Lecture 2

Editing file

MED438
KING SAUD UNIVERSITY

Patient Management

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

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PATIENT MANAGEMENT

Introduction

- The Family physician role as a 'Gatekeeper' between primary and secondary care.
- Management should be considered under the following broad headings:

1. **Reassurance**
2. **Prescription**
3. **Referral**
4. **Investigation**
5. **Observation**
6. **Prevention**

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. **always do ICE (Ideas,Concerns,Expectations/Effect)**
- The **patient-centered clinical method**, like the conventional method, gives the clinician a number of 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.
- Basically it shouldn't be physician-centered, you should explain everything to the patient and get her/him involved in the management and decision

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. (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 suggests that the situation may have slightly improved, with first interruption occurring after **23.1** seconds. Although it is an improvement it's still considered a short interval (Marvel, Epstein, Flowers, and Beckman, 1999).

REASSURANCE & EXPLANATION

1- Reassurance/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 true 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. (e.x. Positively 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, the patient might think that you're rejecting him)
- Certain symptoms and/or signs are strongly suggestive of a specific disease, e.g. chest pain, high blood pressure, headache, palpable mass,etc. 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 in consideration ;education, medical background, social class, personality...
    - **Second Influential factor: Trust** (Depends on communication)
        - Reassurance carries more weight if there is a strong bond between the doctor and the patient.

Counseling:

- 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 counseling 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.

2- Prescription:

- 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 Osteoarthritis or back pain
    - Curative: Antibiotics in bacterial infections
    - Preventive: Prophylactic use of antibiotics, Aspirin in MI
  B. **Tactical:**
    - To **Gain time** when collecting more information eg. 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 or 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. (like in pediatrics)

- **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. (ex. How to use insulin injections)
  - **Compliance.**

- **Weekend Prescription:** is when you prescribe an Antibiotic for example on Thursday in case the Patient's illness didn't resolve, as in pediatric otitis media it should resolve in 72h if it was caused by viral but need an antibiotic if it was caused by bacteria.

3- Referral:

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

1. Practice Size
2. Qualification and experience of family physicians[1]
3. Location
4. Ability of Family Physician to tolerate uncertainty
5. Attitude to illness
6. Value of hospital care
7. Relationship with hospital colleagues
8. Access to diagnostic services[2]

- **Referral of patients to secondary care has a number of reasons:**
  - To obtain specialist **Treatment** e.g:. SSRI cant be prescribed by family physicians.
  - 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.
- **What should be included in the appropriate referral?**
  - History of patient:
    - Complaint.
    - Clinical findings.
    - Provisional or Final diagnosis.
    - Significant results.
    - Medication
    - Reason of referral.

Outpatient attendees:

- Multiple outpatient appointments 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.

1. The more experienced the family physician is, the less need for referral.
2. More access means less referral.

4- Investigations:

- The decision to investigate a patient, as with the decision to refer, is based on clinical judgment
- 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.**
- 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.
- The Conclusion is that investigations should answer the specific clinical questions.
- Normal CBC can be repeat after 3 years.

Why are they performed?

1. To **Make Or Confirm** a suspected diagnosis (e.g. thyroid in a patient with tendency to sleep).
2. To **Exclude** an unlikely but important and treatable diagnosis (to R/O Celiac disease in a patient with diarrhea / IBS.
3. To **Monitor** the effects or side effects of medicine (Lipid and LFT in Patient on Isotretinoin or B12 in patient on long treatment with Metformin).
4. To **Screen** asymptomatic patients (e.g. mammography for breast cancer).
5. To **Reassure** an anxious patient that nothing is seriously wrong.

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 & PREVENTION

5- Observation:

- **Follow–up is an essential part in patient management.** Its very important in OSCE, especially in chronic illnesses
- 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.

6- 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 an appropriate way e.g. how to lift and what should be avoided in Lower back pain.
- 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…etc.

An area for your notes

CONCLUSION

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.

An area for your notes

Case study 1:

- 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's asymptomatic, non-smoker, no past history of drugs and full history is unremarkable.

- **What do we start with?**
  - History starting with open ended questions, avoiding unnecessary inappropriate reassurance.
- **Differentials?**
  - Cancer, Malnutrition, Anemia, thalassemia trait, bleeding…
- **What is the appropriate way of management?**
  - For management we do both colonoscopy and gastroscopy to check for GI cancer.
- **Diagnosis was stomach cancer.**
- **As a rule, any male patient with anemia should be investigated even if mild anemia**

Case study 2:

- A 59-year-old man known case of DM on diet and hypothyroidism on thyroxine presents with swelling of **left Lower Limb 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 **2.5–3cm** , Looks pale.
- CVS: S1, S2 and 0 Chest: vesicular and no added sounds Abdomen: no tenderness, lax and no organomegaly

- **The patient believes his symptoms are caused by the fracture, what indicates otherwise on physical examination?**
  - The size of the swollen limb is very large which might indicate DVT.

Case study 3:

- 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**

Case study 4:

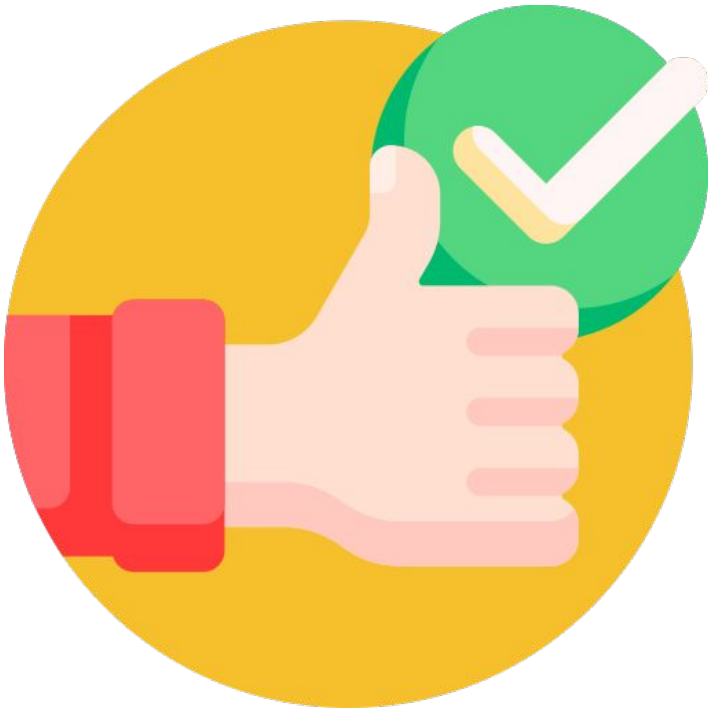
❖ A 48-year-old man asymptomatic, diagnosed incidentally in International Diabetes Day to have high blood sugar of 268 mg/dl and came to you in clinic.

- **Which investigations are you going to request after history taking and examination?**
  - FBG, HbA1C, Lipid profile, ACR, Renal profile (to assess compatibility with medications)

Case study 5:

❖ 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, Smoking status,exercise, diet …



THANKS!!

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