Class 1 PHE Notes

Foundation of health assessment

Clinical encounter

Approach to the clinical encounter

Skills essential to clinical encounter. Clinical skills = clinical competence. Gathering of information – clinical history, physical examination, mental examination, initiate test/procedures, diagnosis and therapeutic intervention.

1. Approach to the clinical encounter
    a. **Symptom focused clinician centered approach** – clinician takes charge in interaction to meet his or her need to acquire the symptoms, details and other data that will help identify the disease or a problem. **This approach can bypass personal dimensions of illness.** This framework emphasizes the features of pathologic disease at the risk of understanding the highly individual needs and perspectives of each patient. As a consequence, information required to understand and manage patients' problems may never be elicited.
    b. Patient orientated approach (POA)– patient take the lead/patient is allowed to express their feeling, emotions, concerns, needs. Patient tells the story. Open ended questions.
    c. Which on of these is least likely to add clinician's perspective to clinical history – POA
    d. Disease/illness distinction model
    e. Disease – is the explanation that the clinician uses to organize symptoms that leads to diagnosis
    f. Illness is the construct that explains how the patient experiences the disease, including its effects on relationship, function, and sense of wellbeing
    g. The clinician's interview must incorporate both clinician and patient orientated models. Skilled – merge both and get most information.
    h. It will lead to more complete picture and will better achieve desired health outcomes (patients)
2. Structure and sequence of clinical encounter
    a. Stage 1: Initiating the encounter

- Set the stage – clinicians' appearance, patient comfort
- Adjusting environment
- Review the clinical records
- Set your agenda
- Greet the patient – establishes initial report. Lay the foundation of your ongoing relationship. If it is the first time you are seeking the patient explain your role, your status as a student or trainee and how you will be involve in process.
- Identify patients title, name, and preferred gender pronoun

b. **Stage 2: Gathering information** – medical history, clinical history, health history
   - This stage has two functions: gathering and providing information. Clinicians gather information from their patients about symptoms, experience and expectations for establishing a diagnosis and treatment plan.
   - Patients, on the other hand, need information that clarifies their health problems, reduces possible uncertainties, and supports their coping efforts.
   - This stage is also the basis for shared decision making later in the clinical encounter.
   - What initiates information gathering – chief complaint or chief concern. Presenting problem if there is more than one concern. Begin with open-ended questions that allow full freedom of response: "What are your special concerns today?", "How can I help you?", or "Are there specific concerns that prompted your appointment today?" These questions encourage the patient to talk about any kinds of concerns, not just clinical ones. Identifying all the concerns at the outset allows you and the patient to decide which ones are most pressing and which ones can be postponed to a later visit. Questions such as "Is there anything else?", "Have we discussed everything?"
   - Gather information about patient's perspective of illness: patients come with ideas about their symptoms shaped by their own concepts of health and frames of reference. FIFE—Feelings, Ideas, effect on Function, and Expectations. The combination of concerns and

expectations has been shown to have a major influence on the patient's decision to seek help from a clinician.
    - Gather important background information
c. **Stage 3: Performing physical examination**
d. **Stage 4: Explaining and plan**
    - This stage includes the elaboration of the patient's chief concerns from the disease and illness perspectives. Your goal is to assess and respond to the patient's needs for information
    - Two-way communication
    - 40-80% of information received by the patient is forgotten immediately, 50% information is incorrect
    - Teach back
e. **Stage 5: closing the encounter**

3. Disparities in health care
    a. WHO: defines social determinants of health as condition in which people are born, grow up, work and live
    b. Economic stability (employment, food scarcity, housing stability)
    c. Education (early childhood, language, literacy)
    d. Social and community contexts
    e. Health and health care
    f. Neighborhood environment
    g. Racism and bias
    h. Cultural humility
4. Other major concerns
    a. Spirituality
    b. Medical ethics
    c. Clinical documentation

Techniques of skilled interview

1. Active listening – open ended question
2. Guided questions – to clarify the story
3. Empathetic response
4. Summarization
5. Transition
6. Partnering

7. Validation
8. Empowering the patient
9. Reassurance
10. Nonverbal communication
11. Use of non-stigmatizing language
    a. Instead of saying drug abuser, you would say person who used drugs
12. All of these are techniques of skilled interview except

Comprehensive assessment – all elements of health history and full physical examination

1. New patient
2. Provides personal and fundamental knowledge about the patient
3. Strengthens relationship between C and P
4. It helps to identify, and rules out causes of patients concern
5. Provides baseline for future assessment
6. Creates a platform for health promotion
7. Develops proficiency in essential skills

Focused assessment – problem orientated assessment

1. Appropriate for established patients
2. Addresses focused concerns
3. Address symptoms orientated to specific body system
4. Applies examination methods relevant to assessing concrete issue

Data of Medical history

1. Subjective data
    a. What the patient tells
    b. The information that provides from Chief complaint (CC) to review of systems (ROS)
2. Objective data
    a. What is detected by clinician
    b. All physical examination findings

Patient tells you that he has high fever of 103 F – subjective

Clinician measure T and finds it to be 100 F – objective

Comprehensive assessment of adult

Initial information

a. Date and time of history
b. Identifying data
c. Reliability

1. Chief complaint (CC)
   a. I am here because of severe headache for 3 days.
   b. Presenting problem
   c. Triggers begging of information gathering
   d. Documentation: CC: “I am here because of severe headache for 3 days” . “I am here for my regular checkup”
2. History of Present Illness (HPI)
   a. Patient tells you story of presenting problem
   b. Information flows spontaneously form patient, clinician then documents it chronologically
   c. OLD CHARTS – onset, location, duration, character, aggravating/alleviates, radiation, timing, setting
   d. SIQOR AAA – Sight, Intensity, Quality/Quality, Onset, Radiation., Alleviating factors, aggravating factors, Associating factors
   e. Documentation: MN, 50 year old male presents with 3 day headache that is localized to occipital area, usually starts at night, last for 3 min, gests worse with loud music, better in dark quiet room. No other symptoms. Not using anything to make it better.
   f. Documentation ,
3. Past medical history (PMH)
   a. Childhood disease – measles, mumps, rubella, chicken pox, whooping cough, scarlet fever
   b. Adult medical conditions – hypertension, diabetes, cancer, strokes, seizures etc
   c. Surgeries
   d. Hospitalization
   e. Blood transfusions
   f. Medications/supplements

g. Allergic reactions
h. Psychiatric
i. Immunization
j. Obstetric/Gynecological

4. Family history
    a. Same type issues, CC
    b. Major adulthood conditions
    c. Live or dead, cause of death
5. Personal and Social history
    a. Give information on patients personality, interests, coping style, strength, concerns.
    b. Baseline level of function – can patient perform regular daily activities
    c. Sexual orientation and gender identity – to provide relevant, specific and compassionate care that patient centered
    d. Family and Social relationship – clues to physical and sexual abuse
    e. Alcohol history – CAGE
    f. Tobacco uses
    g. Illicit drug use history
    h. Sexual history – 5 Ps+
    i. Spiritual history
6. Review of systems (ROS) – clinician centered
    a. General part – usual weight, recent weight change, weakness, fatigue, fever
    b. Skin – lumps, itching, rashes, changes in color, nails, hair
    c. HEENT – head, eyes, ears, nose, throat
    d. Neck
    e. Breasts
    f. Respiratory system
    g. Cardiovascular
    h. Gastrointestinal
    i. Peripheral vascular
    j. Urinary
    k. Genital
    l. Musculoskeletal
    m. Psychiatric

n. Neurologic
o. Hematology
p. Endocrine

Challenging patients

1. Silent patient
2. Talkative patient
3. Patient with confusing narrative
4. Patient with emotional liability
5. Angry and aggressive