

AETCOM Competencies for Indian Medical Graduates

Your Guide to Attitude, EThics, and COMmunication

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Second Edition

Forewords by Tejas M. Patel and Praveen R. Singh



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Key Highlights

Module Openers

The Architect of Healing: Foundations of Attitude, Ethics, and Communication for the Indian Medical Graduate

The Affective Transformation of the Medical Student

The transition from a student of science to a practitioner of medicine represents one of the most significant psychological and professional shifts in a human life. In the traditional medical curriculum, students were often inundated with cognitive data, biochemical pathways, physiological mechanisms, and anatomical structures,

Every module opens with an introduction to the module that helps aligning the readers with the objectives of the module.

Executive Summary Boxes

Concise executive summaries provide quick overviews of key concepts, ensuring rapid orientation and focused learning.

Executive Summary

In this foundational section, students will explore the multifaceted identity of the physician within the modern health care ecosystem. The module focuses on defining the professional qualities and roles of an IMG as mandated by the NMC. Learners will be introduced to the concept of the physician as a "five-star doctor," balancing clinical excellence with social accountability. The section details the transition from a science student to a medical professional, emphasizing the development of "moral intellect," the capacity to practice with responsibility, accountability, and ethical integrity.

Key learning objectives include understanding the physician's duty to the community, the necessity of lifelong learning in an evolving scientific field, and the importance of altruism in daily practice. Students will also learn how physicians contribute to the generation of health care data through meticulous record-keeping and participation in public health initiatives. By the end of this section, students will be able to articulate the professional expectations of an IMG and recognize the physician's role as a leader in public health initiatives.

Professional Year 1

Tables

Role of the IMG	Functional definition	Professional goal
Clinician	Provides preventive, promotive, curative, palliative, and holistic care	To provide evidence-based care with compassion and competence
Leader and team member	Collects, analyzes, and communicates health data; leads health care teams	To optimize health care delivery systems for the benefit of the patient
Communicator	Effectively interacts with patients, families, colleagues, and the community	To build a "covenant of trust" through transparent and empathetic dialogue
Lifelong learner	Commits to continuous professional development and knowledge updates	To ensure that clinical practice reflects the most current medical evidence
Professional	Upholds ethical values, demonstrates accountability, and respects autonomy	To maintain the dignity and sanctity of the medical profession

Pr 1

Well-organized tables present roles, professional qualities, and key concepts in a structured format for quick reference and recall.

Discussion Questions

Thought-provoking questions encourage reflection on ethical dilemmas and professional responsibilities, while structured analysis and model answers support critical thinking and help students frame appropriate exam responses.

Discussion Questions

Q1. Discuss the commitment to lifelong learning as an important part of physician growth.

Analysis:

Answer: Lifelong learning is not just a personal choice but also an ethical obligation that defines a physician's career growth and ensures the safety of the public.

- The velocity of medical change:** Medical knowledge is estimated to double every few years. New diseases (like COVID-19), breakthrough drugs, and innovative technologies (such as telemedicine and AI) emerge rapidly. A doctor who fails to keep pace becomes an obsolete and potentially dangerous practitioner.
- Ethical duty toward patients:** Patients trust their doctors to provide the most current and effective care. Continuous education reduces medical errors, enhances diagnostic accuracy, and allows for the implementation of evidence-based protocols that lead to better patient outcomes.

Learning Checkpoint: Self-Assessment Questions

Learning Modules for Professionals

Learning Checkpoint: Self-Assessment Questions
1. Describe the role of “altruism” in the daily practice of an IMG working in a resource-limited government hospital.
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Checkpoint questions help learners assess understanding and reinforce key concepts through active recall.

Case Discussion

Realistic case scenarios integrate ethics, communication, and clinical reasoning, promoting application-based learning.

Case Discussion: The Senior Resident's Commitment to Holistic Care
The Situation
Dr. Meera is a Senior Resident in Internal Medicine at a high-volume government hospital in North India. It is 2:30 p.m., and she has already seen over 150 patients in the outpatient department (OPD). The environment is noisy, crowded, and emotionally draining, with the smell of floor cleaner mixing with the humidity of the crowded corridor. Dr. Meera feels the physical strain of the day but maintains her composure.
Mr. Ramesh, a 52-year-old daily wage laborer from a rural village 6 hours away, has finally reached her desk after waiting since 6 a.m. He presents with persistent fatigue

Role Play/Dialogue-Based Learning

Learning Modules for Professionals

Dr. Meera: (Noticing Mr. Ramesh standing hesitantly by the door, she signals the attendant to wait and gestures to the stool next to her) "Please sit, *Rameshji*. I can see you have traveled quite a distance today. My name is Dr. Meera. Tell me, what has been troubling you the most?"
Mr. Ramesh: (Wringing his hands, voice trembling) "*Namaste, doctor sahiba*. I... I feel very weak. I can't even walk to the fields anymore. My clothes are loose, and there is a strange pain here in my stomach. My neighbor said it could be a curse because I sold my old tractor. I am very scared."
Dr. Meera: (She stops her current task, turns fully toward him, and maintains soft eye contact) "It is natural to feel scared when your body feels like it is failing you, but I am glad you came here. A "curse" is how we often try to explain things that feel out of our control, but we are going to look for a medical reason for this. Tell me, when did the pain start? Does it get worse after eating?"

Simulated doctor–patient interactions enhance communication skills, empathy, and professional behavior in clinical settings.

Case and Feedback Discussion

Dedicated case and feedback spaces promote self-assessment and continuous professional development.

Learning Modules for Professionals

Case Discussion
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Feedback/Reflection Decision
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Inclusion of LGBTQ+, Responsible Use of Social Media and Artificial Intelligence

From the Author
LGBTQ+
Using Social Media as a Medical Professional
Artificial Intelligence and Its Ethical Integration in Clinical Medicine
Pedagogical Appendices and Assessment Tools
Appendix 1: Formative Assessment of Non-Technical Competencies
Appendix 2: Clinical Communication Skills Assessment Tool
Appendix 3: Student Engagement and Feedback Framework

Simulated doctor–patient interactions enhance communication skills, empathy, and professional behavior in clinical settings.

Foundation Booklet

Comprehensive, Modular, and NMC-Aligned Curriculum with Embedded Assessment

The Foundation booklet presents an integrated 84-hour modular curriculum with mapped competencies and built-in assessments for standardized, NMC-aligned training.

Master Bouquet of Topics and Session Syllabi per Module

The master catalog below provides a structured bouquet of topics designed for the modern 84-hour curriculum. This layout allows medical colleges to select individual sessions while remaining fully compliant with NMC guidelines.

You can select sessions from each module as per choice; ensure covering all modules and 84 hours of sessions.

Master Curriculum and Topic Selection Catalog (Comprehensive Topic Bouquet)

Module Number and Name	Core Topic and Session Title	Session Duration (Hours)	Suggested Teaching-Learning Method	Associated Competency Code	Assessment and Validation Method
Module 1: Orientation and the History of Indian Medicine	Session 1.1: Welcome and Inaugural Address: Introduction to institutional legacy, mission, and code of conduct	2 Hours	Inspirational Address & Faculty Panel	FC 1.4, FC 1.5	Attendance Registration & Entry Voucher

Contemporary Curricular Expansions

The second edition of this guide-cum-logbook has been meticulously expanded with three pioneering, contemporary modules. These supplementary chapters bridge the gap between traditional medicine and the rapidly evolving sociocultural, professional, and technological landscape of modern clinical practice.

1. LGBTQ+ Inclusivity and Transgender Health in Competency-Based Medical Education

This chapter equips the Indian Medical Graduate (IMG) with the attitudes, legal awareness, and clinical skills required to provide safe, dignified, and non-discriminatory care to sexual and gender minorities.

- **Clinical Inclusivity and Legal Frameworks:** The module traces the landmark legal shifts in India, including the *NALSA vs. Union of India (2014)* ruling recognizing the third gender, the 2018 striking down of Section 377, the Transgender Persons Act 2019, and the historic *S. Sushma vs. Commissioner of Police (2021)* Madras High Court directive that banned unscientific, derogatory queerphobic text in medical curricula and outlawed “conversion therapy” as professional misconduct.
- **The 5Ps of Patient-Centered Queer Health Care:** Students are introduced to a practical, five-dimensional clinical framework to assess and address the unique experiences of LGBTQ+ patients:
 1. Past experience: Managing historical medical trauma.
 2. Present preferences: Documenting correct personal pronouns and chosen names to prevent “deadnaming.”
 3. Perceptions: Addressing bodily dysphoria during physical examinations.
 4. Personal and social challenges: Evaluating familial rejection, financial instability, and socioeconomic barriers.
 5. Psychological aspects: Empathetically screening for elevated rates of depression, anxiety, and minority stress.
- **Trans-Affirmative Clinical History Taking:** The chapter teaches clinical execution of an “anatomic/organ inventory” (decoupling organ screening from gender presentation) in alignment with WPATH SOC 8 to prevent critical diagnostic omissions (e.g., cervical Pap smears for trans men or prostate screenings for trans women).
- **Endocrine Society of India GAHT Protocols:** Students will learn the physiological, pharmacological, and risk-management parameters of gender-affirming hormone therapy (GAHT), including tracking venous thromboembolism (VTE) risks under feminizing hormone therapy (FHT) and monitoring hematocrit/lipid profiles under masculinizing hormone therapy (MHT).

2. Professional and Ethical Social Media Conduct for Registered Medical Practitioners

As digital platforms transform public health outreach, this chapter provides a vital ethical compass for doctors navigating the professional boundaries of the digital space.

- **The Abeyance Dilemma and Core Regulations:** The book explores the transition from the old Indian Medical Council (IMC) Regulations 2002 to the modern draft NMC RMP Regulations 2023, establishing these guidelines as the absolute ethical standard.

- **Information vs. Commercial Solicitation:** The chapter details the “Golden Rule” of digital marketing: RMPs may publish factual, verifiable public health education, but are strictly prohibited from soliciting patients. The book features a comprehensive, easy-to-use **Permitted vs. Prohibited Digital Engagement Matrix** mapping platform metrics, practice announcements, patient testimonials, before–after photos, and clinical outcome displays.
- **High-Fidelity Digital Case Studies:** Students engage in interactive, case-based analysis of three real-world social media violations:
 - The LPG Burn Viral Post: Examining the legal consequences (under the DPDP Act 2023) of sharing patient-related clinical photographs without explicit, written informed consent, even when names are omitted.
 - The Reels Consultation: Analyzing the ethical hazards of recommending specific Rx therapeutic dosages on public videos, violating telemedicine guidelines and bypassing the necessary doctor–patient relationship.
 - The Insecure WhatsApp Peer Group: Exploring passive complicity and the ethical mandate for robust data de-identification when sharing imaging scans on professional digital networks.

3. Artificial Intelligence and Its Ethical Integration in Clinical Medicine

This highly futuristic module prepares students to ethically harness the power of AI, machine learning, and Large Multimodal Models (LMMs) without compromising patient safety, privacy, or professional accountability.

- **Global and National Ethical Mapping:** The book aligns clinical practice with the World Health Organization (WHO) guidance on Ethics and Governance of AI for Health (2021) and the Indian Council of Medical Research (ICMR) Ethical Guidelines (2023). It details how AI must function under six non-negotiable principles: human autonomy, data privacy (aligned with the DPDP Act 2023), transparency, accountability, equity, and risk minimization.
- **The “Human-in-the-Loop” (HITL) Liability Model:** The module provides a clear legal and moral breakdown of shared liability: software/code bugs remain the developer’s responsibility, but clinicians who blindly accept flawed algorithmic outputs without clinical verification remain fully liable for medical negligence.
- **Algorithmic Vulnerability Vignettes:** Through interactive case discussions, the chapter exposes major AI failure modes:
 - The Fabricated Oncology Protocol: An alarming scenario where a generative LLM hallucinates a pediatric leukemia chemotherapy regimen, resulting in a 100-fold under-dosage of methotrexate and severe vincristine toxicity.
 - The Confident Misdiagnosis: Demonstrating how triage AI tools trained on statistical frequency can misclassify fatal subarachnoid hemorrhages as benign migraines, failing the critical triage principle of ruling out life-threatening differentials.
 - The Citation Fabrication Scandal: Highlighting the academic and professional consequences of using generative assistants that invent plausible-sounding but completely non-existent NEJM and Lancet references, compromising scientific integrity.

The Architect of Healing: Foundations of Attitude, Ethics, and Communication for the Indian Medical Graduate

The Affective Transformation of the Medical Student

The transition from a student of science to a practitioner of medicine represents one of the most significant psychological and professional shifts in a human life. In the traditional medical curriculum, students were often inundated with cognitive data, biochemical pathways, physiological mechanisms, and anatomical structures, while the “human” element of medicine was left to the “hidden curriculum,” learned through osmosis and often inconsistently applied. Recognizing this gap, the National Medical Commission (NMC) of India, in alignment with global benchmarks in medical education, introduced the Attitude, Ethics, and Communication (AETCOM) module as a core, longitudinal component of the Competency-Based Medical Education (CBME) framework.

This part of the book, covering Modules 1.1 to 1.5, serves as the fundamental bedrock for the first-year medical students. It is designed to move the learner from the “cognitive domain” (knowing) to the “affective domain” (valuing and feeling). The philosophy behind these modules is rooted in the realization that a physician’s competency is not measured solely by their degree but also by their ability to navigate the complex social, ethical, and emotional landscapes of patient care. As students embark on this journey, they are no longer merely learners of biology; they are architects of a new professional identity, the Indian Medical Graduate (IMG).

The IMG is envisioned as a “five-star doctor,” a professional who serves as a clinician, a communicator, a leader, a lifelong learner, and a moral guardian of society. These early modules challenge the student to reflect on the meaning of their chosen path, understand the vulnerability of the “sick role,” master the fiduciary nature of the doctor–patient relationship, and respect the profound gift of the “first teacher,” the cadaver. By integrating insights from foundational Indian texts like the CBS AETCOM Manual and global communication standards such as the Calgary–Cambridge guide, this logbook provides a comprehensive roadmap for developing the “moral intellect” required to serve the diverse and often marginalized populations of India.

1.1 What Does It Mean to Be a Doctor?

Executive Summary

In this foundational section, students will explore the multifaceted identity of the physician within the modern health care ecosystem. The module focuses on defining the professional qualities and roles of an IMG as mandated by the NMC. Learners will be introduced to the concept of the physician as a “five-star doctor,” balancing clinical excellence with social accountability. The section details the transition from a science student to a medical professional, emphasizing the development of “moral intellect,” the capacity to practice with responsibility, accountability, and ethical integrity.

Key learning objectives include understanding the physician’s duty to the community, the necessity of lifelong learning in an evolving scientific field, and the importance of altruism in daily practice. Students will also learn how physicians contribute to the generation of health care data through meticulous record-keeping and participation in public health initiatives. By the end of this section, students will be able to articulate the professional expectations of an IMG and recognize the physician’s role as a leader in public health initiatives.



Theoretical Framework: Roles and Professional Qualities of an IMG

The NMC has redefined the goals of medical education in India to ensure that every graduate is equipped to function as a physician of first contact for the community while remaining globally relevant. This evolution is encapsulated in the five primary roles of the IMG, which are reinforced throughout the professional years.

Role of the IMG	Functional definition	Professional goal
Clinician	Provides preventive, promotive, curative, palliative, and holistic care	To provide evidence-based care with compassion and competence
Leader and team member	Collects, analyzes, and communicates health data; leads health care teams	To optimize health care delivery systems for the benefit of the patient
Communicator	Effectively interacts with patients, families, colleagues, and the community	To build a “covenant of trust” through transparent and empathetic dialogue
Lifelong learner	Commits to continuous professional development and knowledge updates	To ensure that clinical practice reflects the most current medical evidence
Professional	Upholds ethical values, demonstrates accountability, and respects autonomy	To maintain the dignity and sanctity of the medical profession

The physician acts as the vanguard of public health, utilizing local disease surveillance data to inform national health policies.

Professional Qualities of a Physician

To be a doctor in the modern Indian context is to inhabit a role that is simultaneously scientific, social, and moral. The NMC identifies a specific set of professional qualities that every IMG must internalize to command respect and ensure patient safety.

Moral Intellect, Responsibility, and Accountability

A physician with moral intellect does not simply follow a checklist of rules; they possess the capacity for ethical reasoning and the sincerity to apply it under pressure. This quality involves a commitment to selfless service and a sense of “readiness for accountability”—the willingness to be answerable for both successful outcomes and unavoidable mishaps. In a health care environment where complexity is the norm, accountability ensures that the doctor remains the primary advocate for the patient’s welfare, upholding the “covenant of trust” that defines the profession. Accountability in the Indian context involves the transparent disclosure of medical errors to the patient and family, upholding the principle of honesty even when faced with potential litigation.

Altruism and Primacy of Patient Welfare

Altruism is the bedrock of medical ethics. It dictates that a physician must place the interests of the patient above their own personal gain or convenience. This is particularly relevant in India’s multitiered health care system, where doctors often face dilemmas regarding resource allocation. A professional doctor ensures that clinical decisions are driven by the patient’s needs rather than financial incentives or external pressures.

Clinical Competence and Caution in Care

Scientific expertise is the prerequisite for all other professional qualities. A good doctor uses all their clinical acumen to save lives, which necessitates staying current with medical literature and technological advancements. However, competence must be tempered with “caution and care.” This involves maintaining detailed, accurate records to facilitate follow-up and provide a clear legal defense, if necessary, as well as practicing within the defined scope of one’s training.

Personal Attributes and Cultural Competence

Beyond technical skill, the physician must be kind, compassionate, and accommodating. Effective listening is a core clinical tool; it provides the patient with peace and confidence, which are documented to hasten recovery. Furthermore, given India’s vast diversity, an IMG must demonstrate cultural competence, respecting the diverse backgrounds, beliefs, and socioeconomic realities of their patients.

Professional quality	Core action/application
Moral intellect	Practicing with sincerity and ethical reasoning
Altruism	Prioritizing the patient’s best interests above all else
Accountability	Taking responsibility for clinical decisions and outcomes
Honesty and integrity	Transparency in interactions and disclosure of errors
Confidentiality	Protecting patient privacy as a sacred trust
Relevant referrals	Recognizing the limits of competence and seeking expert help

Physician’s Role in Health Care Data Generation

A physician’s duty extends to the broader health care system through the generation and management of data. This is achieved by the following:

1. **Clinical documentation:** Meticulously recording medical histories, physical examinations, diagnoses, and treatments in electronic health records (EHRs).
2. **Public health reporting:** Reporting notifiable diseases (e.g., tuberculosis, malaria, and COVID-19) to health authorities, which helps in tracking disease trends and managing outbreaks.
3. **Clinical research:** Participating in trials and observational studies that advance medical knowledge and improve treatment protocols.
4. **Vital statistics:** Issuing accurate medical certificates, birth and death notifications, and medicolegal reports.

Lifelong Learning: An Ethical Imperative

The commitment to lifelong learning is not a luxury; it is a fundamental professional obligation. In a field where medical knowledge doubles every few years, a physician who fails to update their skills becomes a danger to their patients. This involves self-directed learning, attending Continuing Medical Education (CME) programs (mandated at 30 hours every 5 years by the NMC), and critiquing new research through the lens of evidence-based medicine.

Discussion Questions

Q1. Discuss the commitment to lifelong learning as an important part of physician growth.

Analysis:

Answer: Lifelong learning is not just a personal choice but also an ethical obligation that defines a physician's career growth and ensures the safety of the public.

- *The velocity of medical change:* Medical knowledge is estimated to double every few years. New diseases (like COVID-19), breakthrough drugs, and innovative technologies (such as telemedicine and AI) emerge rapidly. A doctor who fails to keep pace becomes an obsolete and potentially dangerous practitioner.
- *Ethical duty toward patients:* Patients trust their doctors to provide the most current and effective care. Continuous education reduces medical errors, enhances diagnostic accuracy, and allows for the implementation of evidence-based protocols that lead to better patient outcomes.
- *Objective self-assessment:* Lifelong learning involves metacognition, the ability to identify one's own clinical weaknesses and seek targeted improvement. This reflective practice is essential for moving from a novice to an expert clinician.
- *Professional advancement and innovation:* Engaging in CME, attending conferences, and contributing to research allow a physician to grow as a leader and innovator in their field, contributing to the overall growth of the medical community.

Q2. In what ways can a physician contribute to the generation of health care data?

Analysis: Data are the “currency” of modern public health. Without accurate data from the bedside, national policies on disease control are impossible to formulate.

Answer: Physicians are the primary architects of health care data in any modern medical system. Their role has expanded significantly with the digitization of records and national health initiatives.

- *Documentation of the clinical encounter:* By recording medical histories, physical findings, and diagnostic results in EHRs and Ayushman Bharat Health Accounts (ABHA), physicians provide the data necessary for individual care coordination and clinical audits.

- *Disease surveillance and reporting:* Doctors are mandated to report data on communicable diseases, vaccination rates, and mortality. This information is vital for managing epidemics and evaluating the impact of national programs like the tuberculosis management or family welfare programs.
- *Conducting clinical and community research:* Physicians participate in community-based statistical research to evaluate the benefits of health care delivery and identify regional health risks. They also generate data through clinical trials and translational research.
- *Informing future health care strategies:* The data collected and synthesized by physicians serve as the information backbone for planners to allocate resources and launch health promotion initiatives at the social level.
- A physician contributes to data generation not only through EHRs but also through mandatory reporting of notifiable diseases under the Integrated Disease Surveillance Programme (IDSP) and by documenting social determinants of health during community visits.

Learning Checkpoint: Self-Assessment Questions

1. Describe the role of “altruism” in the daily practice of an IMG working in a resource-limited government hospital.

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2. How does the “five-star doctor” concept of the WHO align with the NMC’s definition of the IMG?

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3. Explain the concept of “moral intellect” and how it differs from simple clinical expertise.

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4. Why is the physician considered the “leader of the health care team”? Provide an example involving a nurse and a lab technician.

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5. Enumerate the professional consequences for a physician who fails to maintain NMC-mandated CME requirements, including potential suspension of the license to practice under the 2023 Ethics Regulations.

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Case Discussion: The Senior Resident's Commitment to Holistic Care

The Situation

Dr. Meera is a Senior Resident in Internal Medicine at a high-volume government hospital in North India. It is 2:30 p.m., and she has already seen over 150 patients in the outpatient department (OPD). The environment is noisy, crowded, and emotionally draining, with the smell of floor cleaner mixing with the humidity of the crowded corridor. Dr. Meera feels the physical strain of the day but maintains her composure.

Mr. Ramesh, a 52-year-old daily wage laborer from a rural village 6 hours away, has finally reached her desk after waiting since 6 a.m. He presents with persistent fatigue, weight loss of 10 kg over just 2 months, and a dull, constant ache in his upper abdomen. He looks physically exhausted, his skin is pale, and he is visibly anxious, clutching a plastic folder filled with disorganized, torn reports from local “RMPs” in his village. He is terrified that his body is failing him and believes he might be under a “curse” because he recently sold his old tractor to pay for his daughter’s upcoming wedding. He is reluctant to be admitted as each day away from work would mean money being lost for the wedding expenditure.

 **Dr. Meera:** (Noticing Mr. Ramesh standing hesitantly by the door, she signals the attendant to wait and gestures to the stool next to her) “Please sit, *Rameshji*. I can see you have traveled quite a distance today. My name is Dr. Meera. Tell me, what has been troubling you the most?”

Mr. Ramesh: (Wringing his hands, voice trembling) “*Namaste, doctor sahiba*. I... I feel very weak. I can’t even walk to the fields anymore. My clothes are loose, and there is a strange pain here in my stomach. My neighbor said it could be a curse because I sold my old tractor. I am very scared.”

 **Dr. Meera:** (She stops her current task, turns fully toward him, and maintains soft eye contact) “It is natural to feel scared when your body feels like it is failing you, but I am glad you came here. A “curse” is how we often try to explain things that feel out of our control, but we are going to look for a medical reason for this. Tell me, when did the pain start? Does it get worse after eating?”

 **Intern (Dr. Arjun):** (Interrupting) “Ma’am, the patient load is increasing. Should I just send him for an ultrasound and blood work immediately to save time?”

 **Dr. Meera:** (Correcting the intern with professionalism) “Dr. Arjun, remember that the history is 80% of the diagnosis. If we rush, we miss the patient’s story. *Rameshji*, please continue. Tell me about your appetite.”

Mr. Ramesh: “I don’t feel like eating anything, doctor. Even the thought of food makes me feel sick. And I am worried... I am a daily wage laborer. If I am admitted, who will earn for my daughter’s wedding next month?”

Dr. Meera: (Practicing altruism and accommodation) “I understand your worry about the wedding and your work. We will try our best to do the initial investigations today itself so you don’t have to stay back unless it is absolutely necessary. I will order only the tests that are essential. (To Dr. Arjun) Let’s ensure we get a complete blood count, liver function tests, and an urgent abdominal ultrasound. I will personally speak to the radiologist to accommodate him today given his travel distance.”

Mr. Ramesh: “Thank you, *doctor sahiba*. No one in the village clinic really listened. They just gave me some colorful pills.”

Dr. Meera: “We are going to find the real cause, *Rameshji*. While we wait for the tests, I want you to talk to our dietitian. Even if you don’t feel like eating, we need to find high-energy liquids you can tolerate to keep your strength up.”

Recap and example of professional qualities: In this scenario, Dr. Meera demonstrates the *IMG as a clinician* by performing a comprehensive clinical evaluation and integrating structured diagnostic thinking. She avoids “investigative overkill,” adhering to the principle of *nonmaleficence* while ensuring that the patient’s anxiety is managed through empathetic communication. Her *professionalism* is evident as she maintains confidentiality and obtains informed consent before proceeding with investigations. Crucially, she exemplifies the *collaborator* role by recognizing that Mr. Ramesh’s complex symptoms require a multidisciplinary approach, involving a gastroenterologist and a dietitian. Her consideration of Mr. Ramesh’s financial status when ordering tests is a practical demonstration of *altruism* and socially responsible care, ensuring that her management plan is economically viable and patient-centered.

Action taken	Professional quality expressed
Thorough examination and broad differential	Clinical competence
Use of simple language to explain diagnosis	Effective communication
Referrals to a gastroenterologist and a dietitian	Interprofessional teamwork
Seeking cost-effective medication	Altruism and social sensitivity

Feedback/Reflection Decision

Students should reflect on how Dr. Meera’s approach balances the “science” of medicine with the “art” of caring. How does a physician’s awareness of a patient’s financial constraints contribute to treatment adherence?

Case Discussion

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Feedback/Reflection Decision

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Engagement Level	Abbreviation	Feedback
Present	P	
Participated	Pa	
Contributing	C	
Stimulating	S	

Signature of Learner

Signature of Faculty

The Evolution of Clinical Professionalism: Attitude, Ethics, and Communication for the Phase II Indian Medical Graduate

The transition from the preclinical phase to the clinical realm is one of the most profound shifts in a medical student's journey. While the first year focuses on the "first teacher"—the cadaver—and the foundational roles of the Indian Medical Graduate (IMG), the second professional year demands a move from theoretical virtues to clinical application. As defined by the National Medical Commission (NMC), the curriculum must now address the complexities of patient-centered communication, the legal and moral nuances of bioethics, and the collective responsibility of the health care team. This module is designed to bridge the gap between knowledge and practice, ensuring that the physician of tomorrow is not merely a technician of the body but also a compassionate advocate for the person. Aligned with the goals of the National Board of Examinations (NBE) and global standards of medical professionalism, these chapters serve as both a pedagogical guide and a longitudinal logbook for the developing clinician.

2.1 The Foundations of Communication – 2

Executive Summary

In this initial section of the Phase II curriculum, students will undergo a sophisticated exploration of the medical encounter. Moving beyond basic conversational etiquette, this module introduces the Kalamazoo Consensus Statement, a globally validated framework for evidence-based clinical communication. Students will learn the cognitive and behavioral skills required to build a therapeutic alliance, gather clinical data effectively, and understand the patient's perspective through the “ICE” (ideas, concerns, and expectations) model. The section further addresses the critical role of nonverbal cues and the clinical necessity of jargon-free dialogue. By the end of this module, learners will be able to demonstrate communication that is not only respectful and nonjudgmental but also strategically designed to improve patient adherence and clinical outcomes.



The Architecture of the Medical Encounter

Medical communication is the fundamental prerequisite of the profession, serving as the “bedrock” that supports the transformation of a student into a mature professional. Research indicates that effective communication is directly correlated with higher patient satisfaction, better diagnostic accuracy, and a significant reduction in medical litigation. In the Indian context, where the outpatient departments (OPDs) are often overwhelmed by patient volume, the ability to communicate concisely yet empathetically is a vital clinical competency.

The Kalamazoo Consensus Statement identifies seven evidence-based tasks that constitute an effective medical encounter. These tasks are not linear steps but overlapping competencies that must be maintained throughout the interaction.

Kalamazoo essential element	Core clinical skill	Professional objective
Build a relationship	Greeting the patient and establishing rapport	Fostering trust and a “covenant of trust”
Open the discussion	Allowing the patient to speak without interruption	Eliciting the full set of patient concerns early
Gather information	Balancing open- and closed-ended questions	Ensuring diagnostic accuracy and “active listening”
Understand perspective	Exploring ICE	Identifying psychological and cultural barriers
Share information	Using “information chunking” and simple language	Empowering the patient with health literacy
Reach agreement	Negotiating a mutually acceptable management plan	Enhancing treatment adherence and “partnership”
Provide closure	Summarizing the visit and planning for follow-up	Ensuring patient safety and clarifying next steps

Building the doctor–patient relationship is the foundation of this architecture. It requires the physician to use verbal and nonverbal techniques to establish a personal connection. Nonverbal cues, such as maintaining eye contact, adopting a forward-leaning open posture, and using a calm, professional tone, often communicate more than the words themselves. In the Indian cultural context, these cues must be balanced with sensitivity; for instance, maintaining a comfortable physical distance and ensuring the presence of a female attendant when a male doctor examines a female patient are both ethical and medicolegal requirements.

Gathering information effectively requires “active listening.” A common mistake in medical practice is the “early interruption,” where the doctor cuts off the patient’s opening statement after only a few seconds. The Kalamazoo model advocates for allowing the patient to complete their opening statement, which rarely takes more than 2 minutes but often reveals the true reason for the visit.

Discussion Questions

Q1. Why is effective communication important in patient care?

Answer: Effective communication is essential in patient care because it helps build trust and rapport, enabling patients to feel comfortable sharing their symptoms and concerns. This facilitates the elicitation of a precise medical history, which is the basis for correct diagnosis in over 80% of cases. Beyond diagnostics, it strengthens the therapeutic relationship, builds patient confidence, and ensures that the patient understands the diagnostic and treatment options. This leads to better adherence to medication and lifestyle advice and improved health outcomes.

Q2. How can doctors improve their communication skills?

Answer: Physicians can improve through structured training, such as role-playing with simulated patients and receiving critiques from peers or faculty. Adopting models like “AIDET” (Acknowledge, Introduce, Duration, Explanation, Thank you) or “SBAR” (Situation, Background, Assessment, Recommendation) provides a systematic way to ensure no vital information is missed. Additionally, self-reflection and seeking feedback from patients themselves can help a clinician identify and rectify subconscious biases or hurried mannerisms.

Q3. What is the role of nonverbal cues in patient interactions?

Answer: Nonverbal communication encompasses facial expressions, gestures, body language, tone of voice, and even professional attire. These cues signal to the patient whether the doctor is truly interested or merely performing a task. Simple actions like sitting at eye level rather than standing over a patient, nodding to show understanding, and tolerating short silences (“Silence is Golden”) can significantly lower a patient’s anxiety and encourage them to share sensitive or stigmatized information.

Q4. What is medical jargon, and why is it important to avoid it in medical consultations?

Answer: Medical jargon refers to technical terminology (e.g., “malignancy,” “idiopathic,” “ambulatory,” “hypoglycemia”) that is used by health care professionals but is often incomprehensible to the general public. Using jargon creates a power imbalance and a “semantic barrier” that prevents the patient from truly being informed. In a country like India with diverse literacy levels, avoiding jargon and using the local language is a professional and ethical duty to ensure the patient can make autonomous choices about their health.

Learning Checkpoint: Self-Assessment Questions

1. Explain the “ICE” (ideas, concerns, and expectations) model and how exploring these three elements improves diagnostic accuracy.

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2. Based on the Kalamazoo Consensus Statement, describe why “opening the discussion” without early interruption is vital for eliciting the patient’s full set of concerns.

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3. Identify three specific nonverbal cues a doctor can use to signal active listening in a busy OPD.

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4. Define “medical jargon” and explain how its use creates a “semantic barrier” that undermines patient autonomy.

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5. In the case of Mr. Rao, why is established “implied consent” from family members insufficient for disclosing a new diagnosis of malignancy?

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Case Discussion

The Situation

Dr. Sharma, a Junior Doctor covering the medical wards over a high-volume weekend, is approached by Priya, the duty nurse. She is flustered because the relatives of Mr. Rao, a 58-year-old patient admitted for obstructive jaundice, are demanding to know the results of his recent computed tomography (CT) scan. The scan has confirmed a periampullary malignancy with liver metastasis. Dr. Sharma has just taken over the ward and has not yet met Mr. Rao. The patient's son, Suresh, and his younger brother are waiting outside the nurse's station. They are visibly anxious and insist that the "family head" should be told the truth first so they can decide how, or whether, to tell the patient. There is no documentation in the file regarding Mr. Rao's preferences for information sharing. Dr. Sharma must navigate the tension between the family's collectivist demands and the patient's individual right to confidentiality as mandated by the NMC.

Setting: The nurse's station at the end of a busy corridor. Dr. Sharma is reviewing the file. Suresh (son) and Ramesh (brother) approach him.

Suresh (Son): "Doctor, we have been waiting for hours. My father had his scan this morning. We need to know what it says. Is it cancer? Please be honest with us."

Dr. Sharma: (Standing up, maintaining eye contact, speaking in a calm tone) "I understand how difficult this waiting has been for you, Suresh. I can see you are both very concerned about Mr. Rao. My name is Dr. Sharma, and I am looking after him today. I have the results here, but before we discuss them, I need to know if Mr. Rao has talked with you about how much information he wants us to share with the family."

Ramesh (Brother): "Doctor, he is our elder, but we manage everything for him. He is a very nervous man. If it is bad news, he will lose the will to live. It would be better if you tell us first, and we will break it to him slowly."

Dr. Sharma: (Acknowledging the concern but establishing a boundary) "I respect that your family is very close and that you want to protect him. That support is vital. However, under the law and our professional ethics, every adult has the right to decide who knows about their health. Since I haven't had a chance to speak with Mr. Rao yet, I don't know his wishes. I cannot share his private medical details with anyone else without his permission first."

Suresh: "But I am his son! How can you keep this from me?"

Dr. Sharma: (Using the NURSE mnemonic—naming the emotion) "Suresh, I can see you are frustrated and scared. It's natural to feel this way when a loved one is sick. (Supporting) We want the same thing: the best for your father. (Strategy) Here is what I am going to do: I will go into Mr. Rao's room now. I will introduce myself and talk to him about his reports. I will ask him directly who he wants to be part of the discussion. If he

gives me the word, I will call you both in immediately so we can all talk about the next steps together. Does that seem like a fair way to proceed?”

Suresh: (Nodding slowly) “Okay, Doctor. We will wait here. Please, just don’t tell him in a way that scares him.”

 **Dr. Sharma:** “I will be very careful. Thank you for understanding.”

Recap and example of professional communication foundations: This scenario presents a fundamental tension between *compassion for the family* and the *patient’s right to confidentiality*. In the Indian cultural context, family members often feel entitled to a patient’s medical information, sometimes even demanding that the patient not be told “the truth” to spare them from worry. However, the NMC and Indian laws are clear: every competent adult has a right to confidentiality regarding their own body.

1. **Establishing the ethical boundary:** Dr. Sharma’s first responsibility is to the patient, Mr. Rao. Since he has not yet established a relationship with the patient, he cannot assume that the relatives have “implied consent” to receive sensitive news about a malignancy. Disclosing this information without the patient’s express permission is a breach of the professional code of ethics.
2. **Using the Kalamazoo elements:** Dr. Sharma should start by *building a relationship* with relatives. He might say: “I can see you are very concerned about Mr. Rao, and it is important that we support him together. However, I have not had the opportunity to speak with Mr. Rao yet about his preferences for sharing information.”
3. **Taking the case ahead:** Dr. Sharma must prioritize a private meeting with Mr. Rao. During this meeting, he should assess Mr. Rao’s *understanding and perspective*. He should ask: “Mr. Rao, how much information would you like to receive about your test results today, and is there anyone from your family you would like me to include in our discussion?”
4. **Managing the family anxieties:** If Mr. Rao consents, the doctor can then provide a structured update to the family. If Mr. Rao refuses, the doctor must politely inform the family that he is legally and ethically bound to respect the patient’s privacy while still offering to discuss the general care plan and emotional support they can provide. This approach upholds *patient autonomy* while maintaining professional *kindness and empathy* for the support system.

Case Discussion

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Feedback/Reflection Decision

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Engagement Level	Abbreviation	Feedback
Present	P	
Participated	Pa	
Contributing	C	
Stimulating	S	

Signature of Learner

Signature of Faculty

Cultivating Compassion, Ethics, and Professional Excellence in the Next Generation of Medical Professionals

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