- **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.

- **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:**

  Breaking bad news

  Bereavement or grief

  Terminal illness/palliative care

  Sexual dysfunction

  Sexual abuse / domestic or child violence

- **Diagnostic triads: PROMPT**

  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.

- **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).

- **Patient centered diagnosis:**

  ABC —> Anxiety, Beliefs, Concerns.

  FEFI —> Function, Expectations, Feelings, Ideas.

- **Principal factors for diagnostic possibilities:**

  - Probability

  - Seriousness

  - Treatability

  - Novelty

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

- **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**
  Manage presenting problem
  Manage continuing problems
  Modify health-seeking behaviors
  Opportunistic health promotion

- **Phases of consultation:** building rapport, diagnostic phase, management phase

- **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).

- **Breaking bad news:**

  1)ABCDE approach:

  A: Advanced preparation.

  B: Build a therapeutic relationship.

  C: Communicate well.

  D: Deal with patient and family reactions.

  E: Encourage and validate emotions.

  2)SPIKES model:

  S: Setting up interview.

  P: Perception of the patient.

  I: Invitation by the patient.

  K: Knowledge to the patient.

  E: Emotions of the patient.

  S: Strategy and summary.

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

3) SAAIQ emergency approach:

S: Setting the scene as soon as possible.

A: Assessing the understanding of the news recipient.

A: Alerting about the bad news.

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

- **Management plan: RAPRIOP**

  R: Reassurance and explanation.

  A: Advice.

  P: Prescription.

  R: Referral.

  I: Investigations.

  O: Observation.

  P: Prevention.

- **Foundations of health promotion and disease prevention:**

  - Risk avoidance.

  - Risk reduction.

  - Early identification.

- **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.

  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

  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 .

  Tertiary is follow-up for patient.

- **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.
  2. Open.
  3. Gather.
  4. Elicit patient's perspective.
  5. Communicate during examination.
  6. Patient education.
  7. Planning.
  8. Closure.

- **Techniques that helps maximize patient understanding:**

  - Signposting.
  - Chunk and check.

- Avoiding jargon.
- Using visual and physical techniques to communicate.

- **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.

- **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).

b. Formal (mini-mental state examination 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.

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

- ⇨ 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)

- **Classic geriatric syndromes:**

- Dementia. - Dizziness. - Delirium.

- Poor nutrition or feeding impairment.

- Urinary incontinence.

- Falls and gait abnormalities.

- Behavioral changes. - Sleep disorders.

- Weight loss.

- **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.

- **Multimorbidity**: a group of morbidities in a single patient without a dominant morbidity.

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	● 50-80, smoker (in last 15 years) → annual LDCT
breast cancer 40 - 75	● 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