PRIMARY CARE
MED437

Patient management

Objectives:

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

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References

- Doctor's slides and notes

Important *Notes* *Extra* *Golden*

Editing file link

PATIENT MANAGEMENT

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 You should be a good listener and make eye to eye contact

- At the beginning of Consultation, 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**. It means you should observe the body language and if the patient is worried, anxious or depressed
- 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.** Although there is improvement it’s still considered a short interval

HISTORY

- 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, makes the clinician to decide some actions. "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. Basically it shouldn't be physician-centered, you should explain everything to the patient and get her/him involved in the management and decision

ICE should include **I**DEAS, CONCERNS, **E**XPECTATIONS

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 favourable direction.

- **Inappropriate** reassurance can be a positive danger to the patient and can damage the doctor –patient relationship. (like reassuring the patient when he has serious condition)

- **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, you should wait to obtain enough information to reassure or reassure before the results , you reassure only after you know the diagnosis and management)

REASSURANCE and/or EXPLANATION

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

First influential factor: **Communication**

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

Second influential factor: **Trust**

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

CASE HISTORY

- 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
- Full History (FH): unremarkable

as a rule, any **male** patient with anemia should be investigated even if mild anemia

- **What is the role of reassurance?** No rule of premature reassurance
- **What is the appropriate way of management?**
  For management we do both colonoscopy and gastroscopy to check for GI cancer - dx was stomach cancer.

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CASE HISTORY

- A 59-year-old man known case of DM on diet and hypothyroidism on thyroxine presents with swelling of left LL for one week and he claimed that he fell down 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. (very large)
- Looks pale
- CVS: S1, S2 and 0
- Chest: vesicular and no added sounds
- Abdomen: no tenderness, lax and no organomegaly

- **What is the appropriate way to deal with this patient?**

Don't jump and reassure the patient that it's probably from the fall. Investigate further based on what you suspect.
Duplex US was ordered (to see if the patient has DVT) and the results came back as normal! Still, the size of the limb is too large to be caused by a fall. Imaging of lower abdomen revealed a compressing mass which turned out to be a lymphoma

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 particular 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 have to 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.

- What are the clinical aims of prescribing?

A. Therapeutic?

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

B. Tactical?

- ❏ To gain time when collecting more information e.g. antacid until endoscopy. (because giving PPI before endoscopy can mask the problem so you use antacids first instead)
- ❏ 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.

You have to consider the following in Prescription:

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

REFERRAL

Referral Rate is varied according to many situations:

- Practice size
- Qualification and experience of family physicians (the more experienced the family physician is, the less need for referral)
- Location
- Access to diagnostic services (more access means less referral)
- Ability of FP to tolerate uncertainty
- Attitude to illness
- Value of hospital care
- Relationship with hospital colleagues

Referral of patients to secondary care has a number of reasons:

- To obtain **specialist treatment** e.g:. SSRI cant be prescribed by family physicians in KKUH so you need to refer the patient
- To obtain a **specialist opinion** on diagnosis and/or management of a difficult problem.
- To gain access to certain **diagnostic and therapeutic facilities** that not available to Family Physicians.
- To **relieve patients'** or relatives' anxiety or pressure
- To provide **reinforcement of advice** given to a poorly-compliant patient.

Secondary care is **medical care provided by a specialist e.g. cardiology, endocrinology...etc**

Case

A 58-year-old man, known case of diabetes, presents to clinic for follow up and claimed to have chest pain when climbing stairs of two flights which is relieved within few minutes by rest. His ECG is within normal.

How are you going to manage him?

This is an example that this patient deserves referral for further assessment like Thallium scan (nuclear scan) as this patient diagnosed as a case of Angina/Ischaemic heart disease

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

In OSCE you must mention that you will follow-up with the pt in case of chronic diseases

OUTPATIENT ATTENDANCES

- Multiple outpatient attendances 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 diarrhoea / 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).
  (any patient taking metformin should have B12 level monitoring)
- 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, as with the decision to refer, is based on clinical judgment.**

Case history

- 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? HbA1C, lipid profile, ACR….

Diabetes mellitus
Fasting plasma glucose (FPG) in mg/dL (mmol/L): ≥ 126 (≥ 7.0)
2-hour glucose value after oral glucose tolerance test (OGTT) in mg/dL (mmol/L): ≥ 200 (≥ 11.1)

- If a doctor is still in considerable doubt about the diagnosis after taking history and examining the patient, it is unlikely that laboratory investigations will be very helpful.

- 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.

INVESTIGATIONS

- The studies emphasized the **considerable cost** of **indiscriminate** (i.e ordering everything) 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.

So before requesting investigations you have to 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?

OBSERVATION

"Follow up , very imp , you should always mention it "

- **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 Very important

- **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 complaint(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,……. (vaccination state is more important than the URTI)

Case history

- 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? His BP ,BMI it's also important to ask about smoking history here

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

1. While working in the hospital, you get called to help during a code blue. The patient is a 66-year-old Caucasian female with a history of hyper- tension. The arrest was witnessed by a floor nurse and the initial rhythm was ventricular fibrillation. Which of the following characteristics of this situation make CPR less likely to be successful?

a. The fact that it was a witnessed arrest
b. The fact that the initial rhythm was ventricular fibrillation
c. The patient's comorbid hypertension
d. The patient's age
e. The patient's gender

2. You are caring for a woman who has lung cancer and is discussing treatment options with you. She is choosing radiation therapy over surgery, despite the fact that the 5-year survival rate for radiation is lower than the 5-year survival rate for surgery for her type of cancer. In both cases, the survival rate is lower than 25%. You think surgery is the better option. According to the ethical principle of autonomy, which of the following is correct?

A. You should comply with the patient's treatment request.
B. The patient should have surgery because of physician autonomy.
C. The patient must respect your decision because the principle of physician paternalism overrides patient autonomy in this case.
D. You should explain your preferences for treatment, then honor the patient's preference.
E. You should refuse to treat the patient.

Questions

3. You are working with a patient who has been on benzodiazepines for more than 2 years. She was initially prescribed the medication for help with sleep, but you are now concerned that she has become dependent. After a brief discussion, the patient admits that she'd like to be off the medication. You decide to withdraw her from the medication using a trial of placebo sleeping aids. Which of the following statements is most correct regarding the use of placebos in this situation?

a. Placebo use is never ethical.
b. Placebo use is not ethical in this case.
c. Placebo use is ethical in this case because the patient's diagnosis is likely depression, and depression has a high response rate to placebos.
d. Placebo use is ethical in this case because the alternative to placebo use is unacceptable.
e. Placebo use is ethical in this case because the patient is demanding treatment.

4. You were involved in a minor motor vehicle accident on the way to work. As a result, you saw your first patient of the morning more than 1 hour after the scheduled appointment time. When you walk in, he appears extremely angry. Which of the following alternatives is the most patient-centered way to approach this situation?

a. Explain what happened so that he will understand why you are late.
b. Acknowledge his anger with a statement like, "You seem very angry."
c. Apologize for the delay and efficiently take care of his problem.
d. Explore the reasons for his anger if he brings it up.
e. Help the patient understand that his anger should be directed at his illness, not at you.

Answers:
1.d
2.d
3.b
4.b