken words or sign language to share information.
   - It can either happen face to face or through other channels, such as mobile phone and video conferencing.

II. Non-verbal-
   - Nonverbal communication involves passive communication through the use of gestures, tone of voice, body language and facial expressions to share your thoughts and feelings.
   - It also involves communicating through the way you dress.

III. Written-
   - Written communication includes communicating through writing, typing or printing.
   - It is done through channels such as letters, text messages, emails, social media and books.

Importance of efficient communication in healthcare setting:

- An efficient communication enables healthcare providers to establish rapport with their patients and work effectively with all members of the care team.
- Providers can help patients feel heard, ease their fears, and encourage them to disclose relevant information.
- Clear, honest and empathetic communication between patient and provider minimizes misunderstandings and paves the way for accurate diagnoses and treatment decisions.
- Moreover, it also helps the healthcare provider to reveal sensitive information regarding the treatment outcomes to the patient and relatives.
- In terms of patient counselling for various psychiatric disorders, effective communication plays a vital role.
- Furthermore, a sense of trust is established between the patient and physician which is essential for patient wellbeing.

## Module 2.2 The foundations of bioethics

### Q. Describe and discuss the role of non-maleficence as a guiding principle in patient care

The principle of nonmaleficence requires healthcare providers to not intentionally create a harm or injury to the patient, either through acts of commission or omission.

Role of non-maleficence in patient care:

- Physicians must refrain from acting with malice toward patients.
- The guiding principle of *primum non nocere*, “First of all, do no harm,” is found in the Hippocratic Oath.
- An act of omission means that some action could have been done to avoid harm but wasn’t done and an act of commission is something actually done that resulted in harm.
- The benefit of any treatment intervention must be balanced against the harm and is considered ethical only if the benefit outweighs.
- Physicians should not provide ineffective treatments to patients as these offer risk with no possibility of benefit and thus have a chance of harming patients.

- An informed consent must be always provided to the patient and it's the physician's duty to explain him/her all the possible risks and benefits associated, so that the patient can choose the right treatment option.
- Breaking confidentiality by releasing information that becomes harmful to the patient also violates the principle of non-maleficence and is considered unethical.
- Certain issues around withholding or withdrawing life support, extraordinary measures and death with dignity must involve considerations regarding further harm to the individual.

### Q. Describe and discuss the role of autonomy and shared responsibility as a guiding principle in patient care

The principle of autonomy states that every individual should have the power to make rational decisions and moral choice, and each should be allowed to exercise his/her capacity for self-determination.

Role of autonomy in patient care:

- According to the law, autonomy upholds the right of individuals to make decisions about their own healthcare.
- Respect for autonomy requires that patients be told the truth about their condition and be informed about the risks and benefits of treatment.
- Autonomy forms the basis of 'informed consent' from the patient.
- An ethical surety is that the physician, or any other healthcare professional, cannot make a unilateral healthcare decision without the consent of that competent adult.
- However, the physician should not neglect his/her responsibility to deliver all the necessary guidance to the patient.
- A deliberative approach should be followed and patients must be empowered to participate in making decisions.
- The principle of autonomy does not extend to persons who lack the capacity (competence) to act autonomously; examples include infants and children and incompetence due to developmental, mental or physical disorder.
- In such cases, a parent/legal guardian or a surrogate takes the decision in collaboration with the healthcare provider.

While autonomy is usually compulsory, there are certain instances where personal autonomy has to be sacrificed for the well-being for a large number of people, that is when patient's decision is impacting community health adversely on a large scale; e.g. COVID-19 patient refusing isolation.

### Q. Describe and discuss the role of beneficence of a guiding principle in patient care

- The principle of beneficence is the obligation of physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger. It is worth emphasizing that, in distinction to nonmaleficence, the language here is one of positive requirements. The principle calls for not just avoiding harm, but also to benefit patients and to promote their welfare. While physicians' beneficence conforms to moral rules, and is altruistic, it is also true that in many instances it can be considered a payback for the debt to society for education (often subsidized by governments), ranks and privileges, and to the patients themselves (learning and research).

- This principle is at the very heart of health care implying that a suffering supplicant (the patient) can enter into a relationship with one whom society has licensed as competent to provide medical care, trusting that the physician's chief objective is to help. The goal of providing benefit can be applied both to individual patients, and to the good of society as a whole. For example, the good health of a particular patient is an appropriate goal of medicine, and the prevention of disease through research and the employment of vaccines is the same goal expanded to the population at large.
- One clear example exists in health care where the principle of beneficence is given priority over the principle of respect for patient autonomy. This example comes from Emergency Medicine. When the patient is incapacitated by the grave nature of accident or illness, we presume that the reasonable person would want to be treated aggressively, and we rush to provide beneficent intervention by stemming the bleeding, mending the broken or suturing the wounded.
- In this culture, when the physician acts from a benevolent spirit in providing beneficent treatment that in the physician's opinion is in the best interests of the patient, without consulting the patient, or by overriding the patient's wishes, it is considered to be "paternalistic."
- The most clear cut case of justified paternalism is seen in the treatment of suicidal patients who are a clear and present danger to themselves. Here, the duty of beneficence requires that the physician intervene on behalf of saving the patient's life or placing the patient in a protective environment, in the belief that the patient is compromised and cannot act in his own best interest at the moment. As always, the facts of the case are extremely important in order to make a judgment that the autonomy of the patient is compromised.

Q. Describe and discuss the role of justice as a guiding principle in patient care

- Justice is generally interpreted as fair, equitable, and appropriate treatment of persons. Of the several categories of justice, the one that is most pertinent to clinical ethics is distributive justice. Distributive justice refers to the fair, equitable, and appropriate distribution of healthcare resources determined by justified norms that structure the terms of social cooperation. Justice in health care is usually defined as a form of fairness, or as Aristotle once said, "giving to each that which is his due." This implies the fair distribution of goods in society and requires that we look at the role of entitlement. The question of distributive justice also seems to hinge on the fact that some goods and services are in short supply, there is not enough to go around, thus some fair means of allocating scarce resources must be determined.
- It is generally held that persons who are equals should qualify for equal treatment. This is borne out in the application of Medicare, which is available to all persons over the age of 65 years. This category of persons is equal with respect to this one factor, their age, but the criteria chosen says nothing about need or other noteworthy factors about the persons in this category. In fact, our society uses a variety of factors as criteria for distributive justice, including the following:
    - To each person an equal share
    - To each person according to need
    - To each person according to effort
    - To each person according to contribution
    - To each person according to merit
    - To each person according to free-market exchanges

### Q. Describe and discuss the role of a physician in health care system

*Refer to Section Pathology*

## Module 2.3 Healthcare as a right

### Q. State the importance of healthcare as a right in accordance to the universal declaration of human rights.

In 1948, the United Nations - Universal Declaration of Human Rights mentioned health as part of the right to an adequate standard of living (article 25).

Healthcare is defined as efforts made to maintain or restore mental, physical, or emotional well-being by licensed and trained professionals.

Importance of healthcare as a right includes:

- To address health crisis and alleviate the standard of living among the lower socio-economic populations.
- To harness an affordable and uniform medical treatment for all.
- To have transparent and quality health care service throughout.
- To maintain uniform distribution and availability of healthcare delivery at primary, secondary and tertiary levels.
- To address the rights of the patient, treating him/her with respect and dignity without violating autonomy in any form.
- To address the disparities pertaining to ethnicity, sex and gender in the healthcare setup, increasing accessibility to everyone.
- To eradicate dubious health services and list out problems associated with medical terrorism.
- To educate people about disease prevention.
- To establish sanitary living conditions and distribution of clean water.

### Q. State the implications (for example, social and economic) of health care as a right?

International Covenant on Economic, Social and Cultural Rights (1966) stated in Article 12 that the implications of healthcare as a right include:

I. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.
II. The improvement of all aspects of environmental and industrial hygiene.
III. The prevention, treatment and control of epidemic, endemic, occupational and other diseases.
IV. The creation of conditions which assure to all medical service and medical attention in the event of sickness.

Other implications:

- It lowers the health care costs for an economy and creates an affordable environment to seek healthcare.
- Uniform standard of health care can be established throughout.
- It eliminates administrative costs by eliminating need to deal with private insurance.

**Q. What are the missing links and barriers to implementation of healthcare as a universal right?**

The missing links and barriers to implementation of healthcare as a universal right include:

I. High costs of health care:
- Current costs for treatments especially for chronic diseases economically burdens the patient's family at a considerable scale.
- This disables the patient from choosing the best treatment option for him/her.

II. Poor quality of care delivery:
- Inequitable distribution of qualified healthcare workers.
- The public sector is perceived as being unreliable, of indifferent quality and generally is not the first choice, unless one cannot afford private care.

III. Commercialization of health care:
- Biased prescriptions and treatment plans in the private setup, which profits the physician or organization is on a rise.
- Cash-for-referral practices, over-testing and over-treatment.

IV. Non-uniform accessibility:
- Healthcare facilities are not equally distributed in urban and rural populations.
- Patients seeking advanced facilities have to overcome geographical barriers.

# SECTION 2: PATHOLOGY

Pauras Mhatre

## Modules:

2.4. Working in a healthcare team

2.8. What does it mean to be family member of a sick patient?

# Module 2.4: Working in a health care team

## Background

This session is aimed at introducing students to health care systems and their functioning. It allows students to "tag along" with members of health care teams, observe their work and gain experience about their perspectives. It is hoped that this experience will help students to understand the need for collaborative work in health care, how each member of the health care team is important and also develop respect.

## Competencies addressed

| The student should be able to: | Level |
|---|---|
| 1. Demonstrate ability to work in a team of peers and superiors | SH |
| 2. Demonstrate respect in relationship with patients, fellow team members, superiors and other health care workers | SH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 6 hours (4 hours "tag along" + 2 hours discussion)

i. "Tag along" session in hospital- 2 x 2 hours

ii. Small group discussion session - 2 hours

**Contents:**

This module may be done as two interdependent sessions:

1. A "tag along" session where students spend time with other health care workers including nurses, technicians and others, observe their work, their interactions, conduct a small interview with them and write a narrative based on this interview.
2. A small group discussion which is based on the students' observations, experiences, reflections and inferences and what must be done by them to work as an integral part of the health care team.

## Assessment

**Formative:** Student participation in session 2 with assessment of submitted narrative.

# Module 2.8: What does it mean to be family member of a sick patient?

## Background

Doctors deal with human suffering throughout their professional careers. A balanced approach to the patient care experience requires an understanding of support systems of patients, priorities coping and emotions of families, the role of the doctor, an exploration of empathy vs equanimity and the difference between healing and curing and support.

## Competency addressed

| The student should be able to: | Level |
|---|---|
| Demonstrate empathy in patient encounters | SH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 6 (includes 2 hours of SDL)

i. Hospital visit & interviews - 2 hours
ii. Large Group Discussions with patients' relatives - 1 hour
iii. Self-directed Learning - 2 hours
iv. Discussion and closure - 1 hour

1. Students are assigned to patients in the hospital, interview their family about their illnesses, experience, reactions, emotions, outlook and expectations (or can be done in a controlled environment with standardised patients.
2. Family members of patients with different illnesses may be brought to a large group discussion with permission and an interactive discussion (based on the items outlined in option A. Can use standardised patients)
3. Self-directed learning where students write a report from reflection based on sessions 1 & 2 and on other readings, TV series, movies etc.
4. A closure session with students to share their reflections based on 1, 2 and 3 so that it includes how they intend to incorporate the lessons learnt in patient care.

## Assessment

1. **Formative:** The student may be assessed based on their active participation in the sessions and submission of the written narrative.

2. **Summative:** Short questions on the role of doctors in the community and expectations of society form doctors. e.g. 1. What is empathy? What is the role of empathy in the care of patients?

# Questions and Answers

## Module 2.4 Working in a healthcare team

### Q. What is a team? What is a healthcare team? What are the types of teams?

- Team: A team is defined as a group of people who perform interdependent tasks to work toward accomplishing a common mission or specific objective. A team can be defined as a distinguishable set of two or more people who interact dynamically, interdependently and adaptively towards a common and valued goal/objective/mission, who have been assigned specific roles or functions to perform.
- Healthcare team: Health care team means 2 or more health care professionals working in a coordinated, complementary and agreed-upon manner to provide quality, cost-effective, evidence-based care to a patient.
- Types of teams: An early and influential classification was offered by Sundstrom and colleagues (1990), who proposed 4 categories: (a) advice and involvement teams (eg. Quality improvement team, which serves to recommend process changes in a healthcare practice or hospital and to engage people in making the changes successfully), (b) production and service teams (eg. All clinical teams), (c) project and development teams (eg. Electronic health records team), and (d) action and negotiation teams (eg. Health system executives and attorneys seeking a merger with another system).

### Q. What are the stages of team building?

- Forming: Typically characterized by ambiguity and confusion. Team members may be unclear about tasks at this stage. They have not yet chosen to work together and may communicate in a superficial and impersonal manner.
- Storming: A difficult stage when there may be conflict between team members and some rebellion against the assigned tasks. Team members may get frustrated here when do not progress well in the tasks.
- Norming: Open communication between team members is established and the team starts to confront the task at hand. Generally accepted procedures and communication patterns are established.
- Performing: The team focuses all of its attention on achieving the goals. The team is now close and supportive, open and trusting, resourceful and effective.

After being formed and continue to develop, healthcare teams interact dynamically and have the common goal of delivering health services to patients.

Q. What is an effective team? What are the benefits of effective teamwork? Mention some characteristics making effective healthcare team. What are the hurdles to effective teamwork?

- Effective team: An effective team is a one where the team members, including the patients, communicate with each other, as well as merging their observations, expertise and decision-making responsibilities to optimize patients' care. Understanding the culture of the workplace and its impact on team dynamics and functioning will make a team member a good team player.
- Benefits of effective teamwork:
    - Organizational benefits: Reduced time and costs of hospitalization, Reduction in unexpected admissions, Services are better accessible to patients
    - Team benefits: Improved coordination of care, Efficient use of health-care services, Enhanced communication and professional diversity
    - Patient benefits: Enhanced satisfaction with care, Acceptance of treatment, Improved health outcomes and quality of care Reduced medical errors
    - Benefits to team members: Enhanced job satisfaction, Greater role clarity, Enhanced well-being
- Challenges to effective teamwork: Several barriers exist to establishing and maintaining effective teamwork in health care:
    - Changing roles: In many health-care teams, there is considerable change and overlap in the roles played by different health-care professionals. These changing roles can present challenges to teams, in terms of acknowledgement and role allocation.
    - Changing settings: Some changes in the nature of health care such as increased delivery of care for chronic conditions require the development of new teams and the modification of existing teams.
    - Health-care hierarchies: The strongly hierarchical structure of health care can be counterproductive to well-functioning and effective teams where all members' views are considered.
    - Individualistic nature of health care: Many health-care professions, such as nursing, dentistry and medicine, are based on the autonomous one-to-one relationship between the health care provider and patient. While this relationship remains a core value, it is challenged by many concepts of teamwork and shared care.
    - Instability of teams: Some health-care teams are transitory in nature, coming together for a specific task or event (e.g. Trauma team).
    - Failing teamwork leads to accidents: Reviews of high-profile incidents have identified three main types of teamwork failings, namely, unclear definition of roles, lack of explicit coordination and other miscommunication.
    - Resolving disagreement and conflict: The ability to resolve conflict or disagreement in the team is crucial to successful teamwork. This can be especially challenging for junior members of the team or in teams that are highly hierarchical in nature.

- Characteristics making effective healthcare team:
    - Common purpose
    - Measurable goals
    - Effective Leadership
    - Effective Communication
    - Good Cohesion
    - Mutual respect
    - Flexibility
    - Performance monitoring
    - Conflict resolution and learning
    - Reliability
    - Willing to compromise
    - Commitment
    - Dedication
    - Adaptability

Q. State the various components of a (a) laboratory team OR (b) surgical team OR (c) research team.

- Surgical Team:
    - Consultant/ attending Surgeon
    - Surgical residents
    - Anaesthesiologist
    - Certified registered nurse anesthetist
    - Scrub Nurse
    - Operating room nurse or circulating nurse
    - Surgical technologist
    - Physician assistant
    - Cleaning staff
- Research Team:
    - Principal Investigator (PI)
    - Sub-Investigator (Sub-I) / Co-Investigator (Co-I)
    - Regulatory Coordinator.
    - Data Coordinator
    - Statistician
    - Research Coordinator/ Research Nurse
- Laboratory Team:
    - Laboratory Director
    - Head (Professor) Pathologist/ Biochemist/ Microbiologist or Technical Supervisor
    - Residents
    - General supervisor or head technician
    - Assistant laboratory technicians or Medical Laboratory Scientist (MLS) or Medical Technologist (MT)

- Phlebotomist
- BSL Monitor
- Cleaning staff

Q. State the need of collaborative work in health care. State the hurdles in the same.

- Interdisciplinary teamwork is an important model for delivering health care to patients. Researchers have found that integrating services among many health providers is a key component to better treat underserved populations and communities with limited access to health care.
- Collaboration in health care is defined as health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care. Collaboration between physicians, nurses, and other health care professionals increases team members' awareness of each other's type of knowledge and skills, leading to continued improvement in decision making. Effective teams are characterized by trust, respect, and collaboration. Deming is one of the greatest proponents of teamwork.
- When considering a teamwork model in health care, an interdisciplinary approach should be applied. Unlike a multidisciplinary approach, in which each team member is responsible only for the activities related to his or her own discipline and formulates separate goals for the patient, an interdisciplinary approach coalesces a joint effort on behalf of the patient with a common goal from all disciplines involved in the care plan. The pooling of specialized services leads to integrated interventions. The plan of care takes into account the multiple assessments and treatment regimens, and it packages these services to create an individualized care program that best addresses the needs of the patient. The patient finds that communication is easier with the cohesive team, rather than with numerous professionals who do not know what others are doing to manage the patient.
- Across health care, there is an increasing reliance on teams from a variety of specialties (e.g., nursing, physician specialties, physical therapy, social work) to care for patients. At the same time, medical error is estimated to be "the third most common cause of death in the US", and teamwork failures (e.g., failures in communication) account for up to 70-80 percent of serious medical errors. The shift to providing care in teams is well founded given the potential for improved performance that comes with teamwork, but, as demonstrated by these grave statistics, teamwork does not come without challenges. Consequently, there is a critical need for health care professionals, particularly those in leadership roles, to consider strategies for improving team-based approaches to providing quality patient care.
- Teams offer the promise to improve clinical care because they can aggregate, modify, combine, and apply a greater amount and variety of knowledge in order to make decisions, solve problems, generate ideas, and execute tasks more effectively and efficiently than any individual working alone. Given this potential, a multidisciplinary team of health care professionals could ideally work together to determine diagnoses, develop care plans, conduct procedures, provide appropriate follow up, and generally provide quality care for patients.
- Hurdles to collaborative work: It is important to point out that fostering a team collaboration environment may have hurdles to overcome: additional time; perceived loss of autonomy; lack of

confidence or trust in decisions of others; clashing perceptions; territorialism; and lack of awareness of one provider of the education, knowledge, and skills held by colleagues from other disciplines and professions. However, most of these hurdles can be overcome with an open attitude and feelings of mutual respect and trust. A study determined that improved teamwork and communication are described by health care workers as among the most important factors in improving clinical effectiveness and job satisfaction.

## Q. Describe the importance of respect in relationship with patients, fellow team members, superiors and other health care workers.

Respect is an essential component of a high-performance organization. It helps to create a healthy environment in which patients feel cared for as individuals, and members of health care teams are engaged, collaborative and committed to service. Within a culture of respect, people perform better, are more innovative and display greater resilience. On the contrary, a lack of respect stifles teamwork and undermines individual performance. It can also lead to poor interactions with patients. Cultivating a culture of respect can truly transform an organization and leaders set the stage for how respect is manifested.

Respect to patients:

- From a social psychological perspective, respect has been defined as "the social acceptance of another person". The humanistic clinical psychologist Carl Rogers is well known for the concept of unconditional positive regard. Regardless of what the patient may have thought, felt or have done, Rogers advocated for accepting them unconditionally. Put another way, Rogers advocated for approaching patients by respecting them as individuals who have incontestable worth as they are, and not expecting them to behave differently to earn this respect. Also, according to another study, patients believed that respecting persons incorporates the following major elements: empathy, care, autonomy, provision of information, recognition of individuality, dignity and attention to needs.
- Using a large sample of survey data from the Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), the authors tested the hypothesis that the most important communication predictor of patients' overall physician rating is the item assessing patient's perception of whether the physician showed respect. For 23 of 28 medical specialties, showing respect was the most predictive item of overall physician ratings, accounting for more than four times as much variance as the other survey items assessing communication behaviors.

Respect to co-workers and superiors:

- Research demonstrates that people value two distinct types of respect: 'Owed' and 'Earned.' Owed respect meets the universal need to feel valued and included. It rests on the concept that all individuals have inherent value and the right to be treated with dignity. When owed respect is lacking, it manifests as over-monitoring (i.e., micromanagement), distrust, misconduct and indifference (i.e., making people feel like they are easily replaceable). Disrespect can lead to a toxic atmosphere that diminishes joy and fulfillment, leading to dissatisfaction and burnout. Earned respect recognizes individuals who have gone above and beyond expectations. It meets the need to

feel valued for accomplishments and a job well-done. Neglecting to provide earned respect can reduce motivation and accountability.

- Respect is also established by supporting other members of the health care team. Speaking poorly of another service or health care professional undermines patients' confidence in the entire health care team and lowers their impression of the system. Interactions with colleagues can be improved by always assuming best intentions and giving other people the benefit of the doubt. Before reaching a negative conclusion, ask questions to clarify and assume that best intentions were in mind.
- In 2012, Virginia Mason launched a 'Respect for People' initiative that engaged all of their employees in approaches to respecting one another in the workplace. The program involved training, simulation and defining what respect meant. The outcome was a greater sense of personal ownership for how employees respect, support and appreciate their coworkers. The following is their "Top 10" list of ways to show respect:
    - Listen to understand
    - Keep your promises
    - Be encouraging
    - Connect with others
    - Express gratitude
    - Share information
    - Speak up
    - Walk in their shoes
    - Grow and develop
    - Be a team player
- A culture of respect also recognizes that everyone in the organization plays a meaningful role in the ability to care for patients. All members of the team are valued and have important contributions to make. Respect is given to everyone, regardless of their position on the organizational chart. For example, when a physician holds the door for a hospital cleaner, this simple act boosts self-worth and appreciation. The same effect is seen with a thank you letter from a peer or supervisor for a job well done.

Q. What is empathy? What is the role of empathy in the care of patients?

- Definition: Empathy is the ability to emotionally understand what other people feel, see things from their point of view, and imagine yourself in their place. Essentially, it is putting yourself in someone else's position and feeling what they must be feeling. It is the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner.
- Signs of Empathy: Empathy is shown by various signs like being good at really listening to what others have to say, picking up on how other people are feeling, thinking about how other people feel, trying to help others who are suffering and so on.
- Types of Empathy: Empathy can be either affective empathy, cognitive empathy or somatic empathy.
- Role of Empathy:

- Empathy involves more than just understanding a patient's medical history, signs, and symptoms. It entails more than just a medical diagnosis and therapy. Empathy is one of the most important instruments in the therapeutic interaction between caregivers and their patients, and its contribution has been shown to improve health outcomes.
- It strengthens the development and improvement of the therapeutic relationship between the two parts by allowing health care providers to detect and recognise the patients' experiences, worries, and perspectives.
- It is widely accepted that a health professional's ability to empathise with patients leads to greater treatment outcomes. The health professionals' empathetic relationship with their patients strengthens their participation in developing a therapy plan and a tailored intervention, boosting the patient's pleasure with the therapeutic process. As a result, the quality of care is improved, errors are reduced, and a higher percentage of health-care recipients have a favourable experience with therapy.
- Furthermore, it has been discovered that the sympathetic bond formed during the care process enhances therapeutic outcomes by allowing patients to better adhere to the therapeutic plan of action. Patients who are shown empathy during their treatment had better outcomes and a higher chance of improving.
- Furthermore, healthcare workers with higher empathy levels perform more efficiently and productively in terms of fulfilling their role in social transformation. This occurs because empathy allows the healthcare worker to understand and feel sympathy for their patients, allowing them to feel safe in expressing their concerns and issues. This creates a foundation for trust, which leads to therapeutic change and an improvement in the overall social functionality of the care recipient.
- The ability of a person to accomplish everyday activities (preparing and keeping meals, seeking accommodation, taking care of themselves, commuting) as well as their ability to fulfil social roles (parent, employee, member of a community) according to the requirements of their cultural environment are assessed by the social worker.
- Empathy aids in the accurate appraisal of the scenario in which the health-care user finds himself. It allows therapists to make effective use of nonverbal clues (behaviour modelling, body gestures, tone of voice, and so on) while also assisting them in managing the user's emotions. Empathy also improves the user's ability to perceive reality and thus their quality of life.
- Thus, in totality, expressing empathy is highly effective and powerful, which builds patient trust, calms anxiety, and improves health outcomes. Research has shown empathy and compassion to be associated with better adherence to medications, decreased malpractice cases, fewer mistakes, and increased patient satisfaction.

### Q. State how to break bad news to the family using SPIKES protocol.

The aim for any health-professional is to use their skills to deliver bad news clearly, honestly and sensitively in order that patients can both understand and feel supported. It is necessary to plan as carefully as possible and to respect the people to whom the information is being given by listening and watching them at all stages and being responsive to their wishes and reactions, which will be diverse. The SPIKES protocol is a six-

part method that sets out a straightforward process for sharing difficult-to-hear and difficult-to-deliver news.

The SPIKES process acknowledges that the situation challenges both doctor and patient. For the doctor, it is clearly hard to be in the position of shattering your patient's hope for their recovery. On the other hand, nothing compares to the harsh reality that the patient themselves must face. The four main objectives laid out by the SPIKES protocol include sharing information with the patient, gathering responses from them, providing vital support, and creating a plan to move forward.

The steps of SPIKE are:

- Setting: The set-up of the meeting is important. You should create a warm and welcoming space that does not seem cold or clinical. If the patient wants family or close friends to be there in support, make sure that these people are included as well. It is not necessary to rush into the news like dropping a bomb on an enemy; take a moment to connect and build rapport with your patient. Whether you understand it or not, you are about to change your patient's life. Take time to show empathy and emotional connection.
- Perception: Perception refers to the patient's current level of knowledge about their medical issue and what they think about their status on the road to recovery. It is important to do more listening than talking at this stage; there is no need to challenge the patient on inaccurate or hopeful beliefs at this point.
- Invitation: At this stage, ask your patient if they want to know the details of their condition or the treatment they might face. Meet your patient where they are; if they are not ready for the details, it is not necessary to force them to listen. The SPIKES method acknowledges that each patient has a right not to know the details if they are not ready for them. Wait for permission from your patient before proceeding with the news.
- Knowledge: In this stage you are sharing knowledge and information with your patient. Again, it is important to ask the patient how much they understand and meet them there. Your patient often will need you to speak in plain terms, not medical jargon. Consider the individual before you; have they understood what you said? Do not rush this part of the protocol.
- Emotion: The sharing of bad news is emotional for both doctor and patient. Create space for your patient to express their emotion and practice deep empathy. Put yourself in their shoes by identifying their reaction – sadness, shock, denial—and helping them to identify it too.
- Strategy and Summary: End the meeting on an intentional note: what will come next? Summarize your thoughts and your understanding of the patient's reaction, and set expectations for the next appointment

### Q. Compare empathy vs equanimity.

Empathy is the ability to listen to a troubled individual and literally opening your mind up so that all the problems, worries, negative emotions, traumas and anxiety can flow into you. You literally feel the pain as you balance the garbage so that the other person starts to feel better when the weight gets transferred off their shoulders and onto yours. This is basically what therapy is about, or starts out as.

Equanimity is then exactly the opposite of empathy as it's an inner state of total deflection from external negativity, misery and nuisances. This means that whatever inner emotional state you are in is very stable, completely of your own making and other people's misfortunes or troubles don't mean anything to you on a mental/emotional level.

### Q. What is sympathy? What is difference between empathy and sympathy?

- Meaning: Empathy is the ability to emotionally understand what other people feel, see things from their point of view, and imagine yourself in their place. Essentially, it is putting yourself in someone else's position and feeling what they must be feeling. It is the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner.
- Sympathy is the perception, understanding, and reaction to the distress or need of another life form. According to David Hume, this sympathetic concern is driven by a switch in viewpoint from a personal perspective to the perspective of another group or individual who is in need.
- Empathy is shown by various signs like being good at really listening to what others have to say, picking up on how other people are feeling, thinking about how other people feel, trying to help others who are suffering and so on.
- Empathy can be either affective empathy, cognitive empathy or somatic empathy. On the other hand, sympathy is rather a broad term, signifying a general fellow feeling, no matter of what kind.
- Empathy requires active listening. Sympathy requires giving unasked advice or being told what to do. Sympathy states "I know how you feel". Empathy states "I feel how you feel". In this case, having empathy is being more aware of the other person's feelings, not your own.
- Sympathy often involves a lot of judgement. Empathy has none.
- Sympathy involves understanding from your own perspective. Empathy involves putting yourself in the other person's shoes and understanding WHY they may have these particular feelings. In becoming aware of the root cause of why a person feels the way they do; we can better understand and provide healthier options.
- Sympathy tends to suppress your own and others' emotions. Emotions get pushed aside and avoided until it culminates in an intense fit of pain. Empathy acknowledged your own and others' emotions.
- Lastly, empathy is a skilled response, while sympathy is reactive response, which is why developing the skill of empathy is a more realistic goal for medical education, whereas teaching sympathy seems counterintuitive.

### Q. Write a short note on role of doctors in the community.

Roles doctors play in the community:

1. Healer
2. Educator
3. Researcher
4. Planner
5. Health Advocate

6. Communicator

Under these roles, doctors carry out the following responsibilities:

- Saving life: The COVID-19 pandemic has reminded all of us of the vital role doctors play to relieve suffering and save lives. The pandemic has also highlighted the extent to which doctors are willing to go in ensuring a functioning health system and a functioning society. On a daily basis doctors also play key roles that save lives such as an emergency procedure or an elective procedure for a rather time sensitive or serious illness. An accidental injury and troubled labor also account for the same.
- Extending life: Unfortunately, not every illness can be cured completely. But with the effort of doctors and medicines and therapies, the lifespan of the patient or onset of the worst effect of an illness can be extended significantly. Though this time varies greatly from case to case and patient to patient, the efforts behind the cause are commendable.
- Preventive Medicine: Nobody wants to become sick, disabled or helpless. Preventing sickness or injury is a better choice: It's less expensive, better for our health and we lose less income if we don't get sick too often. Preventive treatment is also important for society as a whole. Many people in the U.S. and around the world can't afford drugs, hospital stays or surgery. By promoting preventive medicine and keeping people healthy, doctors reduce the health gap between rich and poor populations.
- Stopping Pandemics: Although doctors have not been able to completely stop the current Coronavirus pandemic, they have significantly reduced mortality from the disease. Black death and smallpox have wiped out millions of people throughout history; polio paralyzed thousands in the 20$^{th}$ century. By working to contain potential epidemics, doctors prevent disasters. Individual doctors don't fly solo in these crises. Fighting plagues takes money and organizations that work on a national and international scale. But doctors and other medical professionals are vitally important in the fight.
- Improving lives: Not every disease threatens the life of the patient. However, living with the discomforts for a lifetime is not an acceptable option either. The effort of doctors makes it possible to mitigate these discomforts and help live their life to the fullest.
- Economic Impact: A medical practice is a small business. Most doctors employ staff and rent or buy office space, pay contractors for repairs and generally improve the community's economic health as they improve their patients' health. For instance in 2018, Illinois had 30,000 doctors who support 146,000 jobs and indirectly support 250,000 more. A hospital or medical practice can be an economic driver in towns too small to support most other industries.
- Nutritional Emergencies: Doctors play a major role in nutritional emergencies, hunger and malnutrition are rampant among refugees and displaced populations, representing currently around 40 million people worldwide, many of whom – infants, children, adolescents, adults and older people – suffer from one or more of the multiple forms of malnutrition.
- Educating People: In the internet age, there's no shortage of medical malarkey flying around online. Whatever you're suffering from, someone knows a miracle cure. Whatever you're scared of, some website will shriek that it is much, much worse than you think. Doctors have the standing and the knowledge to push back against fake medical news. It's not just about teaching patients the real

steps to staying healthy. Sometimes it's explaining that there is no cure and so no point to spending money trying to conjure one up.

- Shaping Health Policy: State, local and federal governments have a big influence on our communities' health. Is our water safe to drink? Our food safe to eat? Is there a local treatment program for alcoholics or people hooked on painkillers? If contagious disease is a threat, how does the government mobilize doctors and other professionals? Doctors are only one voice among many that shape public policy. But they have a unique position of respect and trust, which they can use to push governments toward healthcare policies that will genuinely benefit the public.
- Military Roles: A military doctor provides health care to military personnel and their families and can work in a variety of settings, including hospital ships and international medical centers. Doctors enlisted in the military might take part in international relief efforts by providing care to victims of natural disasters. The military primarily employs doctors with specializations in common types of medicine such as pediatrics, family care, and neurology. If you would like to become a military doctor, you must earn a medical degree and meet military requirements.

### Q. Write a short note on expectations of society from doctors.

The society has various expectations from doctors and the healthcare care. These can be summarised as follows:

- The services of the healer: Society's primary expectation is that individuals will receive the services of the healer. They want caring and compassionate treatment, with their confidentiality respected and their dignity preserved. Furthermore, they want to retain control of the direction of their own treatment. Medicine must fulfill this role.
- Guaranteed competence: Society expects that the profession will ensure the competence of each physician by setting and maintaining standards for education, training, and practice—and by disciplining incompetent, unethical, or unprofessional conduct. The obligation of individual professionals is to maintain their own competence and to participate in the process of self-regulation.
- Altruistic service: Physicians are empowered to ask intrusive questions and carry out invasive procedures. For this to be permitted, patients must trust that their physicians will not pursue self-interest but have the patient as their first priority. This must not be an open-ended commitment that is incompatible with a healthy physician's lifestyle, but altruism is central to the social contract. The pervasive nature of conflicts of interest must be recognized and managed by individual physicians if they are to maintain patient trust. Professional organizations are also expected to demonstrate altruism, putting the interests of society above their own.
- Morality and integrity: Physicians are expected to demonstrate morality and integrity in their practice, and in their day-to-day lives. Physicians who do not do so will, without question, lose trust, and this will reflect upon the profession as a whole.
- Promotion of the public good: Inasmuch as the profession is given a monopoly over the practice of medicine, it is expected that its members will address the problems faced by individual patients and also concern itself with issues of importance to society.

- Transparency: Historically, professions carried out their deliberations in a relatively closed manner. This is no longer acceptable; it is now expected that public membership in regulatory bodies will be significant and that the establishment and maintenance of standards and policy will be done in consultation with public representatives.
- Accountability: For generations, physicians recognized that they were accountable to individual patients, to the public for advice on policy, and to each other for self-regulation. As medicine became more costly, it was inevitable that physicians would become accountable in both economic and political terms. These newer levels of accountability are a cause of major tension. A physician's fiduciary duty to patients now comes into conflict with the social purposes of medicine. Devoting resources to the care of a single patient inevitably diminishes the resources available for other patients. As the contract evolves, this tension will remain, but medicine's fiduciary duty to individual patients must take priority.

# SECTION 3: MICROBIOLOGY

Prashant Saraf, Harsh Marathe, Pauras Mhatre

## Modules:

2.5. Bioethics continued: Case studies on autonomy and decision making

2.6. Bioethics continued: Case studies on autonomy and decision making

2.7. Bioethics continued: Case studies on autonomy and decision making

# Module 2.5: Bioethics continued – Case studies on patient autonomy and decision making

## Background

The important parts of ethical care of the patient are best learnt in a hybrid problem-based format with additional lectures and other sessions that allow students to learn collaboratively with different learning styles. A guide for case discussion is provided in the resources section of this module and may be used as a guide for other modules. The key element is that students remain in the same group with the same facilitator since groups mature in their learning over time.

## Competency addressed

| The student should be able to: | Level |
|---|---|
| Identify, discuss and defend medico-legal, socio-cultural and ethical issues as it pertains to patient autonomy, patient rights and shared responsibility in health care | KH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 6

i. Introduction and group formation - 1 hour
ii. Case introduction - 1 hour
iii. Self-directed learning - 2 hours
iv. Anchoring lecture - 1 hour
v. Case Resolution - 1 hour

### Case: The Cover Up

You evaluate Mrs. Lakshmi Srinivasan who is a 48 year old woman presenting with lymphadenopathy. She had been complaining of mild fever and weight loss for the past 4 -5 months. Examination of the neck shows large rubbery lymph nodes that are present also in the axilla and the groin. There is a palpable spleen. She is accompanied by her caring husband.

Lakshmi undergoes a lymph node biopsy and the pathologist calls you and tells you that she has a lymphoma. That evening Mr. Srinivasan comes in first into your office and leaves the report on your table. As you read the description you realise that the final diagnosis has been altered to Tuberculosis by whitening out the pathologist's report. When you look up he tells you –"Sir, I googled lymphoma - it is almost like a cancer. My wife can't handle that diagnosis. She has always been a worried frightened person. I want you to tell my wife that she had TB. She is waiting outside, doctor. I thought I will call her in after I had a chat about this with you".

### Points for discussion:

1. Does the patient have a right to know their diagnosis?

2. What should the patient be told about their diagnosis, therapy and prognosis?
3. How much should be told to a patient about their illness?
4. Are there exceptions to full disclosure? Can family members request withholding of information from patient?

Assessment

1. Formative: The student may be assessed based on their active participation in the sessions.
2. Summative: Short questions on: 1) Define patient autonomy, 2) Contrast autonomy and paternalism, 3) What are the responsibilities of patients and doctors in shared decision making? 4) What is full and reasonable disclosure?

The suggested location, duration and requirements are as in item 2.

Once the case (or part of the case) is resolved, the next case (or the next part of the case) is introduced.

# Module 2.6: Bioethics continued: Case studies on autonomy and decision making

## Background

This introduces the student to further issues in autonomy including competence and capacity to make decisions (also see module 2.5).

## Competency addressed

| The student should be able to: | Level |
|---|---|
| Identify, discuss and defend medico-legal, socio-cultural and ethical issues as they pertain to refusal of care including do not resuscitate and withdrawal of life support | KH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 5

i. Introduction of case - 1 hour

ii. Self-directed learning - 2 hours

iii. Anchoring lecture - 1 hour

iv. Discussion and closure of case - 1 hour

### Case: Life on a machine

You are taking care of 78-year-old Mrs. Mythili who was living all alone in an apartment with only a live-in caretaker, 3 streets away from your clinic. She is a widow and her only son emigrated to the US 32 years ago. He visits her once a year. One year ago, she had a fall with a hip fracture that healed badly. She has hypertension which is reasonably controlled on medications. She continues to come to your clinic once a month. Four months ago, she spent some time talking about her sister who recently died following metastatic breast cancer. “My sister suffered a lot, Doctor - they put a tube down her throat to breathe. Even when her heart stopped they kept thumping her chest - it was awful. If I ever fall sick I don't want to go through all this. Promise me, doctor, that you won’t do all of this to me. I have lived all alone since my husband died but I have lived independently - now I don't want to depend on a machine to live”. You had reassured her that she would be ok and this was just the recent death of her sister affecting her. On subsequent visits she would still bring up this issue and state that there was no use of her living as a burden to anyone and that no one should endure what her sister had undergone.

One day you get a call from the Emergency Room of the local hospital stating that Mrs. Mythili has been admitted by the caretaker. She had developed fever and shortness of breath. She was brought hypoxic to the emergency room and they had intubated her. Chest X ray revealed a large pneumonic patch. Laboratory testing revealed hyponatremia.

When you visited her she is somewhat drowsy, intubated and restrained. The nurse tells you that she is sometimes lucid; at other times not even able to recognise her son who was there since this morning. She points out at the ET and makes a pleading gesture to remove it. Her son accosts you in the hallway. He tells you that he got a call while he was traveling in Singapore and took the first flight out to be with his mom. He was very distressed at his mother's health and that he wants "everything" possible done for her. You ask him if she had ever indicated what she wanted to be done if she were to require hospitalization and intubation - he says that he used to speak to her every month on the phone and she was always cheerful and enquiring about her grandchildren but did not talk about her health.

Points for discussion:

1. Extent of patient autonomy.
2. Elements in decision making: Competency vs Capacity.
3. Surrogacy in decision making.
4. Autonomy vs beneficence.
5. How much does family wishes count?
6. Legal, ethical and social aspects of 'Do not resuscitate'.

Assessment

1. Formative: The student may be assessed based on their active participation in the sessions.
2. Summative: Short questions on:
   a) What determines decision making capacity and competency?
   b) Who has the right to make decisions for a patient who cannot determine for himself?

Resources: See Module 2.5

# Module 2.7: Bioethics continued: Case studies on autonomy and decision making

## Background

This introduces the student to further issues in autonomy including informed consent and refusal (also see module 2.5).

## Competency addressed

| The student should be able to: | Level |
|---|---|
| Identify, discuss and defend, medico-legal, socio-cultural and ethical issues as they pertain to consent for surgical procedures | KH |

## Learning Experience

**Year of study:** Professional year 2

**Hours:** 5

i. Introduction of case - 1 hour
ii. Self-directed learning - 2 hours
iii. Anchoring lecture - 1 hour
iv. Discussion and closure of case - 1 hour

### Case: Who is the doctor?

A 54 year old man named Mr. Surendra Patel is admitted for acute chest pain in a medical centre. His father had died of a myocardial infarction at the age of 60. Two years ago, his brother had been admitted to a hospital with a myocardial infarction and had died after complications following an angioplasty. Mr. Patel is a diabetic and is on multiple oral hypoglycemic agents with moderate control. He is a businessman with his own small industry. After initial stabilization, the patient is comfortable and pain-free after analgesics, nitrates and statins. Preliminary blood tests and ECG confirm an acute coronary event. The next morning, the senior cardiologist makes rounds and reviews the patient. “You have unstable angina, Mr. Patel and require an angiogram. You may also require either a stent or coronary bypass after the procedure. The nurse will provide you with the necessary paperwork. Please sign it and I will plan the procedure for 4.35 AM tomorrow morning.”. “Doctor sahib”, asked Mr. Patel, “I am not comfortable with the idea of an angiogram; my brother died on the table when an angioplasty was being done. Aren’t there other tests thatyou can do? I am not happy with this option”. “Your brother would have had it with someone else, Mr. Patel - I have the best hands in town; nothing will happen when I do it” retorted the cardiologist. “But aren’t there any other options to see what I have? Is this the only test? I have read somewhere that you can do a CT angiogram”, persisted Mr. Patel. “Are you the doctor or am I the doctor?” retorted the cardiologist angrily. “If you are ready to do as I say, sign the papers and I will see you in the Cath lab tomorrow. Otherwise you are free to get discharged”. He stomped out.

Points for discussion:

1. Extent of patient autonomy.
2. Informed consent and informed refusal.
3. Conflict between autonomy and beneficence.
4. What should the patient be told about a procedure?
5. What must the informed consent include?

Assessment

1. Formative: The student may be assessed based on their active participation in the sessions.
2. Summative: Short questions on 1) What is informed consent? 2) What is informed refusal?

Resources

See module 2.5

# Questions and Answers

Q. Define patient autonomy

- Autonomy is one of the four principles of bioethics.
- Autonomy can be defined simply as patient's right over his/her own body.
- Principle of autonomy implies that any decision during the course of diagnosis and treatment of a patient should not be taken by physician alone without patient's permission. It is the patient and only the patient who can take the ultimate decision about what happens with his/her own body.
- Example of patient autonomy: A 45 year old man with no mental incapacity is diagnosed with cancer. Many treatment options like chemotherapy, radiotherapy are available. The doctor should present the available options and the patient has to choose any one or he can even deny any treatment.

*For more info, refer to section Pharmacology*

Q. What is paternalism? Contrast autonomy and paternalism. Describe soft vs hard paternalism.

- Paternalism is acting in fatherly manner to take decisions on the behalf of another person in their best interest based on superior knowledge and experience.
- In case of healthcare arena, it is the doctor taking decision on the patient without their full potential knowledge and consent.
- Paternalism violates the principle of autonomy.

| Paternalism | Autonomy |
|---|---|
| Promoting and restoring the health of patient | Respecting the patient's right to self determination and information |
| Providing good care | Respecting patient's integrity |
| Assuming responsibility | Promoting human rights |

- In soft paternalism, the physician acts on grounds of beneficence (and, at times, nonmaleficence) when the patient is nonautonomous or substantially nonautonomous (e.g., cognitive dysfunction due to severe illness, depression, or drug addiction). Soft paternalism is complicated because of the difficulty in determining whether the patient was nonautonomous at the time of decision-making but is ethically defensible as long as the action is in concordance with what the physician believes to be the patient's values. Hard paternalism is action by a physician, intended to benefit a patient, but contrary to the voluntary decision of an autonomous patient who is fully informed and competent, and is ethically indefensible.
- On the other end of the scale of hard paternalism is consumerism, a rare and extreme form of patient autonomy, that holds the view that the physician's role is limited to providing all the medical information and the available choices for interventions and treatments while the fully informed patient selects from the available choices. In this model, the physician's role is constrained, and does not permit the full use of his/her knowledge and skills to benefit the patient, and is tantamount to a form of patient abandonment and therefore is ethically indefensible.

Q. What is shared decision making? Elaborate on its importance.

Shared decision making (SDM) has been defined as: 'an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences"

Importance of SDM:

- Internationally, shared decision making is seen as a hallmark of good clinical practice, an ethical imperative,4 and as a way of enhancing patient engagement and activation. Increasingly, it is being advocated for in clinical guidelines and health care policies. While shared decision making is applicable to most situations, it is especially important in certain circumstances; for example, where the evidence does not strongly support a single clearly superior option (most clinical decisions) or where a preference-sensitive decision is involved. That is, when there is uncertainty as to which option is superior, each option has different inherent benefits and harms, or the decision is likely to be strongly influenced by patients' preferences and values.
- The relationship between shared decision making and evidence-based practice is becoming increasingly recognised. Shared decision making provides a process for bringing evidence into the consultation and incorporating it into discussions with the patient, along with discussion about the patient's values and preferences. In other words, it is an important, if under-recognised, component to evidence translation, a route by which evidence is incorporated into clinical practice. Shared decision making may also help reduce the unwarranted variation in care10 that may partially arise from clinicians' opinions dominating decision making, with insufficient consideration of both empirical evidence and patients' preferences.
- Patients and clinicians typically overestimate the benefits of interventions and underestimate their harms. Shared decision making can provide the opportunity for resolving this mismatch between clinician and patient expectations and the demonstrated benefits and harms of screening, tests and interventions. Consequently, shared decision making may reduce the inappropriate use of tests and treatments, such as those that are not beneficial for the majority or are associated with substantial risks or harms. As such, it can play a role in reducing the problem of overdiagnosis and overtreatment. Patients tend to choose more conservative options than their clinicians when fully informed about the benefits and harms.
- Most evidence about the effectiveness of shared decision making comes from trials of decision aids, where most research has been conducted to date. Decision aids have demonstrated effectiveness for increasing knowledge and risk-perception accuracy; improving patient–clinician communication; and reducing decisional conflict, feeling uninformed, passivity in decision making, and indecision about the choices made.

### Q. What are the responsibilities of patients and doctors in shared decision making

In shared decision making, the doctor should:

- Explain the diagnosis
- Avoid using medical jargon
- Explain treatment options
- Not hide information
- Tell pros and cons of every option

In shared decision making, the patient should:

- Listen to all medical concerns
- Should put his/her concerns in front of the doctor without hesitation
- Should give full history

### Q. What is full and reasonable disclosure? What are the exceptions to full disclosure?

A physician must disclose information that a reasonable person would want to have for decision making even though that information may cause the patient to refuse the treatment that the physician believes is in the patient's best interest. No piece of information should be kept hidden. Important concerns of the patient should be addressed. In other words, the doctor is legally bound to pass on every detail regarding the disease condition, nature of the proposed treatment, alternative treatments if any, and prognosis with possible risks and benefits of the procedure to the patient.

Exceptions to full disclosure:

1. Therapeutic privilege of doctor: Patient's physical and mental state, personality, and age should be considered. Full disclosure can result in frightening a patient who is already fearful or emotionally disturbed, who may refuse treatment when there is really little risk. The doctor should explain the risks to the family, note the same in patient's records explaining his intension and the reasons. For example, malignancy and unavoidable fatal lesions may not be disclosed to the patient. In such case scenario, if the family member requests that certain information should not be revealed to the patient, the doctor should ask the patient if they would prefer to ne told everything or would prefer their family to filter information.
2. Materiality: Materiality states that only that information should be stated that impacts the decision of the patients and unnecessary information should not be disclosed.

### Q. Elements in decision making: Competency vs Capacity - Compare and contrast.

Health care decision making is a process that includes definable steps in a desirable sequence. The process is universally relevant (i.e., it applies in all settings) and enduring (i.e., it has remained applicable over time and will continue to apply in the future). Physicians play an essential role in the health care decision-making process.

| Capacity | Competency |
|---|---|
| Capacity is defined as "a functional determination that an individual is or is not capable of making a medical decision within a given situation". This is relative to the baseline abilities of the patient, pertains only to the current situation, and takes into consideration the severity of the possible consequences. | Competency is defined as "the ability of an individual to participate in legal proceedings". Legal competence is presumed. To disprove an individual's competence, a hearing and presentation of evidence is required. |
| Capacity is determined by a physician. | Competence is determined by a judge. This legal determination is never determined by medical providers. |
| Capacity is also called clinical competency. | Competence is also called as legal capacity. |

| | |
|---|---|
| Assessment based primarily on the patient's capacity to understand an informed consent discussion. | Multiple areas of competency may be addressed in legal settings, such as competency to:<br>• Stand trial<br>• Be executed<br>• Be a parent<br>• Make a will<br>• Sign a contract<br>• Make health care decisions<br>Judges make final decisions about competency, sometimes after input from psychiatrists and psychologists, or other physicians.<br>Court opinions about competency should generally be left to psychiatrists with specific training in forensic psychiatry, except for competency to make health care decisions. |
| It uses information from clinical interview. | It uses testimony from legal representatives and physician's report. |
| Surrogate is an activated health care power of attorney. | Surrogated is a court appointed guardian. |

**Q. What is medical decision-making capacity? What are the components to determine decision making capacity? State the conditions in which decision-making capacity can be impaired.**

- Medical decision-making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment).
- The four key components to address in a capacity evaluation include: 1) communicating a choice, 2) understanding, 3) appreciation, and 4) rationalization/reasoning.
- Risk factors for impaired decision-making capacity:
    - Fear, discomfort
    - Age less than 18 or more than 85
    - Neurological, Psychiatric and developmental conditions
    - Significant cultural or language barriers

**Q. Define an advance directive. Write briefly on the documentation and scenarios of AD.**

- Definition: The term advance directive (AD) refers to treatment preferences and/or the designation of a surrogate decision-maker in the event that a person becomes unable to make medical decisions on their own behalf.
- Underlying principle: autonomy (self-determination)
- Studies have found that use of ADs decreases use of life-sustaining treatment and increases use of hospice and palliative care services.
- When to obtain an advance directive
    - The best time is often during a routine outpatient visit: Allows time for deliberation in a low-pressure situation

    - Physicians should start discussions with patients regarding ADs as early as possible, while a patient is healthy and competent.
    - Advance directives should be obtained/updated:
        - On hospital admission
        - Prior to surgery
        - On diagnosis with: A terminal illness or a disease associated with dementia
    - Desires regarding life-sustaining treatments are not always stable over time and may change. Therefore, ADs should be revisited and updated periodically.
- Common scenarios: Some of the most common scenarios in which ADs are used include:
    - Coma
    - Persistent vegetative state
    - Severe brain injury
    - Stroke
    - Dementia or advanced Alzheimer's disease
    - Critical medical illness affecting mental capacity
- Documentation
    - In order for an AD to be honored, it must be prepared before the patient loses medical decision-making capacity.
    - Advance directives must be noted in the medical records.
    - Often requires assistance from the attending physician and an attorney (exact requirements and policies differ between states)

Q. Describe the various types of advance directives briefly.

There are multiple types of ADs, including living wills, designation of a health care proxy and/or a durable Power of attorney, or physician's orders for life-sustaining treatment.

- Living will
    - Written document that states what medical treatments the patient desires (and which they prefer to omit or refuse) should the patient become incapacitated.
    - May be very general or very specific
    - Includes instructions for things such as:
        - Rejecting artificial airways (i.e., intubation) and/or ventilators
        - CPR
        - Use of feeding tubes and/or IV fluids for nutrition and hydration
        - Analgesia/pain relief
        - Use of antibiotics
    - The most common statement in a living will reads something similar to, "If I suffer an incurable, irreversible illness, disease, or condition, and my attending physician determines my condition is terminal, I direct that life-sustaining measures that serve only to prolong my dying be withheld or discontinued."
- Health care proxy
    - A legal designation in which a patient designates another person (also called a surrogate) to make health care decisions on their behalf if the patient is rendered incapable of making their wishes known

    - The health care proxy has the same rights to request or refuse treatment that the individual would have if they were capable of communicating their wishes.
    - The health care proxy is someone who should make decisions (to the best of their ability) that are consistent with and based on the patient's will.
- Durable power of attorney
    - A signed legal document authorizing another person to make medical decisions on the patient's behalf
    - Unlike the health care proxy, a power of attorney also allows the designated person the ability to execute certain legal documents and activities, including:
        - Make bank transactions
        - Sign social security cheques
        - Apply for disability
        - Write cheques to pay bills
    - In health care, the POA may be referred to more specifically as a durable power of attorney for health care (DPAHC).
- Physician's orders for life-sustaining treatment
    - Newer form of AD
    - Agreement between the doctor and the patient regarding the patient's condition that records the patient's wishes as medical orders
    - The physician's orders for life-sustaining treatment could be void if they contradict a preexisting living will.
- Do not resuscitate and do not intubate orders
    - Do not resuscitate (DNR) and do not intubate (DNI) orders are ADs in the form of a physician's order that instruct health care personnel not to perform resuscitation or intubation for patients in critical condition.
    - Requested by a patient as part of living will or by the patient's health care proxy
    - Order must be written by doctor
    - Typical DNR/DNI orders prevent health care providers from performing the following procedures:
        - CPR (chest compression)
        - Intubation and mechanical breathing
        - Electrical cardioversion
        - Administering antiarrhythmic or cardiac resuscitation medications (e.g., epinephrine)
    - Although DNR is not yet legally recognized in India; in May 2020, the Indian Council of Medical Research (ICMR) published its long-awaited 'do-not-attempt resuscitation' (DNA-R) guidelines.
- Ethics committees
    - Can help in cases where patients left no AD and/or have no health care proxy
    - Provide both legal and moral support to doctors when there are no further treatment options available

**Q. What is surrogacy in decision making. Who has the right to make decisions for a patient who cannot determine for himself?**

*Refer to the above question of Advance directive*

## Q. Describe the process of choosing autonomy vs beneficence in a setting of ethical dilemma.

- By definition, an ethical dilemma involves the need to choose from among two or more morally acceptable options or between equally unacceptable courses of action, when one choice prevents selection of the other. It is a clinical situation in which 2 ethical principles are at odds. Advances in medicine, increasing economic stress, rise of patient self-determination and differing values between healthcare workers and patients are among the many factors contributing to the frequency and complexity of ethical issues in healthcare. Course of the action must be taken in transgression of one of the two.
- Each one of the 4 principles of ethics is to be taken as a prima facie obligation that must be fulfilled, unless it conflicts, in a specific instance, with another principle. When faced with such a conflict, the physician has to determine the actual obligation to the patient by examining the respective weights of the competing prima facie obligations based on both content and context.
- Faced with the contrasting paradigms of beneficence and respect for autonomy and the need to reconcile these to find a common ground, Pellegrino and Thomasma argue that beneficence can be inclusive of patient autonomy as "the best interests of the patients are intimately linked with their preferences" from which "are derived our primary duties to them."
- One of the basic and not infrequent reasons for disagreement between physician and patient on treatment issues is their divergent views on goals of treatment. As goals change in the course of disease (e.g., a chronic neurologic condition worsens to the point of needing ventilator support, or a cancer that has become refractory to treatment), it is imperative that the physician communicates with the patient in clear and straightforward language, without the use of medical jargon, and with the aim of defining the goal(s) of treatment under the changed circumstance. In doing so, the physician should be cognizant of patient factors that compromise decisional capacity, such as anxiety, fear, pain, lack of trust and different beliefs and values that impair effective communication.
- In the resource book for clinicians, Jonsen et al. have elucidated a logical and well accepted model, along the lines of the systematic format that practicing physicians have been taught and have practiced for a long time (Chief Complaint, History of Present Illness, Past History, pertinent Family and Social History, Review of Systems, Physical Examination and Laboratory and Imaging studies). This practical approach to problem-solving in ethics involves:
    - Clinical assessment (identifying medical problems, treatment options, goals of care)
    - Patient (finding and clarifying patient preferences on treatment options and goals of care)
    - Quality of life (QOL) (effects of medical problems, interventions and treatments on patient's QOL with awareness of individual biases on what constitutes an acceptable QOL)
    - Context (many factors that include family, cultural, spiritual, religious, economic and legal).
- Using this model, the physician can identify the principles that are in conflict, ascertain by weighing and balancing what should prevail, and when in doubt, turn to ethics literature and expert opinion.

## Q. What is informed consent? Explain in details about contents of an informed consent in surgical procedures or research. What is informed refusal?

Informed Consent:

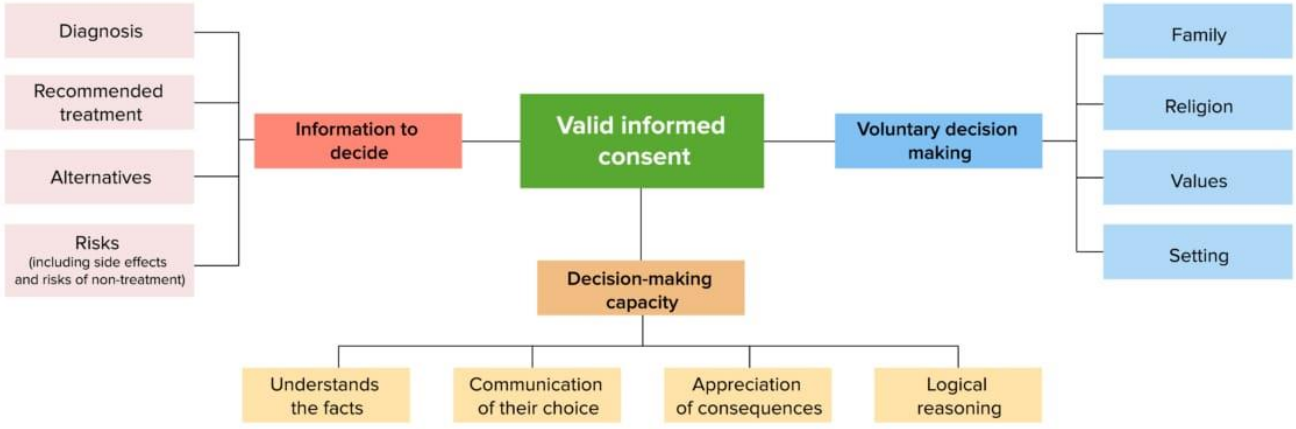
- Definition: Informed consent (IC) is a medicolegal term describing the conversation between patient and physician wherein the physician provides all relevant and necessary information for a patient to make an informed and free decision regarding their care.

- Characteristics of informed consent:
    - Fits firmly with the foundation of ethical medical practice, consisting of the basic ethical principles of autonomy, beneficence, nonmaleficence, and justice.
    - To keep the patient's best interests intact first and foremost, IC has the underlying specific principle values of autonomy:
        - Voluntariness (exercise of autonomy free of external influence)
        - Patient well-being
    - The 3 basic components of IC—competency, disclosure, and voluntariness—were expanded to 4 basic elements by Cordasco in 2013:
        - Description of the clinical problem, the proposed treatment, and alternatives, including no treatment
        - Discussion of the risks and benefits of the proposed treatment, with comparisons to the risks and benefits of alternatives, and discussion of medical and clinical uncertainties regarding the proposed treatment
        - Assessment of the patient's understanding of the information provided by the medical provider
        - Solicitation of the patient's preference and consent for treatment
    - Incorporates ethical and legal obligations of medical professionals to ensure that:
        - The patient is competent (i.e., has decision-making capacity); they have the ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
        - The patient comprehends the information provided, including explanations and disclosures of the: Intended intervention, Possible risks and complications, Benefits of procedures, Available alternatives, including the consequences of forgoing treatment
    - Represents collaborative decision-making between the clinician and the patient regarding the steps that will be followed in care. "Informed consent" is both a written form and a discussion.
- Instances to obtain informed consent:
    - Informed consent is obtained for procedures or interventions with significant risks that must be understood by the patient or the surrogate decision-maker. Includes enrollment in research studies, which also contemplates proper use of data.
    - Although there is no universal rule concerning when and which procedures require consent and documentation, a written consent form is usually prepared for invasive procedures that have relatively higher risks in clinical practice.
    - Verbal consent is sufficient for minor parts of care (e.g., physical examination, taking blood pressure, taking blood samples); it may also be used if the patient has a disability that prevents them from signing a consent form.
- Format and documentation:
    - Consent is formally obtained as a written document signed by the patient and the physician. Information that must be contained in the informed consent document:
        - Nature of the procedure or intervention
        - Risks and benefits of the procedure
        - Reasonable alternatives
        - Risks and benefits of alternatives

        - Assessment of the patient's understanding
    - The "teach-back" technique—asking patients or prospective participants to discuss the proposed treatment in their own words—is recommended: allows for gauging comprehension and identifying gaps in participants' understanding:
        - "Can you describe the study in your own words?"
        - "Do you have any questions about the purpose of the proposed treatment?"
    - Verbal consent must also be documented in the medical record.
    - Legally, written consent has precedence over verbal consent.
    - If there is no consent document for a specific procedure, physicians may write notes about possible risks in the chart.

<u>Informed refusal:</u>

- Informed refusal is where a person has refused a recommended medical treatment based upon an understanding of the facts and implications of not following the treatment. Informed refusal is linked to the informed consent process, as a patient has a right to consent, but also may choose to refuse.
- It is an attempt to balance provider's duty to care for patient with respect for patient autonomy and patient's right to self-determination.
- It deals with legal issues and denotes that the doctor has fulfilled his duty.




**For further reading, students may read the cases and their discussions given in** - Varkey, B. (2020). Principles of clinical ethics and their application to practice. In Medical Principles and Practice. S. Karger AG. https://doi.org/10.1159/000509119 - https://www.karger.com/Article/FullText/509119

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