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 **L**eader	Nasser AbuDujain
Members	Abdulaziz Aljasser, Munirah Aldofyan
Revise	Nasser AbuDujain, Moaid Alyousef, Dina Aldussary
Sources	Doctor's 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. Not all these components should be in every patient's management it depends on the case

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** (involve the pt in his management plan) 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** (the reassurance should be in solid data) 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), it affect the pt trust on the doctor.
- **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.

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

you should not reassure him b/c he is a male and any man with anemia you've to know the cause, order upper and lower endoscopy.

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.

Lymphoma>lymphatic obstruction>leg swelling

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.

- The most common problem facing the doctors in counselling is that it's a time consumer

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, statin

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. You give a drug and you wait and see if the patient got better or not. Like pt have lymph node swelling and you give him antibiotics to see if he has infection and resolved or not after the antibiotics
- **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 (the knowledge)
- 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: to get a second opinion

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
- Reason of referral.

Case Scenarios

A 58 Years old male , known case of diabetes, presents to clinic for follow up and claimed to have chest pain when climbing stairs of two flights which is relived within few minutes by rest. His ECG is within normal, how are you going to manage him?

He needs stress ECG and should be referred, stating , aspirin, nitrate, beta blocker

Outpatient attendance

- Multiple outpatient attendences can be confusing to patients, especially if they see different doctors on each occasion.
- Those who re-attending clinics tend to be seen by the more junior hospital doctors, who commonly rotate.
- Misunderstanding about diagnosis, prognosis and treatment can easily arise.
- The more individuals involved in the care of the patient, the greater the potential for confusion and conflicting advice.
- The concepts of whole person medicine and continuity of care are of **particular** relevance in those patients who have frequent or varied contact with hospital services.

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.

  Pt has neurologic symptoms like numbness…, we have to request B12 level test b/c the metformin affect vitamin B12 deficiency. You give B12 complex.

- 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?

Another test , FBG, Hg A1c, Renal function test, lipid profile, LFT " needed for metformin and statin" lipid panel, urine analysis albumin/creatinine ratio. TSH. But if HTN you will order CBC , renal function test, lipid panel, blood sugar, ECG.

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?

Conclusion

- Reassurance and/or explanation: Must be specific and related to the patient's perception of the problem with implementation of communication and trust.
- Advice: Tailored to the personality and state of patient
- Prescription: Aims of prescribing can be therapeutic, tactical or both
- Referral: Whenever a referral is made, the family physician should act as a reference point, coordinator and source of explanation for the patient
- Investigation: Investigations should be considered in terms of their cost-benefit and risks, and should be requested when helping diagnosis and management.
- Observation: A doctor should monitor the progress of patient especially in chronic problems and life threatening conditions.
- Prevention: Involves health promotion and disease prevention to reduce premature death and disability.

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