# Patient Management

Color Index

IMPORTANT | NOTES | GOLD | EXTRA

## OBJECTIVES

- Recognize management of patient under the following headings; reassurance, advice, prescription, referral, investigation, follow-up and prevention.
- Identify patient's perception of the problem with implementation of communication and trust.
- Recognize investigations to be in terms of their cost-benefit and risks, and to be requested when helping diagnosis and management.
- Relate health promotion and disease prevention in patient management.

## DONE BY


| | |
|---|---|
| Team Leader | Nasser AbuDujain |
| Members | Abdulaziz Aljasser |
| Revise | Nasser AbuDujain, Moaid Alyousef |
| Sources | Drs Slides and Notes |

## PATIENT MANGMENT

**Management should be considered under the following broad headings:**

- Reassurance and/or Explanation
- Prescription
- Referral
- Investigation
- Observation
- Prevention

The Family physician role as 'Gatekeeper' between primary and secondary care.

## LISTENING

- At the beginning of an interview, the physician should try, by every means possible, to encourage the patient to tell his/her own story in his/her own way.
- Listening to the patient with undivided attention is a very difficult discipline. It requires intense concentration on everything the patient is trying to say, both verbally and nonverbally.
- Doctors, often, are not good listeners. We frequently interrupt. In one study, the average interval between the patient beginning to tell his story and the doctor interrupting was 18 seconds (Beckman and Frankel, 1984).
- A more recent study (Marvel, Epstein, Flowers, and Beckman, 1999) suggests that the situation may have slightly improved, with first interruption occurring after 23.1 seconds.

## HISTORY

Don't Forget ICE

- Understanding the patient's feelings, fears, ideas, expectations, and the impact of the illness on his or her daily functioning is specific for each patient
- The **patient-centered** clinical method, like the conventional method, gives the clinician several injunctions. "Ascertain the patient's expectations" recognizes the importance of knowing why the patient has come.
- "Understand and respond to the patient's feelings" acknowledges the crucial importance of the emotions. "Make or exclude a clinical diagnosis" recognizes the continuing power of correct classification.

## REASSURANCE and/or EXPLANATION

- The need for reassurance may be the main reason for the patient presenting to the doctor, and management may and often does consist solely of this. (Michael Balint; 1986)
- The patient is often relieved by our sincere reassurance and afterwards the things will go in a favorable direction.
- **Inappropriate reassurance** can be a positive danger to the patient and can damage the doctor –patient relationship. (Reassure the Patient when he has a serious Problem)
- **Premature reassurance** is ineffective and may be interpreted by the patient as a rejection. The patient must be convinced that the physician has obtained the information necessary for reassurance. (Reassuring the Patient before he even finishes the History)
- A more recent study (Marvel, Epstein, Flowers, and Beckman, 1999) suggests that the situation may have slightly improved, with first interruption occurring after 23.1 seconds.
- Certain symptoms and/or signs are strongly suggestive of a specific disease, e.g. chest pain, high blood pressure, headache, palpable mass,
- Unless the doctor explores the patients' understanding of their symptoms and their possible significance, it will not be possible to reassure them adequately.

## REASSURANCE and/or EXPLANATION

**Communication** and **trust** are two other factors that influence the success of reassurance as a management technique.

- 1st influential factor: **Communication**

  First explain the problem in terms that the patient can understand taking inconsideration; education, medical background, social class, personality, …

- 2nd influential factor: **Trust**

  Reassurance carries more weight if there is a strong bond between the doctor and the patient.

## Outpatient Attendances

- **Follow–up** is an essential part in patient management.
- For many problems, reassurance, explanation and follow-up are the only parts of management which are necessary.
- For minor, self-limiting conditions (near 50% of consultations), such as URTI and dyspepsia, no formal follow-up is required except if there is a dramatic change in patient condition.
- Follow-up is necessary for chronic conditions like DM, HTN, Asthma, …
- Acute and life-threatening conditions like MI need follow-up after discharge.

## Case Scenarios

A 42-year-old man referred from blood bank as he is not candidate for blood

transfusion as his Hb 12.7 gm/dl (Normal:13 – 18).

He is totally asymptomatic

- Non-smoker No H/O drugs
- FH: unremarkable

Turned out to be "Stomach CA"

A 59-year-old man known case of DM on diet and hypothyroidism on thyroxin presents with swelling of left LL for one week and he claimed that he fell from a height near 2 meters by jumping. He came to his doctor who used to see him in all visits.

BP 136/72 Pulse 76 bpm BMI 20.4

O/E: the limb was swollen “calf and thigh” and different from other limb reaching 2.5 – 3 cm. Looks pale CVS: S1, S2 and 0 Chest: vesicular and no added sounds Abdomen: no tenderness, lax and no organomegaly.

## COUNSELLING

- Sometimes **reassurance**, **advice and explanation are insufficient**, and the doctor may be required to assume a more formal counselling role to help patients work through or come to terms with their problems.

- Counselling has been defined as ‘the various techniques and methods by which people can be helped to understand themselves and to be more effective (Munro et al., 1988)

- The fundamental aim of counselling is to assist patients to identify and implement their own unique solutions to a problem. This will open courses of action from which they can make a choice.

- Many doctors prefer to refer their patients to psychiatrist, psychologist or social worker to deal with such situations.

## PRESCRIPTION

**Weekend Prescription** is when you prescribe an Antibiotic for example on Thursday in case the Patient's illness didn't resolve.

- First you must minimize the occurrence of unwanted drug interactions between prescribed and self-administered drugs, by checking patient medication.
- The decision whether to prescribe or not in a consultation is critical.

# clinical aims of prescribing

## 1- Therapeutic

- **Symptomatic**: NSAIDs in OA or Backpain
- **Curative**: Antibiotic for bacterial infection
- **Preventive**: Prophylactic use of antibiotics, Aspirin in MI

## 2- Tactical

- **To gain time** when collecting more information e.g. antacid until endoscopy.
- **To maintain contact with the patient** e.g. to initiate an antihypertensive in asymptomatic patient.
- **A trial of treatment** e.g. beta agonist for patient with cough and no wheezes, antibiotic in a patient with swelling of LN and still not diagnosed.
- **To prescribe antibiotic** e.g. URTI (could be bacterial or viral) to relieve doctor's anxiety and satisfy patient

## consideration in Prescription

- Compliance
- Instructions given to patient
- Indications and contraindication to its use
- State of patients; pregnancy, lactation, comorbidity like renal or liver problems.
- Appropriate doses regarding Age, Weight, Drug instructions

# REFERRAL

**Referral Rate is varied according to many situations:**

- Practice size
- Qualification and experience of family physicians
- Location
- Access to diagnostic services
- Ability of FP to tolerate uncertainty
- Attitude to illness  Value of hospital care
- Relationship with hospital colleagues

## Referral of patients to secondary care has several number reasons:

1. To obtain specialist **treatment**
2. To obtain a specialist **opinion** on diagnosis and/or management of a difficult problem.
3. To gain access to certain **diagnostic and therapeutic facilities** that not available to Family Physicians.
4. To **relieve patients'** or relatives' anxiety or pressure.
5. To provide **reinforcement** of advice given to a poorly-compliant patient.

## What should be included in the appropriate referral?

- History of patient
- Complaint.
- Clinical findings.
- Provisional or Final diagnosis.
- Significant results.
- Medication, and Reason of referral.

# INVESTIGATIONS

## Why performed?

- To make or confirm a suspected diagnosis (e.g. thyroid in a patient with
- tendency to sleep).
- To exclude an unlikely but important and treatable diagnosis (to R/O Celiac
- disease in a patient with diarrhea / IBS.
- To monitor the effects or side effects of medicine (Lipid and LFT in Patient on Isoretenoic acid or B12 in patient on long treatment with Metformin).
- To screen asymptomatic patients (e.g. mammography for breast cancer).
- To reassure an anxious patient that nothing is seriously wrong.

- The decision to investigate a patient, referring, is **based on clinical judgment.**
- If a doctor is still in considerable doubt about the diagnosis after taking Hx and examining the patient, it is unlikely that lab investigations will be very helpful.

# Studies

- **Sandler (1979),** in a study of 630 hospital medical patients, found that routine CBC, ESR, U&E and Urine analysis in the absence of any clinical indication were of minimal value, contributing to only **1%** of all diagnosis.
- Conclusion that investigations should answer the specific clinical questions.

◊ The studies emphasized the **considerable cost of indiscriminate** investigation and stressed the over-riding importance of a good clinical history.

◊ **Reduction** in request of investigation and cost could be by ongoing policy of intervention, including guidelines, seminars and experience.

◊ The **inappropriateness of 'routine' investigations** is probably even greater in general practice since most patients suffer from non-life threatening and of self-limiting conditions.

## INVESTIGATIONS

**So before requesting investigations you must consider:**

Taking a more focused clinical history and ask:

- Why am I ordering this test?
- What am I going to look for in the result?
- if I find it, will it affect diagnosis?
- How will this affect my management of the case?
- Will this ultimately benefit the patient?

### Case Scenarios

A 48-year-old man asymptomatic, diagnosed incidentally in International Diabetes Day to have high blood sugar of 268 mg/dl and came to you in clinic.

Which investigations are you going to request after history taking and examination?

## Observation

= Follow Up

- Follow–up is an essential part in patient management.
- For many problems, reassurance, explanation and follow-up are the only parts of management which are necessary.
- For minor, self-limiting conditions (near 50% of consultations), such as URTI and dyspepsia, no formal follow-up is required except if there is a dramatic change in patient condition.
- Follow-up is necessary for chronic conditions like DM, HTN, Asthma……….
- Acute and life-threatening conditions like MI need follow-up after discharge

## PREVENTION

- Prevention, care and cure are all part of anticipatory care, which include both health promotion and disease prevention.
- Prevention should always be part of patient management plan as in appropriate way how to lift and what should be avoided in LBP.
- The preventive opportunities not related to the presenting complain(s) – e.g. check BP in a patient with OA, asking for H/O smoking and give advice, check vaccination state of a child coming for URTI..........

## Case Scenarios

A 58-year-old man came to clinic because of being diagnosed as having high blood pressure

BP 174/112 BMI 38

What areas of prevention are you going to tackle with this patient?

# QUESTIONS

## QUESTIONS (1)

Which of the following is the two factors that influence the success of reassurance as a management technique?

Trust and confidence | Communication and trust | Communication and confidence

## QUESTIONS (2)

Which of the following can be a positive danger to the patient and can damage the doctor –patient relationship.

A-Inappropriate reassurance | B-premature reassurance | C-mature reassurance

## QUESTIONS (3)

Which of the following is an ineffective reassurance and may be interpreted by the patient as a rejection?

A-Inappropriate reassurance | B-mature reassurance | C-premature reassurance

## QUESTIONS (4)

- Which of the following is **Tactical** clinical aims of prescribing?

A-Symptomatic | B-To gain time | C-Curative

**ANSWERS**

B, A, C, B