Family Summary with added notes

Counseling: therapeutic process, help the Pt to explore their problems, and to make decision about it without direct reassurance or advice

Who: GP, Psychologist, Social worker, Marriage guidnes counselers (make commitment, attend workshop, discuss cases with colleagues)

features of counseling: educational, change and developmental, sensitive response with caring relationship, goal directed

Aim to: Self awarnes, Self Confidence, feeling feel Insight

⊖ time consuming ⊕ reach accurate Dx, encourge the patient to understand and grow themselves

Aims of counseling

① Provides emotional security and comfort.
② Promotes insight.
③ Generates self awareness
④ Facilitates confidence

- **Environmental factors affecting communication**: waiting room, privacy, barriers, time pressure.
- **'The dirty dozen' block effective communication:** e.g., criticizing, moralizing, ordering, threatening, name-calling, reassuring.

Communication skills in Counseling.

1. Use Reflective Q
2. Use supportive words
3. Use silence
4. Summerize
5. Don't reassure too soon
6. Use guess

facilitation, Clarification
Confrontation, Silence and active
Listening, Summerizing → take most of the time

DO NOT QUESTIONING.

Listen to Pt: feeling, experience, issues, events,

feeling → experience → events → Problem
→ inequinity → manipulation
→ Llostability → Fear
→ Anger

- **Counseling models:**

1- **PLISSIT model:**

P: Permission giving.

LI: Limited Information.

SS: Specific Suggestion.

IT: Intensive Therapy.

2- **Colagiuri and Craig model**: for teaching contraceptive and abortion.

- **Patients unlikely to benefit from counselling:** psychotic, with little awareness or language, psychosocial problems.
- **Applications of counselling:**

Chronic Pain, Sexual Dysfunction, infertility, Child abuse, family issues, marital issues
Crisis, grief, anxiety, Depression
↳ Stick to routine
occupy your time
talk to friends
give time to Relaxation excersice
visit family doctor if you need help.

Breaking bad news

Bereavement or grief

Terminal illness/palliative care

Sexual dysfunction

Sexual abuse / domestic or child violence

Cognition: thoughts, beliefs and Perception.
Cognition behavioral therapy: knowing, understanding the Pt thoughts, beiliefs and Perceptions.

- **Diagnostic triads: PROMPT**

Disease: Dr. Diagnosis, Pathological process
illness: Pt Diagnosis, from Pt experienc

P: Probability (prevalence and incidence)

R: Red flag (wt loss, vomiting, altered cognition, fever > 38°, dizziness, syncope, pallor).

O: Pitfalls (often missed): hidden abscess, Addison's, drugs, celiac, endometriosis, foreign bodies, chronic fatigue syndrome, allergies, candida.

M: masquerades (depression, DM, drugs 'self abuse-alcohol-narcotics-nicotine', thyroid and other endocrine disorders, spinal dysfunction, UTI).

P: Patient want to

T: tell me something.

Diagnosis
reach the Condition or the Disease by Systemic Analysis of Hx, Px, Investigation
– Statment of Propapility not Certainty
– Provisional until approved by response to Drug or Course of Dx

Good prognosis can't Be reached without Good Dx

methods to reaching Diagnosis
① Inductive: unfocused, time consuming, not used by Practioner (down to top)
② Hypoductive: (top to down)

Inductive	deductive
Starts with facts and details and moves to a general conclusion. (Observation -> pattern -> hypothesis -> Theory) "Bottom-up" logic	Starts with a conclusion and then explains the facts and details. (Theory -> hypothesis -> observation -> conformation) "top-down" logic

Triple Dx
taking into Consideration
↳ physical
↳ Social
↳ psychological

- **Things are not always CUT & DRIED:**

  C: Connective tissue disorder.

  U: UTI.

  T: Thyroid disease. &

  D: Depression.

  R: Remember to rule out serious and rare causes.

  I: Iatrogenic causes.

  E: Emotional needs.

  D: Diabetes.

- **Communicating with adolescents:**

  HEADSSS

  H: Home.

  E: Education/ Employment/Exercise

  A: Activities, hobbies.

  D: Drugs and diet.

  S: Sexuality and sexual activity.

  S: Suicide and depression.

  S: Safety (violence and abuse).

With Children ♥

1. waiting Room (colors, toys) ⊏ ↓ Anxiety assess the Progress
2. call them by name
3. explain what will happen / Procedures
4. Check understanding
5. take Permission from Parents before Procedures
6. check family dynamics ← child abuse, over Protective Parents, manchausen Syndrome

- Parents behaviour Differs Depending on:
  * Severity of the Disease, or Procedure.
  * the disease Course

- **Patient centered diagnosis:**

  ABC —> Anxiety, Beliefs, Concerns.

  FEFI —> Function, Expectations, Feelings, Ideas.

ICEE
1. Ideas
2. Concerns
3. Expectation
4. effect

Skills help in PTC
1. Shared understand
2. empathy
3. Good Communication

Pt Centered medicine
Pt liked to Be:
1. Valued
2. understood
3. involved in mx plan
4. Integration between pt experience and the Disease

- **Principal factors for diagnostic possibilities:** Ranking of Possibities

  - Probability most likely Diagnosis
  - Seriousness Life threating Condition
  - Treatability ↑ to be treatable
  - Novelty Rare, memorable Due to Personal experience.

Uncommon Presentation of Common Disease is more Common than Common Presentation of Uncommon Diseases

- **4 Ds:** Disease, Drugs, Diet, Dukhan.

Past medical
Past Surgical
Previous Similar attacks

Drugs, herbs, allergy
Addiction

Appetite
wt loss
Specific Diet
Hydration

① Smoking
② Alcohol
③ Insurance
④ Education
⑤ Job → Financial
⑥ Sexual HX
⑦ Psycological
⑧ life cycle

Consultation
meeting between 2 expert
Diagnostic Procedure,
the Process of gathering
Info, to reach Dx and
Put Mx Plan.

Aim of consultation:
① to know what is the specific cause of presentation - why and why now
② reach good therapeutic out comes.
③ Build pt Dr. relationships

- **Models of consultation:**
  1- **Pendleton and colleagues (**task oriented, doctor centered):
  Define the reason for attendance > consider other issues > choose appropriate action > shared understanding > involve in management >use time and resources efficiently > maintain relationship.

  2- **Scott and Davis** A→ C → B → D
  Manage presenting problem
  Manage continuing problems
  Modify health-seeking behaviors
  Opportunistic health promotion

- **Phases of consultation:** building rapport, diagnostic phase, management phase (OPENING) Hx Px Investigation, Close termination
  Position, Smiling, Shating, Call by Prefered name RAPPORT

- **Doctor patient relationship:**

Transference: when we respond to a new relationship according to patterns from the past (emotions are passed on).

Countertransference: emotional involvement in the therapeutic interaction (feelings which the doctor has towards his patient).

Bad news: informations affect the Pt future life
Newly Diagnosed Cancer
Newly Diagnosed Chronic Disease
miscarrige

- **Breaking bad news:**

1)ABCDE approach:

A: Advanced preparation. → Family, Support; → time, Place; → know what already understand; → be ready emotionally; → Decide what to use

B: Build a therapeutic relationship. → Private Place; → Sit Close → to touch; → Seats for all

C: Communicate well. Be direct, avoid Jargons, check understanding, arrange other meetings

D: Deal with patient and family reactions. listen actively, explore feelings, empathy

E: Encourage and validate emotions. effect of the news, referral for more support, follow up

Methods of Delivering Bad News
- **ABCDE** approach - Rabow and McPhee
- **SPIKES** approach – Baile and Buckman
- **SAAIQ** emergency approach – Pakistan
- **Breaks** approach – IJPC
- **SAD NEWS** approach - Canada

2)SPIKES model:

S: Setting up interview. Private Room, Quit, without Interepions

P: Perception of the patient. what they already know? , avoid confrontation of denial

I: Invitation by the patient. ask the Pt if he wants to know about His condition now or not

K: Knowledge to the patient. warning shot, simple phrases, give Positive aspects

E: Emotions of the patient. Validate emotions, empathy, listen then Identify the source of emotions

S: Strategy and summary. Focus on goals, you are available for other meetings
Put medical plan
ask Pt to repeat understanding

3) SAAIQ emergency approach:

S: Setting the scene as soon as possible. Review the case in Details.

A: Assessing the understanding of the news recipient.

A: Alerting about the bad news. Giving Shot

I: Informing clearly.

Q: Quickly summarizing the communication with information-based hope.

4) BREAKS approach:

B: background

R: rapport

E: explore

A: announce

K: kindling

S: summarize

5) SAD NEWS approach:

S: sit up and down

A: ask

D: don't tell

N: no fancy lingo

E: expect and respond to emotion

W: wait

S: summarize

Difficult patients

1. Dependent Clanger
   - need constant Reassurance.
   - Break the Professional Rules to get their needs, calling in Home, unplanned presentation
   - Show empathy with clearly explain the Rules

2. entitled Demander
   - try to control the doctor by expressing guilt and fear in the doctor.
   - Show the power, with Respect and clearly show the boundries when it is broken

3. manipulated help rejecter
   - clang to Dr.
   - refuse medical advice due to fear that the improvement will affect the Relation with the Dr.

4. Self Distructive Denier
   - they self destruct themselves By refusal the medical advice

- **Management plan: RAPRIOP**

  R: Reassurance and explanation.

  A: Advice.

  P: Prescription.

  R: Referral.

  I: Investigations.

  O: Observation.

  P: Prevention.

6 Dxx should be ruled out: Depression , Panic disorders Anxiety , Dysthymia , multiple Somatoform Disorders , Drug or alcohol Abuse

Strategies

- give up to cure them
- Accept their symptoms as Signs of neurosis
- make a program for them
- maintain trust and be honest
- Avoid Placebo and Self convenience
- extra care for familiar Pt or Gift bringer
- Show the Pt Fair time with Clear
- Don't Abandon the Patient
- Don't undermine other doctors
- Show interest in the Patient Life, work with less interest in their complaint lists

☆☆ Heart Sink survival kit

1. Feeling understood
   full Hx, Px
2. Broad the agenda
   Discuss the emotional and psychological aspect
   Reframing the Patient symptoms
3. make the Link
   educate the Patient

Angery Patients

Anger causes:
* Being disappointed after situation crisis like grief disease Diagnosis
* financial transcation preceded by Poor service, no respond to Drug, Superiority from the doctor

Strategies

DON'T
- touch the Pt
- reject the Pt
- Be Judgemental

Be Calm
Step back
eye to eye contact
ask the Pt to sit, call them by Ms, Mr.
allow the Pt to ventilate their feelings
Listen actively
allow time (20min at least)
Rappot building I appreciate How you feel
Confrontation you look angry
facilitation I understand that ...
Clarification
Searching. Is there anything you concern about ?
How is your work, sleep?

- **Foundations of health promotion and disease prevention:**
  - Risk avoidance. low risk Pt → remain low risk
  - Risk reduction. cure or control the disease
  - Early identification. early detect the disease

- **Components of EBM (3E's):** Evidence, expertise, expectations

EBM has **one goal**, **two** fundamental **principles**, **three components**, and **four steps**.
- One **goal**: Improve quality of clinical care;
- Two **principles**: (1) Hierarchy of evidence and (2) Insufficiency of evidence alone in decision-making;
- Three **components**: Triple **Es** (Evidence, Expertise and Expectations of patients);
- Four **steps**: Four **As** (Ask, Acquire, Assess and Apply)

- **Steps of Evidence Based Medicine:**

  4As:

  Ask clinical questions. (PICO)

  Acquire the best evidence. (by searching resources)

  Assess the evidence / critical appraisal. (importance, validity, relevance, consistency)

  Apply evidence to patient care.

- **Asking for the required information (PICO):**

  P: Patient population. (type of pt)

  I: Intervention. (new approach)

  C: Comparison. (compare to old approach)

  O: Outcomes. (that are imp to the pt)

- **Levels of evidence (USPSTF):**

  Level I: RCT

  Level II-1: CT w/o randomization

  Level II-2: well-designed cohort or case-control

  Level II-3: multiple time series designs with or without the intervention

  Level III: Opinions

Grade	Definition	Suggestion for practice
Level A	benefits >>> risks	offer the service
Level B	benefits > risks	offer the service
Level C	benefits >= risks	offer the service for individual considerations
Level D	Risks > benefits	don't offer the service to asymptomatic patients.
Level I	cannot be assessed	if offered the pt should understand the uncertainty of evidence

- **Levels of prevention:**
  1- **Primary:** prevent risk factor
  ⇨ Immunization, exercise, seatbelts, folate.
  Prophylaxis Education
  2- **Secondary:** early detection preventing subclinical illnesses from advancing.
  ⇨ Screening and case finding.

  3- **Tertiary:** reducing complications and disease advancement.
  ⇨ B-blockers post MI, rehabilitation
  Long term control

OR

Primary is Prevention (notice p with p) you prevent a disease from happening like in pregnant lady we give folic acid supplements to prevent folate deficiency.

Secondary is mainly screening (notice s with s) you try to early diagnose a condition like in breast cancer we do mammograms . Pre symptoms phase

Tertiary is follow-up for patient. Control the disease and ↓ complication

- **Five A's smoking cessation counseling strategy**
Ask, Advise, Assess, Assist (or refer), Arrange for follow-up

Five R's:
Relevance to stop smoking, risks, rewards of cessation, roadblocks and barriers, repeat

- **Smoking cessation therapies:**
  1- **First line:** NRT (gum, lozenge, inhaler, spray, patch), NRA (Varenicline, Bupropion)
  2- **Second line:** Clonidine, Nortriptyline

- **Communication cycle:**
  1. Prepare. physical environment (comfy and Private) / Position, Dress code, Posture / Ready to Read Body Language
  2. Open. call the Pt by Preferred name, ask open ended Question - be unhurried, try to make Pt comfortable
  3. Gather. Verbal & Start with active Listening then talking / Non verbal & Nodding
  4. Elicit patient's perspective. Facilitation open to Close Cone / Summerization — Nodding, sounds, eyecontact — explore the Pt intial concerns
  5. Communicate during examination. make the Pt valued
  6. Patient education.
  7. Planning.
  8. Closure. avoid doorknop presentation, announce the Pt that the ending of the meeting is started

Principles facilitate Communication Process :
① time factor
② meseage clear and Correct
③ Attitude of both Communicator and Recepient

- **Techniques that helps maximize patient understanding:** Pt education
  - Signposting. explain what you will do / or what done
  - Chunk and check. give chunk of Information and make sure the Pt understanding

- Avoiding jargon. < age Education
- Using visual and physical techniques to communicate. models, Hands out, Diagrams, Videos

- **Stages of counseling:**
  1. Build rapport.
  2. Assessment and analysis of problem.
  3. Supportive counseling.
  4. Planning and initiation.
  5. Implementation of planning.
  6. Terminology and follow up.

Geriatrics Definition

Aging: Proces of becoming older / gradual, Spontanous
Start from fertilization / greatest risk factor of disease

Senesence: Negative aspect of Aging / Biological Aging
accumulation of cellular damage → ↓ Physical, mental Capacity
→ Disease
* Gradual detoriation of functional Characteristic

Homeostenosis: ↓ the ability to maintain Homeostasis under Stress
↓ reserve capacity

Health: Total physical, mental, social well being rather than be free from disease

Healthy aging: Developing and maintaining functional ability to enable well being in older age

Functional Ability Domains: meet basic needs, mobile, learn and make Desicions, make and maintain Relations, contribute to Socaity

- **Geriatric**

1- Mental status testing:

Cognitive screening tests:

a. Informal for rapid screening (clock drowning test, Mini-cog test, set test, 3 items recall test).

3 words Registration → Draw clock → Remember the 3 words

b. Formal (mini-mental state examination MMSE or neuropsychological testing) → For patients with concerning signs or symptoms of cognitive impairment or whose screening test is worrisome

2- Assessment of the functional status:

Activities of daily living (ADL): basic self-care activities. Katz Index

1.
   - ⇨ 6 functions: bathing, dressing, toileting, transferring, continence and feeding.
   - ⇨ **Test**: physical self-maintenance scale (PSMS)

Instrumental activities of daily living (IADL): complicated, higher-level Lawton

- ⇨ 8 functions: ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibilities for own medications, ability to handle finances.
- ⇨ **Test**: functional activities questionnaire (FAQ)

Advanced. the first to be affected

- **Classic geriatric syndromes:**

- Dementia. - Dizziness. - Delirium.

multiple pathology in multiple organ systems leads to Loss of functional Capacity

Screening in older Pt depends on:
- Life expectancy
- Comorbidites
- Functional Status

- Poor nutrition or feeding impairment.
- Urinary incontinence.
- Falls and gait abnormalities.
- Behavioral changes. - Sleep disorders.
- Weight loss. (Depression, Polypharmacy.

- **Geriatric vaccination:**
  - ✓ Pneumococcal ,65th, twice max, contraindication: prior severe immediate hypersensitivity reaction.
  - ✓ Influenza, around September, yearly, contraindication: egg allergy, history if GBS.
  - ✓ Herpes zoster, 60th, once, contraindication: severe reaction to gelatin or neomycin, pregnancy, immunocompromised state.
  - ✓ Tetanus and diphtheria, when needed, every 10 years, contraindication: prior severe immediate hypersensitivity reaction.

- **Pneumococcal vaccines:**
  1. Pneumococcal conjugate vaccine.
  2. Pneumococcal polysaccharide vaccine.

- **Comorbidity**: a group of morbidities in a single patient with one morbidity being the dominant/most prominent.
  the condition that coexist in the context of index disease
- **Multimorbidity**: a group of morbidities in a single patient without a dominant morbidity.
  Co-occurrence of 2 or more condition in the patient which may or may not interact in Pt.

Problem oriented medical record = Lawrence Weed // SPIKES = Baile and Buckman // Models of the consultation =Pendleton and colleagues, Scott and Davis // Wilson's criteria = for screening test // Elements of DPR = per brown and pedder

Physiological variable	Change	Potential consequence
Gastrointestinal absorption and function	Slowing gastrointestinal transit	Rate of drug absorbtion may be slowed
Cardiac output	Decreased/unchanged	Increased peak plasma concentration
Hepatic clearance	Decreased liver mass and blood flow	Decreased clearance in first pass metabolism and increased plasma concentrations
Renal clearance	Decreased size and functional capacity of kidneys ↓in renal blood flow and glomerular infiltration rate	↑plasma concentrations of renally cleared drugs
Body composition	↑body fat ↓intracellular body water ↓muscle mass	↑ volume of distribution and half-life of lipophilic drugs
Protein binding	↓ albumin Drug specific binding changes	Volume of distribution changes.

Disease	Screening
lung cancer	• 55-80, smoker (in last 15 years) → annual LDCT

breast cancer	• 40-49
	  ○ Individual decision
	  ○ If there is family Hx → q2 years mammography
	• 50-74 → q2 years mammography
	• Women >75 years, all women, dense breasts → Level I, cannot be assessed

cervical cancer	• 21-65 years
	  ○ Cytology q3 years
	  ○ Or if 30-65 years → Cytology + HPV testing → q5 years
	• If <21 → no screening
	• If >65 + adequate prior screening + no high risk → no screening
	• Hysterectomy + removal of cervix → no screening

colorectal cancer	• 50-75 years → start at 50
	• 76-85 years → Individual decision → consider if never screened, healthy with no comorbidities
	• Stool based
	  ○ guaiac based fecal occult blood or fecal immunological test → Q1 year
	• Direct visualization
	  ○ Colonoscopy → Q 10 years
	  ○ CT colonography or flexible sigmoidoscopy → Q 5 years
	• Or flexible sigmoidoscopy Q 5 years with fecal occult blood testing Q 3 years

prostate CA	prostate CA in men with PSA (prostate specific antigen) → dont screen
HTN	• > 18 years ○ Measurement at and outside the clinic
depression	General adults + Pregnant + postpartum women → should be done , implemented in adequate system in place (Dx+ Tx + Follow up)
DM II	• if 40-70 + overweight or obese → should be done ⇒ if abnormal → counselling • Done with Fasting plasma glucose (FPG) or 2-hour post-load plasma or HbA1c ○ DM if FPG ≥ 126 mg/dL + confirmation (repeat test in separate day. • Q 3 years
Thyroid disorders	evidence cannot be assessed
Osteoporosis	• Men → evidence cannot be assessed • Women → if > 65 or in white women <65 with risk of fracture • Use dual-energy x-ray absorptiometry (DXA) of the hip and lumbar spine • Prevention with → Ca+2, vit D, wt bearing exercise, bisphosphonates, parathyroid hormone, raloxifene, and estrogen.
Dyslipidemia	• Blood tests on HDL and LDL levels • Preventions: ○ 1- Lower cholesterol through diet 2- Statins
Abdominal Aortic Aneurysm	• 65-75 years, men, if ever smoked → one time Abdominal US
Hepatitis B infection	• Only at high risk pts
HIV	• adolescents and adults aged 15 to 65 years • all pregnant women
Obesity	• all adults • (BMI) of 30 kg/m2 or higher → intensive, multicomponent behavioral interventions

- **First-Line Therapies for Smoking Cessation in Adults**
  1- NRTs (skin patches, gum, inhalers, lozenges,..)
  2- Varenicline (Chantix)
  3- Bupropion (can be used with NRTs unlike Varenicline)

- **Second-Line Therapies for Smoking Cessation in Adults**

  Clonidine (Catapres) and nortriptyline (TCA, Pamelor)

Drug	OTC or prescription	Preg category	weight gain	SE	Dosage
Nicotine gum (Nicorette)	OTC	C	delay weight gain.	GI, mouth or throat irritation.	2 mg for light, 4 for heavy smokers
Nicotine lozenge (Nicorette)	OTC	D	delay	Nausea, heartburn, headache	2 mg for light, 4 for heavy smokers
Nicotine inhaler (Nicotrol)	Prescription	D		Mouth or throat irritation , coughing, rhinitis	6- 16 cartridges per day
Nasal spray (Nicotrol NS)	Prescription	D		nasal irritation (continues throughout use)	Initial dosage is 1-2 doses /hour Minimum → of 8 doses per day
Nicotine patch	OTC	D		Skin reactions , HA, insomnia	14 mg light,21 for heavy smokers
Varenicline (Chantix)	Prescription	C		HA, nausea (dose related), insomnia, abnormal dreams, flatulence neuropsychiatric	Not combined with NRT
BUPROPION	Prescription	C		Insomnia , dry mouth , suicidality	Can be used with NRT

Doorknob definition
the raising of a patient concern that happens as the doctor puts his or her hand on the doorknob to allow the patient to leave the room