

Beyond the diagnosis: what I learned from a case

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God gives life, doctors save lives. For as long as I can remember, I have grown up hearing doctors compared to God, the middlemen of fate, pulling people back to the realm of the living, when they should have been long gone. I hear the reverence for doctors in the voice of my grandfather when he talks about how his doctor at the hospital skillfully diagnosed the root cause of his prolonged leg issues. I grew up seeing doctors as people who save their patients, long before I learned exactly how they do it. Throughout my short posting in anaesthesia and specifically the Intensive Care Unit (ICU), I learnt that doctors do more than save lives and despite our biggest hopes, doctors are humans at the end of the day. They can't create miracles, but they will always give everything they have to help.

When I walked into the ICU on my first day, there was a flurry of activity; nurses, MOs, specialists, all walking around the ward reviewing patients, administering medications, and talking to their families. When we joined the rounds, I started to get a clearer picture of the exact role of an anaesthetist in the ICU. In my other postings, if a patient has other comorbidities, the topic of discussion would still mainly revolve around the specific specialty. But in the ICU, the anaesthesiologists discussed the patients' comorbidities in detail. They were the conductors deciding what to do next, what approach to take, and leading the management of the patient. It was here I met a patient whose case left an indelible mark on me.

The patient was a middle-aged woman connected to several machines. Despite the growing noise of the doctors and nurses in the ICU, she did not stir; the only constant was the rising and falling of her chest. The anaesthesiologist began explaining that this patient was brought in for a routine gynaecological procedure when she suffered a blood clot to the brain. After that it was complication after complication and despite the valiant efforts of the operating team, she was pronounced brain-dead. Everyone knows the term; we understand the implications of being

brain-dead but the difference between knowing in theory and seeing it for yourself is truly jarring. You know the patient is dead, but you see the rising of her chest, the colour in her cheeks: it looks like she's just taking a nap, ready to wake up anytime. If I, as a stranger found it hard to believe that she was truly gone, how could her family face this reality? Families often find it difficult to understand that their relatives could be brain-dead since they simply look asleep.¹ After our rounds, we had a discussion with the specialist. She said a brain-dead patient is medically considered dead. According to a study, brain death is defined as the irreversible loss of all functions of the brain, including the brainstem.²

In situations like this, the doctor would explain the patient's condition to the family and ask if they could discontinue the patient from the ventilator and pronounce the time of death when the patient stops breathing. I asked my doctor, "What if the family does not want to discontinue the ventilator? What if they cannot accept that the patient is gone?" She explained that they would respect the family's wishes and give them time to accept the reality. Compassionate communication during end-of-life care is essential for helping families navigate grief and uncertainty.³ "Wouldn't it just be a waste of resources?" asked my course mate. "We do not just treat the patient; we also treat the patient's family. We help them understand what has happened to their loved ones with compassion, we make decisions which are not just for the patient's or the hospital's benefit but for their families as well. The patient is gone but their family is still here praying for hope, and we must help them through this loss the best way we can" she said. A brain-dead patient will eventually pass despite ventilator support. Over time, the patient will suffer from multi-organ failure and most brain-dead patients pass within hours to days. I heard from the doctor that the patient's family was unable to accept that their loved one was brain-dead. After all, she was just supposed to go for a routine procedure. The following day, as I walked past the ICU, I saw the patient's husband crying on the lap of the gynaecologist who was comforting him. The patient had passed.

This case taught me empathy, compassion, communication, qualities that cannot be found in the textbook but in the ICU. As students, we learn to focus on the chief complaint and elicit just enough history to reach a diagnosis. In the ICU I learned that we need to look at the bigger picture, treat the patient as well as their family, communicate with compassion, and use words they understand instead of spitting out the medical terminology that we've memorized. Empathy and effective communication have been shown to improve both patient satisfaction and clinical outcomes.⁴ In anaesthesiology, doctors do more than put preoperative patients to sleep, they safeguard their comfort, monitor their comorbidities, and coordinate critical care.⁵ Even when there is nothing they can do to save the patient, they support them through the grief.

This posting has truly been a turning point in my life, giving me a new perspective, showing me that being a good doctor goes beyond clinical knowledge and technical skills. It requires empathy and clear communication with both patients and their loved ones. I hope this article reminds trainees that medicine is not just about managing diseases and performing procedures. Guiding families through difficult realities, showing compassion in moments of loss, and communicating with clarity and kindness is an integral part of the job. My time in the ICU showed me that anaesthesia is more than physiology and machines, it is the art of combining knowledge with compassion.

References

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