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Review Article

Education Section

Will AETCOM Resurrect Empathy in Medical Profession? A Lost Touch of Compassionate Communication

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ABSTRACT

To make the existing Bachelor of Medicine and Bachelor of Surgery (MBBS) curriculum more effective as per the healthcare needs of the nation, the Medical Council of India (MCI) has taken a bold step by proposing new teaching-learning approaches including, a structured longitudinal program on attitude, ethics, and communication, which is named as the Attitude, Ethics and Communication Module (AETCOM). Intervention like AETCOM is required because the fragmental, ignored and traditional approach of learning empathy and communication was not standardised nor effective. This lead to devastated doctor patient relationship resulting in rising number of medicolegal cases in the scenario. It's been two years since the introduction of the module and many studies have been conducted to analyse the effectiveness of the same. However, some questions still remain unanswered, such as- Will this introduction of humanities in medicine infuse values and art of medicine with ever-growing science? Will it be successful in inculcating probity in Indian medical graduate? If no, then what needs to be done to get a better outcome for the same. Authors want to spread awareness by sparking curiosity in both medical and general population through this article and in the process, make efforts wants to find out improvements to be done right now to ensure we get good doctors in the future.

Keywords: Attitude ethics and communication module, Humanities in medicine, Medical council of India, National medical commission

INTRODUCTION

What is the Problem?

When every medical student starts their journey in the first year all have different dreams and aspirations, but one goal is common for all, they all want to be "a good doctor". Every human has certain notions about "good doctor", but the most important is the perception of the patient [1]. So, the next question is-are we as a system producing doctors who are good enough? The highest governing authority in the health system is trying its level best to achieve the same. The medical curriculum and training programs designed by the MCI and currently updated by the National Medical Commission (NMC) were to address Specific Learning Objectives (SLOs) addressing primarily three domains: cognitive, psychomotor, and affective (head, hand, and heart, respectively). However, until recently, the traditional way of medical education in India dealt mainly with the head compared to the hand and nearly neglected the heart. Hence, it was not upto the mark to produce a clinician who could provide a holistic approach to patient care (i.e., preventive, curative, and palliative care) with empathy and compassion [2].

The rising number of medicolegal cases in present time are in support with foresaid statement [3]. Bevinahalli N, in his article has mentioned that best way to deal with medicolegal issue is preventing them and changing the attitude. He also states that good communication skill is beneficial for doctor patient relationship [3]. These kinds of outcomes based on current observation and previous research demanded a dire need for revision of the existing medical curriculum, but, with careful approach towards understanding medical student needs also while keeping patient centered training [4]. So by applying trial and error method and after lots of churning, Competency-Based Medical Education (CBME) came into existence starting from 1st phase to 4th phase of medical school in forms of three curriculum modules [5-7]. After completing national level sensitisation of faculties proactively, this programme was implemented for undergraduate medical batch from the year 2019 as per the latest Graduate Medical Education Regulation (GMER 2019) by NMC. The uniqueness is that the outcome is expressed in terms of competencies which are standardised even to teach empathy, communication and leadership; the nuances which addresses the affective domain covered in AETCOM [8]. The CBME curriculum has successfully incorporated the AETCOM, which addresses the "heart" and emphasises on instilling proper attitude and communication skills and to prepare medical graduates to practice ethically in the real world scenario.

The GMER and AETCOM module are more of a guideline and every college and university are given the freedom to adapt and form their working plan of assessment. Whatever the plan of action is, a record of every proceeding is to be maintained and sent to the MCI regional centre. The regional centre will then compile all the activities of the sister medical college and hospitals and communicate to the nodal centre and subsequently to MCI. Even after clear cut division of AETCOM competencies according to subject disciplines and faculty sensitisation, AETCOM module is getting mixed response [9,10].

So, the onus is on medical faculty to introduce and teach AETCOM modules in a way that is motivating and interesting enough to grasp and practice soft skills as per their professional and personal needs. Medical teachers also need to develop a proper assessment methodology for feedback purposes for the newly introduced modules. But the question here is- Are the students willing to learn all this? As a student, they will not focus on "what to learn" if they are not sensitised enough for "why to learn". Medical students are already stressed about the herculean task of completing the course before the exam [11] so they plan strategically and stake-wise where AETCOM may be the last of their list to do if not enough sensitisation and weightage according to marks is given. It is also reported that students grow more apathetic towards AETCOM skills in the 4th phase compared to the 1st phase [4].

Some researchers found that students were not showing keen interest and exhibiting casual behaviour towards this module and some found that when taught properly and assessed properly AETCOM modules are perceived well by students [12,13]. So, it is

required to work out probable reasons for the apathetic behaviour of the students towards soft skills as they are moving ahead in their medical studies and atleast try to find the middle ground.

Some of the reasons for apathetic behaviour towards the module could be as given below:

- Lack of proper weightage in marking system of the paper (six marks for this module assessment).
- Wrong methods for assessment [12].
- Inability to understand the importance of the module.
- Not taught in a way that excites them or makes them curious to learn more about the same [13].
- Soft skills were never taught to medical students as a part of the curriculum, so they are nonchalant about this, though it is a known fact that soft skills play a very important role in the doctor-patient relationship and can be used judiciously for a better outcome.
- The confined environment of medical schools leads to difficulties in accepting newer module introductions other than their conventional medical subjects [14,15].
- As it is new for the teacher as well, they are struggling with authentic resources and content [15].

THE PROPOSED SOLUTION TO THE PROBLEM

Solution of a problem requires giving consideration to several points of a problem which should be addressed properly to get a better solution, so brainstorming sessions among the faculty should be encouraged by the medical education unit of the institutions to answer the following questions:

- How much training for skill development (AETCOM) will be sufficient and effective?
- Which Teaching-Learning methods (T-L methods) should be included to make the students more receptive towards the subject?
- How can students be sensitised for soft skill development and interest in humanities in the medical field?
- How can we motivate students to take this module seriously as lifelong learners?

Following are the points which can be taken into account when we are planning to introduce the AETCOM module:

A better understanding of the module with its importance in the medial field

(What is AETCOM? Why practice AETCOM?)

First thing is to explain to the students about the importance of soft skills in every phase of their lives, professional as well as personal. With examples, they can be assured that effective communication and empathetic behaviour towards a patient will help them not only to become a good doctor but also score better in standardised patient examinations [16]. For this, faculty can opt for interactive discussions where they can act as a moderator and let the students discuss the topic at length and can encourage them to discuss how a good communication skill can change the scenario between a patient and doctor and how a doctor can secure faith of a patient using soft skills [17,18]. Role playing as T-L a method can be chosen to convey the message loud and clear [19].

Reflection Method

If students are asked to share/write some good, not so good or bad experiences of their life depicting the importance of soft skills, they will realise the magnitude of its importance in-depth to maintain work/life balance [20].

It's a proven fact that assessment motivates a student to learn better. "Good Student" who is on top of the curve bell based on the marking system might not be a "Good Doctor" [21]. But an age-old fact is that good scoring in the long run is always motivation for learning [22]. So, to promote interest academically, internal marking system can be included for this module, where students will be observed and marked for their soft skills during the clinical labs where they are interacting in simulating environment (holistic evaluation).

Activity based Learning

To ensure good empathetic compassionate communication skills in future Indian medical graduates, history taking should be made compulsory in phase one of university exams, emphasising soft skills which can be taught as a part of Early Clinical Exposure (ECE) [23]. Medical students are already burdened with the shortage of time, but a creative solution like the use of compulsory extracurricular time slots may be pondered over. The NMC has made it compulsory to provide some slots for extracurricular activity which needs recording in logbooks of students. During those sessions, debate or monologue or essay writing competitions can be arranged on topics (under the guidance of faculty) like:

- Violence against doctors
- Good clinical practices
- Reasons and solution for increasing medicolegal cases against doctors
- Expectations of a doctor from the patient and their relatives
- Expectations of a patient from the hospital and the doctor
- Importance of local languages in clinical practice
- How to use soft skills to break bad news
- Importance of body language in doctor patient relationship
- Communication skills to break the bad news to patient's relatives
- Use of soft skills in dealing with patient's relatives

There is research indicating that point of view writing can improve affective dimension skill, although the translation in clinical correlation is a matter of further research [24].

Learning through Available Research Material

First-year onwards students can be moved from theory to practice mode asking them to share their experiences of clinical postings. Students could be asked to choose soft skills in their postings and then to write their experiences of soft skills. Such small reflections will motivate them to become good empathetic communicators. Lots of research work has been done on, "Empathetic and compassionate behaviour and good communication skill." Following points with scientific proofs can be discussed at length for a better understanding of the subject in interactive sessions for students:

1. Proper dressing which is respectable in your community and culture, apron and stethoscope is a must [25,26].
2. Wearing a smile or soft gesture even in case of tension. Use of small introductory sentences to make the patient comfortable [27].
3. Showing interest while listening to the patient's problem by slightly leaning forward and maintaining eye contact. Non verbal expressions which we discussed in the above examples are important, such as eye contact, the facial expression of a doctor, your gestures, body language, tone of your voice and silence [27].
4. Maintain distance that is comfortable for the patient, going too close may be uncomfortable for both doctor and patient.
5. To sit in relaxed and attentive mode. There is a study which states that, when doctors on rounds sit beside the patient,

the history taking is fast and productive compared to standing doctors, because, when doctor sits near bedside the patient feels calm and properly attended [28]. During faculty-student interaction one clinical faculty suggested that students should not wear their backpack during history taking because it is an indirect sign to the patient, that they want to complete history faster, if possible and allowed the student to sit on a stool or chair nearby the patient while taking history.

6. Some minor behaviours give wrong impressions to the patient while he or she is telling their problem to the doctor. We should avoid such behaviours such as checking watch too often, wearing a backpack, doing another work, talking over the phone or talking to someone else. Even small movements like shaking legs/hands, tapping fingers on table or bedside were included as unprofessional behaviour [29]. Unprofessional behaviour breaches patients' trust to open up to the doctor and creates disinterest in sharing their things. The patient might hide the most crucial details which are very personal in the case of psychiatric patients or sexually transmitted disease patients.
7. During student-faculty interaction one unique question came where student raised an issue that "the events reported by patients were so tragic I got no words to say. What can I do in that position? Then a psychiatric faculty replied a silent pause is also empathetic. Then she gave example "what I mean by silence- some time lady patient shares a very bad experience with us, like a death in her family and she starts crying. At that time, you might be confused about how to give her consolation? Your intention might be good, and you would say something like "Its god wish. What can we do?" if your tone is not appropriate it may sound rude and apathetic to patients. On such occasions when you are not sure about words, silence is better. Just take a silent pause and if the patient is female then you can just slightly gently tap her on the back or hands, or if the patient is male, please don't touch just offer her water. Don't try to rush on the next question. Just give her some time in such scenario, as silence has empathetic value.
8. Gender issues- As discussed in the above scenario, in our Indian culture if you touch the opposite gender, even in an attempt to console, it might be taken offensively by patient. So as a doctor, whenever you are examining a patient of the opposite gender, for example you are male doctor and examining female patient, a lady attendant who can be patient relative or your doctor colleague or a nurse must be present there to avoid medicolegal complication [3,29]. In examination room, third party attendant should be always present regardless of gender of patient [3,29].
9. Summarising in the end is very important- After taking such long history and examination you must inform patient that why did you ask all this. How it helped in provisional diagnosis and what is next stage. If you are a student than ask to your clinical teacher about this and communicate appropriately. Don't forget to thank the patient for their time and cooperation. Leaving without informing them is impudently unprofessional [29].

Despite the guidance given by NMC, faculties and students both are novice exploring the new course ahead. In this review we are lacking in communication and information from patient side at local level and no generalised concepts have been given by faculties regarding patients point of view. The previous researches done in western countries are used for concept. But India is very different in societal, cultural, geographical and religious manner. So, translating their thoughts and ideas in accordance to Indian community is challenging and limiting factor for this article.

CONCLUSION(S)

The introduction of the AETCOM module in different phases of undergraduate medical course is an attempt to reintroduce the lost touch of humanity in medicine. In earlier times, these soft skills were taught by seniors and clinical teachers through their actions, but in the present scenario, it is almost negligible in magnitude. Soft skills and empathy can be used by a medical practitioner as a tool in the treatment process. The AETCOM module introduction has its share of problems related to its implementations and assessments. To overcome these hurdles medical fraternities are advised to learn through reading, research, brainstorming sessions, and then to make the module interesting, motivating, and assessable for the students. A lot of revisions of these sessions will be required to get the desired outcome. So, there is a hope that the AETCOM module might resurrect empathy and compassionate communication in the doctor-patient relationship in the future.

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