Beyond medical diagnosis & treatment: Uncovering & prioritizing tasks at the visit

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Our backgrounds

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- Internal Medicine
- Clinical Faculty, Department of Medicine

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Introduction

I. Who we are
II. Learning objectives
III. Overview:
   A. Description of the challenges
   B. What are we looking for (statistically)
   C. How do we find it? (why don't patients just announce what they need?)
   D. Case examples/discussion

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Why prioritize?

Time factors:

- prepaid group practice
- staffing resources (clinician & other staff)
- all visits are finite (at some point, you always have to decide what to do with what you have right now)

Concentration factors:

- even mental health visits have fixed time limits
- how much can you manage at a single visit?
- what can a student remember?

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What can you learn from the actual visit?

- Who comes with the patient?
- Are they late?
- Do you notice a particular smell?
- How do they appear?
- Are they settled in the room?
- Where do they sit?
- What kind of eye contact do you get?

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Postpone or different format?

Task	Alternative
Flu shot availability Breast self exam STI screenings	Secure message Dorm talk Campus newspaper Website news Health fairs
Immunization updates at problem visit ?	Place in chart where you will find it at a later date Send a secure message Document why not today
Consistent condom use Tobacco cessation messages “Ideal” body weight	Non-shaming venue—see above Document why you omitted

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Textbook definitions

Primary Care Medicine.

Office Evaluation and Management of the Adult Patient (Sixth Edition) 2009

Allan H Goroll MD and Albert G Mulley Jr. MD
Harvard Medical School
Massachusetts General Hospital

Chapter I: The Practice of Primary Care by John D Stoeckle

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The tasks of primary care (Stoeckle)

I. Medical diagnosis and treatment
II. Psychological diagnosis and treatment and personal support
III. Eliciting and addressing patient expectations and requests
IV. Communication of information about illness
V. Care of the chronically ill
VI. Prevention of disease and disability

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I. Medical diagnosis and treatment

- Central tasks BUT
- "alone, they do not provide the care of patients."

In our setting, we may need to ask whether it will be us doing the diagnosis:

- will patient stay here or go home?
- if the issue is potentially serious, do we need to communicate with personal physician at home? Parents?

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Korean undergrad with neck nodes

II. Psychological diagnosis and treatment and personal support

"Tasks of both medicine's art and its science"

Emerge from the biopsychosocial model of illness/distress (George Engel)

Intermingling of the mind with the body—the mind/body connection which many talk about but don't fully understand

"The recognition of the patient's anxiety and/or depression helps in the interpretation of bodily complaints"

A tool for making our priority list

Understanding a patient's psychological makeup helps us refine the pre-test likelihood of disease.

Is the patient about to die or do they only feel as though they're about to die?

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Conditions such as anxiety and depression are "associated with amplification of chronic medical symptoms as well as psychophysiologic symptoms (headache, epigastric pain, insomnia). The tendency to amplify symptoms and the stigma of mental illness are the primary reasons that many patients present with somatic complaints when they are suffering from a mental illness."

Wayne Katon MD. Panic Disorder in the Medical Setting.
National Institute of Mental Health
NIH Publication No. 94-3482

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III. Eliciting & addressing: patient expectations and requests

Important tasks because “they often play a major part in patients’ decisions to seek medical help, in their adherence to treatment plans, and in their satisfaction with care.”

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Stoeckle: why patients go to doctors

1. enhance status by seeing socially important professionals
2. achieve catharsis of grief, anger & despair (releasing strong emotions)
3. obtain sanction for failure to cope
4. find understanding & control of illness through medical scientific explanations.

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College health version

1. Is there something you were worried about or were hoping I was going to do?
2. The student who needs a note
3. The student who is sent by someone else
4. The student who wants to set the record straight

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IV. Communication of information about the illness

Inform, explain, reassure, advise.

Communication tasks “often depend on knowledge of the patient’s attributions, that is, what the patient thinks is the cause of illness.” {or the parent?}

“If the patient’s attributions differ from the doctor’s and are not uncovered, the patient’s anxieties may not be relieved, nor will the doctor’s explanation be accepted.”

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Multiculturalism and this task

"In essence, the patient's beliefs about the illness need to be elicited so that they can be used in explanation, education, and reassurance, even more so today with the cultural diversity of the population seeking medical aid."

Asking about what the patient studies/majors in—so you can figure out how to communicate information (and how they look at the world)

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V. Care of the chronically ill

Many separate issues involved in this task

Mostly this is not the focus of the college health clinician so we won't elaborate on this except:

Self-management strategies for students with conditions like bipolar illness. We realized that we are trying to establish patterns of regular contact & the primary care clinician may notice change in behavior before the student visits a psychiatrist.

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VI. Prevention of disease and disability

Assessing and communicating risk coupled with achieving the behavior change necessary to reduce risks that can be altered (eg smoking, violence, alcohol, drugs, diet).

Attention to the patient's social network:

- illness precipitated by a disruption of interpersonal relationships
- and now we know how social network contributes to habits (good and bad)

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Tasks special to college health

Role clarification:

- who will take the lead in a diagnostic process?

Disposition

- are they okay to return to a dormitory situation
- are they okay to attend class, work, etc

Risk assessment

- suicide, homicide, accidental

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Risk Assessment for College Students

To prioritize tasks:

- What conditions are students most likely to have (pre-test likelihood)?
- What is most important – most serious, biggest impact?

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Risk Assessment: Developmental Perspective

College students are emerging young adults:

Ages 18 to 25

Brain is still developing

Still completing developmental tasks

The New Adolescents: An Analysis of Health Conditions, Behaviors, Risks, and Access to Services among Emerging Young Adults

Lawrence S. Neinstein, MD 2013

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Leading Causes of Death

ALL Emerging Young Adults	College Students
1. Unintentional Injury	1. Unintentional Injury
2. Homicide	2. Suicide
3. Suicide	3. Other*

*Suicide attempts, firearm injury, assault

Turner JC, Keller A. Leading causes of mortality among American college students at 4-year institutions. APHA Annual Meeting. Washington, DC. 2011.

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Sexual assault and intimate partner violence

Between 20 and 25% of college age women will be victims of rape or attempted rape during their college career.

5% of men have experienced sexual violence other than rape in the past year.

More than 1 in 3 women and more than 1 in 4 men have experienced rape or physical violence by an intimate partner in their lifetime.

http://www.cdc.gov/violenceprevention/nisvs/

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Why do we need to know this?

One of the best predictors of future victimization is past victimization.

4% of victims suffer 44% of the offenses.

Child sexual abuse victims are 3-5 times more likely to experience subsequent adult victimization.

http://victimsofcrime.org/

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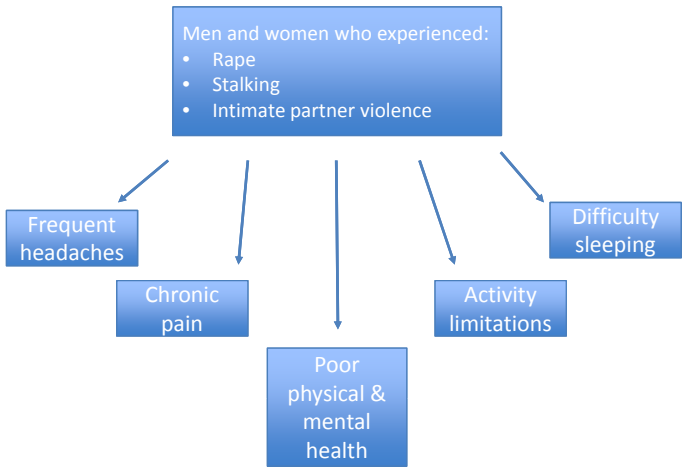

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Table 6.2

Prevalence of Physical and Mental Health Outcomes Among Those With and Without A History of Rape or Stalking by Any Perpetrator or Physical Violence by an Intimate Partner — U.S. Men, NISVS 2010

	Weighted %		
Health Outcome	History	No History[1]	p value[2]
Asthma	14.5	12.9	n.s.[3]
Irritable Bowel Syndrome	4.4	3.5	n.s.[3]
Diabetes	10.0	10.5	n.s.[3]
High Blood Pressure	30.1	29.3	n.s.[3]
Frequent Headaches	17.0	8.9	<.001
Chronic Pain	23.5	13.1	<.001
Difficulty Sleeping	33.0	18.4	<.001
Activity Limitations	29.7	17.9	<.001
Poor Physical Health	5.1	2.6	<.001
Poor Mental Health	2.7	1.2	<.01

[1]No history of rape, stalking, or intimate partner physical violence
[2]p-value determined using chi-square test of independence in SUDAAN™
[3]Non-significant difference

http://www.cdc.gov/violenceprevention/nisvs/

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Table 6.1

Prevalence of Physical and Mental Health Outcomes Among Those With and Without a History of Rape or Stalking by any Perpetrator or Physical Violence by an Intimate Partner — U.S. Women, NISVS 2010

	Weighted %		
Health Outcome	History	No History[1]	p value[2]
Asthma	23.7	14.3	<.001
Irritable Bowel Syndrome	12.4	6.9	<.001
Diabetes	12.6	10.2	<.001
High Blood Pressure	27.3	27.5	n.s.[3]
Frequent Headaches	28.7	16.5	<.001
Chronic Pain	29.8	16.5	<.001
Difficulty Sleeping	37.7	21.0	<.001
Activity Limitations	35.0	19.7	<.001
Poor Physical Health	6.4	2.4	<.001
Poor Mental Health	3.4	1.1	<.001

[1]No history of rape, stalking, or intimate partner physical violence
[2]p-value determined using chi-square test of independence in SUDAAN™
[3]Non-significant difference

http://www.cdc.gov/violenceprevention/nisvs/

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So clearly looking for students who have been the victim of intimate partner violence, sexual assault, and childhood sexual abuse is worthwhile.

From “root cause analysis”, we know we want to find out what is causing the patient’s symptoms not just “best practice” the symptom they have.

Mental Health Risks

High rates of mental illness, psychological distress, and suicidality:

- 11% have depression
- 9% have thought about, planned, or attempted suicide

The New Adolescents: An Analysis of Health Conditions, Behaviors, Risks, and Access to Services among Emerging Young Adults. Lawrence S. Neinstein, MD 2013

Substance Use Risks

Binge drinking is more common – understanding the risks of binge drinking is less common.

More likely to use marijuana and to abuse prescription pain medications.

The New Adolescents: An Analysis of Health Conditions, Behaviors, Risks, and Access to Services among Emerging Young Adults. Lawrence S. Neinstein, MD 2013

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Sexual Health Risks

Substance use can affect decision-making skills.

High rates of sexually transmitted infections.

Condoms and OCP are the preferred method of birth control.

- 10% have used EC; 1% get pregnant unintentionally

The New Adolescents: An Analysis of Health Conditions, Behaviors, Risks, and Access to Services among Emerging Young Adults. Lawrence S. Neinstein, MD 2013

American College Health Association. American College Health Association-National College Health Assessment II: Reference Group Data Report Fall 2012. Hanover, MD. American College Health Association; 2013.

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Are these problems in our clinic?

29% of patients presenting with physical complaints to a general medical clinic had a depressive or anxiety disorder. (1)

Almost one-third of adult patients who present to a primary care office with a complaint of headache report moderate symptoms of depression. (2)

Of adolescents (ages 13-19) presenting to the Emergency Department, 12% of those with traumatic and 19% of those with medical chief complaints endorsed either moderate or severe depressive symptoms. (3)

1. Kroenke K, Jackson JL, Chamberlin J.Depressive and anxiety disorders in patients presenting with physical complaints: clinical predictors and outcome. Am J Med. 1997 Nov;103(5):339-47.
2. Marlow RA, Kegowicz CL, Starkey KN. Prevalence of depression symptoms in outpatients with a complaint of headache. J Am Board Fam Med. 2009 Nov-Dec;22(6):633-7
3. Scott EG, Luxmore B, Alexander H, Fenn RL, Christopher NC. Screening for adolescent depression in a pediatric emergency department. Acad Emerg Med. 2006 May;13(5):537-42.

Effective Communication ("health literacy")

Limit information provided to two or three important points at a time. (Joint Commission)

40–80% of medical information provided by healthcare practitioners is forgotten immediately.

- The greater the amount of information presented, the lower the proportion correctly recalled.
- Almost half of the information that is remembered is incorrect

Kessels RP. Patients' memory for medical information. J R Soc Med. 2003 May; 96(5): 219–222.

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Tools for preparing ourselves

Take care of your own needs first:

1. Physical readiness
2. Mental readiness
   - quiet internal anxiety
   - put aside need to be viewed as the expert

Start the visit on time (this communicates respect for the student's time—apologize if you're late)

Dress for the role you are occupying

Use the visit to focus on the patient's needs

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Other guidelines

Read the questionnaire they may fill out beforehand but don't let it limit your thinking.

Add clinical decision making tools as you need them not before you start

See the patient alone first when someone has come along too (thank them for coming and leave them in the waiting room).

Think about what they're not saying or bringing to the visit.

Medical Student

22 year old medical student presents with headache during the first week of classes.

Came on suddenly during weight-lifting. Worse with exertion. No previous history of headache.

Law Student

32 year old law student presents with chronic respiratory issues:

"I just got health insurance"

Violin Student

22 year old violinist with pain in her left hand/forearm.

Why don't they just tell us what's wrong?

1. They don't know—haven't put it together or cannot look at it yet.
2. Multiple reasons "not to know" about childhood trauma.

Examples of trauma discovered

Presentation	Discovery
Needlestick follow up, healthcare worker	Childhood sexual abuse
SLE evaluation	Gang rape a year before medical crisis
Resident in training, alopecia	Death of a parent in childhood
Med student with cough	Wife who had died of cystic fibrosis

3. Developmental issues: difficult for an 18 year old sometimes to identify why they're feeling bad (without Mom or Dad's help).
4. Emerging identity issues (sexual orientation, gender identity) that complicate coming for help
5. Multicultural issues: don't ask for mental health help; okay only for physical issues.
6. Not much time to develop perspective.

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Summary

There's no single right way to do this (there are a few ways that will lead you astray).

Reflect on your own practice and choose what works for you.

Make a conscious choice about how to use your time.

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