CLASS OF 2013

INTRODUCTION TO AMBULATORY MEDICINE
A Physician’s Office-Based Experience

S. Benham Kahn, M.D.
Course Director

Kaye A. Finneran
Academic Program Coordinator
(kfinnera@drexelmed.edu)

(215) 991-8527
Welcome back to clinical skills and to the Doctor’s Office Experience. Now that you’ve had an opportunity to interact with the elderly, it is time to allow you to practice some clinical skills in a real clinical rotation.

Clinical skills are defined as those thought processes and physical skills a physician requires in order to perform his or her duties properly. It is, therefore, important that the medical student learn these skills early on in his/her career since familiarity with them will lead to recognition of the importance of much of the material that is presented during the four years of medical education. The overall goal of this course is to establish a meaningful structure for the medical student to attain in order to become a successful clinician.

The medical world is presently undergoing many momentous changes that will affect how medicine will be practiced during the early decades of this century. At the core of these changes is the emergence of primary care as the important focus of the new structure and reorganization. This has led to the reconsideration of what primary care actually is and how it is practiced. Primary care as broadly defined means the care administered by the physician for the patient first entering the health care delivery system and for follow up care and guidance a patient might require throughout his or her lifetime. Primary care physicians focus their attention on many aspects of their patients’ lives from prevention to health maintenance and so forth up to the care required for the terminally ill. The impact of health and disease involves not only each individual but also the social environment in which the patient lives. Primary care practice means familial and even societal impacts must be taken into consideration. It is paradoxical that all the time when interest once again in primary care focuses attention on the patient that change in the methods of health care delivery focuses more on the volume of patients seen rather than on individual patient, family or societal needs. This is one of the basic conflicts in medicine today. There has also been a switch of emphasis from inpatient care to ambulatory outpatient care as a means of curtailing costs. In so doing, the methods available for medical education have changed.

Medical care, in the past, has been described as episodic, rather than continuous. Briefly, one went to the doctor when one became ill. When health was restored, one returned to one’s environment. If the illness was found to be more complex and ongoing, the patient might have been referred to a specialist. It was in this situation that patients often found themselves without an anchor to coordinate their care. These events lead to the recognition of the need for such an anchor, the primary care physician. It is within this context that the ambulatory medicine course will expose the first year students to how primary care is practiced. It is hoped that many of you will chose primary care as your field and thus help satisfy the need of the country for more primary care.
practitioners. We also hope that whether you chose primary care or not that you will still embrace many of the principles of primary care and apply them to your own field and style of practice.

What then is primary care? It is composed of three different fields – family practice, general internal medicine, and pediatrics. The terms that constantly appear in any definition of primary care include coordinated, comprehensive, continuous, and personal care. The primary care practitioner is usually the first contact the patient has when there is a health problem. The physician then is responsible for reaching a diagnosis and initiating treatment. If there is a need for further treatment, the primary care practitioner will coordinate and arrange it, keeping in continuous contact with the patient even though other physicians may be participating in the care. The primary care physician will try to attend to all the patient’s comprehensive needs, but will seek help from consultants, if such is indicated.

The most important aspect of patient care is caring for the patient. The personal attention given the patient and the emphasis on a strong and productive doctor-patient relationship is the underlying feature of good medical care. The practice of primary care recognizes the total patient, which includes not only the patient’s disease but also the patient’s reaction to that disease and the resultant needs and requests. The patient does not exist apart from an emotional and social background. The primary care physician must also understand this background. It is well known that emotional and psychological issues may influence the patient’s response to treatment as well as the patient’s interaction with the physician. Therefore, primary care also focuses on psychological diagnosis and treatment so that the physician can give appropriate support to the patient. This type of personal care and support can create a powerful therapeutic relationship between the doctor and the patient. Of course, a strong doctor-patient relationship underlies all patient contact be it by a primary care physician or a highly skilled subspecialist.

Physicians, primary care and specialists, also have the responsibility of educating their patients about the diseases they have. This requires good communication skills and the willingness to listen to questions and to advise appropriately. Communication is an ongoing process that is part of the continuous care that a primary care physician provides. It is a dynamic process wherein the patient’s expectations, needs and understanding may change during the course of a disease. Good primary care includes an awareness of those changes and the ability to talk about them with the patient.

Finally, primary care involves risk assessment, health maintenance and disease prevention. The specifics of risk assessment are related to the age of the patient. Advice for health maintenance and disease prevention is part of the continuous care of the primary care patient. Advice and education are given not only to the healthy patient but also to the acute or chronic care patient as well. This counseling is part of the long-term doctor-patient relationship.
Illness may be broadly defined by the clinical terms acute (meaning sudden) vs. chronic. In the distant past, acute illness (often in the form of infection) killed many patients. Now, gains made against infection have changed the problems physicians have to face. Chronic illness (chronos = time) is now the by-word of medical practice. Unfortunately, issues of importance in chronic illness are often given short shrift in medical school. One of the purposes of this course will be to get you, the medical student, to recognize the important issues in dealing with chronic illness.

Once again this year there will be a written assignment. The focus on the paper will be on the management of a patient with a chronic illness and that the physician must do so that the patient may adjust his or her life to this illness or disability. Doctors should be more than medicine givers. A chronic illness means that other prescriptions have to be given. The patient’s family has to adjust and often the physician needs to advise them. Other life-style issues have to be addressed. We also want to introduce you to the process of clinical reasoning (see further on this in the handout). We know that you have had only minimal clinical experiences. The purpose of this exercise is not so much to learn the details of how to manage one illness (see special circumstance associated with assignment to pediatric practice); rather, it is to focus your attention on what are the overall methods of patient/disease management. You are going to have to learn how to do this in great detail during the spring of this year. This exercise will be the beginning of that learning process. We know your preceptor will help you to define these issues because, come to think of it, that’s what good care is all about.

We hope that the student experience in ambulatory primary care will illustrate many of the aspects mentioned above. Even though you as students are new to medicine and don’t have an extensive background, we still feel you are able to communicate with patients on a very basic level. In most cases, the patients will appreciate your interest. What you get out of the office-based experience will depend on your efforts to learn and the office environment in which you will be working. The rotation is an opportunity to experience different aspects of the doctor-patient relationship first-hand. In an era of large group practices and health maintenance organizations, the patient and his/her relationship with the doctor are frequently ignored in the name of efficiency. We hope that you, as future physicians, will help restore the emphasis where it should be – on the patient. We realize that physician contact time with patients is becoming more and more limited as demands grow for more productivity. We hope, however, that you will learn to make that time quality time which is valuable and meaningful for both your patients and you. Now is a good time to start.

S. Benham Kahn, M.D.
Course Director
INTRODUCTION TO AMBULATORY MEDICINE

GOALS:

1) To gain understanding of how ambulatory medicine is practiced.

2) To apply newly developed clinical skills to actual patient encounters, including a history and physical exam.

3) To learn the impact of a chronic illness or disability on the patient, on the patient’s lifestyle and on the patient’s family.

4) To recognize some of the complexities in doctor-patient interactions and to discuss the impact that managed care has had on medical practice.

5) To become familiar with the concept of disease management and to learn how a disease is managed by practicing on one patient.

6) To begin to understand the process of clinical reasoning.

OBJECTIVES: By the end of the ambulatory experience, students will be able to –

1) Perform a risk factor assessment on one patient.

2) Describe ways the patient’s family are affected by the patient’s condition and how one would use the family in the evaluation and management of a patient.

3) Recognize how the physician can positively influence patient adherence.

4) Perform a history and segments of a physical exam on a patient with some degree to comfort, correlating the patient’s complaints with the physical findings.

5) Discuss/describe the management of the disease/condition/disability of a patient (with a chronic illness/disability).

6) Be able to discuss the process of clinical reasoning; specifically, relating the findings of the history and physical exam directly to the patient’s clinical findings and to begin to understand how to make a diagnosis and to decide on therapy.
WHAT IS CLINICAL REASONING?

Clinical reasoning is the thought process by which a physician most efficiently obtains information. He/she then uses that information, establishes the diagnosis, and assesses the specific problems the patient has. He/she then determines all the steps necessary to manage the patient so that a cure is effected, or, if no cure is possible, the patients’ problems are alleviated. To be successful, the physician must have a strong knowledge of basic science, clinical epidemiology and clinical and laboratory medicine.

One of the most important aspects of clinical reasoning (especially for the second year student) is knowing how to take a history, focusing on those features that direct the physician towards establishing a correct diagnosis. Establishing a diagnosis requires that specific criteria be met. Most historical facts, physical findings and even some laboratory and imaging studies are non-specific. For example, the same complaint or test may be positive in several conditions. This forces the clinician to act upon facts and tests sometimes without being 100% confident that the diagnosis is correct.

(Think about a 50 year old man with chest pain. Sometimes tests done are normal, yet the history is suggestive. The physician then acts as if the patient has a serious cardiac problem, which after a time may be shown to be present. Yet, not knowing that in advance, the physician acted because he/she didn’t know if the patient was ill or not!)

The second year student must begin to establish the mindset of clinical reasoning. Your visit to a doctor’s office and your assignment to an individual patient ought to help you to learn how a physician establishes a diagnosis and how the patients’ problems are set for management. The faculty wants you to take the time and to ask your mentor how these processes are learned.

Here’s an example of what we mean:

Preface: A 60-year-old otherwise healthy man complains that he has a bulge in his left inguinal area for the past 6 months.

Physician (thinking): What’s in that area? Answer: skin, muscle, vessels and nodes.

Physician (asks): When did you first notice this bulge? Does it hurt? Is there anything that changes it?

Patient (says): About 6 months ago. It seems to be getting bigger. It doesn’t hurt, but if I lie down it disappears!

Physician (thinking): Ah, Ha! Sounds like a hernia.
**Physician** (thinking): Wait a minute! Why did it appear at this age? Maybe he has increased intra-abdominal pressure.

**Physician** (asks): Are you having trouble moving your bowels or passing urine? Do you have a cough?

**Question for student:** Why the question about bowels, urine and cough?

**Answer:** Think about this. If constipated or if prostate enlargement inhibits urine flow or if patient has a cough, intra-abdominal pressure increases because each of these problems causes a human being to do the Valsalva maneuver.

**Physician** (orders): Rectal exam, prostate exam and chest x-ray.

End of Scene

**Comment:** This scene is an example to illustrate a thought process. (It’s not a complete work-up!) The process of clinical reasoning must include not only the diagnosis (the hernia is obvious) but also why the hernia appeared. Clearly if this patient has a cancer in the sigmoid colon that is obstructing his colon causing constipation, repair of the hernia without treating the colon cancer would be tragic.

One final note about basic science: It’s clear that a strong knowledge about basic science is a requirement. Even in the above example, the Valsalva maneuver is a fact of basic science (even if you may have learned about it in high school).
PATIENT EDUCATION

Patients frequently fail to adhere to prescribed therapies. Patients fail to follow short-term curative regimens up to 30% of the time and up to 40% of the time when the therapy is preventive. With lifetime or behavioral change regimens such as dietary changes for diabetes or hypertension, initial non-adherence is 50% and rises over time. Physicians typically overestimate their patients’ rate of adherence and fail to identify non-compliant patients. Patients often signal their low level of adherence by failing to keep follow-up appointments, costing the physician time and money.

A multitude of factors can contribute to patient non-compliance. Behavioral explanations, such as patients’ rejection of authority, denial of illness, and avoidance of dependency probably account for many adherence problems. Many of the behaviors that physicians ask their patients to change, such as smoking, overeating, and alcohol consumption, are not easily changed. Environmental factors, such as poverty, social isolation and lack of family and social support, may adversely affect adherence. Sometimes physician behaviors inadvertently lead to non-compliance. Physicians may unintentionally embarrass patients (e.g., “You didn’t take your pills?”) or inhibit patient questions or admissions of difficulty with a regimen by failing to elicit patient concerns.

Decreased cooperation with prescribed therapy is often due to ineffective patient education. There are two sides to the problem of ineffective patient education: Physicians do not always effectively communicate information, and patients are fallible, with failures of memory and judgment. Shortly after their consultations with physicians, patients forget up to one-third of what is told to them, and half or more of the instructions and statements about treatment. Patients often make interpretive errors when reading the labels of their pill bottles. When successfully implemented, however, patient education can be a powerful force. Documented benefits include decreased medications needs, duration of therapy, hospital stays, risk behaviors, morbidity and mortality, and an overall positive effect on patients’ coping.

Patient education is actually a complex process and entails more than communication of information. There are a number of specific skills and interventions useful in educating patients. Physicians must elicit the patient’s understanding of the problem since the patient’s concept about his/her susceptibility to complications and consequences to health, the effectiveness of treatment and the cost/benefit ratio of treatment, (costs in terms of money and emotional cost) will effect the patient’s intention to comply. Physicians must clear up any patient misconceptions about causes, treatment and prognoses of illness. Physicians should give explanations in clear language, avoiding all jargon, remembering that patients often misunderstand even simple medical terms. It is often helpful to use metaphors that the patient understands in explaining disease mechanisms (e.g., a plumbing metaphor to explain the consequences of hypertension: what too much pressure in the pipes would do to the pump, etc.). It is helpful to organize the message, presenting simpler concepts first, and to give information in readily digestible “chunks” saving further information for later visits. (Telling a patient all at
once that he must reduce his salt intake, diet, stop drinking, stop smoking and take medications can be overwhelming.) It is often helpful to personalize information, making the information more relevant to a patient by relating to the patient’s family history or social situation. The use of educational aides, such as pictures, written instructions and videos can be quite helpful. Some physicians find it useful to tape record their presentation of complicated explanations and instructions, giving the patient the tape to review at home. It is important to check frequently for patient’s understanding by asking patients to repeat back what has just been told. It is also important to invite questions in the middle of an explanation so that patients can follow the explanation, and to provide sufficient time also to ask questions at the end.

The effective use of interpersonal skills during explanations can often enhance understanding and improve motivation. Other useful interventions include expressions of optimism and reassurance. Physicians may need to negotiate with patients to determine mutually agreeable treatment plans. When asked, patients may have disagreements with physicians about what they are willing or are able to do. It is important to explore obstacles to adherence and work with patients to overcome those obstacles. Finally, it is useful to rehearse with patients the intended changes and reaffirm patients’ commitment.

With careful attention to the skills of giving information and patient education, physicians can improve patient adherence, improving their patients’ health and well-being.
A. **ACADEMIC LOGISTICS:**

You’ll be assigned a patient. After establishing a relationship with the patient you should do a history and perhaps a part of the physical exam. **After looking up the patient’s clinical disease or problem in a medical text, you should discuss the patient’s problems with your preceptor.** You should concentrate on how the patient’s condition is managed. Your preceptor may give you all the information you need but you must look up your patient’s condition in a text and you must cite the reference at the end of your paper. You are to write your assigned paper using this patient. (See below for information that is to be included in the paper)

B. **PRACTICAL LOGISTICS:**

1) Students should always remember they are guests in the preceptor’s offices and should therefore act appropriately.

2) Students are expected to arrive at the preceptor’s office on time and to remain there during the hours noted on the confirmation letter.

3) Each student will bring a stethoscope, white jacket, and I.D. card that can be attached to their jacket. If you have a neuro rubber hammer and oto and ophthalmoscope kit bring that too.

4) **In the case of an absence, the student must call Kaye Finneran, academic program coordinator, at (215) 991-8527 or e-mail at (kfinnerradrexelmed.edu).** The preceptor’s office should also be notified. Preceptors will call our office if the student is not present for the session. Make-up sessions must be arranged if the student is to get credit for the course.

5) If there is an emergency, call or e-mail Kaye Finneran. If there is a problem with a preceptor, call S. Benham Kahn, M.D. at (215) 991-8527.

6) **Students are responsible for the own transportation to the preceptor offices.**

We have asked preceptors –

- To make their medical reference library available to the students during the office session.

- To give feedback to the students as the four-week block goes on.
To be as encouraging and supportive as possible of the students’ interviewing efforts.

As much as time allows, to be willing to discuss the patient with the student after the visit is over.

To assign you a patient with a chronic illness and to discuss with you case management.

To discuss the thought process that underlies making a diagnosis and deciding on therapy.

READ THIS BEFORE YOUR FIRST VISIT

WRITING YOUR ASSIGNMENT PAPER: (Remember, no longer than 3 single sided sheets of 8”x11” paper!)

In order to understand what is expected of you, please read the following article:
   Bodenheimer, T., Disease Management – Promises and Pitfalls.

This article explains the concept of illness or disease management. Briefly, treatment of a chronic ongoing illness requires more than taking medicine (i.e., “Take a pill and see me next week”). Chronic illness/disability may involve life style adjustments, vocational or job related changes and familial reordering. For example, a patient with diabetes may require insulin or oral hypoglycemic drugs, dietary shifts, job change if the work involves dangerous machinery, alteration of routine meal times, weight reduction, blood glucose monitoring, etc. The optimum management of the diabetic state will do a lot in the long run to prevent the dreaded complications of renal failure, blindness, neuropathy, vascular disease, etc.

Who should monitor this management? We believe the primary care physician should be in control. (As you’ll note from the article by Bodenheimer, drug firms are attempting to control this aspect of medicine to the detriment, according to the author, of the patient and the doctor).

Finally, you should ask if the patient has unmet needs or barriers to adherence. For example, lack of transportation inhibits compliance with attendance at clinic or rehab.

Our purpose in giving you this assignment is to sensitize you to the issues so nicely presented by Bodenheimer.
Methods:

1) Your preceptor will assign you a patient with an ongoing chronic problem. (Likely the patient may have diabetes, heart disease, cancer or severe arthritis). **IF YOUR PRECEPTOR DOES NOT VOLUNTARILY ASSIGN YOU A PATIENT ON YOUR 1ST VISIT, ASK HIM/HER TO DO SO! WE SHOULD LIKE YOU TO ESTABLISH A RELATIONSHIP WITH THIS PATIENT SO THAT YOU, YOUR PRECEPTOR AND THE PATIENT WILL FEEL COMFORTABLE WITH ALLOWING YOU TO CALL OR SEE (HOME VISIT IS PREFERRED) THE PATIENT AT LEAST WEEKLY DURING YOUR ROTATION.**

2) Discuss disease management with your preceptor.

3) Consult standard textbooks for review and supplemental information. Make sure you use your reference. (N.B. A review article about diseases in a journal is also acceptable. **You must include a reference in your paper. No reference cited = failure.**)

4) Question your patient about his/her condition. Do a history and a physical exam. Ask about unmet needs and barriers to adherence.

5) Write a paper – no longer than 3 single sided type written pages. The following outline is suggested. (Please see pages marked “overall disease management” for complete instructions about the paper. A brief outline of what must be included follows:

   a) history and physical (follow format below)
   b) diagnosis
   c) therapy being used
   d) monitoring methods (how do you know therapy is working)?
   e) changes which have had to occur in order to manage the disease. (For example, dietary changes, weight reduction, changes in job, changes in familial relationships, coping with side effects of drugs, if any, etc.)
   f) patient compliance with orders and impediments and solutions
   g) difficulties in changes faced by patient at home/work/social affairs and how condition affected family
   h) unmet needs/barriers to adherence
   i) preventive care
   j) **NOTE:** *Do not use the patient’s real name*. You may use initials or a fictitious name. List the patient’s age and marital status at the beginning of your paper.
The paper is due 1 week after completing your rotation. Failure to hand in the paper assignment 1 week after completing your session will result in a “U” on your transcript for this clinical experience. You will not be permitted to enter the 3rd year of studies unless the unsatisfactory grade has been remediated. Please e-mail your paper to Kaye Finneran (kfinn@drexelmed.edu), she will keep copies on file. If you hand in a hard copy, BE SURE TO SAVE A COPY ON YOUR COMPUTER. We will not accept the excuse that you have not kept a file copy of your paper should your paper be lost.

See following page for information about how to write the paper for a pediatric experience.
STUDENTS ASSIGNED TO PEDIATRIC OFFICES

It may not be possible for your pediatric mentor to assign you a patient with a chronic illness/disability. However, pediatricians see children and children do have a marked impact on family life. Therefore, your paper should describe the impact that having and raising children has had on parents, siblings and other family members. This year the focus is on disease management.

If you are assigned a patient with a chronic illness, please follow the general outline for the paper listed in your manual above. Don’t forget to describe (briefly) the family of the patient. Concentrate on overall disease management.

If you are assigned to a patient with an acute illness (i.e., otitis media, influenza, diarrhea, etc.) follow the same outline. Don’t forget to discuss how the condition might be prevented from recurring as well as overall management and how the acute illness might disrupt normal family activities. (Describe the overall development of the child in your paper).

If you are assigned a healthy baby, please discuss overall management of well children, stressing overall management of changing needs of patients (children) as they grow and mature. Again, describe how these changes have had an impact on the family. Describe preventive measures needed including vaccinations, diet, conditions at home, and who gives care (day care, nanny etc). Make sure your history includes prenatal care and any problems at birth. Also include time and difficulties with labor and delivery. Finally, ask about unmet needs and barriers to adherence. Be sure you include a reference.

You will need to hand in your written assignment paper 1 week after you have completed your session to Kaye Finneran in the Office of Medical Education at Queen Lane, Room 221 or you can e-mail them to Kaye Finneran at (kfinnera@drexelmed.edu). She will keep copies on file. If you hand in a hard copy, be sure to keep a copy on your computer.
EVALUATION

The student’s final grade for the Introduction to Ambulatory Medicine, is based on the following items:

1) Preceptor evaluation = 75%

2) Written assignment paper = 25%

Final grades will be either - I = Incomplete (see written remarks. You will have to rewrite your paper to obtain a Satisfactory grade), or Satisfactory (pass). To pass, all objectives of the paper should be met. If you fail to hand in a paper or you do not obtain a passing grade following a rewrite, you will fail and will not be permitted to enter 3rd year.

Grading: I read all of your papers. I expect you to follow directions and include all required information (see following pages for instructions). I expect all papers to be clearly written. It is not difficult for me to sense from your writing how much effort you put into this learning experience.

Honors: We rarely give Honors grades. However, if YOUR PRECEPTOR writes in his/her evaluation that you deserve HONORS AND IF YOUR PAPER FULFILLS ALL CRITERIA, then HONORS may be bestowed.
OVERALL DISEASE MANAGEMENT

TOPIC #1 - DOING A HISTORY AND A PHYSICAL EXAM and DISCUSSING DISEASE MANAGEMENT.

Goals:

a) Students will increase their comfort and confidence in performing a HISTORY AND PHYSICAL EXAM on one of the preceptor’s patients using the techniques from the Clinical Skills course. (see following for remarks about how to do a history and physical exam)

b) After discussing the findings with the preceptor, the student and preceptor will discuss the diagnosis and overall management of the patient’s chronic illness.

How to do a history: The classical history has a number of elements that ought to be ascertained. 1) CC or chief complaint (what brings you in to see me?); 2) HPI or history of present illness. Tell me how this began? Then what happened. (If patient has been treated in past, ask what type of treatment and what happened as a result of treatment); 3) PMH or past medical history (What other illnesses have you had and results of treatment but all illnesses or treatments in past that have bearing on HPI should be included in HPI. Surgical history belongs here or as next item. Always ask about how surgery went, were there complications such as bleeding or infections etc.); 4) Family history. Don’t forget to mention spouse. A pedigree including parents and grandparents is indicated. Find out if still alive or dead and if dead what disease they had and how old were they when they died; 5) Social history (Includes items such as work, home life, use of alcohol, tobacco etc); 6) Drug history and use (list of drugs being taken including illicit drug use); 7) Sexual history; 8) Review of systems (ROS). Begin with head, eyes, ears, nose, throat (HEENT), then lungs, heart, abdomen, then cardiovascular (CV), then extremities and neuro.

What should be included in the physical exam: It may or may not be possible to do a physical exam but YOU SHOULD TRY. If a complete exam is not possible, then FOCUS ON THE SYSTEMS DEALING WITH THE CHIEF COMPLAINT (for example, if CC is - I have high blood pressure, focus on heart and lungs, try to look at retinal vessels, check for edema etc.
HOW TO TAKE A BLOOD PRESSURE: You must take your patient’s blood pressure. The proper techniques are as follows:

1) Patient and you should be sitting facing each other, both should be relaxed. If patient is tense, try to engage in conversation to relax.
2) Patient’s arm should be level with heart and resting comfortably. (The upper arm, where the cuff is applied, should be about at the heart level. It will be close enough if the patient rests his/her elbow on a desk or table; otherwise, the examiner must support the relaxed arm – the patient should not be actively holding the arm up).
3) BP cuff should be placed on upper arm, midway between shoulder and elbow; BP cuff should be placed with the bladder towards the “front” (note the “artery” indicator on most cuffs).
4) Palpate a pulse – humeral artery at elbow or radial pulse.
5) Count pulse rate, though best way to measure heart rate is by heart auscultation.
6) With finger on radial pulse, inflate cuff until pulse disappears and then inflate to 10-20 mm above.
7) Slowly let air out and again begin to feel radial pulse.
8) Deflate cuff and then place stethoscope on humeral pulse area.
9) Inflate cuff to 20-30 mm above indicated radial pressure.
10) Slowly release air and note first sound (systolic pressure) and when sound changes and disappears (diastolic pressure).
11) Repeat on other arm.
12) Repeat on one arm with patient standing.
13) Record all results.

(NOTE): A 10-minute videotape describing the above is available on the Clinical Skills Website.

Discussing findings: You should make every effort to discuss your evaluation with your preceptor. BEFORE YOU DO THIS YOU MUST READ ABOUT PATIENT’S DISEASE IN A MEDICAL TEXT OR PATHOLOGY TEXT. THEN DISCUSS MANAGEMENT, MAKING SURE THAT YOU DISCUSS NOT ONLY DRUGS BUT THE FOLLOWING: 1) Dietary changes; 2) Work; 3) Home situation; 4) Need for community resources; 5) Preventive measures.
**Topic #1 Continued:**

**Objectives:** After being assigned a patient with a chronic illness, the student should perform a focused physical exam guided by the patient’s history, looking for physical signs that might confirm a diagnosis. Remembering that the physical exam starts from the moment the examiner first sees the patient, the student should have four observations about the patient (gait, mood, appearance, degree of wellness, tone of voice, etc.) before starting the formal physical exam.

The student will write a brief history and concise physical exam on the patient (to incorporate later into the assigned paper).

**Suggested Methods:** The preceptor identifies a patient on whom the student will perform a physical exam.

The preceptor will observe the examination, if possible, and make comments for the student later.

The preceptor should review and explain physical findings, and should then discuss patient’s illness and disease management.
OVERALL DISEASE MANAGEMENT

TOPIC #2 - IMPACT OF ILLNESS ON THE FAMILY AND ON PATIENT’S SOCIAL/OCCUPATIONAL ENVIRONMENT

Goals:

To understand why the family should be considered in the evaluation of a patient and how the family may play a role in patient management. To learn all of the other elements are required for proper patient management.

To learn what are the burdens placed on the family care givers and how the patient and the family view these burdens.

To define the impact of illness and therapy on the patient’s work and social life.

To learn about preventive care.

Objectives:

Student should be able to discuss ways the family can impact in either a positive or negative way on a patient’s medical course.

Students should be able to discuss the ways the family can impact on a preceptor’s management plan.

Students should learn what has been the impact of disease management on patient’s work and social life.

Students should learn about preventive care by discussing needs of assigned patient.

Suggested Methods:

Student will talk with assigned patients (or others seen) about their families and how the families react to the patient’s illness.

If approved by the preceptor and allowed by the patient, the student will talk separately with the family members in the office or by phone, if possible, to learn how they perceive the patient’s illness, how they respond to it, and how they feel about it.

Student will discuss with the preceptor how to interact with the patient’s family.

Student will discuss with the preceptor to what extent the family should be involved in patient care and how family issues can be incorporated into the therapy plan.
Topic #2 Continued:

The student, with permission, might wish to call the patient to discuss issues dealing with work or social life if there has not been sufficient time to do this during the office visit. (If all agree, repeated calls to discuss matters which have to be discussed in your assigned paper are encouraged).

Suggested Readings:


TOPIC #3 - WHAT IS DISEASE MANAGEMENT

1) Giving drugs and nothing else is not disease management.

2) Disease management means what a physician must do to help the patient accommodate to the illness.

3) Example: A person with hypertension needs medicine, advice about diet, exercise counseling, risks that might be encountered, i.e., driving a car or using dangerous machinery, etc. In other words, all of the procedures needed to control the illness.

4) Make sure you discuss unmet needs and barriers to adherence and include these data in your paper.

5) LOOK UP YOUR PATIENT’S CONDITION IN THE TEXTBOOK AND DISCUSS HOW THE DISEASE SHOULD BE MANAGED WITH YOUR MENTOR. DON’T HESITATE TO ASK!!!

6) See above remarks about elements of proper patient management.
TOPIC #4 – CONTINUING A RELATIONSHIP

1) By now you should have gotten to know your patient.

2) Please continue to contact your patient by phone or otherwise (personal visit or even e-mail) to “see how he/she is doing”.

3) Try to practice some patient education.

4) **Always close your relationship by thanking the patient.**

Suggested readings:
