04 - The Difficult Consultation

FDMSEC Insights | April-2026

From

FOGSI, Food Drugs & Medicosurgical Equipment Committee

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Message From Dr. Bhaskar Pal

Dr. Bhaskar Pal
President FOGSI-2026

It gives me great pleasure to share a few words for this April 2026 issue of **FDMSEC Insights**, which takes up a subject that is central to everyday clinical practice, though not always discussed with the seriousness it deserves.

A difficult consultation is not necessarily about a difficult diagnosis. More often, it is about a difficult moment. It may arise when the patient has already decided the treatment, when internet-based information has created confusion, or when the doctor has to explain why a requested option is not the safest one. In such situations, medical knowledge alone is not enough. Clarity, judgement and balance become equally important.

This issue addresses these realities through very relevant topics such as **"When the Patient Has Already Decided the Treatment," "Google-Informed, Half-Informed, Misinformed: Managing the New Patient,"** and **"How to Say No Without Losing the Patient."** These are situations that every Obstetrician and Gynaecologist faces, irrespective of place of practice or years of experience.

I am particularly happy that the issue has focused on practical communication within the framework of safe and responsible care. When a doctor explains well, listens carefully, and guides firmly without losing respect for the patient's concerns, better decisions become possible.

I compliment **Dr Asha Jain**, Chairperson, FDMSEC, for choosing a theme of immediate relevance and for developing it in a manner that is useful to practicing doctors. I am sure this issue will be read with interest and applied in day-to-day work.

With best wishes,
Dr Bhaskar Pal
President, FOGSI

Message from Dr Suvarna Khadilkar

Dr. Suvarna Khadilkar
Secretary General FOGSI

I am pleased to know that the April 2026 issue of **FDMSEC Insights** is devoted to The Difficult Consultation, a theme that is highly relevant to present-day Obstetric and Gynaecological practice.

Very often, the success of a consultation depends not only on what the doctor knows, but also on how the discussion is conducted and how clearly it is documented. This is especially true in situations involving anxiety, disagreement, financial sensitivity, misunderstanding, or emotionally charged decision-making. Many avoidable problems in practice do not arise from lack of treatment options, but from lack of clarity in discussion and recording.

In this context, I find the inclusion of articles such as **"The 7-Minute Consultation: How to Counsel Well Without Rushing," "Counselling for Costly Care Without Sounding Commercial," "Documenting a Difficult Consultation Properly,"** and **"Words That Build Trust, Words That Create Trouble"** particularly valuable. These topics remind us that communication is not separate from care. It is part of care.

The strength of this issue lies in its practicality. It addresses situations that doctors face every day and offers a more thoughtful approach to handling them with professionalism and calmness. Good communication improves not only understanding and trust, but also continuity of care and professional safety.

I congratulate **Dr Asha Jain**, Chairperson, FDMSEC, and her team for selecting a subject of such immediate use and presenting it in a manner that will benefit readers across different settings of practice.

With best wishes,
Dr Suvarna Khadilkar
Secretary General FOGSI

Message From Dr.Vidya Thobbi

Dr.Vidya Thobbi
VP South Zone FOGSI
Incharge FDMSEC

I am happy to note that the April 2026 issue of **FDMSEC Insights** has taken up a subject that touches the real working life of every clinician. The difficult consultation is one of the commonest and yet least formally taught parts of medical practice.

In Obstetrics and Gynaecology, communication often becomes complex because the consultation is rarely between doctor and patient alone. Families may dominate, expectations may be fixed, emotions may run high, and treatment decisions may carry personal, social and financial weight. That is why the choice of articles in this issue is especially meaningful.

Topics such as **"When Families Dominate the Consultation," "What to Do When the Patient Refuses the Best Option," and "The Angry Patient in OPD: De-escalation That Works"** reflect the kind of situations in which the doctor's patience and communication are tested as much as clinical skill. These are not rare events. They are part of routine practice, and they influence trust, compliance and safety in a major way.

I appreciate the practical orientation of this issue. It does not remain at the level of ideals, but brings the discussion to the OPD, ward and procedure room, where these conversations actually unfold. Such guidance is useful not only for senior doctors, but also for younger colleagues who are still developing their consultation style.

My compliments to **Dr Asha Jain** and the FDMSEC team for bringing out an issue that is thoughtful, timely and truly relevant to practice.

Warm regards,
Dr Vidya Thobbi
Vice President Incharge, FOGSI

Dr.Asha Jain
Chairperson
FOGSI FDMSE Committee

FOREWORD

Every Obstetrician and Gynaecologist knows that some of the most difficult moments in practice are not always created by disease severity alone. Very often, the real challenge lies in the consultation itself. A patient may come with fear, anger, confusion, family pressure, fixed beliefs, financial limitation, or reluctance to accept what appears to be the most appropriate medical advice. The science may be clear, yet the conversation becomes difficult because the human situation around it is not.

This issue of FDMSEC Insights focuses on that daily reality. The difficult consultation is not an occasional event. It is part of routine practice. It may arise in antenatal care, infertility work, menopause counselling, abnormal bleeding, post-operative review, discussions around expensive treatment, refusal of admission, refusal of surgery, or in situations where family members speak more than the patient herself. These encounters test not only our clinical knowledge, but also our patience, judgement, communication, and ability to preserve clarity under pressure.

Medical training prepares us well in diagnosis and management, but much less systematically in handling conversations that are emotionally charged, time-limited, or complicated by misunderstanding. Yet these are the consultations that often shape trust, compliance, safety, and later perceptions of care. A poorly handled conversation can turn a manageable issue into prolonged dissatisfaction, conflict, avoidable delay or litigation. A well-handled consultation can do the opposite. It can reduce anxiety, improve understanding, support shared decisions, and protect both patient and doctor.

The purpose of this issue is therefore practical. It is not meant to discuss communication in abstract language. It is meant to address what doctors face in actual clinics and hospitals. How do we counsel well in a busy OPD without sounding hurried? How do we respond when a patient has already decided the treatment? How do we manage half-information from the internet, treatment refusal, family dominance, anger, and costly care discussions without sounding defensive or commercial? How do we document such consultations properly so that the record reflects not only what we found, but also what we explained and what was decided?

Communication in medicine is often misunderstood as style. In reality, it is part of care itself. It influences consent, compliance, continuity, and patient safety. It also protects the doctor, not through clever wording, but through clear explanation, patient-centred discussion, and accurate recording.

This month's issue has therefore been designed to help the practicing ObGyn handle difficult consultations with more structure and confidence. Each article addresses a familiar challenge from the point of view of daily work. The aim is not only to make the issue readable, but to make it useful the very next day in practice.
Good medicine does not end with the right prescription, procedure, or investigation. It also includes the difficult conversation done properly. That part of practice deserves the same seriousness as every other part of care.

With warm regards,
Dr Asha Jain
Chairperson, FDMSEC, FOGSI

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The 7 minute consultation - how to counsel well without rushing

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Introduction:

The 7-minute consultation is a model often used in primary care to manage high patient volumes while maintaining clinical safety and patient rapport. Counseling effectively in this timeframe requires a shift from a broad "chat" to a highly structured, patient-centered conversation. While time constraints can be challenging, they also present an opportunity to develop efficient and effective counselling skills.

To maximize impact without rushing, clinicians often use a 7-step approach that distributes tasks across specific phases(1):

The "7-Minute Consultation" Framework

1. **Preparation:** Review the patient's record before they enter. Memorise their history and previous processes so you can focus entirely on them during the visit.
2. **First Minutes (Agenda Setting)**: Establish a connection and immediately set an agenda. Avoid interruptions early on; most critical patient information emerges in the first moments if the patient is allowed to talk.
3. **Exploration (ICE)**: Use the ICE framework to explore the patient's Ideas, Concerns, and Expectations. This uncovers hidden fears and aligns the management plan quickly.
4. **Evaluation**: Conduct a focused clinical assessment and examination targeting the relevant system or symptom.
5. **Collaborative Plan:** Develop a plan together. Explain likely conditions and next steps clearly, using manageable parts like medication or investigations.
6. **Closure & Safety Netting**: Summarize the plan and provide "safety netting"—clear instructions on when to return if symptoms don't improve.
7. **Final Reflection:** Take a moment after the patient leaves to reflect on the case and prepare for the next one.

Strategies to Counsel Well Without Rushing

- **Active Listening & Non-Verbal Cues**: Use open body language, warm smiles, and a friendly tone to build rapport quickly. Active listening (nodding, eye contact) helps the patient feel "heard" even when time is short.

- **Brief Counseling Techniques:**

BATHE Technique (2): Rapid Psychosocial Support A quick way to address psychosocial factors. Developed by Stuart and Lieberman, the BATHE technique is a "one-minute" psychotherapeutic procedure used to screen for emotional distress and provide support. It is particularly effective for patients with vague somatic complaints or those who appear "difficult" or overly talkative.

B – Background: "What is going on in your life?" (Elicits the context of the visit).
A – Affect: "How does that make you feel?" (Allows the patient to label their emotional state).
T – Trouble: "What about this situation troubles you the most?" (Helps focus the consultation on the patient's primary concern).
H – Handling: "How are you handling that?" (Assesses current functioning and coping).
E – Empathy: "That sounds very difficult." (A legitimizing response that closes the loop and builds deep rapport)

Motivational Interviewing(3): For chronic disease management (e.g., smoking, obesity, medication adherence), MI provides a "guiding" rather than "directing" style of communication. In a 7-minute slot, the clinician focuses on the RULE principles (4):

1. **Resist the Righting Reflex:** Avoid the urge to tell the patient what to do, which often triggers resistance.
2. **Understand Motivation:** Explore the patient's own reasons for change.
3. **Listen with Empathy:** Use reflective listening to ensure the patient feels heard.
4. **Empower the Patient:** Highlight their autonomy and past successes.

Efficient Information Giving: Avoid medical jargon and use layman's terms. Use pre-prepared materials like patient leaflets or digital resources to save time on explaining common conditions.

Strategic Negotiation: If a patient has multiple concerns, acknowledge them all but negotiate which "most concerning" item to manage today, scheduling follow-ups for the rest.

Refocusing Between Patients: Taking a deep breath and awarely getting rid of tension before the next patient enters helps maintain a calm, unhurried demeanor.

By "BATHEing" the patient during the initial assessment and applying "RULE" during the planning phase, a clinician can address the psychosocial and behavioral roots of illness with high precision. Research shows that these methods **do not significantly increase visit length** but dramatically improve patient satisfaction and empowerment.

Summary of Quality Indicators

Indicator	Strategy
Preparation	Review triage notes and old records a week or minutes before the clinic.
Patient Agency	Encourage patients to write down questions or symptoms in advance.
Active Listening	Allow the patient to speak for the first 60–90 seconds without interruption.
Shared Decision Making	Explain pros and cons of 2–3 options rather than just giving one directive.

Conclusion:

Ultimately, counseling well in seven minutes is not about "cutting corners," but rather cutting through the noise. The goal of the 7-minute encounter is not to rush through a checklist, but to create a "dense" clinical moment—one where the patient feels heard, the diagnosis is secure, and the management plan is mutual. By mastering structured communication, preparation, and patient-centered rapport, clinicians can deliver safe, empathetic, and effective care within tight time constraints. These techniques allows the modern practitioner to thrive in high-pressure primary care environments while upholding the core tenets of the therapeutic relationship.

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When the Patient Has Already Decided the Treatment

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When the Patient Has Already Decided the Treatment

It is a familiar consultation.

The patient sits down and speaks before the history is complete:

"Doctor, I want a caesarean."

"I need this scan today."

"I don't want tablets- I've decided on surgery."

In that moment, the nature of the consultation shifts.

What was expected to be a process of evaluation becomes an interaction shaped by a decision that has already been made.

In Obstetrics and Gynaecology practice, such encounters are increasingly common. They reflect a changing patient profile- more informed, more anxious, sometimes influenced by prior experiences, family opinions, or fragmented information from multiple sources. The challenge is not simply to correct or agree, but to guide the consultation in a way that remains respectful, clear, and clinically appropriate.

A Common Scenario from Practice

A 28-year-old primigravida at term requests an elective caesarean section at her first visit. She reports having "heard" that normal delivery leads to long-term complications and expresses fear after witnessing a relative's difficult labour.

There is no obstetric indication for caesarean section.

The consultation now requires more than explanation- it requires understanding what lies behind the request, and responding without dismissing the concern.

Understanding the Decision Before Addressing It

A pre-formed decision is rarely arbitrary. It often reflects an underlying concern that has not yet been voiced clearly.

Common drivers include:

- Previous negative or traumatic experiences
- Fear of pain, complications, or loss of control
- Advice from family members or peers
- Selective or misinterpreted information
- Desire for certainty in an uncertain situation

Beginning with correction may create resistance. Beginning with curiosity often opens the conversation.
A simple question can change the tone of the consultation:
"Can you tell me what made you feel this would be the best option for you?"

Allowing the patient to speak, even briefly without interruption, often reveals the concern that actually needs to be addressed.

Separating Preference from Indication

Once the underlying concern is understood, it becomes easier to distinguish between patient preference and clinical indication.

In daily practice, this may present as:

- Request for caesarean section without obstetric indication
- Repeated demand for imaging without clinical need
- Preference for immediate intervention over conservative management

Rather than directly opposing the request, it is often more effective to reframe the discussion:
"That option is available in certain situations. Let us look at whether it is necessary in your case."
This approach preserves patient dignity while bringing the focus back to clinical reasoning.

Responding Without Creating Resistance

Tone plays a critical role in such consultations.
Statements that directly negate the patient's belief- "That is wrong" or "You should not have read this"- may close the conversation.

In contrast, neutral and contextual responses maintain engagement:
"That information is correct in some situations. Let me explain how your condition is different."
The aim is not to challenge the patient's knowledge, but to place it within the correct clinical context.

When the Requested Option is Not Appropriate

There will be situations where the requested intervention is unnecessary or carries avoidable risk.

In these cases, clarity is essential:

- Explain why the option is not recommended
- Discuss potential risks or lack of benefit
- Offer a safer or evidence-based alternative

For example:

"I understand your concern and why you prefer this option. However, in your situation, it may not provide additional benefit and may expose you to risks that we can avoid. What I would recommend is…"

Such communication allows refusal without appearing dismissive.

Offering Alternatives and Shared Decisions

Patients are more receptive when they are not left without choices.

A structured approach can help:

- The recommended option (best evidence-based choice)
- An acceptable alternative (if the patient is hesitant)
- Clear explanation of limitations and expectations

This reinforces shared decision-making while maintaining clinical responsibility.

When the Patient Still Prefers Their Choice

Even after a balanced discussion, some patients may continue to prefer their initial decision.

At this stage:

- Confirm that the patient understands risks and limitations
- Avoid confrontation or withdrawal of care
- Continue to provide appropriate support

The consultation does not fail because the patient does not change their decision. It succeeds when the decision is made with understanding rather than assumption.

Documentation in Such Consultations

Clear and factual documentation is essential.

It should include:

- Patient's stated preference
- Information and options discussed
- Risks explained
- Final decision taken

Example:

"Patient requests elective LSCS despite absence of obstetric indication. Risks, benefits, and alternatives explained. Patient verbalises understanding and prefers LSCS."

Documentation should remain neutral and descriptive, avoiding judgemental language.

Practical Phrases for Daily Use

- "I understand your concern."
- "Let us go through what is best in your situation."
- "This option is useful in some cases- let me explain where you stand."
- "My concern with this approach is…"
- "What I would recommend is…"
- "We can consider this alternative if you are not comfortable."

Conclusion

Consultations where the patient has already decided are now a routine part of clinical practice.
They require neither confrontation nor passive agreement, but a structured and thoughtful approach-understanding the concern, clarifying the indication, communicating without resistance, offering alternatives, and documenting clearly.

In such moments, the role of the clinician is not to override the patient's decision, but to ensure that it is informed, safe, and aligned as far as possible with good clinical care.

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03 Google-Informed, Half-Informed, Misinformed: Managing the New Patient

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MS OBG Bhimavaram

The traditional hierarchy of medical knowledge has undergone a profound transformation. In contemporary Obstetrics and Gynaecology, the clinical encounter is no longer a blank slate- it is increasingly shaped by prior digital exposure. Today's patient often arrives informed, partially informed, or misinformed, creating a complex negotiation between clinical expertise and digitally acquired beliefs.

This evolving "Digital Patient" exists across a spectrum of health literacy: the Google-Informed, the Half-Informed, and the Misinformed. For the practising Obstetrician- Gynaecologist, navigating this spectrum is no longer an ancillary skill but a **core clinical competency and ethical responsibility.**

Understanding the Information Spectrum

In reproductive health- where decisions are time-sensitive, emotionally charged, and deeply personal- the quality of patient-acquired information significantly influences clinical outcomes.

The **Google-Informed patient** engages with credible, peer-reviewed sources and seeks collaborative decision-making. These patients often arrive with focused questions, enabling efficient consultations and improved shared decision-making.

The **Half-Informed patient** represents fragmented health literacy. While familiar with certain medical terms or concepts, they lack contextual understanding- particularly regarding risk interpretation. This frequently results in disproportionate anxiety or misplaced reassurance.

The **Misinformed patient**, however, presents the greatest challenge. Influenced by anecdotal narratives, social media trends, and unverified wellness content, these patients may reject evidence-based interventions such as vaccinations, antenatal screening, or fertility treatments. This phenomenon is part of a broader global issue termed the infodemic.

The Sociology of the Digital Patient

Emerging research in medical sociology highlights that patients do not merely seek information- they seek **agency, reassurance, and validation.** Studies show that pregnant women frequently use digital platforms to confirm the normalcy of their symptoms, particularly when clinical consultations are brief [1]. This "normalcy-seeking behaviour" drives patients toward peer forums and social media groups.

Simultaneously, a widening trust gap has emerged. Despite the availability of high-quality medical information, patients often prioritise relatable narratives over clinical authority.

A significant proportion of online reproductive health information about contraception; abortion and fertility related is misleading, and patients are increasingly influenced by relatable, narrative-driven content from non-expert sources.[2]

The appeal of peer-generated content lies in its accessibility, emotional resonance, and perceived authenticity- qualities that traditional medical communication often lacks.

Health Literacy: The ACOG Perspective

The American College of Obstetricians and Gynecologists identifies health literacy as a critical determinant of clinical outcomes. Limited health literacy is associated with poorer understanding, reduced adherence to treatment, and increased healthcare utilisation.[3]

Importantly, cognitive science suggests that under stress- a common state in obstetric and gynaecological settings- a patient's ability to process complex medical information can decline significantly. This necessitates a shift toward **simplified, structured, and patient-centred communication.**

ACOG emphasises the importance of proactively addressing misinformation through structured, patient-centred communication. Instead of responding to myths reactively, clinicians should anticipate common misconceptions and incorporate their clarification into routine counselling.

For example:

"You may come across claims suggesting that ultrasounds are harmful; however, extensive evidence over decades confirms their safety when used appropriately."

This anticipatory approach reduces the likelihood of misinformation taking root.

The Infodemic: WHO Framework

The World Health Organization defines an infodemic as an overabundance of information—accurate and misleading—that spreads rapidly and influences health behaviours.

Infodemiology research identifies distinct mechanisms through which misinformation spreads:

- **Information Voids:**

Misinformation thrives in areas where scientific evidence is evolving or unclear, such as emerging assisted reproductive technologies.

- **Emotional Anchoring:**

Misinformation is often rooted in powerful emotions—particularly fear (e.g., infertility, fetal harm) and hope (e.g., miracle cures).

Crucially, the WHO emphasises that **emotional validation must precede factual correction**. If a patient's fear is not acknowledged, they are less likely to engage with evidence-based explanations.

Ethical and Legal Dimensions: GMC 2024 Standards

The General Medical Council, in its Good Medical Practice (2024) framework, reinforces that informed consent is valid only when based on accurate understanding.

In the digital age, misinformation poses a direct threat to ethical medical practice. If a patient makes a decision based on incorrect information- and this is not addressed- the integrity of consent is compromised.

Furthermore, communication research highlights that direct contradiction of a patient's belief may trigger a defensive response. Instead, clinicians are encouraged to adopt a **motivational interviewing approach**, such as:

"What about that information resonated with you?"

This strategy fosters trust, reduces resistance, and creates an opening for evidence-based discussion.

The Backfire Effect and Communication Science

One of the key challenges in addressing misinformation is the **Backfire Effect-** a cognitive phenomenon where directly confronting false beliefs can reinforce them.

Research suggests that effective correction requires structured communication strategies. One such approach is the "Truth Sandwich":

1. Present the correct information
2. Briefly acknowledge the misinformation
3. Reinforce the correct information

This ensures that the factual message remains dominant in the patient's memory.

Practical Clinical Strategies

In the reality of a 10–15 minute consultation, clinicians require efficient and structured approaches:

- **Acknowledge:**

Validate the patient's effort in seeking information.

- **Explore:**

Identify the sources of their knowledge—their "digital diet."

- **Bridge:**

Connect general online information to the patient's individual clinical context.

- **Guide:**

Direct patients toward credible, evidence-based resources.

- **Document**:

Record the correction of significant misconceptions as part of ethical practice.

These strategies transform the consultation from a corrective interaction into a collaborative dialogue.

From Information to Understanding: A Paradigm Shift

The rise of the digital patient signals a fundamental shift in medical practice. The clinician is no longer the sole authority but rather a **curator, interpreter, and navigator of information.**

This shift is particularly significant in Obstetrics and Gynaecology, where decisions are influenced not only by clinical evidence but also by emotional, cultural, and social factors.

By integrating:

- the behavioural insights of medical sociology,
- the communication frameworks of ACOG,
- the infodemic strategies of WHO, and
- the ethical mandates of GMC,

clinicians can bridge the gap between information and understanding.

Conclusion

In the digital era, access to information is no longer the primary challenge- interpretation is. Patients are increasingly informed, but not always accurately. The responsibility of the Obstetrician–Gynaecologist, therefore, extends beyond diagnosis and treatment to include **guiding patients through a complex informational landscape.**

The most powerful intervention in modern clinical practice may not be a surgical technique or pharmacological therapy, but the **clarity, empathy, and precision of communication.**

As the volume of digital information continues to grow, so too must our ability to transform that information into meaningful, evidence-based understanding- for the benefit of both patients and the profession.

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04 How To Say No Without Losing The Patient

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Saying "no" to a patient while maintaining a professional relationship (as outlined by the GMC, NMC, and ACOG) requires a shift from a flat refusal to a collaborative, shared decision-making process. The goal is to make the patient feel heard and supported even when their specific request is declined.

Key Strategies for Saying "No

"Elicit the Patient's Perspective: Before refusing, ask why they want the specific test or treatment (e.g., "What is your main concern about these symptoms?"). Often, a request for antibiotics is actually a request for symptom relief or reassurance.

Practice the "Indirect No": Instead of a blunt "No," use phrases like, "We can consider that, but let me tell you why I think another option might be safer for you right now".Use "Yes, If" instead of "No, Because":

Frame the refusal as a pathway to a better outcome. For example: "I am willing to proceed with this procedure if we can first ensure [safety condition] is met".

Acknowledge Discomfort: If there is a disagreement, verbally acknowledge it (e.g., "I can see we have different views on the best plan here"). This can defuse tension and move toward a compromise.

Provide Clear, Jargon-Free Explanations: Briefly explain the clinical reasoning without using technical language that might make the patient feel excluded.

Key Approach	Recommended Tool/Method
Ensure care continuity; any ending of a relationship must be factual, objective, and documented.	Focus on clinical necessity and patient safety.
Compassionate, inclusive care that empowers the patient.	Use kindness and active listening to maintain a sense of safety.
Prioritise patient values and shared decision-making.	**RESPECT Model**: Rapport, Empathy, Support, Partnership, Explanations, Cultural Competence, Trust.

Phrases that help explain better

Instead of "No, you don't need that": Try "I'm worried that [medication/test] might cause more harm than good in this situation, but here is what I recommend for your symptoms...".Instead of "I can't do that": Try "That specific treatment isn't the standard for your condition, but let's look at [alternative] which has better results for patients with your symptoms".

To validate feelings: "I know this isn't the answer you were hoping for, and I can see you're frustrated".

SOME COMMON EXAMPLES

Refusing Antibiotics for a Viral Infection

Context: A patient insists on antibiotics for a cold/flu. The NMC and GMC advise against prescribing them without clinical evidence of a bacterial infection.

- **Step 1:** Validate Concern: "I can hear how much this cough is bothering you and how tired you're feeling. It's completely understandable that you want something to help you feel better quickly."
- **Step 2:** Explain Clinical Reasoning: "Based on my assessment, your symptoms are very typical of a virus. Antibiotics only work against bacteria—they won't clear a virus or help you feel better faster. In fact, taking them when they aren't needed can cause side effects like stomach upset and makes them less effective for you in the future."
- **Step 3:** Offer a "Safety Net" / Alternative: "While I'm not prescribing antibiotics today, I want to make sure you're supported. I recommend [supportive care, e.g., paracetamol/rest]. Let's agree that if you don't feel better in [number] days, or if you develop [specific red-flag symptom], you'll contact me immediately so we can re-evaluate."

A patient requests a C-section with no medical indication.

ACOG recommends exploring the patient's reasons first and informing them that vaginal delivery is usually the safer option.

Step 1: Explore Motivation: "I've noted your request for a C-section. To help me support you best, could you tell me more about why you feel this is the right choice for you? Are you worried about pain, the timing, or perhaps a previous experience?

"Step 2: Address Fears: If the fear is pain: "It's very common to feel anxious about labor pain. We have excellent pain management options, including early epidurals and continuous support. We can build a birth plan specifically around your comfort.

"Step 3: State the Recommendation: "As your doctor, my priority is the safety of both you and your baby. For a healthy pregnancy like yours, a vaginal birth is the safest path with a faster recovery. A C-section is major surgery with risks like infection and potential complications for future pregnancies, such as placenta issues."

Step 4: Respect Autonomy (The Referral): "If, after we've discussed these risks, you still feel strongly about this, GMC guidelines suggest I can refer you to a colleague for a second opinion to ensure all your options are covered."

If you disagree with a patient's choice of option

You must respect your patient's right to decide. If their choice of option (or decision to take no action) seems out of character or inconsistent with their beliefs and values, it may be reasonable to check their understanding of the relevant information and their expectations about the likely outcome of this option and reasonable alternatives. If it's not clear whether a patient understands the consequences of their decision, you should offer more support to help them understand the relevant information. But you must not assume a patient lacks capacity simply because they make a decision that you consider unwise.

If a patient asks for treatment or care that you don't think would be in their clinical interests, you should explore their reasons for requesting it, their understanding of what it would involve, and their expectations about the likely outcome. This discussion will help you take account of factors that are significant to the patient and assess whether providing the treatment or care could serve the patient's needs. If after discussion you still consider that the treatment or care would not serve the patient's needs, then you should not provide it. But, you should explain your reasons to the patient and explore other options that might be available, including their right to seek a second opinion.

Key Principles Applied

ACOG's RESPECT Model: Building rapport and seeing the patient's point of view before declining.

GMC's Ethical Integrity: You are not required to provide treatment you believe is not of overall benefit, but you must explain why and explore alternatives.

NMC's Collaborative Care: Involving the patient in the management plan to empower them

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05

When Family Members Dominates Consultation

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In our busy Gynac OPDs, it is very rare to see a patient alone. Whether it is a husband coming for infertility issues or a mother-in-law leading the talk for a pregnant daughter-in-law, family presence is an integral part of our culture. While family support is usually a pillar of strength, it becomes a difficult consultation when the family takes over and the patient's own voice is lost or shadowed. This dynamic, often called family surrogation or dependency, can make a routine check-up feel like a battle for the patient's right to speak.

Knowing the Difference: Support versus Control

Family involvement is helpful when it gives the patient emotional strength and helps her make sense of a diagnosis. However, it becomes a problem when a family member tries to take over the main decision-making role. In many cases, the family member might even put forward a plan that contradicts what the patient actually wants. We must learn to spot the different ways this control happens in the clinic.

- **Active control** is often loud and clear. Here, the relative speaks over the patient, answers for her, or dismisses her concerns directly.
- **Passive control** is more quiet and harder to see. It involves using silence, acting superior, or staying distant to make the patient feel small and obey.
- **The cultural factor** is very strong in India. In many homes, the whole family decides on health matters. This can lead to the patient feeling like a "voiceless maid" who has no say in her own treatment or life.
- **The In-Law Dynamic** is a common reality where parents-in-law feel entitled to manage the personal affairs and household decisions of the couple, or the lady's mother feels that she alone can decide the wellbeing of her daughter, or vice versa, extending into the doctor's chamber.

Protecting the Patient's Rights and Privacy

We often talk about autonomy, which means the right to make one's own choices. In our context, a person's choices are naturally tied to their family and community. However, the doctor's main duty is always to the patient herself if she has the capacity to decide. Strong family influence is only a problem when it stops the patient from choosing freely among different options.

- **The Solo Minute**: Doctors should make a simple excuse to see the patient alone. This could be during a physical exam in the inner chamber. It is the best time to find out what the patient really wants without others listening.

- **Direct Attention:** Even if a relative answers every question, keep looking at the patient. Ask her directly for her specific opinion on the plan.
- **Professional Expectations:** As the clinician, you can set the rules for the room. Tell the family clearly that you need to hear from the patient first before discussing the plan with everyone.
- **Establish Boundaries:** It is important to set firm limits on what behaviour is acceptable in the consultation room to protect the patient's voice.

Simple Scripts for the Doctor

When a family member starts to take over, you do not need to be rude. You should use polite but firm words to get the talk back on track.

- **If the relative is answering for the patient**

  "I value your help and I know you care for her, but I need to hear exactly how the patient feels in her own words to give the right treatment."
- **If the family is pushing for a plan the patient has refused**

  "The patient's own choice is my priority. Let us talk about why there is a disagreement and what the patient is worried about."
- **If the relative is being too forceful**

  "I need to talk to the patient privately for a few minutes to make sure she is comfortable with this choice."

Handling Common O&G Situations

In our daily practice, certain situations see more family interference than others.

- **Infertility**: Often, the husband or in-laws direct the entire treatment path. It is important to check if the patient is agreeing because she truly wants the treatment or because she is being pressured by the family.
- **Geriatric and Chronic Care**: Studies show that in about 60% of cases involving older patients, adult children make the decisions. Often, they override what the patient actually wants.
- **Birth Control and Menopause**: Privacy is very important here. Family members might use guilt or religious reasons to make the patient follow their wishes.
- **Cancer and Surgery**: Decisions about major operations often involve the whole family, but the patient must remain at the centre of the talk.

How to Help the Patient Cope

Sometimes, the problem is that the patient is too dependent on the family for approval. As a doctor, you can guide her on how to handle a dominating relative outside the clinic as well.

- **Setting Boundaries:** Advise the patient to establish clear limits on what behaviour is okay. Sometimes this means saying a firm "no".
- **Reducing Dependence:** Encourage the patient to work towards making her own emotional choices without always seeking approval.
- **Limited Interaction:** In very extreme cases where the relative is causing mental harm, the patient may need to limit contact or share less personal information to stay healthy.
- **Physical Space:** For some, moving into a separate household is the only way to stop constant interference from in-laws.
- **Emotional Upkeep:** Suggest that the patient practice self-care and talk to supportive friends after stressful family events to protect her energy.

Writing Down the Details Properly

Your clinical notes must show if the family is influencing the decision. This is not about being "anti-family," but about keeping a factual record of the patient's care.

- **Proper Note:** "Patient expressed a desire for medical management, but the husband insisted on surgery. I spoke to the patient alone and she said she still prefers medicine. We will review again in a week."
- **What to Avoid:** Do not use angry or blaming words about the family in the medical records. Stick to facts about what was said and who said it.
- **Documenting Refusal:** If a patient refuses the best option because of family pressure, ensure the risks explained and the reasons for refusal are clearly recorded.

Dealing with Ongoing Problems

If the family continues to interfere despite your efforts, you must shift your approach.

- **Accept Small Changes:** Dominant behaviour is often a long-standing pattern. Small shifts, like setting time limits on the talk or sharing who leads the discussion, are better than expecting a total change overnight.
- **Reward Improvement:** If a relative allows the patient to speak and stays balanced, acknowledge it briefly to encourage that behaviour.
- **External Help:** If the control is harming the patient's mental health or involves manipulation and abuse, tactfully suggest a family therapist, a mediator, or a legal advisor.
- **Protect Well-being:** If the situation does not improve, the focus must shift to protecting the patient from long-term harm through controlled exposure.

Summary Checklist for the Consultation

1. Did I look at the patient while talking rather than just at the relative?
2. Did I ask the patient what she thinks at least twice?
3. Did I manage to talk to the patient alone for a few minutes?
4. Is the final decision written down as the patient's own choice?
5. If the family and patient disagreed, did I write that down clearly and factually?

Conclusion

Managing a consultation where the family dominates requires a delicate balance of cultural respect and professional firmness. By making small, consistent changes in how we manage these visits—such as using private time for exams and direct questioning—we can protect the patient's well-being and her right to choose. Our goal is not to push the family away, but to ensure they remain a source of support rather than a barrier to the patient's own health and voice.

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06 What to Do When the Patient Refuses the Best Option

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A Familiar but Unsettling Moment

A sudden rush fills the hospital's treatment area after sunset. In walks a young adult reporting intense discomfort below the waist, alongside confirmation of conception. Imaging results hint at a possible implantation outside the uterus. Entry into the facility appears necessary, followed by swift medical steps. She listens, anxious but composed, and then says, “Doctor, I want to go home. I will come tomorrow with my husband.”

Right now feels heavy for anyone in scrubs. Urgency shows up loud, risks stand clear, outcomes could weigh hard. Still, a line must hold - patient choice stays central. What sits here goes beyond medicine; ethics speak, dialogue matters, and people remain at the core.

Refusal of advised medical steps happens often in women's health care, be it hospitalization, operations, tissue sampling, blood products, specialist visits, or later check-ups. What matters most stands not in persuading someone to agree, but instead lies in acting appropriately should they decide otherwise.

1. Understanding Refusal: Beyond Non-Compliance

Labelling a patient as “non-compliant” is often an oversimplification. Refusal is rarely irrational; it is usually rooted in context.

Common reasons include:

- Fear of surgery, anaesthesia, or diagnosis (especially malignancy)
- Financial limitations or lack of insurance coverage
- Family influence or decision-making hierarchy
- Cultural or religious beliefs (e.g., refusal of blood transfusion)
- Previous negative healthcare experiences
- Mistrust or inadequate doctor–patient rapport

In the Indian setting, decisions are often influenced by family members, particularly in obstetrics and gynecology. A young woman may defer to her husband, parents, or in-laws. Recognising this dynamic is essential—not to bypass the patient’s autonomy, but to understand the real determinants of her decision.

2. Informed Refusal: The Ethical Counterpart of Consent

One cannot exist without the other - where consent is respected, so too must be the right to decline. When people understand their choices, turning something down becomes just as valid. Clarity does not only supports agreement; it upholds rejection equally well. Without space to refuse, permission loses meaning entirely.

A valid refusal according to the General Medical Council and the American College of Obstetricians and Gynecologists

- Understanding health details comes first for patients when choices must be made. Information stays clear in their mind long enough to consider options carefully. Weighing facts happens after thoughts settle into meaningful patterns. Clarity of thought supports balanced judgment naturally. Retention of key points allows a realistic assessment over time

- Information must be sufficient. Diagnosis explained without ambiguity. Options presented, each accompanied by possible outcomes. Risks disclosed in straightforward terms. Consequences detailed ahead of any decision. Understanding forms the base for the next steps. Clarity was maintained throughout the process

- Voluntariness: Freedom from coercion or undue pressure

Responsibility remains unchanged when refusal occurs. Instead of lessening duty, such moments call for a sharper focus on how messages are shared.

3. Checking Understanding: The Most Missed Step

Confusion, rather than opposition, often lies behind most rejections. When meaning slips, responses shift without intent. Misreading cues shapes outcomes more than stance ever does. Clarity fades before conflict even appears. Assumptions take root where explanation should stand.

A simple but powerful approach is the “teach-back” method:
“Can you please tell me what you understood about your condition and the risks we discussed?”
This often reveals:

- Underestimation of severity (“It is just weakness” in severe anaemia)
- Misconceptions (“Biopsy can spread cancer”)
- Selective listening influenced by fear or denial

Should these gaps be addressed, a shift in the patient’s choice might follow. Where such shifts do not occur, clarity still remains - refusal then rests on full awareness. Only when details are complete can consent or its absence, carry real weight.

4. Communicating Material Risk: Be Specific, Not Vague

When details about dangers lack clarity, clear choices become impossible. Uncertainty clouds judgment, leaving understanding incomplete. Without precise warnings, decision-making falters. Vagueness disrupts awareness, blocking true comprehension. Clarity shapes thought; its absence weakens response.

Instead of saying:
"There could be complications."
One finds greater success when stating it this way

"If this is an ectopic pregnancy and it ruptures, there can be sudden internal bleeding, which can become life-threatening within a short time."
Essential hazards ought to be:

- Concerning the individual's health status
- Clearly explained in simple language
- Evenly weighed - without reduction or enhancement

For example:

- When severe anaemia occurs, the heart may face added pressure. Fainting becomes more likely under such conditions. Complications during pregnancy often follow. One consequence is reduced oxygen delivery. The body struggles to maintain normal function. Weakness intensifies over time. Medical attention may become necessary. Outcomes worsen without intervention
- Preeclampsia brings possible seizures. Despite appearing stable, a stroke may occur without warning. Placental function can decline gradually - yet sudden changes are common too
- Postmenopausal bleeding: possibility of underlying malignancy

Understanding outcomes matters more than causing fear in a person. Clarity shapes perception far better than alarm ever could.

5. Respecting Refusal Without Abandoning Care

Among key ideas stands one clear point
When someone says no, attention need not fade.

Patient choice stands firm, even when survival hangs in the balance. Still, medical professionals carry duties that persist regardless. Decisions rest with individuals, though care obligations remain fixed under such conditions. Boundaries shift for neither urgency nor outcome. Responsibility stays constant, whatever the patient decides. Clinical duty does not fade, no matter how refusal unfolds

- Maintain a non-judgmental attitude
- Avoid showing irritation or negative judgment
- Continue to offer care and support

Despite differences, ongoing treatment remains a requirement under guidelines such as those set by the National Medical Commission. Care must continue even when opinions diverge, according to professional expectations. Where conflict exists, maintaining service is still mandatory per established norms. Though disputes may arise, medical conduct rules insist on uninterrupted support. As defined by regulatory bodies, persistence in care follows all disagreements. Following policy direction, provision does not halt due to personal discord. Even in contention, adherence means staying engaged with patients throughout.

Where possible, offer alternatives:

- Observation instead of immediate intervention
- Medical management where surgery is declined
- Temporary monitoring replaces hospitalization

Should the top choice be rejected, another route with lower risk could remain available.

6. Documentation: Clinical Responsibility, Not Just Legal Protection

Though frequently seen as a protective measure, documentation exists mainly to ensure clear patient care understanding.

- A good note should include:
- The patient’s condition and clinical findings
- Appropriate care method or action
- Specific risks explained
- Patient's stated worries or justifications for declining
- Assessment of decision-making capacity

If required, an observer may be present. Where relevant, a person might accompany. In certain cases, someone could attend. When necessary, a witness can appear. Should it apply, another individual may join

Sample Documentation Note

Patient advised admission for suspected ectopic pregnancy. Risks explained, including rupture, internal bleeding, and life-threatening emergencies. Patient understands but declines admission, stating preference to return with family. Capacity assessed and intact. Advised immediate return if pain worsens, dizziness, or syncope. Written instructions provided.

7. Written Advice and Safety-Netting

A person who declines treatment must receive straightforward instructions in writing before departing. Only then may they go, having been given what is necessary. Clarity matters when choices are made against medical advice. Written form ensures understanding remains intact afterward. Departure follows only once documentation has been provided clearly.

This must include:

- Diagnosis or provisional diagnosis
- Warning signs requiring urgent attention
- When and where to return
- Follow-up plan

Checklist for Patients Leaving Against Medical Advice

- Diagnosis explained clearly
- Risks discussed and understood
- Refusal documented
- Written advice provided
- Emergency symptoms explained
- Follow-up arranged or advised

8. High-Risk Scenarios in Gynecologic Practice

Particular scenarios call for focused attention

Suspected Ectopic Pregnancy: Should admission or surgical intervention be declined, the risk of rupture emerges swiftly. The course may shift without warning. Progression toward haemorrhagic shock follows in some cases. Instability might appear minimal at first glance. Sudden decline is a possibility each time. Unfolding events are not always visible early on. Severe outcomes arise despite seeming calm. Timing plays an unseen role. Each case moves at its own pace.

Severe Anaemia: Often seen within Indian medical settings. When a patient declines a blood transfusion, risks such as heart stress must be reviewed alongside tiredness and issues during childbirth. Consideration shifts toward how bodily systems respond under low blood volume, particularly in pregnancy. Conversations unfold slowly, shaped by cultural views on treatment choices.

Preeclampsia: Stability in patients does not rule out rapid decline. Risks emerge through seizure potential alongside breakdowns in maternal-fetal balance. Though outward signs seem calm, internal shifts can progress without warning. Complications arise not only from convulsions but also from disrupted physiological coordination between mother and child. Sudden changes demand awareness even when the initial presentation appears benign.

Postmenopausal Bleeding: When evaluation or biopsy is declined, a detailed conversation about cancer risk becomes necessary. Malignancy concerns require explanation if diagnostic steps are not taken. Should testing be refused, risks tied to undetected tumors need to be stated. Without assessment, potential harm from a missed diagnosis ought to be addressed. If procedures are declined, the implications for tumor development warrant mention.

Suspected Malignancy: Prognosis may worsen if biopsies or referrals are interrupted. Underneath refusals, emotional hesitation, and social unease typically reside.

Case Vignette

A 50-year-old woman presented with postmenopausal bleeding. Ultrasound revealed endometrial thickening. An endometrial biopsy was advised. She refused, saying, “Doctor, if it is cancer, I do not want to know.”

Instead of insisting, the consultation focused on her fears. She revealed concerns about financial burden and lack of family support. After involving her daughter and reassuring her about early-stage outcomes, she agreed to the procedure. The biopsy confirmed early carcinoma, and she underwent timely treatment with a good prognosis.

Insight: Refusal is often a surface expression of deeper fears. Addressing those fears can change decisions.

Script Box: Language That Helps

- "I respect your decision. My responsibility is to make sure you have all the information."
- "Can I share what concerns me most about your condition?"
- "If you decide not to proceed today, these are the warning signs you should not ignore."
- "You can come back at any time- we are here to help you."

Conclusion

The difficult consultation is not about asserting authority or securing agreement. It is about **balancing medical responsibility with patient autonomy.**

When a patient refuses the best option:

- Ensure the refusal is informed
- Check understanding carefully
- Communicate risks clearly
- Document thoroughly
- Provide safety-net advice
- Continue care without judgment

In clinical practice, we are often remembered less for the decisions we recommend and more for the way we support patients through uncertainty. Respect, clarity, and continuity of care remain our most powerful tools- even when the patient chooses a different path.

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07 The Angry Patient In Opd : De-Escalation That Works

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Introduction

Angry or distressed patients are a common reality in outpatient departments (OPD), particularly in high-volume obstetric and gynaecologic practice. While challenging, these encounters are critical moments that can either damage or strengthen the therapeutic alliance.

Doctors have an ethical obligation to **foster and preserve a therapeutic relationship**, even when conflict arises. Effective de-escalation is not just a communication skill—but an **ethical responsibility grounded in beneficence, respect for autonomy, and professionalism.**

1. Common Triggers for Anger

System-related triggers

- Long waiting times
- Perceived neglect or lack of attention
- Administrative delays (billing, reports)
- Poor coordination between staff and doctor

Clinical triggers

- Unexpected diagnosis (e.g., infertility, malignancy suspicion)
- Pain or unresolved symptoms
- Complications or poor outcomes
- Repeated visits without perceived improvement

Communication-related triggers

- Use of medical jargon
- Inadequate explanation
- Contradictory information from different providers

Psychosocial triggers

- Financial stress
- Family pressure (common in obstetrics/infertility cases)
- Cultural beliefs and stigma

2. Early Warning Signs of Anger

Verbal signs

- Raised voice, rapid speech ,Repetitive questioning ,Sarcasm or accusatory tone

Non-verbal signs

- Clenched fists or jaw, Pacing or restlessness ,Avoiding eye contact or intense staring

Behavioural cues

- Interrupting frequently ,Refusing to sit ,Escalating demands

Early intervention at this stage prevents confrontation.

3. Tone and Body Language of Angry Patient and Doctor

Angry patient

- Loud, sharp tone ,Pointing fingers, leaning forward aggressively and Invading personal space

Doctor's ideal response

- Calm, slow, measured speech ,Neutral facial expression ,Open posture (uncrossed arms, slight forward lean) .If the doctor becomes defensive or authoritative, escalation is almost inevitable.

4. Seating and Privacy

Physical environment significantly influences behaviour.

Best practices

- Offer a seat → reduces agitation
- Sit at eye level → reduces hierarchy
- Maintain appropriate distance (not confrontational)

Privacy

- Shift to a quieter area if possible
- Avoid addressing conflict in crowded OPD corridors

Privacy allows patients to express emotions without embarrassment and reduces performative anger.

5. How Staff Should Respond Before the Doctor Enters

Frontline staff play a **crucial role in de-escalation.**

Do's

- Listen without interrupting
- Acknowledge concern:
  - "We understand your concern, doctor will see you shortly"
- Provide realistic timelines
- Inform doctor early if escalation is brewing

Don'ts

- Arguing or blaming the system
- Ignoring the patient
- Giving false reassurance

Staff must be trained to

Listen → Acknowledge → Inform → Escalate (to doctor if needed)

A well-trained receptionist or nurse can prevent 50% of conflicts.

6. How to Separate Emotion from Allegation

Angry patients often mix **emotional distress with factual allegations.**

Step 1: Address emotion first

Step 2: Clarify allegations

Step 3: Reframe

Step 4: Respond objectively

This prevents defensive reactions and keeps discussion constructive.

7. When to Pause and Reschedule ? Not all encounters should be completed in one sitting.

Indications to pause

- Patient is too emotional to process information
- Repeated interruptions prevent meaningful discussion
- Time constraints affecting quality of care
- Risk of verbal escalation

Doctor must say

- "I want to give you proper attention. Let us continue this discussion in a short while / later today."

Pausing is **not avoidance**- it is a strategy to preserve quality and safety.

8. When to Involve a Senior or Security

Involve senior colleague when: Complex clinical dispute ,Loss of patient trust and Medico-legal concern

Involve security when: Threatening behaviour , Verbal abuse escalating to physical risk and Damage to property

Safety principles

- Never manage physically aggressive patient alone
- Maintain exit access
- Protect staff

9. How to Document the Encounter if Conflict Persists

Proper documentation is essential for **clinical continuity and medico-legal safety**.

What to document

- Patient's complaints (verbatim if possible)
- Observed behaviour (objective description)
- Information provided by doctor
- Efforts made to resolve conflict
- Advice given and patient response
- Any witnesses present

Avoid

- Judgmental language ("patient was rude")
- Emotional comments.

If relationship breakdown occurs

- Provide referral options
- Ensure no abandonment
- Document clearly

Good documentation protects both **patient rights and physician integrity.**

Conclusion

The angry patient encounter is not a disruption- it is a clinical and ethical opportunity.

De-escalation works when the doctor:

- Recognizes underlying distress
- Maintains composure
- Communicates with empathy and clarity
- Sets boundaries when needed

Conflict should be approached not as confrontation, but as **restoration of trust.**

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08 Counselling For Costly Treatment Without Sounding Commercial

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Introduction

India is a developing country. Not many can afford treatment which entails heavy cost. So costly treatment become a burden for most of our patient .We have to adopt a practical, patient friendly way to counsel for costly treatment so that it feels like partnership and not an obstacle .

Here is how to introduce the topic of high cost treatment with clinical empathy and professional transparency .

The "Care first" opening

The transition into financial talk should happen after the clinical benefits have been established

- The script "Now that we have discussed the clinical benefits let's discuss how to make this treatment a clinical reality. We know that the financial aspect is a major part of the journey lets address it openly ,so you feel fully supported "

Cove pillars of introduction

To avoid sounding commercial rest your introduction on these pillars

1 Transparency as a clinical Tool

You should positionthe cost discussion as a part of 'informed consent '.Make sure the patient has all the facts required to make a safe decision .

2 Validating the burden

Do not try to ignore the high price, name it .Try to convey to them that the treatment is an investment .

Key phrase "we recognise that this is a significant undertaking and your concern for the logistic of the cost are justified "

3 The "Advocate" stance

You should not sound like the "provider" (who takes money)but rather like an "advocate" (one who finds solution)

Key phrase "we are here to help you navigate this. We have resources and options specifically designed to help patient manage there types of specialised treatment"

Comparison commercial versus empathic Introduction table

Aspect	Commercial counselling	Empathic counselling
Primary Focus	Selling or promoting treatment	Patient's well-being and informed choice
Tone	Persuasive, business- like	Warm, understanding patient - centered
Approach	Highlights benefits,may downplay limitations	Balanced discussion of benefits,risks,and alternatives
Language Used	"This is the best option,you should go for it."	"Let's discuss what suits your situation best."
Cost Discussion	May be delayed or softened	Transparent and upfront about costs
Patient Autonomy	Subtle pressure possible	Fully respects patient's decision-making
Handling Concerns	Reassurance focused on closing decision	Validates fears, encourages questions
Alternatives	Limited or briefly mentioned	Clearly explains all options, including conservative ones
Emotional Support	Minimal	High–acknowledges stress, financial burden
Trust Building	May feel transactional	Builds long-term trust and rapport
Outcome Goal	Treatment acceptance	Informed, comfortable decision (even if patient declines)

To move into the heart of the councelling session,the focus must shift from 'explaining the cost' to 'removing an obstacle' The following strategies will be helpful in maintaining a patient friendly atmosphere

1.The Dual Focus Strategy

Separate the 'clinical benefits' from the financial logistics. Mixing the two often makes a conversation 'commercial'

- The language "from a medical stand point, this is our best path forward. Now let's look at the logistical side together to see how we can Bridge the gap.
- The logic you are treating the cost as a complication to be managed much like the side effect

2. Use“shared Decision Making”

Counselling is a two way channel .The patient should be invited to be a part of the problems solving process.

- Ask open questions
- How do you feel about the facts discussed?
- What are the main concerns coming to your mind?
- Acknowledge the patient concerns “we understand that choosing this treatment often involves priortising health over other plans. It is a significant decision and we want to give you space”

3 Normalize “Financial Toxicity”

In medicine “financial toxicity” means the stress caused by the cost of care. Using clinical terms for the burden will actually make it feel less like a ‘bill’ and more like a part of the medical care

The script “we talk about financial wellness” just like physical health because we know thatcost stress can impact your recovery. We will try and reduce that stress as much as possible.

4 The “Quiet” closing

Instead of telling the patient to make the deposit try and say “we have given you all the required information .Take some time and discuss with your family .We are here for you in case you need to talk about the next step or to answer your queries”

The Final Statement

The very last sentence should reinforce the partnership

“we are in this journey with you. Our goal is to make sure the path to your recovery is as clear and as stress free as possible

Reflection For the Provider

As you wrap up observe the patient .If they still seem tense it may be worth adding’ I can see this as a lot to take in. Just remember we are not just giving you a plan we are giving you a team to help you navigate it ‘

Summary

Counselling for high cost care is about shifting the narrative from purchasing a service to investing in a clinical outcome. The process is rooted in maintaining the “clinician advocate” role rather than becoming a “service provider”

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09 Documenting A Difficult Consultation Properly

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INTRODUCTION-

Difficult patient encounters and disagreements are an integral part of obstetrics and gynecological practice. Navigating through such situations require patience, proper understanding and adequate documentation. In challenging cases, high-quality documentation protects the provider, ensures continuity of care, and clearly outlines the rationale for treatment decisions.

WHY CONSULTATIONS BECOMING CHALLENGING-

Each patient and their attendants/guardians bring their own personalities, individual medical needs, expectations, varying levels of health literacy, and communication styles to their interactions with doctors. Doctors on the other hand, are overburdened with patient care, documentation, time constraints and lack of support staff. On top of that, increased misinformation and general distrust towards healthcare providers have increased the strain of the patient-physician relationship.

HOW TO HANDLE DIFFICULT SITUATIONS-

Handling a difficult situation in OPD and emergencies need patience, good clinical judgement, eye to eye conversation with the patient or attendants and proper documentation of all events. It is pertinent to remember that “if you did not write it down, it did not happen”. Documentation of present medical history, examination findings, recommendations, decisions and follow up planned for the individual and keeping a copy of it for future reference is utmost necessary. Maintaining the records at proper time and at each consultation, before a challenging situation arises, can help mitigate the adverse events that can arise if the situation becomes extremely volatile; as sometimes we may not get adequate time to write everything down once the circumstances become difficult to handle.

Identifying situations which can turn volatile help us to prepare better. These include high risk pregnancies with complications, complicated deliveries, gynecological emergencies like ruptured ectopic pregnancies, ovarian torsion, sepsis, shock etc.

Careful listening & communication- This is the first step in handling a troublesome situation.

- Be gentle, patient and empathetic in your approach
- Explain the situation in clear words without using medical jargon, preferably in the language of understanding of the patient and keeping in mind the medical literacy of

the patient. Patient expectations can be more effectively managed when they have all the necessary information to make informed decisions about their treatment.

- Explain all warning signs of the present disease and all possible options available for treatment. Patients may have unmet expectations for their care. They may ask for specific care that cannot be provided or may ask for treatments that are not indicated; specially in this era of internet, where they read about everything before coming to the hospital. Not complying to these requests or expectation can result in conflict. Thus, listening to their queries and giving scientific evidence-based answers can help resolve this problem to some extent.

- Whenever questions arise, it should be answered with confidence and clarity; making sure that they are comprehending what has been told. They may be asked to repeat whatever has been said to them in order to know whether they have understood the situation.

- Need of follow up and timing should be clearly explained and emphasized in relevant situations.

- Keep some staff members alongside while explaining. It is better to work as a team with other health practitioners at the hospital or clinic, while handling such patient.

- Avoid arguing, talking over the patient, or making judgmental statements. In some situations, it may be appropriate to allow the patients to express their anger and for you to acknowledge their experience: "I can see that you are very angry about this." Acknowledging the patient's experience does not necessarily mean you agree with what they are saying; but it helps in defusing the situation to some extent.

Documentation- this is the next important step.

- All the explanations made to the patient and party should be well documented legibly.

- Avoid complicated medical terms and abbreviations. In the document, using appropriate vocabulary and terminology and mentioning date, time and place of explanation is necessary.

- Document the relations of all attendants who have been present while explaining.

- Document the decision of treatment taken by the patient and/or party; especially if they are refusing or deferring a particular suggested treatment

- If a particular treatment option is not available in the centre, that should be explained and documented as well. The refusal or acceptance of referral to higher centre again should be clearly documented. The time and date of referral should be clearly written in the records.

- It is preferable to take signatures of the person explaining and documenting the facts, the patient/ attendant and a witness in a note, which has mentioned all the risks and options explained to the party.

- In a factual and non-judgmental way, document in patients' medical records any inappropriate statements or behaviour by patients towards the doctor and/or staff. Description of the words used, tone of voice, use of gestures and posture is more helpful than just stating that a patient was rude and aggressive.

- If one is terminating treatment of a patient due to any reasons, the facts and reason of termination, example non-compliance, abusive behaviour etc. should be clearly documented.

- All telephonic consultations should be documented in the patients' medical records. However this is difficult in Indian scenario, as all documents are sent off with the patient after the consultation.

Patient hand-offs- During shift changes of staff, a proper document can help the next members in duty to proactively manage the difficult patient, save time and prevent volatile situations. Even while transferring such patient to higher or referral centres, a communication hand-off should be written properly which include demographic information, a brief history, physical examination findings, an active problem list, medications and allergies, pending test results, ongoing or anticipated therapy, key patient values and preferences.

DOCUMENTATION PRINCIPLES TO BE FOLLOWED IN DIFFICULT SITUATION-

- Context- reason for visiting the hospital and complaints

- Treatment and investigations offered- treatment options to be documented along with patient's choice. For example:- in a symptomatic fibroid, "patient has been explained about medical(trenaxemic acid, OCPs, mifepristone, GnRH agonist) management and surgical management(myomectomy). Patient opts for Mifepristone treatment after discussing all the options".

- Timeliness ensured- date and time of encounter to be accurately mentioned.

- Record patient refusals- Clearly document when a patient refuses advice, ignores risks, or refuses to follow the proposed treatment. For example: "patient advised caesarean section for non-progress of labour. All complications like fetal distress, stillbirth, postpartum hemorrhage, infections explained. Patient refuses caesarean section".

- Be objective and specific- avoid using nonspecific language like "patient was rude". Record exact quotes of aggressive, threatening, or particularly inappropriate language and record what they are demanding for treatment.

- Document actions- Detail any de-escalation attempts, boundaries set, and advice given.

- Document outcome- The result of the encounter (e.g., patient left, appointment terminated, security called).

Examples of good and poor documentation-

SITUATION	GOOD DOCUMENTATION	POOR DOCUMENTATION
Leaving against medical advise	"At 14:00, the patient stated that she wants to leave the hospital against advice. Dr. Gupta explained the risks of leaving, including potential infection(mention common complications). Patient understood the risks but stated, 'I have to go home as my child is sick.' Patient left the unit at 14:15." DAMA forms signed by patient, attendant & witness	"Patient wants to leave hospital and refuses treatment. Patient left hospital at 14:15" Appropriate signs not taken
Non-compliant patient	"Patient refuses morning dose of antihypertensive(10:00). Stated, 'I'm not taking that.' Patient educated about maternal & fetal risks of increased BP. Patient was polite but firm. Dr. Sheila notified at 10:15."	"Patient is being difficult and refusing all medication."
Unexpected clinical deterioration	"11:00 Patient reported sudden shortness of breath. Vitals: BP 90/50, HR 120, SpO2 88% on room air. Positioned patient upright, initiated 2L O2 via nasal cannula. Dr. Patel notified. 11:05 Orders received: ECG, bolus 500ml NS. Party explained about present condition. Patient shifted to ICU at 11:10."	"Patient had difficulty in breathing. ECG done, IV fluids started and shifted to ICU"
Breaking bad news	"At 20:30, husband and attendants explained about present condition of fetal death due to the presence of abruption of placenta. Risk of mother like heavy bleeding, shock, need of blood transfusions, need of immediate induction, deterioration of present condition and need of LSCS explained. Husband and family members including patient's mother and brother expressed understanding of the disease." Husband, witness, doctor signed the written note and consent for labour induction and blood transfusion	"Husband and party explained about fetal death. Complications and need of urgent delivery explained."
Bad behaviour	Patient shouted at the doctor and staff, used abusive language(quote the exact words) and demanded the specific medication despite repeated counselling.	Patient was rude and aggressive

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10

Words that build trust, words that create trouble

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In obstetrics, we often speak of interventions- induction, caesarean, magnesium sulphate, insulin. Yet, one of the most powerful interventions we employ daily is far less tangible: **our words. . "A technically correct sentence, poorly framed, can erode trust faster than a clinical complication."**

They precede decisions, accompany crises, and linger long after discharge. They shape perception, influence compliance, and often determine how patients remember their care- irrespective of the outcome.

Communication is not merely about conveying information. It is about **containing uncertainty, directing emotion, and maintaining trust in moments when medicine itself may have limits**

The Illusion of Neutral Language

We often assume that if our words are factually correct, they are adequate. But in obstetrics, language is never neutral. Every sentence carries tone, implication, and emotional weight.

A technically accurate statement can still destabilize:

- It can amplify fear
- It can sound like loss of control
- It can unintentionally assign blame
- It can create expectations that reality cannot sustain

The challenge, therefore, is not only what we say—but how, when, and in what context.

When Uncertainty Is Misheard

Obstetrics is filled with grey zones- borderline Dopplers, equivocal CTG tracings, lab values that do not fit neatly into protocols. As clinicians, we are trained to live with uncertainty. Patients and families are not.

When we say, "We are not sure what is happening," we intend honesty. What they may hear is, "The situation is out of control."

Unstructured expressions of uncertainty can quickly erode confidence, prompting anxiety-driven decisions- multiple opinions, loss of continuity, or even refusal of appropriate management.

Experienced clinicians learn to **frame uncertainty within a plan:**
There are findings that need closer attention. We will monitor carefully and take timely action to ensure safety.

The difference is subtle, but its impact is profound. Uncertainty remains- but it is **contained, guided, and purposeful.**

Urgency Without Panic
"Urgency must be communicated without transferring panic."

Few moments test communication more than an obstetric emergency. A falling fetal heart rate, a concealed abruption, a sudden eclamptic seizure- these demand rapid clinical action.

Yet, in these very moments, words can either steady the situation or escalate it.

When urgency is expressed as alarm-
"This is critical… anything can happen… sign immediately…"-
it transfers panic to the patient and family. Comprehension narrows, consent becomes questionable, and retrospectively, communication may be perceived as coercive.

The seasoned obstetrician communicates urgency differently:
We need to act quickly to ensure safety. Our team is ready, and we recommend immediate intervention.

The tempo is preserved. The seriousness is conveyed. But panic is not transmitted.

The Language of Loss
"In moments of crisis, patients do not just hear words- they absorb tone, intent, and control."

There are moments when medicine fails- despite vigilance, despite adherence to guidelines, despite best intentions. Intrauterine fetal demise, severe neonatal compromise, unexpected maternal deterioration.

In such moments, the instinct to explain is strong. To justify. To reassure that everything was done correctly. But grief does not receive explanation well.

Statements such as "These things just happen" or "We did everything possible" may be clinically valid, yet emotionally discordant. They can sound distancing, even defensive.

What patients and families seek first is not reasoning, but recognition: I am deeply sorry.

I understand how difficult this is.
Only after this acknowledgment can explanation find its place. In obstetrics, **empathy must lead; science can follow.**

The Burden of Labels

Terms like “high-risk,” “complicated pregnancy,” or “severe case” are embedded in our clinical vocabulary. They guide management, triage resources, and structure protocols.

But when spoken without context, they can impose a psychological burden.
A patient labelled “high-risk” may begin to experience her pregnancy as fragile, precarious, and perpetually threatened-even when outcomes remain favourable.

Language that shifts from labels to actions changes this perception:
This condition requires closer monitoring, and we will take additional precautions to ensure everything remains on track.

The risk is not denied-but it is **translated into a plan**, rather than a prognosis.

When Words Assign Blame

Non-adherence is a common and complex issue- dietary lapses in gestational diabetes, missed visits, delayed reporting of symptoms. The temptation to correct firmly is understandable.

Yet, phrases that imply blame-
“You didn’t follow instructions,”
“You came too late,”
-often achieve the opposite of their intent.

They provoke defensiveness, reduce openness, and sometimes lead to concealment of information. Blame closes conversations; shared responsibility keeps patients engaged.”

A more effective approach reframes the issue:
Sometimes, despite best efforts, control remains difficult. We may need to adjust our approach.
Responsibility is shared. The patient remains engaged. The conversation moves forward.

The Risk of Reassurance

Reassurance is one of the most commonly used tools in obstetrics- and one of the most misused.

Statements such as “Everything will be fine” or “There is nothing to worry about” offer immediate comfort. But they carry an implicit promise that medicine cannot guarantee.

When complications arise- as they inevitably do in a subset of cases- these words return with force, often perceived as misinformation or false assurance.

Experienced clinicians adopt a more measured reassurance:
Most patients in this situation do well. We will monitor closely and respond to any changes.
Hope is offered- but it remains anchored in vigilance.

The Subtle Dynamics of Decision-Making

Modern obstetrics emphasizes patient autonomy. Yet, in practice, decision-making is rarely individual. Families, cultural expectations, and social pressures often converge at critical moments.

When clinicians step back entirely-
"You decide what you want to do"-
it may appear respectful, but can create confusion, conflict, and later regret.

Patients often seek not just information, but **guidance grounded in expertise:**
Based on your condition, this is the safest option. I will explain it clearly so you can make an informed decision.
Autonomy is preserved- **but it is supported, not abandoned.**

The Obstetrician's Voice

Words carry disproportionate weight. They can:

- Resolve uncertainty- or amplify it
- Calm a family- or alarm them
- Reinforce team communication- or contradict it

Equally important is the ripple effect. Junior doctors often mirror the language they observe. A culture of hurried, unfiltered communication propagates quickly; so does a culture of measured, thoughtful dialogue. Thus, communication at the senior level is not merely individual practice- it is **institutional leadership**.

What Remains

Patients may not remember the exact details of a Doppler waveform, a drug dosage, or a protocol. But they will remember how they were spoken to:

- In the anxious wait before induction
- In the urgency of an unexpected intervention
- In the stillness of loss

In these moments, words do more than inform. They **hold, guide, and sometimes heal**.

Closing Reflection

Obstetrics is a discipline of unpredictability. Outcomes cannot always be controlled. Complications cannot always be prevented.

But communication- thoughtful, precise, and humane- remains within our control.
"In obstetrics, words are not neutral- they either stabilize or destabilize."

For the experienced obstetrician, mastery lies not only in clinical judgment, but in the ability to speak in a way that:

- Contains uncertainty
- Preserves dignity
- Sustains trust

Even when medicine reaches its limits.
Because in the end, long after the clinical details fade, it is often the **memory of our words** that defines the experience of care. Patients may forget what was done, but they rarely forget how they were spoken to."

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APPENDIX

TOOLKITT

Difficult Consultation Toolkit

1.Begin every difficult consultation by identifying the patient's main fear and not merely the presenting complaint.

2. Allow the patient to speak without interruption at the start whenever possible.

3. Acknowledge anxiety, anger, confusion, or hesitation before moving into advice.

4. Ask what the patient is hoping to achieve from the visit.

5. Clarify whether the barrier is medical, emotional, financial, social, or family-driven.

6. Correct misinformation without humiliating the patient.

7. Explain the situation in simple language before discussing options.

8. Present only the reasonable options and avoid creating confusion with an unnecessary list.

9. State clearly which option you recommend and why.

10. Be honest about uncertainty, but do not leave the consultation directionless.

11. Distinguish between what is ideal, what is acceptable, and what is the minimum safe plan.

12. Keep the patient's voice central even when several relatives are present.

13. Speak to the patient separately when privacy is important for decision-making.

14. Check whether the patient has actually understood the advice given.

15. Ask the patient to repeat the plan back in her own words when the matter is important.

16. Use written instructions when the consultation is emotionally loaded or medically significant.

17. Record what was advised, what was discussed, and what was accepted, refused, or deferred.

18. Note warning signs clearly whenever treatment is postponed or refused.

19. Give a definite follow-up plan instead of vague advice to return if needed.

20. Ensure that front-desk and nursing staff do not worsen a difficult interaction through argument or casual reassurance.

B. RED FLAGS

What commonly goes wrong in a difficult consultation

1. Interrupting the patient too early often makes the rest of the consultation harder than it needs to be.
2. Correcting the patient in a dismissive tone damages trust even when the medical facts are correct.
3. Arguing with internet information instead of addressing the patient's actual fear rarely works well.
4. Allowing relatives to dominate the discussion can leave the patient unheard and the decision unclear.
5. Giving multiple options without guidance may confuse the patient rather than empower her.
6. Saying that it is the patient's choice without explaining consequences is not shared decision-making.
7. Avoiding financial discussion can later be misunderstood as concealment or commercial intent.
8. Reacting emotionally to an angry patient usually escalates the consultation further.
9. Using jargon in a tense consultation creates more misunderstanding and not more respect.
10. Offering false reassurance to end a difficult discussion may create bigger trouble later.
11. Failing to document refusal, indecision, or disagreement leaves the record dangerously incomplete.
12. Writing only the prescription and not the discussion is poor documentation in a difficult consultation.
13. Assuming silence means understanding is a common clinical mistake.
14. Rushing to advice before identifying the real concern often leads to resistance.
15. Ignoring the influence of attendants may hide coercion, confusion, or divided decision-making.
16. Speaking more and listening less usually makes difficult consultations longer and not shorter.
17. Ending the consultation without a clear next step leaves the patient uncertain and dissatisfied.
18. Staff behaviour before the doctor enters the room can destabilise the entire encounter.
19. A defensive tone from the doctor may turn a worried patient into an angry one.
20. Lack of written instructions after a difficult consultation commonly leads to later misunderstanding.

C. FDMSEC COMMITTEE RECOMMENDATIONS

Handling difficult consultations in ObGyn practice

1. Difficult consultations should be recognised as a routine clinical responsibility and not as a personal inconvenience.
2. Communication in such situations should be treated as a practical clinical skill that can be improved and standardised.
3. Every clinic should adopt a simple and consistent structure for handling emotionally charged or high-conflict consultations.
4. The patient's main concern should be identified early in the discussion.
5. The doctor should explain the situation in clear language that the patient can understand.
6. Reasonable options should be discussed, but the doctor's recommendation should also be stated clearly.
7. The patient's voice should remain central even when family members are actively present.
8. Privacy should be created when the nature of the decision requires direct patient expression.
9. Refusal of treatment should be respected, but it should never be left undocumented.
10. Material risks and likely consequences should be explained whenever a patient declines the recommended option.
11. Written instructions should be given when the consultation involves refusal, deferment, high risk, or likely confusion later.
12. Financial counselling should remain medically anchored, transparent, and free from promotional language.
13. Doctors should distinguish clearly between the ideal option, acceptable alternatives, and the minimum safe plan.
14. Documentation in a difficult consultation should include not only findings, but also discussion, recommendation, and decision.
15. Clinical notes should remain factual and should avoid emotional or judgmental wording.
16. Front-desk and nursing staff should receive basic guidance in respectful handling of distressed or angry patients.
17. Second opinions should be supported where they help reduce conflict and improve confidence in care.
18. Difficult consultations should end with a defined plan, warning signs, and follow-up advice.
19. Good communication should be seen as part of patient safety and not merely as bedside manner.
20. Better handling of difficult consultations improves trust, compliance, clarity, and professional protection.

04 - The Difficult Consultation

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