GUIDELINES

For

GENERAL PRACTITIONERS

2024

Press record

First Edition

Printed by SARANA PRESS (Dr. Aung Kyaw Min)

249, Theinbyu Road, Mingalartaungnyunt Township, Yangon, Myanmar

2018

Cover Designer (Tun Zaw)

Inner Designer (Tun Zaw)

Second Edition

Digital Copy Printing (TMO)

249, Theinbyu Road, Mingalartaungnyunt Township, Yangon, Myanmar.

2024 April

Cover Designer (Tun Zaw & Win Zaw)

Inner Designer (TMO)

FOREWORD

It is a great honor for me to write a foreword to Guidelines for General Practitioners by General Practitioners' society, Myanmar Medical Association (Central).

General practitioners are the primary health providers in the community looking after the majority of the people of our country. They are being trusted and depend upon by every families in the surrounding area where they practice. The first and foremost care by the General Practitioners are the most important for all the people.

Guidelines based on a critical appraisal of scientific evidence (evidence-based guidelines) clarify which interventions are of proved benefit and document the quality of the supporting data. They alert clinicians to interventions unsupported by good science, reinforce the importance and methods of critical appraisal, and call attention to ineffective, dangerous, and wasteful practices.

Clinical guidelines can improve the quality of clinical decisions. They offer explicit recommendations for clinicians who are uncertain about how to proceed, overturn the beliefs of doctors accustomed to outdated practices, improve the consistency of care, and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies.

The Myanmar Medical Association together with the GP society has been helping out with the CME and CPD program for the Member doctors both inhouse sessions and online courses. This guideline is one of the essential parts of this CPD for the GPs.

I would like to congratulate the GP society for their effort for producing this guideline and also, I would like to encourage them to review and updated regularly.

Professor Aye Aung
President
Myanmar Medical Association

April, 2024

PREFACE

We are writing this letter to express our sincerest gratitude and appreciation for the successful completion of the **second edition** of the **General Practitioners' Guidelines**. This accomplishment is the result of an exceptional collaborative effort, and we would like to extend our thanks to all those involved.

The General Practitioners' Guidelines has been an invaluable resource since its inception with the launch of the first edition in November 2017. As per the initial plan, the guidelines were intended to be updated every three years to ensure the most up-to-date information reaches Myanmar General Practitioners, enhancing their knowledge in primary healthcare and family health.

However, the unforeseen outbreak of the Covid-19 pandemic disrupted our plans and posed numerous challenges for the team. In-person meetings became impossible due to safety concerns, making it necessary for us to find alternative means of communication and collaboration. Despite the adversity faced, the team members demonstrated remarkable resilience and adaptability by utilizing online platforms and technology to continue the update process.

We would like to extend our deepest gratitude to the dedicated team members who persevered and worked tirelessly during these trying times. Their commitment, professionalism, and unwavering dedication to the project enabled us to overcome the obstacles posed by the pandemic and successfully complete the second edition of the guideline.

Furthermore, we would like to express our sincere appreciation to the specialist societies that actively contributed to the development of the guidelines. Their expertise and invaluable insights have ensured that the content remains current, accurate, and relevant, enabling our General Practitioners to provide the highest quality of care to their patients.

We would also like to extend our heartfelt thanks to the esteemed President of the Myanmar Medical Association, for their continuous support and guidance throughout this endeavor. Their leadership and unwavering commitment to advancing medical knowledge in Myanmar have been instrumental in the success of this Guidelines.

Moreover, the decision to distribute the guideline as electronic copies reflects our commitment to ensuring easy access for all Myanmar General Practitioners. By making it available in this format, we aim to facilitate the dissemination of updated knowledge, thus empowering our healthcare professionals to deliver the best possible care to the community.

In conclusion, we would like to express our deepest gratitude to all those who contributed to the development and distribution of the General Practitioners' Guidelines Second Edition. The unwavering supports and collective efforts have made a significant impact on enhancing primary healthcare and family health care in Myanmar.

Once again, thank you for your outstanding dedication, resilience, and invaluable contributions. We look forward to our continued collaboration in advancing medical knowledge and improving healthcare outcomes for all.

Dr Khine Soe Win and Dr Win Zaw April, 2024
General Practitioners' Society (Central)
Myanmar Medical Association

EDITORIAL

It is my privilege to inform you that our updated and revised edition of "**Guidelines for General Practitioners**" will be published very soon and it is my great pleasure to be the editor-in-chief of this guideline book. There are various reasons for revising and updating the previous edition.

This is the fact that some important topics, for example, malaria and family violence are missing in the first edition and some clinical practice guidelines like Diabetes Management have been changed during the interim period. Of course, this opportunity arises due to the emergence of COVID-19 in the world. As all you know, Medicine is an ever-changing science; we need to consider updating our guidelines at least five- yearly. Hence the time is up now!

Education is achieved by assimilating information from many resources and readers of this book can enhance their learning experience in terms of reflecting in their daily Family/General Practice. We all take immerse pride in contributing good educational resource dedicated to Myanmar General Practitioners. The editors and authors anticipate that the readers will both enjoy and profit from their work in preparing this volume.

Happy studying and learning,

Dr Win Lwin Thein
Editor-in chief
Vice President (GP Society)
April, 2024

ACKNOWLEDGEMENT

We would like to thank all our talented and hard-working colleagues who have contributed to the ongoing development of the **Guidelines for General Practitioners**.

Especially, we would like to highlight the significance of the second edition which appears when the family medicine development process in Myanmar is being idle. Many factors are impeding the developing process lately, which has been accelerated previously by the commitment of the MOHS, the medical universities, and the General Practitioners' Society before the COVID-19 pandemic started.

No one can deny that the Myanmar health care system is lacking a strong and effective primary care task force. The best solution to mend this defect is retraining the thousands of general practitioners who are working individually across the country. Here comes the role of family medicine to train these GPs and primary care doctors to be able to use its principles effectively and, in turn, strengthen primary care.

Many GPs are using some family medicine principles consciously or unconsciously in varying degree of competency. Person-centered care, continuity of care, and family-oriented care became the culture of most practices for a long time. But only a few GPs can enjoy the most effective coordinated care and seamless continuity of care with secondary and tertiary care providers. The reasons behind this would be the absence of standardization in general practitioners' service quality and unawareness of the value of family medicine practitioners by other specialties and the public.

To resolve this ambiguity, primary care doctors should be involved in the retraining programs and thereafter CME/CPD and other life-long-learning programs which prescribe family medicine curricula.

We also acknowledge the effort of the contributors to make this new edition more family medicine-oriented, in addition to the Family Medicine chapter at the beginning of the book. We genuinely believe that the new edition will be a better reference for the GP/FP who wants to practice quality primary care and for future family medicine programs in Myanmar.

Finally, we would like to thank all academic writers who contributed to the General Practice Guidelines-first edition. Without their kind support, this second edition could never have happened.

Regards,

Dr. Tin Aye and Dr. Kyaw Thu

General Practitioners' Society (Central), MMA **April, 2024**

LIST OF CONTRIBUTORS

1. *Aung Cho Myint, Prof*
2. *Aung Maw, Dr*
3. *Aye Aung, Prof*
4. *Aye Aye Than, Dr*
5. *Aye Aye Thein, Dr*
6. *Chit Soe, Prof*
7. *Hla Myat Nwe, Prof*
8. *Hla Myint Tun, Dr*
9. *Hlaing Mya Win, Prof*
10. *Hlaing Myint, Dr*
11. *Htay Win, Dr*
12. *Htin Aung Saw, Prof*
13. *Htun Lwin Nyein, Prof*
14. *Khin Hla Hla, Prof*
15. *Khin Hta Yi, Prof*
16. *Khin Mi Mi, Dr*
17. *Khin Ohnmar Khine, Prof*
18. *Khin Saw Than, Prof*
19. *Khine Khine Zaw, Prof*
20. *Khine Soe Win, Dr*
21. *Ko Ko, Prof*
22. *Kyaw Myint Naing, Prof*
23. *Kyaw Thu, Dr*
24. *Kyaw Zin Wai, Prof*
25. *Kyi Kyi Nyunt, Prof*
26. *Kyi Kyi Thinn, Prof*
27. *Kyin Htwe, Dr*
28. *Lin Htet, Dr*
29. *Lwin May Oo, Dr*
30. *Mar Mar Kyi, Prof*
31. *Maung Maung Sein, Prof*
32. *May Thandar Oo, Dr*
33. *Min Han, Prof*
34. *Min Yazar, Dr*
35. *Min Zaw Oo, Prof*
36. *Moe Naing, Dr*
37. *Moe Wint Aung, Prof*
38. *Mya Thae Han, Dr*
39. *Mya Win Hnit, Dr*
40. *Myint Thaung, Prof*
41. *Myo Khine, Dr*
42. *Myo Lwin Nyein, Prof*
43. *Myo Nyunt Aung, Dr*
44. *Myo Oo, Prof*
45. *Naing Oo, Prof*
46. *Nang Phyu Phyu Aung, Prof*
47. *Nwe Mar Tun, Prof*
48. *Nwe Nwe Aung, Dr*
49. *Nyein Moe Thaw, Dr*
50. *Phyu Phyu Khaing, Dr*
51. *Rai Mra, Prof*
52. *Samuel Kyaw Hla, Prof*
53. *Saw Win, Prof*
54. *Sein Way Lwin, Dr*
55. *Than Htike, Dr*
56. *Than Than Aung, A Prof*
57. *Than Than Aye, Prof*
58. *Thar Thar Oo, Dr*
59. *Thein Aung, Prof*
60. *Thein Myint, Prof*
61. *Thet Naing Maung, Dr*
62. *Thin Thin Nwe, Dr*
63. *Tin Aye, Dr*
64. *Tin Nyunt, Dr*
65. *Tin Tin Aye, Dr*
66. *Tin Tin Hla, Dr*
67. *Tint Tint Kyi, Prof*
68. *Vijay Kumar, Dr*
69. *Win Lwin Thein, Dr*
70. *Win Zaw, Dr*
71. *Yin Yin Soe, Prof*
72. *Yin Yin Zaw, Prof*
73. *Yu Yu Lwin, Dr*
74. *Zaw Lynn Aung, Prof*

SYMBOLS AND ABBREVIATIONS

AAA abdominal aortic aneurysm
ABC airway, breathing, circulation
ABCD airway, breathing, circulation, dextrose
ABO A, B and O blood groups
ACE angiotensin-converting enzyme
ACEI angiotensin-converting enzyme inhibitor
ACTH adrenocorticotrophic hormone
ADHD attention deficit hyperactivity disorder
ADT adult diphtheria vaccine
AFP alpha-fetoprotein
AI aortic incompetence
AIDS acquired immunodeficiency syndrome
AIIRA angiotensin II (2) reuptake antagonist
AKF acute kidney failure
ALE average life expectancy
ALL acute lymphocytic leukaemia
ALP alkaline phosphatase
ALT alanine aminotransferase
AMI acute myocardial infarction
AML acute myeloid leukaemia
ANA antinuclear antibody
ANF antinuclear factor
AP anterior–posterior
APH ante-partum haemorrhage
ASD atrial septal defect
ASIS anterior superior iliac spine
ASOT antistreptolysin O titre
AST aspartate aminotransferase
AV atrioventricular
AZT azidothymidine
BCC basal cell carcinoma
BCG bacille Calmette-Guérin
BMD bone mass density
BMI body mass index
BP blood pressure
BPH benign prostatic hyperplasia
Ca carcinoma
CABG coronary artery bypass grafting
CAD coronary artery disease
CAP community acquired pneumonia
CBT cognitive behaviour therapy
CCF congestive cardiac failure
CCU coronary care unit
CD4 T helper cell
CD8 T suppressor cell
CDT combined diphtheria/tetanus vaccine
CEA carcinoembryonic antigen
CFS chronic fatigue syndrome
CHD coronary heart disease
CHF chronic heart failure
CIN cervical intraepithelial neoplasia
CK creatinine kinase
CKD chronic kidney disease
CKF chronic kidney failure
CML chronic myeloid leukaemia
CMV cytomegalovirus
CNS central nervous system
COAD chronic obstructive airways disease
COC combined oral contraceptive
COCP combined oral contraceptive pill
COPD chronic obstructive pulmonary disease
COX cyclooxygenase
CPA cardiopulmonary arrest
CPAP continuous positive airways pressure
CPK creatine phosphokinase
CPR cardiopulmonary resuscitation
CR controlled release
CREST calcinosis cutis; Raynaud's phenomenon; oesophageal involvement; sclerodactyly; telangiectasia
CRF chronic renal failure
CR(K)F chronic renal (kidney) failure
CRP C-reactive protein
CSF cerebrospinal fluid
CT computerised tomography
CTS carpal tunnel syndrome
CVA cerebrovascular accident
CVS cardiovascular system
CXR chest X-ray
DBP diastolic blood pressure
DC direct current
DHA docosahexaenoic acid
DI diabetes insipidus
DIC disseminated intravascular coagulation
dL decilitre
DMARDs disease modifying antirheumatic drugs
DNA deoxyribose-nucleic acid
DRABC defibrillation, resuscitation, airway, breathing, circulation
drug dosage bd—twice daily, tid/tds -three times daily, qid/qds -four times daily
ds double strand
DS double strength
DSM diagnostic and statistical manual (of mental disorders)
DU duodenal ulcer
DUB dysfunctional uterine bleeding
DVT deep venous thrombosis
EBM Epstein-Barr mononucleosis (glandular fever)
EBV Epstein-Barr virus
ECG electrocardiogram
ECT electroconvulsive therapy
EDD expected due date
EEG electroencephalogram
ELISA enzyme linked immunosorbent assay
ESRF end-stage renal failure
ESR(K)F end stage renal (kidney) failure
ERCP endoscopic retrograde cholangiopancreatography
esp. especially
ESR erythrocyte sedimentation rate
FB foreign body
FBE full blood count

FEV1 forced expiratory volume in 1 second
fL femtolitre = (1e–15) litre
FSH follicle stimulating hormone
FUO fever of undetermined origin
FVC forced vital capacity
g gram
GA general anaesthetic
GABHS group A beta-haemolytic streptococcus
GBS Guillain-Barré syndrome
GFR glomerular filtration rate
GI glycaemic index
GIT gastrointestinal tract
GLP glucagon-like peptide
GnRH gonadotrophin-releasing hormone
GO gastro-oesophageal
GORD gastro-oesophageal refl ux
GP general practitioner
G-6-PD glucose-6-phosphate
GU gastric ulcer
HAV hepatitis A virus
anti-HAV hepatitis A antibody
Hb haemoglobin
HbA haemoglobin A
anti-HBc hepatitis B core antibody
HBeAg hepatitis B e antigen
anti-HBs hepatitis B surface antibody
HBsAg hepatitis B surface antigen
HBV hepatitis B virus
HCG human chorionic gonadotropin
HCV hepatitis C virus
anti-HCV hepatitis C virus antibody
HDL high-density lipoprotein
HEV hepatitis E virus
HFM hand, foot and mouth
HFV hepatitis F virus
HGV hepatitis G virus
HIV human immunodeficiency virus
HNPCC hereditary nonpolyposis colorectal cancer
HPV human papilloma virus
HRT hormone replacement therapy
HSV herpes simplex viral infection
IBS irritable bowel syndrome
ICE ice, compression, elevation
ICS inhaled corticosteroid
ICS intercondylar separation
ICT immunochromatographic test
IDDM insulin dependent diabetes mellitus
IDU injecting drug user
IgE immunoglobulin E
IgG immunoglobulin G
IgM immunoglobulin M
IHD ischaemic heart disease
IM, IMI intramuscular injection
inc. including
IPPV intermittent positive pressure variation
IR internal rotation
ITP idiopathic (or immune) thrombocytopenia purpura
IUCD intrauterine contraceptive device
IUGR intrauterine growth retardation
IV intravenous
IVI intravenous injection
IVP intravenous pyelogram
IVU intravenous urogram
JCA juvenile chronic arthritis
JVP jugular venous pulse
KA keratoacanthoma
kg kilogram
KOH potassium hydroxide
LA local anaesthetic
LABA long acting beta agonist
LBBB left branch bundle block
LBO large bowel obstruction
LBP low back pain
LDH/LH lactic dehydrogenase
LDL low-density lipoprotein
LFTs liver function tests
LH luteinising hormone
LHRH luteinising hormone releasing hormone
LIF left iliac fossa
LMN lower motor neurone
LNG levonorgestrel
LRTI lower respiratory tract infection
LSD lysergic acid
LUQ left upper quadrant
LUTS lower urinary tract symptoms
LV left ventricular
LVH left ventricular hypertrophy
mane in morning
MAOI monoamine oxidase inhibitor
mcg microgram (also µg)
MCV mean corpuscular volume
MDI metered dose inhaler
MDR multi-drug resistant TB
MI myocardial infarction
MRCP magnetic resonance cholangiography
MRI magnetic resonance imaging
MS multiple sclerosis
MSM men who have sex with men
MSU midstream urine
N normal
NAD no abnormality detected
NGU non-gonococcal urethritis
NHL non-Hodgkin's lymphoma
NIDDM non-insulin dependent diabetes mellitus
nocte at night
NSAIDs non-steroidal anti-inflammatory drugs
NSU non-specific urethritis
(o) taken orally
OA osteoarthritis
OCP oral contraceptive pill
OGTT oral glucose tolerance test
OSA obstructive sleep apnoea
OTC over the counter
PA posterior–anterior
PAN polyarteritis nodosa
Pap Papanicolaou
pc after meals
PCA percutaneous continuous analgesia
PCB post coital bleeding

PCL posterior cruciate ligament
PCOS polycystic ovarian syndrome
PCP pneumocystis carinii pneumonia
PCR polymerase chain reaction
PCV packed cell volume
PDA patent ductus arteriosus
PEF peak expiratory flow
PEFR peak expiratory flow rate
PET pre-eclamptic toxaemia
PFT pulmonary function test
PH past history
PID pelvic inflammatory disease
PLISSIT permission: limited information: specific suggestion: intensive therapy
PMS premenstrual syndrome
PMT premenstrual tension
POP plaster of Paris
POP progestogen-only pill
PPI proton-pump inhibitor
PPROM preterm premature rupture of membranes
PR per rectum
prn as and when needed
PROM premature rupture of membranes
PSA prostate specific antigen
PSIS posterior superior iliac spine
PSVT paroxysmal supraventricular tachycardia
PT prothrombin time
PTC percutaneous transhepatic cholangiography
PU peptic ulcer
PUO pyrexia of undetermined origin
pv per vagina
qds, qid four times daily
RA rheumatoid arthritis
RBBB right branch bundle block
RBC red blood cell
RCT randomised controlled trial
RF rheumatic fever
Rh rhesus
RIB rest in bed
RICE rest, ice, compression, elevation
RIF right iliac fossa
RPR rapid plasma reagin
RR relative risk
RSV respiratory syncytial virus
RT reverse transcriptase
rtPA recombinant tissue plasminogen activator
SAH subarachnoid haemorrhage
SARS severe acute respiratory distress syndrome
SBE subacute bacterial endocarditis
SBO small bowel obstruction
SBP systolic blood pressure
SC/SCI subcutaneous/subcutaneous injection
SCC squamous cell carcinoma
SCG sodium cromoglycate
SIADH syndrome of secretion of inappropriate antidiuretic hormone
SIDS sudden infant death syndrome
SIJ sacroiliac joint
SL sublingual
SLE systemic lupus erythematosus
SLR straight leg raising
SND sensorineural deafness
SNHL sensorineural hearing loss
SNRI serotonin noradrenaline reuptake inhibitor
SOB shortness of breath
sp species
SR sustained release
SSRI selective serotonin reuptake inhibitor
SSS sick sinus syndrome
stat at once
STI sexually transmitted infection
SVC superior vena cava
SVT supraventricular tachycardia
T3 tri-iodothyronine
T4 thyroxine
TB tuberculosis
tds, tid three times daily
TENS transcutaneous electrical nerve stimulation
TFTs thyroid function tests
TG triglyceride
TIA transient ischaemic attack
TIBC total iron binding capacity
TM tympanic membrane
TMJ temporomandibular joint
TNF tissue necrosis factor
TOF tracheo-oesophageal fistula
TORCH toxoplasmosis, rubella, cytomegalovirus, herpes virus
TPHA Treponema pallidum haemoglutination test
TSE testicular self-examination
TSH thyroid-stimulating hormone
TT thrombin time
TV tidal volume
U units
UC ulcerative colitis
U & E urea and electrolytes
µg microgram
UMN upper motor neurone
URTI upper respiratory tract infection
US ultrasound
UTI urinary tract infection
U ultraviolet
VC vital capacity
VDRL Venereal Disease Reference Laboratory
VF ventricular fibrillation
VMA vanillyl mandelic acid
VSD ventricular septal defect
VT ventricular tachycardia
VUR vesico-ureteric reflux
VWD von Willebrand's disease
WBC white blood cells
WCC white cell count
WHO World Health Organization
WPW Wolff-Parkinson-White
XL sex linked

Chapter (1)

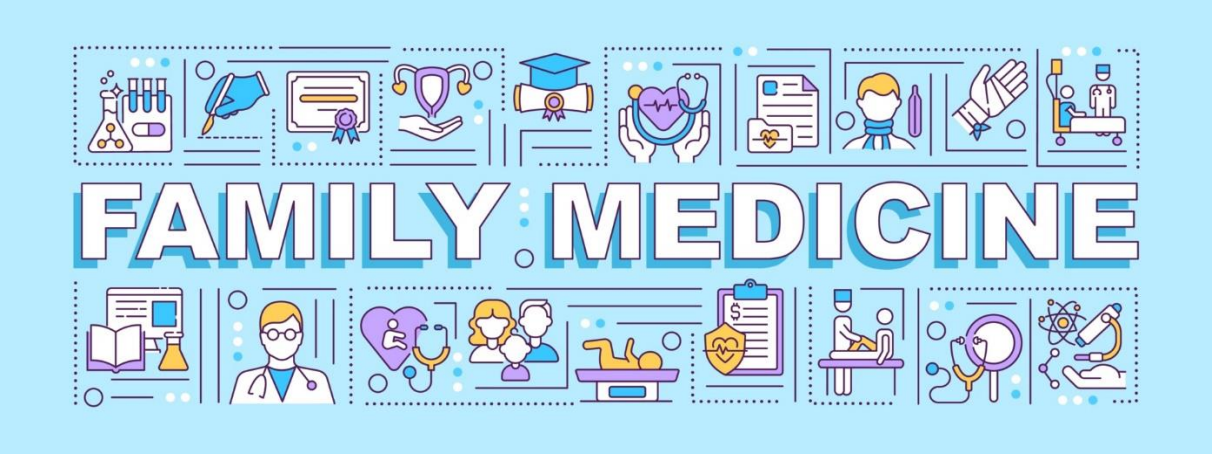
Family Medicine

- Family Medicine
- Diagnostic Process in Family Medicine
- Family Oriented Primary Care (FOPC)
- Community-Oriented Primary Care (COPC)
- The Sick Role, Illness Behaviour and Problem Behavior
- Setting Up a Practice
- Medical Records and Referral
- Emergency Care and The GP's House Call
- Continuing Medical Education for General Practitioners
- Continuing Professional Development
- Evidence- Based Decision Making in Family Practice
- Terminal/Palliative Care and Care of Cancer Patients in General Practice
- Family Violence

MODULE 1:

DEFINITION OF FAMILY MEDICINE

A specialty of medicine which is concerned with providing comprehensive care to individuals and families and integrating biomedical, behavioral and social sciences; an academic medicine discipline that includes comprehensive healthcare services, education and research; known as general practice in some countries.



Source : https://www.vecteezy.com/vector-art/2165375-family-medicine-word-concepts-banner

DEFINITION OF FAMILY DOCTOR OR FAMILY PHYSICIAN

A medical practitioner who is a specialist trained to provide healthcare services to all individuals regardless of age, sex, or type of health problem; provides primary and continuing care for entire families within their communities; addresses physical, psychological and social problems; coordinates comprehensive healthcare services with other specialists as needed; may also be known as a family physician.

DEFINITION OF FAMILY PRACTICE OR GENERAL PRACTICE

Healthcare services provided by family doctors; characterized by comprehensive, continuous, coordinated, collaborative, personal, family and community-oriented services, comprehensive medical care with a particular emphasis on the family units.

DEVELOPMENT OF FAMILY MEDICINE

Family practice is a relatively new area of specialization. The concept of this discipline evolved in 1960s in the UK and USA. In USA, family medicine evolved from general practice as a felt need in personal health care. American Board of Family Medicine (ABFM) conducts certified board examination and accreditate the quality of Family Physician. In UK, the same trend has been noticed in the introduction of a general practice as a specialty of the Royal College of General Practitioners with systematic training programmes or par with other Royal Colleges of the UK.

PRINCIPLES OF FAMILY MEDICINE OR THE ATTRIBUTES OF FAMILY DOCTORS

PRIMARY CARE

It is often used interchangeably with first level of care. The part of a health services system that assures person focused care overtime to a defined population, accessibility to facilitate receipt of care when it is first needed. Quality features of primary care include effectiveness, safety, people-centeredness, comprehensiveness, continuity and integration. When needed, patients and populations know the family doctor is the first point of access to Health Care System.

PERSONAL CARE (PEOPLE-CENTERED CARE)

Care that is focused and organized around the health needs and expectations of people and communities rather than on diseases. Person-centered care extends the concept of patient-centered care to individuals, families, communities and society. The family doctor provides personal health services targeted at the individual, including health promotion, timely disease prevention, diagnosis and treatment, rehabilitation, palliative care and acute-care and long-term care services.

PREVENTIVE CARE

The family physician views his or her practice as a "population at risk" and sees every contact with patients as an opportunity for disease prevention and health promotion. Prevention is central to Family Medicine and its key mission is preserving and promoting health and maximizing functions of patients throughout their lives. Most commitment preventive activity of a family physician is empowering patients in making healthy lifestyle changes.

CONTINUITY OF CARE

A term used to indicate one or more of the following attributes of care (i) the provision of services that are coordinated across levels of care-primary care and referral facilities, across settings and providers; (ii) the provision of care throughout the life cycle (iii) care that continues uninterrupted until the resolution of an episode of disease or risk (iv) the degree to which series of discrete health care events are experienced by people as coherent and interconnected overtime, and are consistent with their health needs and preferences.

COMPREHENSIVE CARE

The extent to which the spectrum of care and range of resources made available responds to the full range of health problems in a given community. Comprehensive care encompasses holistic care, multidisciplinary care, multifaceted care, multipurpose care, pro-active and reactive care, acute care and chronic care. It deals with the interface between illness and disease, and integrates the humanistic and ethical aspects of the doctor-patient relationship with clinical decision making.

COORDINATED CARE

As medicine becomes more and more specialized and sophisticated, the family physician's role as the integrator of health services becomes increasingly significant, by facilitating the patient's access to the whole health care system and interprets the activities of this system to the patient, explaining the nature of the illness, the implications of the treatment, the effects of both on the patient's way of life. (Role of conductor of an orchestra)

THE FAMILY AS A UNIT OF CARE (FAMILY ORIENTED PRIMARY CARE/FOPC)

The family physician recognizes the universal importance of the family and the influence of the family on health and disease. This is the reason why he or she focuses on family oriented primary care. Family Practice addresses the health problems of individuals in the context of their families.

COMMUNITY ORIENTED PRIMARY CARE (COPC)

Family medicine basically integrates individual healthcare and community healthcare virtue of practicing utilization of epidemiological data, screening, environmental health, population health through collected social actions, often provided by state or local health authorities. The family physician sees himself or herself as a part of community wide network of supportive and healthcare agencies. So, family physicians can be much more effective if they can deploy all the resources of the community for the benefit of their patients.

EVIDENCE- BASED PRACTICE

The rapid growth of clinical research over the past 30 years has necessitated the development of a new and different approach to the practice of Family Medicine. The evidence-based approach requires us to make conscientious, explicit and judicious use of the current best research evidence when making clinical decision for our patients. It also requires the integration of the best evidence with our clinical expertise and our patient's unique values and circumstances. (David Sackett)
The family physician has to practice Evidence based medicine (EBM) both in diagnostic reasoning of Hypothetico – deductive approach and management. Basically, there are seven steps of evidence-based practice: Cultivate, Ask, Search, Appraise, Integrate, Evaluate, Disseminate (pneumonic: CASAIED).

PATIENT EMPOWERMENT

Patient empowerment is not only one of the key elements of patient-centered care but also a major principle of Family Medicine. It is basically defined as a process that helps people gain control over their own lives and increases their capacity to act on issues that they themselves define as important. According to the WHO, it is a process through which people gain greater control over decisions and actions affecting their health. Patient Empowerment is processed through four main phases:

(1) patient enablement
(2) patient activation
(3) patient engagement
(4) patient involvement

Working from a similar conceptual framework, the College of Canada has defined four principles that underlie family medicine :-

1. The patient-doctor relationship (PDR) is central to family medicine.
2. The family doctor is an effective clinician.
3. Family medicine is community based.
4. The family doctor is a resource to a defined practice population.

ESTABLISHMENT OF WONCA

As the WHO was articulating a vision of health for all in the 1970, a significant evolution in the training of generalist physicians was occurring in countries around the world. Instead of being educated in an undifferentiated manner as in the past, generalist physicians, termed family doctors, were provided with postgraduate training specifically designed to prepare them to diagnose and treat the majority of the people's health problems within the context of the people's families and communities. These efforts received substantial reinforcement at the 5th world conference on General/Family Practice in Melbourne, Australia in 1972, when representatives of 23 countries established the World Organization of National Colleges, Academies and Academic Association of General Practitioners/Family Physicians (WONCA). Today, WONCA has over 100 member organizations including Myanmar representing family doctors from over 130 countries in all regions of the world. WONCA has expanded rapidly in recent years and now represents more than 300,000 family doctors worldwide.

SCOPE OF PRACTICE OF FAMILY DOCTORS

- Care for patients of all ages, from "womb to tomb"
- Ensure access to comprehensive primary and secondary services
- Manage infectious and chronic diseases
- Provide emergency, acute and long-term care
- Serve as clinicians, teachers, advocates and leaders
- Coordinate individual clinical, community and public health services

Further reading:

1. *The contribution of family Medicine to improving Health Systems (2nd Edition) Edited by Michal Kidd, WONCA, Radcliffe publishing (2013)*
2. *Text book of Family Medicine (9thEdition) Robert, E.Rakle et.al, Elsevier (2016)*

MODULE 2:

DIAGNOSTIC PROCESS IN FAMILY MEDICINE

- Traditional medical training teaches students to elicit an entire (thorough) history and then examine all the systems of the body before considering the provisional diagnosis (Inductive method of problem solving or diagnostic reasoning).
- From the moment the patient enters the room the family doctor starts to formulate hypotheses (Neighbour, 1987). First, allow the patient to tell his/her problem. Family doctors do not collect all the information from a thorough history, full examination and side room tests and then sit down to decide on a diagnosis. Rather it is a continuous process of hypotheses being formulated and tested from the start of the consultation. During one consultation, a number of working hypotheses may be created, tested and discarded. It is quite different from long exhausting lists of differential diagnosis.
- Diagnosis in family medicine (*Consultation skills, by Dr. Ekran A Jalali)*
    - Pattern recognition
    - Hypothetical deductive reasoning method
    - using Clinical epidemiology
    - Living with uncertainty
    - No diagnosis

(HYPOTHETICO-DEDUCTIVE METHOD OF PROBLEM SOLVING OR DIAGNOSTIC REASONING).

Example: -

The information	The Hypothesis
The patient complains of **shortness of breath**	***Asthma****?* The family doctor asks about history of asthma, wheeze/ cough and so on
The patient's answers are not consistent with asthma, but she does seem nervous	Hyperventilation due to ***anxiety?*** The family doctor asks about stress and feelings of anxiety.
The patient has not experienced more stress than usual lately and her anxiety is related to her fear of hearing a bad diagnosis	***Cardiac failure?*** The family doctor asks about change in effort tolerance/ orthopnoea/nocturnal dyspnoea and swollen ankles.
The patient confirms these cardiac failure symptoms.	The family doctor looks for signs and causes of cardiac failure

Initial Hypotheses should relate to the most probable cause in terms of high prevalence to family practice. And also serious hypothesis (high pay off) should be considered (Red Flag consultation).
(e.g. ***Red flags for low back pain*** *(Royal College of General Practitioners, 1997).*

1. *Presentations under 20 yrs of age or over 55 years*
2. *Thoracic pain*
3. *A past history of cancer, steroid use, or HIV*
4. *A feeling of being unwell, weight loss and night sweats*
5. *Neurological signs or symptoms*
6. *Structural deformity*
7. *Sphincter disturbance, gait disturbance and saddle anaesthesia.*

Hypotheses may be reformulated and tested between consultations.

PATTERN RECOGNITION

Combination of Hypothetico-deductive method (HDM) and pattern recognition (PR) is vital to the diagnosis in Family Practice.
Some conditions in family practice are common and you can easily recognize them at a glance, e.g. Shingles, Impetigo, Down Syndrome
Another example is a patient with alcohol problem who frequently asks for a sick certificate and presents with sexually transmitted infections (pattern-recognition).

REFERENCES:

1. Handbook of Family Medicine edited by Bob Mash, second edition, oxford university press.
2. Clinical Method edited by Robin C. Fraser, third edition, Butter worth/Heinemann Press (2008).

STUDY QUESTIONS (FOR HYPOTHETICO-DEDUCTIVE DIAGNOSTIC METHOD)

SCENARIO 1

Hla Hla is a university student, aged 21 years. She attends infrequently for minor illness and holiday immunizations. Today she enters looking well, but appears worried. She tells you she has had lower abdominal pain 'off and on' for some months, and that it 'has got a lot worse' over the last month. It is now present 'almost all the time'.

Q 1

What is your initial diagnostic hypothesis? Explain how you arrived at these.

Q 2

What questions would you want to ask to test your respective hypothesis? Explain how the questions might help you.

Sample Answer for Q 1

Pre diagnostic interpretations

Although the problem is chronic and getting worse, serious pathology is unlikely because she is well despite several months of abdominal pain. However, she is an infrequent attendee and today looks concerned, suggesting she is either worried by her symptoms or is finding they are beginning to interfere with her life. Her age would suggest she is in her final year at University approaching examinations. Accordingly, the most likely cause of her chronic lower abdominal pain could be either physical (GI cause or Gynecological cause) or psychological/social cause. (Bio-psychosocial approach of family medicine)

Hypotheses

Most likely	Less likely
Irritable bowel syndrome (IBS)	Pelvic inflammation disease (PID)
Anxiety state	

IBS is common in young females, is non-serious and you would expect the patient to look well. The pain would be of a recurrent chronic nature, and could be aggravated by the stress of examinations. There may be other worries in her life, e.g. boyfriend difficulties, which would induce anxiety and may present as abdominal pain. Her abdominal pain may itself have induced concern of serious underlying disease that may then have exacerbated it. PID is possible in a young sexually active female, but you as yet unaware of her sexual history and any associated infection.

Sample Answer for Q2

First, clarify the presenting symptom of abdominal pain. This will determine whether it is the same pain throughout, despite becoming worse. If not, you may be required to develop now hypotheses.

1. Site ± radiation. Generalized (lower) abdominal pain would support IBS and anxiety. Pelvic pain would be more supported of PID. Radiation is unlikely to be a feature of either.
2. Quality. A colicky pain would support IBS, a more constant pain would support anxiety and a dragging, constant pain would support PID.
3. Severity. This is likely to be very variable in both IBS and anxiety. The pain of IBS would tend to be either mild or moderate, whilst that of anxiety would tend to be either mild or moderate, whilst that of anxiety would be proportionate to the severity of the anxiety. PID is usually of mild to moderate severity, although it can, rarely, mimic an acute abdomen.
4. Periodicity. You already know the duration and progression of symptoms. You now need to look for alterations within the day or week. Association with food/mealtimes support IBS, times of increased stress would exacerbate the pain of anxiety, whilst increased pain related to her menses would support PID.
5. Precipitating, exacerbating or relieving factors. Is the patient aware of any change that has coincided with the onset or increases of the pain? Stress would aggravate or precipitate the pain of IBS and anxiety, whilst defecation might ease the pain in IBS. Sexual intercourse would aggravate PID pain (deep dyspareunia), whilst the coincidence of pain onset with a new partner might suggest the start of an infection.
6. Associated features. A variable bowel habit alternating between constipation and diarrhoea with abdominal distension, bloating, flatus or mucous per rectum supports IBS. Other symptoms of anxiety include disturbed sleep, palpitations and reduced appetite. Generalized systemic upset would suggest PID, which would further supported by a fever, change in menstrual cycle or vaginal discharge.
7. Confirm the patient's concerns and reason for attendance today. She might be finding the pain unbearable as it is now continuous. However, there may be underlying concerns about what the pain might signify, e.g. "Cervical cancer, that you would be unlikely to address unless mentioned by the patient." Ask and open question, e.g. "You look concerned about the pain, is there anything in particular worrying you?"

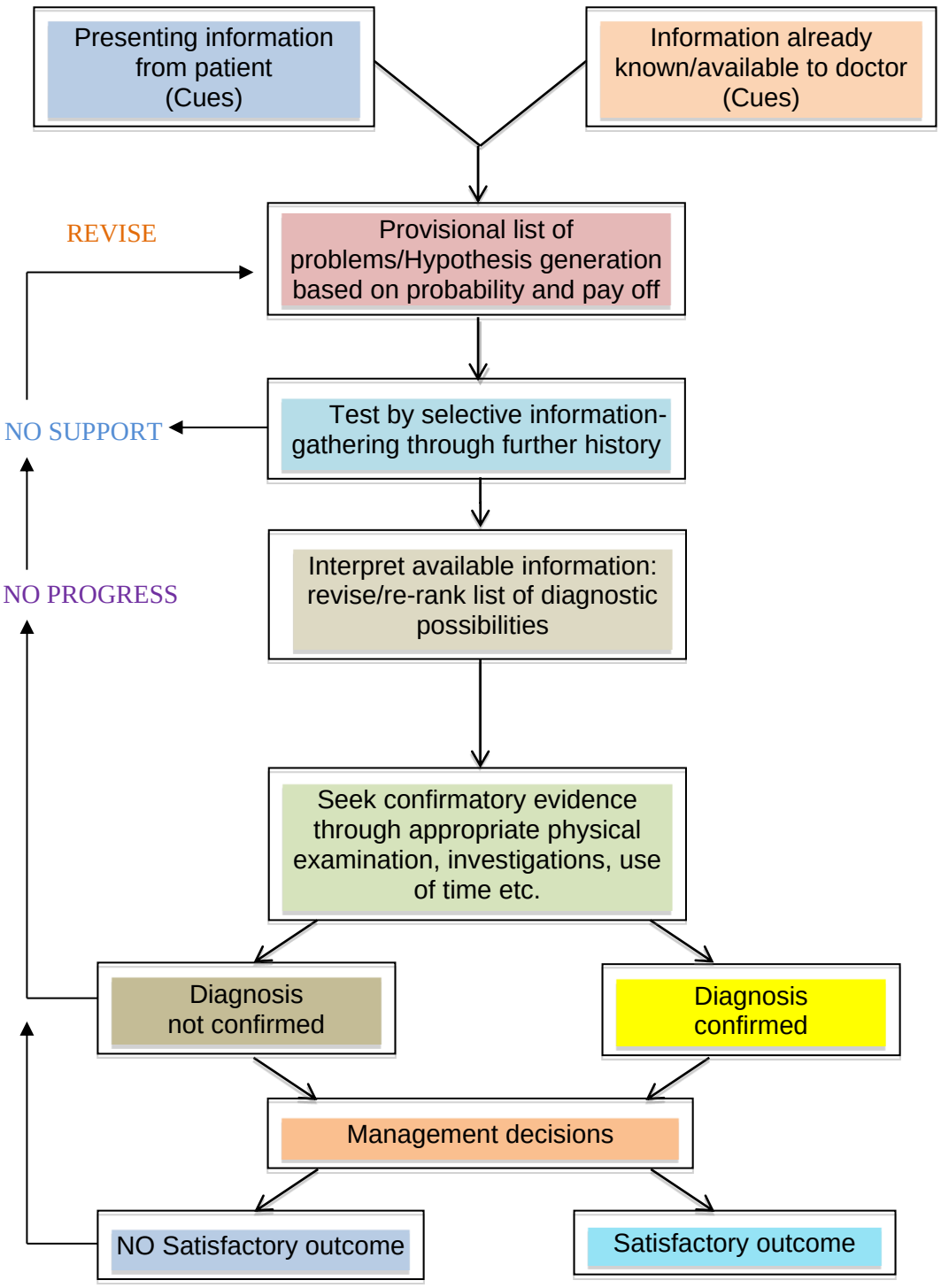
It would then be appropriate to search for specific associated feature relating to be search for specific associated feature relating to each hypothesis still being considered. In doing so, you would need to indicate to the patient the reasons for your particular line of enquiry (signaling), thereby giving implied consent to continue. IBS is recognized to have strong psychological component. You therefore need to explore psychological issues and their effects with appropriate sensitivity. Areas of enquiry would include her studies (remember she is probably nearing her final examinations), relatives and partner(s).

This would also help identify underlying cause of anxiety. If these are not forthcoming, you need to ask specifically about particular symptoms of anxiety.

To diagnose PID you would need to take a sexual history, including previous and present partners who may have put her at potential risk. Establishing her method of contraception is important, as only barrier methods offer protection against PID.

HYPOTHETICO-DEDUCTIVE METHOD OF PROBLEM SOLVING

(SOURCE: ELSTEIN ET.AS., 1978)



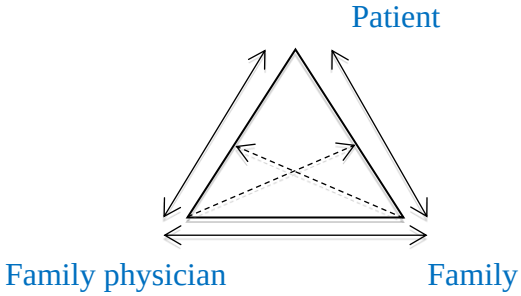
MODULE 3:

FAMILY ORIENTED PRIMARY CARE (FOPC)

The family physician provides family oriented primary care (FPOC) by mobilizing the patient's natural support system to enhance health and well-being.

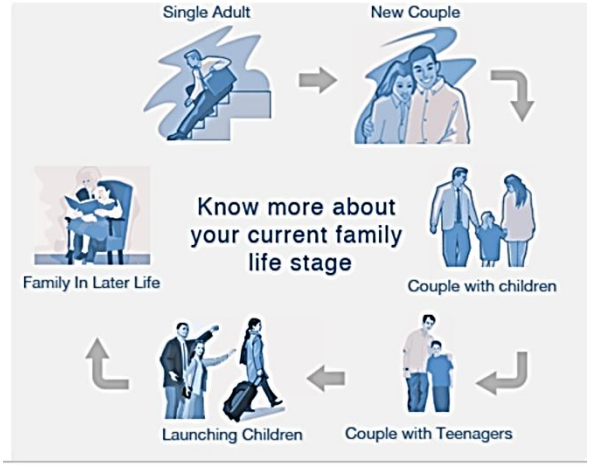
BASIC PREMISES OF FAMILY-CENTERED MEDICAL CARE:

1. Family-oriented healthcare is based on a biopsychosocial systems approach.
2. The primary focus of healthcare is the patient in the context of the family.
3. The patient, family and family physician are partners in the form of triad.



The therapeutic triangle in Family Medicine

4. The family-oriented clinician reflects on how he or she is part of the treatment system.



I. LEARNING TO THINK FAMILY

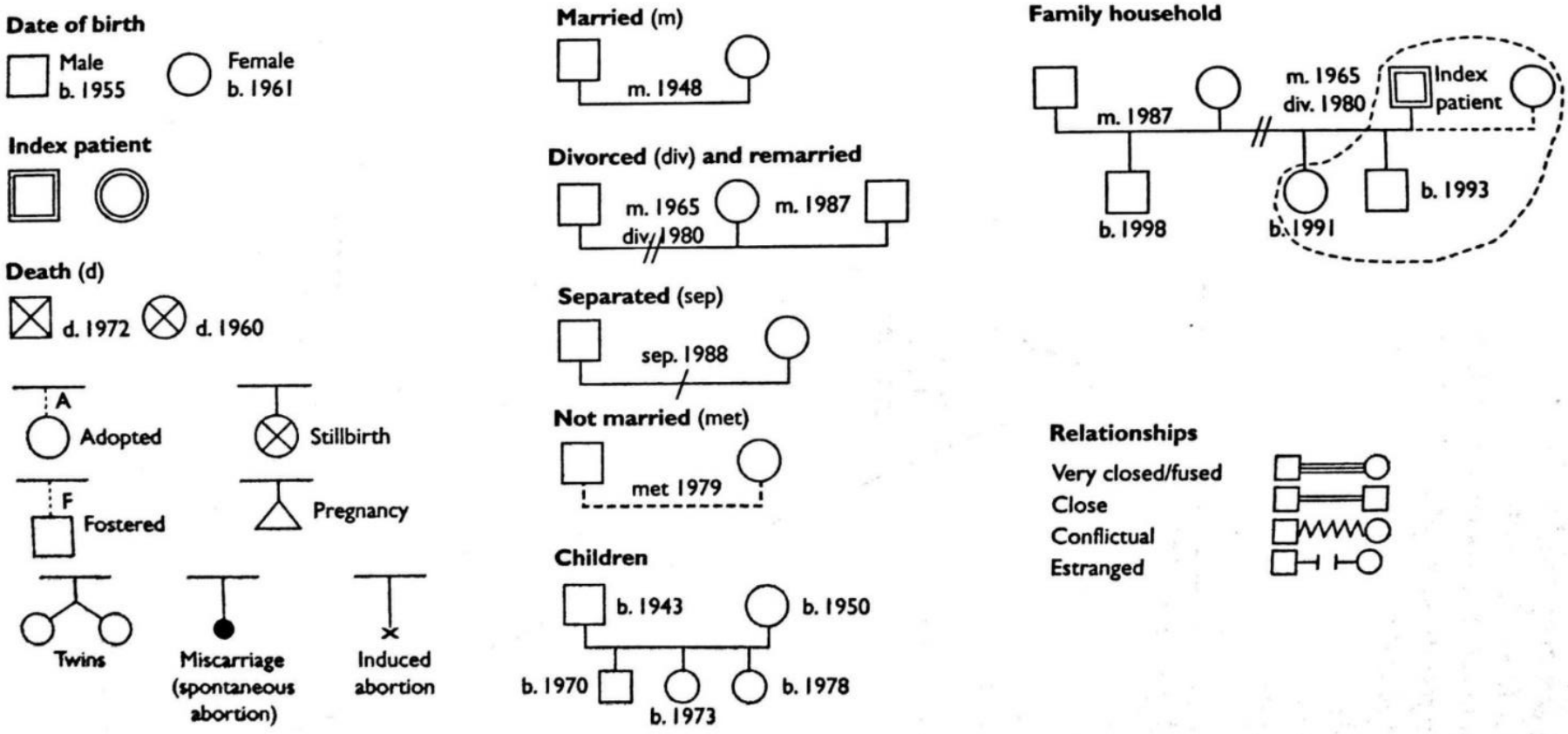
Five helpful questions when 'thinking family' (adapted from Cole-Kelly, 2005)

1. Has anyone else in the family had a similar problem? ***(EXPERIENCE)***
2. What do family members believe caused the problem and how do they think it should be treated? ***(BELIEF AND IDEA)***
3. Who in the family is most concerned about the problem? ***(CONCERN)***
4. Have there been any other recent changes or stresses in your life? ***(TRAUMA)***
5. How can your family or friends help you in dealing with this problem? ***(SUPPORT)***

II. THE IMPORTANCE OF THE GENOGRAM

- The genogram is an essential tool in the practice of family-oriented primary care (FOPC).
- **Drawing a genogram** and identifying the value of a genogram is essential skills for a family physician.

Figure 4.2 Genogram conventions



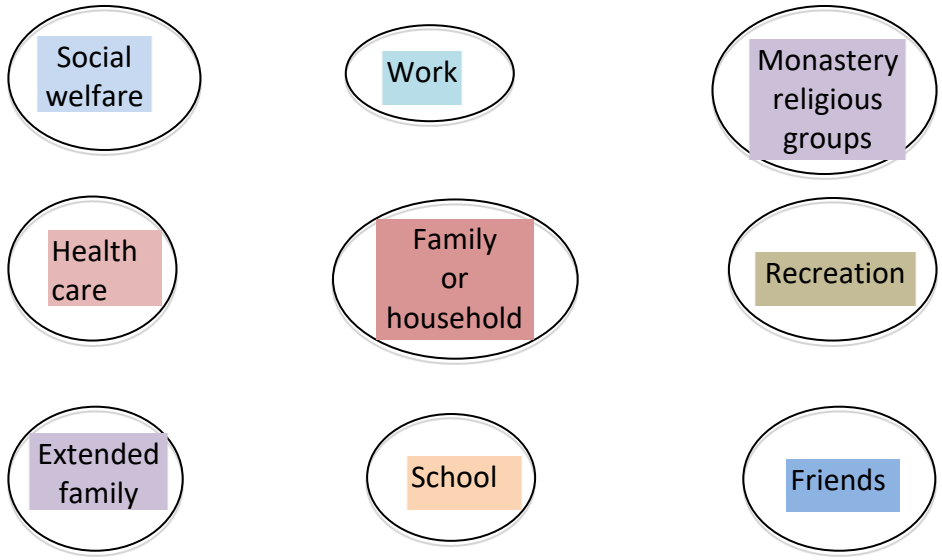
NOTE: Enter the date of the genogram and family name clearly

III. The family within a larger system _ use of an ecomap

The ecomap is one way of diagrammatically assessing the larger system within which a family operates.

ECOMAP CONVENTIONS

Name.....
Date.....



Fill in connections where they exist. Draw different kinds of lines:
———— for strong, --------- tenuous, and - - - - - - for stressful.

IV. CHRONIC ILLNESS AND DISABILITY _ SUPPORTING FAMILY CAREGIVERS

- formulate a three stage assessment of the problems.

A framework for three stage assessment and managements (adapted from Fehrsen & Henbest 1993)

	Assessment	Management plan
Clinical		
Individual		
Contextual		

THE CLINICAL COMPONENT

This is the medical part of the assessment, based on the symptoms, signs and investigations, relating to the patient's disease. This is recorded at the highest level of certainty.

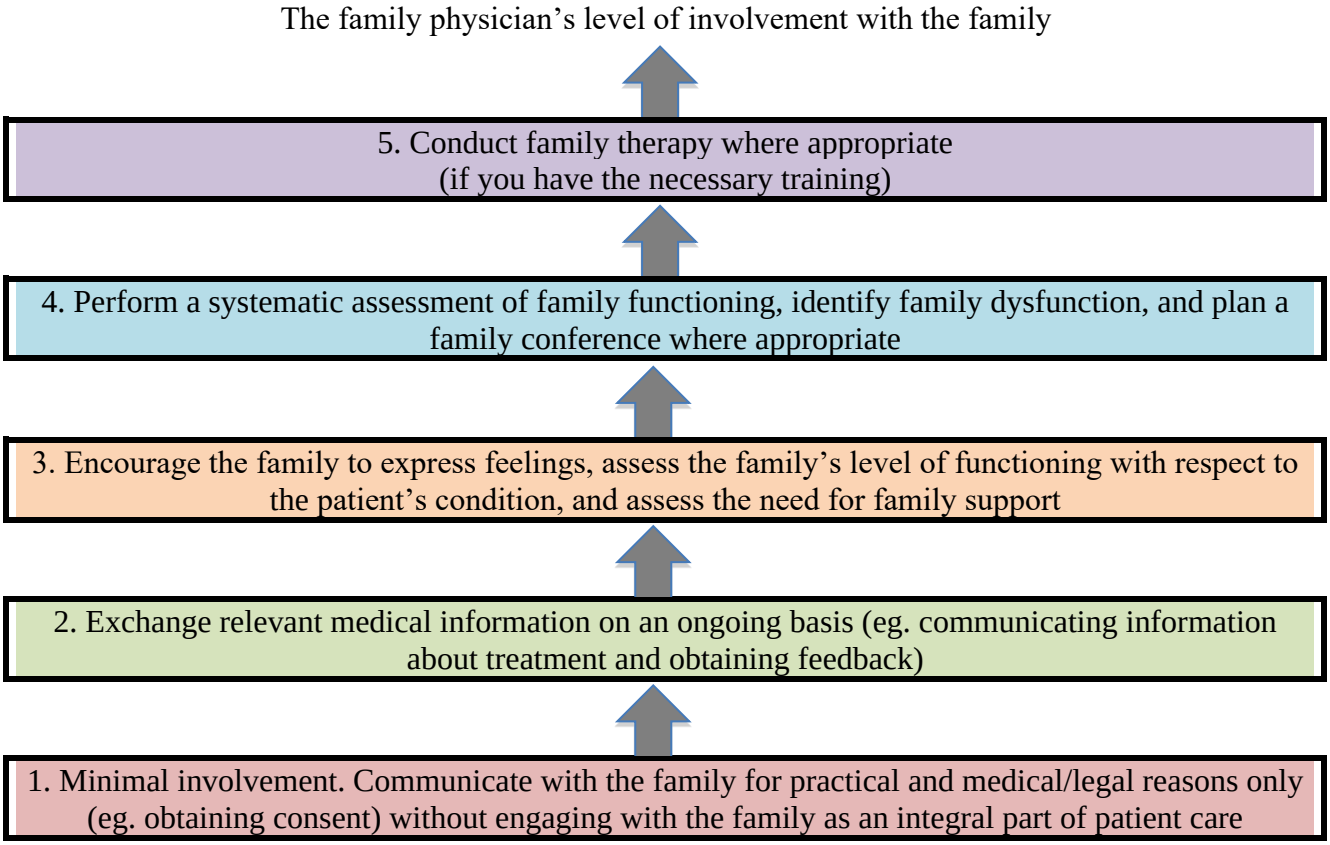
THE INDIVIDUAL COMPONENT

This is the assessment of how the patient is experiencing the illness. It is his/her perception of the problem. It includes the patient's key ideas, fears, expectations, loss of functions and any other important emotions or reactions.

THE CONTEXTUAL COMPONENT

This is the assessment of the patient's environment and how it affects the patient, as well as how the illness impacts on the environment. It includes the person's family, life stage, work, community, environment, and so on.

V. WORKING WITH FAMILY MEMBERS _ THE FAMILY CONFERENCE



Each level beyond level 1 requires additional knowledge, personal development, and skills
SOURCE: Adapted from Doherty and Baird (1986)

VI. IDENTIFYING THE FAMILY AT RISK

Family physicians play an important health promotion role. Attending to personal and family health needs shifts the focus from illness and disease to maintaining and promoting health.
Six Questions to assess family health and identify the family at risk (McWilliam, 1993)

1. What does health mean to this family?
2. What does this family need to maintain or restore its health?
3. Are there any physical, psycho-emotional, or socioeconomic threats to the health of this family? How can I help this family to overcome them.
4. What capacity does this family have to make healthy choices?
5. What does this family need from society to optimize its health?
6. How can I promote a balance between the family needs and expectations and the constraints of the healthcare system.

To consider the key aspects of family functioning, the family physician should use the acronym:
PRACTICE (Christie-Seely 1984)

P – **P**resenting problem
R – **R**oles
A – **A**ffect

C – **C**ommunication patterns
T – **T**ime in life cycle
I – **I**llness history
C – **C**oping with stress
E – **E**cology and culture

FAMILY ASSESSMENT

- Being a family physician, family assessment begins with the first visit and is a continuous process.
- It is important to interview all family members at the same time to observe communication and decision- making patterns.

COMPONENTS OF FAMILY ASSESSMENT

(1) ASSESS EACH FAMILY MEMBER'S HEALTH

(2) ASSESS FAMILY'S HEALTH HISTORY

- Complete a genogram (Family anatomy)

- Include at least two generations back

- Include ages at death and cause of death

- Note patterns of illness distribution across generations (for example: cancer)

(3) ASSESS FAMILY STRUCTURE

- Single, nuclear, nuclear dyad, extended and/or Multigenerational, Single parent, Step family, same gender

(4) ASSESS FAMILY ROLES (FRIEDMAN, 1992)

Format:

- Breadwinner(s)
- Homemaker(s)
- Childrearer(s)
- Financial Manager(s)
- Chauffeur(s)
- Cook(s)
- House repair

Informal roles (Selected)

- Encourager (praises defers)
- Harmonizer (mediator)
- Blocker (opposer)
- Compromiser (yielder / comes halfway)
- Blamer (Faultfinder)
- Scapegoat (recipients of family hostilities)
- Caregiver (nurturer)

Identify the (Alliance and Coalition)

(5) Assess family health

- Concepts of health and illness
- Perceived level of health
- Family health promotion Strategies
- Family Stressors
- Family Strengths
- Support Systems
- Family diet, mealtime practices, who prepares meals
- Family activities
- Time taken for sharing
- Spirituality
- Participation in the Community

- Is has a place for respite, for nurturing?

- Health-seeking behaviours:

- Physical examinations, dental care, family physician, emergency department use, immunization status

- Source of insurance, adequacy of coverage

(6) Assess Family income

- Source (s)
- Adequacy

(7) Assess Family power (Friedman, 1992)

1. Assess who makes decisions about

Household management
Discipline of children
Financial matters
Health care
Family leisure time activities

2. Assess who makes the decision and/or wins when major decisions are made

3. Assess type and sources of power used by family

4. Legitimate: One person is the authority / and this authority is believed by all family members to be appropriate.

5. Helpless and/or powerless: The victims (disabled family members or the children, for instance) gain.

- Referent Power: power gained From Family member's positive identification (parental power)
- Resource and/or expert power: Power is based on who has the most resources (attributes, possessions, expertise). For example, Family member who controls the finances may control decision making in general
- Reward power: When one family member has the power to reward other members
- Coercive power: When power is gained through the use of violence, threats. or coercion
- Informational power: power gained by persuasion
- Affective power: When power is gained by controlling the allocation of affection or sex
- Torsion management power: When power is gained through the use of teas, disagreements or pouting

(8) Assess power or decision- making process

- consensus: mutual agreement
- accommodation: concessions made
- De facto: no decision made

(9) Assess family communication patterns (Clark, 1999)

* Dysfunctional patterns:

- **The Wheel**: one person directs all Communication
- **The Chain:** Communication goes down the ling without opportuning for interaction
- **The isolate:** One person excluded

* Functional pattern of communication:

- The switchboard fair (Communication between all members in all directions)

(10) Assess Family developmental Stage

(Stanhope and Lancaster, 1996)

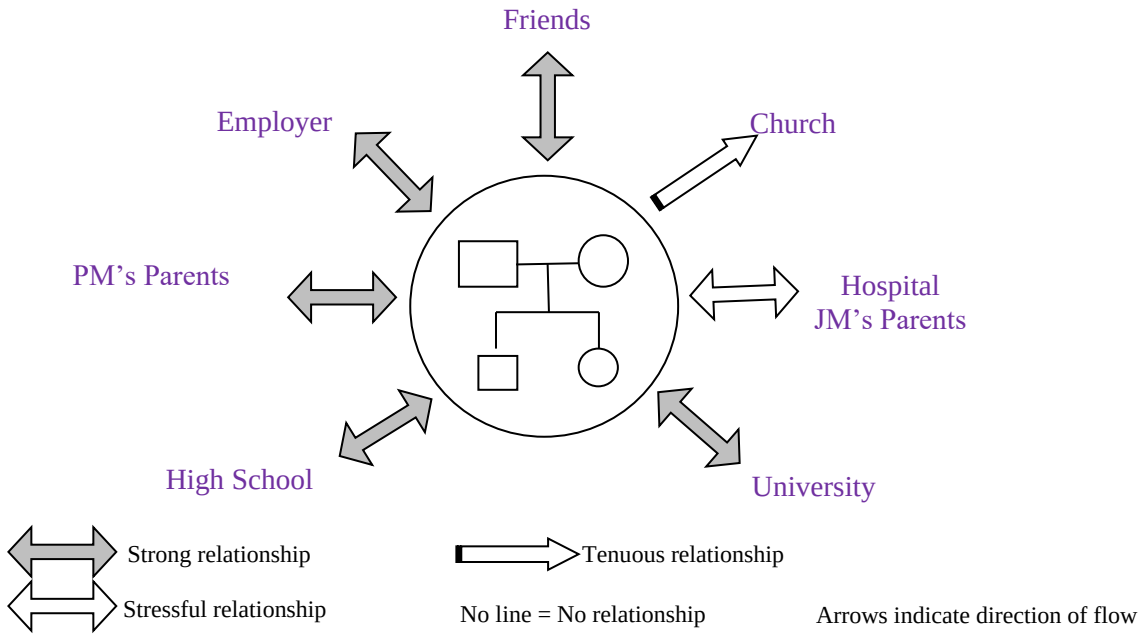
- Beginning Family: Establish marriage
- Early child bearing family: Stabilize family, facilitate developmental needs of family members
- Family with preschool children: maintain marriage, nurture and socialize children
- Family with school-age children: maintain marriage/ socialize children and promote their school achievement
- Family with teenagers: maintain marriage, maintain parent-child communication, build foundation for future family stages, balance teen freedom/responsibility
- Launching family: readjust marriage/ Launch children as young adults, assist aging parents
- Middle-age family: Strengthen marriage, maintain relationship with children/parents, provide healthy environment, cultivate leisure activities

- **Aging Family**: Adjust to retirement, reduced income, health problems, death of spouse: maintain satisfactory living assessment.

- Parenting practices:

- Hopes and plans for children
- Uses parenting styles learned from own parents
- Disciplines children
- Empowers children
- Develops positive attitudes in children toward education, religion, athletics, extra-curricular activities
- Role models for children and teaches altruism, respect for alters.
- Draw ECOMAP depicting family in the center circle with spokes drawn to interacting systems.

Depict direction of emergency exchange and presence of stressful of tenuous relationships.



(11) FAMILY CAREGIVER ASSESSMENT

When are family member is ill or disabled another family member often takes over the role of family caregivers. In home health setting, that role often makes the difference as to wider the family member can remain at home. The family medicine physician in those settings will need do conduct either a complete family assessment or at least the following/mole focused family caregiver assessment especially chronic debilitating illness like STROKE.

Overview

- Age
- Relationship to care recipient
- Number of months since onset of care giving
- Number of hours per day spent in care giving
- Feelings toward care giving: Both negative and positive, advantages and disadvantages.
- Knowledge of care recipient's care needs (physical and emotional)
- Knowledge of care recipient's Medications
- Knowledge of what is involved in the care
- Evaluation of welter care recipient can be left alone
- Evaluation of what care recipient can do for himself or herself.
- Evaluation of whether the care recipient's dependency has increased in the last month
- Personal medical problems
- Personal medications
- Personal illness patterns
- Personal sleep patterns: Length, pattern of interrupted or uninterrupted sleep, place for caregiver to sleep
- Personal nutrition
- Personal exercise
- Personal stress reduction activities
- Frequency of leaving the home, purpose, duration
- Availability and use of respite services: hospital, nursing facility, family, friends, church
- Number of times in last year care recipient has been hospitalized
- Number of times in last year care recipient was hospitalized to provide caregiver with needed rest
- Assistance caregiver identifies as being needed

Family Medicine is one of academic disciplines.

UNDERSTANDING THE FAMILY

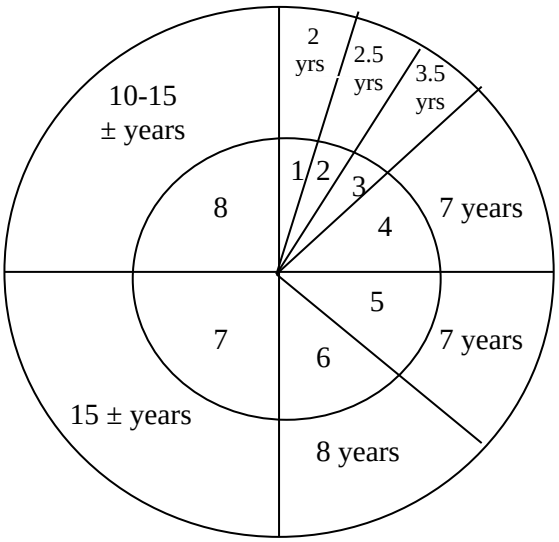
The importance of the family-to-family physician is inherent in the paradigm of Family Medicine. Family Medicine does not separate disease from person or person from environment.

THE INFLUENCE OF THE FAMILY ON HEALTH AND DISEASE

The family has six main effects on the health of its members.

1. Genetic influences
2. The family is crucial in child development
3. Some families are more vulnerable to illness than others
4. Infectious diseases spread in families
5. Family factors affect morbidity and mortality in adults
6. The family is important in recovery from illness

The Family Life Cycle (David Duvall, 1977) (or) Stages of family life cycle



1. Married couples (without children)
2. Childbearing families (oldest child, birth – 30months)
3. Families with preschool children (oldest child 30months – 6years)
4. Families with schoolchildren (oldest child 6 – 13years)
5. Families with teenagers (oldest child 13 – 20years)
6. Family launching young adults (first child gone to last child leaving home)
7. Middle-aged parents (empty nest to retirement)
8. Aging family members (retirement to deaths of both spouses)

An understanding of the family life cycle, together with an understanding of individual development, can help a family physician form good hypotheses about problems patients are experiencing. American Sociologist David Duvall (1977) has developed an eight-stage schema of the family life cycle. In this cycle, the family goes through a number of predictable transitions: marriage, childbirth, school years and adolescence, school graduation and starting work or further education, children leaving home, involution, retirement, widowhood. Families also experience unexpected crises that demand adaptive responses: illnesses, accidents, divorce, loss of job, death of a family member.

Developmental Tasks:

Stages of the Family Life Cycle	Positions in the Family	Stage-Critical Family Development Tasks
1. Married Couple	• Wife • Husband	• Established a mutual satisfying marriage • Adjusting to pregnancy and promise of parenthood • Fitting into the kin network
2. Childbearing	• Wife→ Mother • Husband→ Father • Infant: daughter or son or both	• Having, adjusting to, and encouraging the development of infants • Establishing a satisfying home for both parents and infants
3. Preschool age	• Wife – Mother • Husband - Father • Daughter - Sister • Son - Brother	• Adapting to the critical needs and interests if preschool children in stimulating, growth-promoting ways • Coping with energy depletion and lack of privacy as parents
4. School age	• Wife – Mother • Husband - Father • Daughter - Sister • Son - Brother	• Fitting into the community of school-age families in constructive ways • Encouraging children's educational achievement
5. Teenage	• Wife – Mother • Husband - Father • Daughter - Sister • Son - Brother	• Balancing freedom with responsibility as teenagers mature and emancipate themselves • Establishing post-parental interests and careers as growing parents
6. Launching centre	• Wife-mother-grandmother • Husband-father-grandfather • Daughter-sister-aunt • Son-brother-uncle	• **Releasing young adults into work**, military service, marriage, etc., with **appropriate rituals and assistance**
7. Middle-aged parent	• Wife-mother-grandmother • Husband-father-grandfather	• **Rebuilding the marriage relationship** • Maintaining kin ties with older and younger generations
8. Aging family members	• Widow-Widower • Wife-mother-grandmother • Husband-father-grandfather	• Coping with **bereavement and living alone** • Closing the **family home or adapting it to aging** • Adjusting to retirement

FAMILY ORIENTED PREGNANCY CARE: THE BIRTH OF A FAMILY

Pre-pregnancy

- Encourage the couple to discuss their ideas and plans regarding pregnancy and children.
- Evaluate the extended family and their attitudes about pregnancy.
- Briefly assess where the couple is in the family life cycle and how they have negotiated the tasks of previous stages.
- Review biological and psychological risk factors.
- Support health habits.

First Trimester

- Explore whether pregnancy was desired or planned, and whether there are any thoughts of terminating pregnancy.
- Find out about social supports (e.g., father of child, parents, siblings, friends), and how these people feel about the pregnancy.
- Invite the father of the baby to all prenatal visits.
- Involve the father early on in the pregnancy.
- Be positive and direct about your need for the father to participate in prenatal care.
- Emphasize the importance of the father in the care of the pregnancy; stress the benefits of the partner's involvement to the patient and the pregnancy.
- Offer to call the partner yourself if needed.
- Request that the father come in for one prenatal visit, just to listen, without asking him to participate.

- Meet with the couple.
- Establish rapport with the father at the very beginning of the visit. Ask about his work, hobbies, or other interests.
- Acknowledge the father's importance throughout the pregnancy and after delivery. Use him as a consultant and ask him how he thinks the pregnancy is going.
- Encourage the father to attend prenatal visits whenever possible, and to listen to the fetal heartbeat.
- Suggest that the father also attend to his health.
- When there are signs of marital conflict, acknowledge the stress of pregnancy on a marriage.

Second Trimester

- Elicit the couple's concerns and fears about the pregnancy, especially regarding possible complications of labor or delivery, pain during labor, and birth defects.
- Have the couple go together for any necessary tests, especially ultrasound.
- Invite important family members and friends to prenatal visits. Consider having the woman's mother come for a visit.
- Discuss sexual issues of pregnancy with the couple, including the safety of intercourse throughout pregnancy and the use of different positions.
- Begin the discussion of breastfeeding early on, and provide information about its benefits to the baby and the family.
- Encourage the couple to take a minivacation or "second honeymoon" alone together during the second trimester; suggest that the father schedule one or two weeks of paternity leave for the time of delivery.
- Find out what the couple has told or plans to tell the other child(ren) about the pregnancy.
- Discuss with the couple how they want their children involved in the labor and delivery.
- Help parents anticipate sibling rivalry and regressions in development of siblings of a new baby (e.g., bedwetting, thumbsucking) and offer some suggestions.

Third Trimester

- Provide anticipatory education about mother's and father's roles during labor and delivery.
- Discuss ways for the father to be supportive to the mother during labor and delivery.
- Make preliminary decisions about: where to labor and deliver pain medication breast feeding circumcision

Labor and Delivery

- Encourage families to use family birthing centers, when available.
- Avoid interventions such as enemas, fetal monitoring, IVs, and medication, unless clearly indicated. Encourage the father to take an active role in assisting during labor.
- Recommend continuous support throughout labor.
- If the delivery is uncomplicated, encourage the father to assist as much as he likes (e.g., helping to deliver the baby's head or to cut the umbilical cord); encourage nursing as soon as it is desired.
- Clearly explain to the couple what is happening, especially if complications arise. Allow the father to be present for a Cesarian section if it is required.
- Examine the baby at the bedside and explain normal findings to both parents; when birth anomalies are present, inform parents immediately, but stress the overall health of the baby.

Postpartum

- Encourage feeding on demand and rooming-in, and avoid supplementing breastfeeding; if the mother is having difficulty with breastfeeding, observe a feeding to see what the problems are.
- Encourage siblings to visit when the mother and infant are in the hospital.
- Conduct the newborn's discharge physical at the mother's bedside, and have the couple participate in the examination.
- At 2 weeks, make a home visit to assess how the infant feeding is going and the new family is coping.

Infertility

- Provide education.
- Encourage communication.
- Keep it in perspective.
- Acknowledge the stress.
- Acknowledge the grief.
- Mobilize resources.
- Develop a loving story.

Adoption

- Review motivation for adoption and address any unresolved grief over failure of infertility treatment (if applicable).
- Educate about options for adoption and use knowledge of the family to facilitate appropriate referral.
- Be proactive about addressing risks of adoption and making expectations realistic.
- Acknowledge both emotional and financial stresses.
- Encourage parents to tell their adopted child that they are adopted in an age-appropriate way.
- Provide anticipatory guidance and attend to special cross cultural/ethnic issues; encourage parents to adopt a dual-culture identity.

FURTHER READING

1. *Text book of Family Medicine, 9th Edition, Robert.E.Rakel et.al, Elsevier.2016*
2. *Behavioral Medicine: A Guide for Clinical Practice 3rd Edition, Mitchell D. Feldman, Mc,Graw Hill,2008.*
3. *Family Oriented Primary Care, 2nd Edition,Susan H,Mc.Daniel et.al, Springer, 2005*
4. *Essential Family Medicine: Fundamentals and case studies, 3rd Edition, Robert.E.Rakel et.al, Elsevier,2009.*
5. *Handbook of Family Medicine, Edited by Bob Mash, Oxford University Press, SA, 2007.*
6. *Practical Guide to Health Assessment, through the life span (3rd Edition)*
7. *Mildred O. Hogstel, Linda Cox Curry, (2001.F.A Davis Company)*

MODULE 4:

COMMUNITY-ORIENTED PRIMARY CARE (COPC)

A continuous process by which primary health care is provided to a defined community on the basis of its assed health needs, by the planned integration of primary care practice and public health.(Abramson,1988)
A systemic approach to improving primary health care service through integrating clinical medicine with public health at community level. (Abramson, Nutting, Kark), view
The family physician seeks to understand the context of the illness, view his/her practice as a population at risk, is part of community-wide network of supportive and health care agencies, and is a manager of resources. (Mc Whinney, 1981)

COMPONENTS OF COPC

1. Defining a community by geographical, demographic or other characteristics (defining practice population)
2. Determine the health needs of the community in a systematic manner.
3. Identifying and prioritizing health problems
4. Developing programs to address priorities within the context of primary health care.
5. Assessing outcome.

COPC is a combination of primary care and community care.

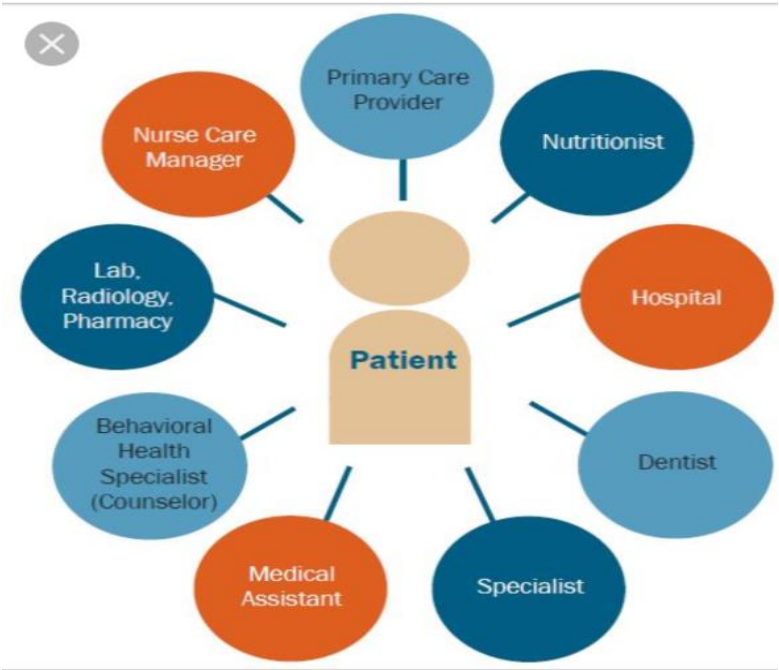
Domain	Primary Care	Community Care
Focus of care	Patients seen as individuals Focus an active users	Member of a population Active and inactive users
Assessment Method	Patient-oriented clinical skills	Epidemiological skills
Planning bias	Utilization by active users	Health needs of community
Personnel	Family physicians, Specialists, and ancillary staffs	Community groups and family physicians
Interventions	Individualized patient education and treatment	Community outreach prevention programmes
Evaluation	Health of the individual patient	Health status of an identified population

A STEP-WISE APPROACH TO COPC

Step 1 Practice profile	Work out (ten) commonest clinical problems presenting to a practice, clinic, ward, or hospital
Step 2 Individual assessment	Find a patient (or patients) with that problem, and understand the individual(s) in detail
Step 3 Home visit	Visit that patient's home, then describe the family and the context in which the illness developed
Step 4 Community assessment	Define/describe the community e.g: denominator data, resources, structures and functioning.
Step 5 Priorities	Identify and prioritize health problems in the community

Step 6 Team formation	Convene a team appropriate to the priority issue in consultation with the district management team or interest groups
Step 7 Plan for action	Plan and complement activities that address the most important problems
Step 8 Evaluation	Evaluate what has happened in terms of the experiences of individuals patients

COPC integrates individual and population-based care, blending the clinical skills of the family physician with epidemiology, preventive medicine and health promotion. The sequence is a dynamic process that may not be linear. The main point is that this process is designed to improve the health of a population through systemic application of principles that have been shown to have health benefit for communities.



FURTHER READING

1. *The contribution of Family Medicine to improving health systems, edited by Michael Kidd. WONCA Paddiffle publishing.2013 WONCA*
2. *Handbook of Family Medicine, Edited by Bob Mash,2nd Ed, Oxford University press, South Africa, 2007*
3. *Family Medicine Module of DFM by family Medicine core faculty,2004*

MODULE 5:

THE SICK ROLE, ILLNESS BEHAVIOUR AND PROBLEM BEHAVIOUR

These three concepts are helpful in analyzing the decision to consult a physician.

1.The concept of the sick role (Sigerist 1960 and Talcott Parsons 1951).

When a person has consulted a physician and been defined as sick, he or she occupies a special role in society. Entering the sick role has certain obligations and privileges. The individual is exempted from normal social obligations and is not held responsible for his or her incapacity. On the other hand, the sick person is expected to seek professional help and to make every effort toward recovery. Whether or not a person decides to enter the sick role when he or she becomes ill is dependent on many individual and group factors that are independent of the severity of the illness.

2. The concept of illness behavior (Mechanic 1962).

The ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons. The illness behaviour exhibited by an individual determines whether or not he or she will enter the sick role and consult a physician. An understanding of illness behaviour can change the physician's perspective "why did the patient come?"

3.The problem behavior (Lamberts 1984).

The action of a patient with a problem of living as distinct from an illness is regarded as the problem behaviour.

Variation in illness behaviour:

a) Under-reporting of serious symptoms and consultation for minor symptoms:-

In the Glasgow survey, failure to consult for serious symptoms was associated with unemployment due to illness, passive religious allegiance, lower social class, living alone, and higher neuroticism scores.

b) Self care and other alternatives to medical care

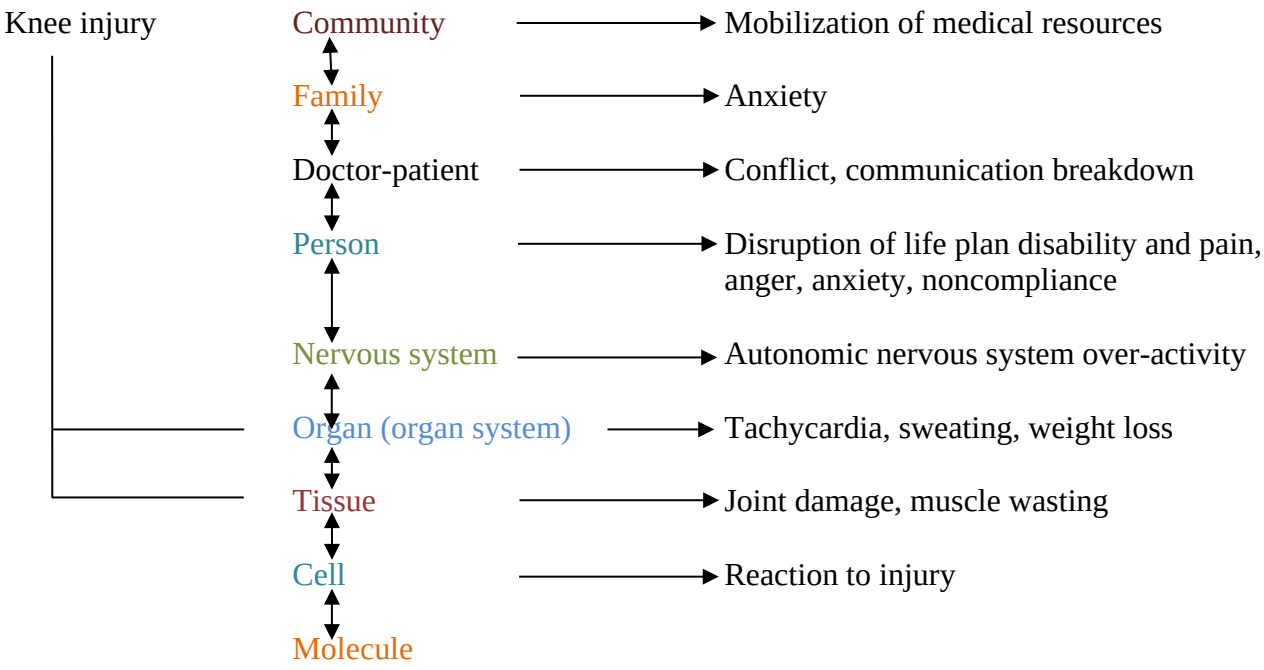
1. High rates of self-medication (between 50-80% of adults reported taking an OTC medication in a 2-4 weeks period. (Freer 1978).
   In Myanmar, the so-called pharmacists (Combo-pack sellers) are often resources of advice to community. The reason of utilization is easy accessibility, low cost and other multifactorial factors. (The most common of these were URTI, stomach and bowel complaints, pain and enquires about vitamins.)
2. Although most attention has been focused on medication, a large number of other remedial actions may be taken. In a study using the health diary method, a large number of nonmedical actions were reported. Some of these were social actions, like talking to friends or relatives, attending a club, or going out for meal.
3. There may be lay referral, or consultation with family members, friends, neighbors, and other nonprofessional people whose advice may be sought. Certain individuals in a neighborhood may have a reputation for being knowledgeable in health matters.
4. Folk healers and practitioners of alternative medicine are widely available in most societies. They may be used as the initial source of care, or as an additional resource when the health care system has not met the patient's expectations.

THE BIOPSYCHOSOCIAL MODEL OF ILLNESS (ENGEL, 1980)

Let's see a following example of a young woman of nineteen injured her knee while playing and admitted to hospital for surgery.

SYSTEMS HIERARCHY

PATIENT'S LIFE IN SYSTEMS TERMS BEFORE KNEE INJURY

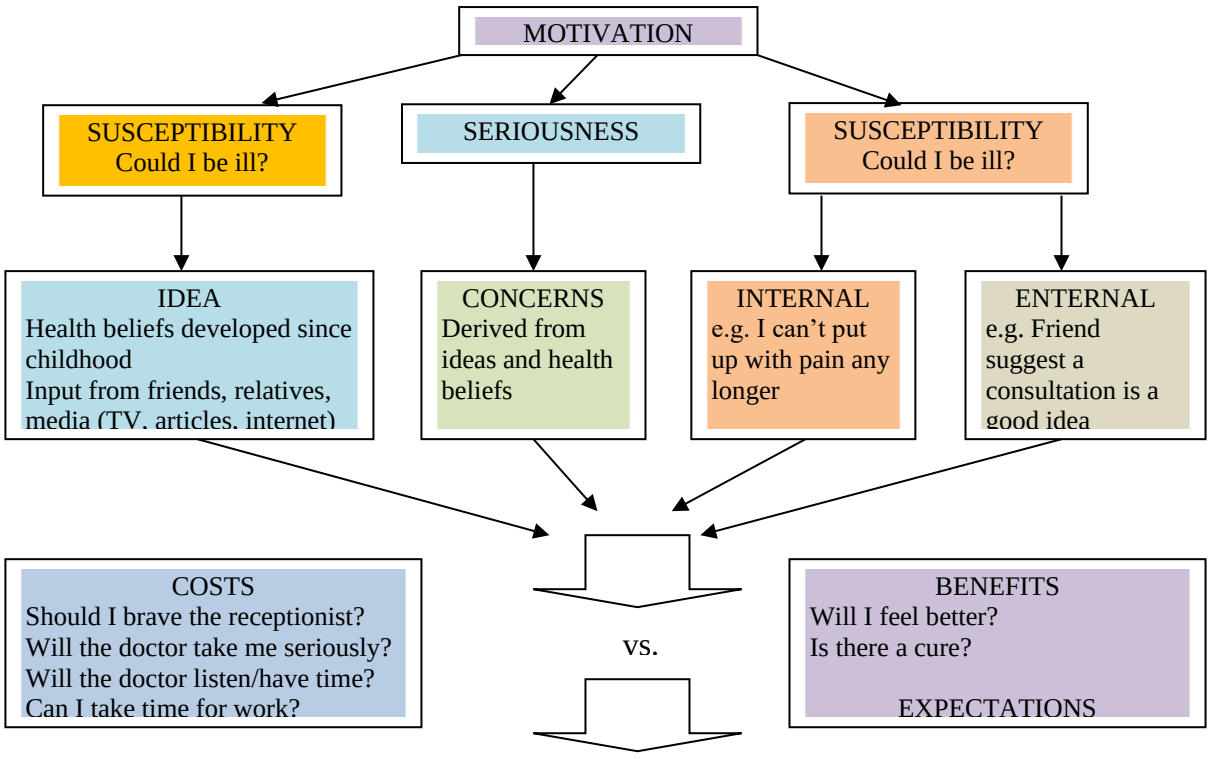


Resolution of problems in system terms (After Engel, 1980)

Establishment of therapeutic relationship

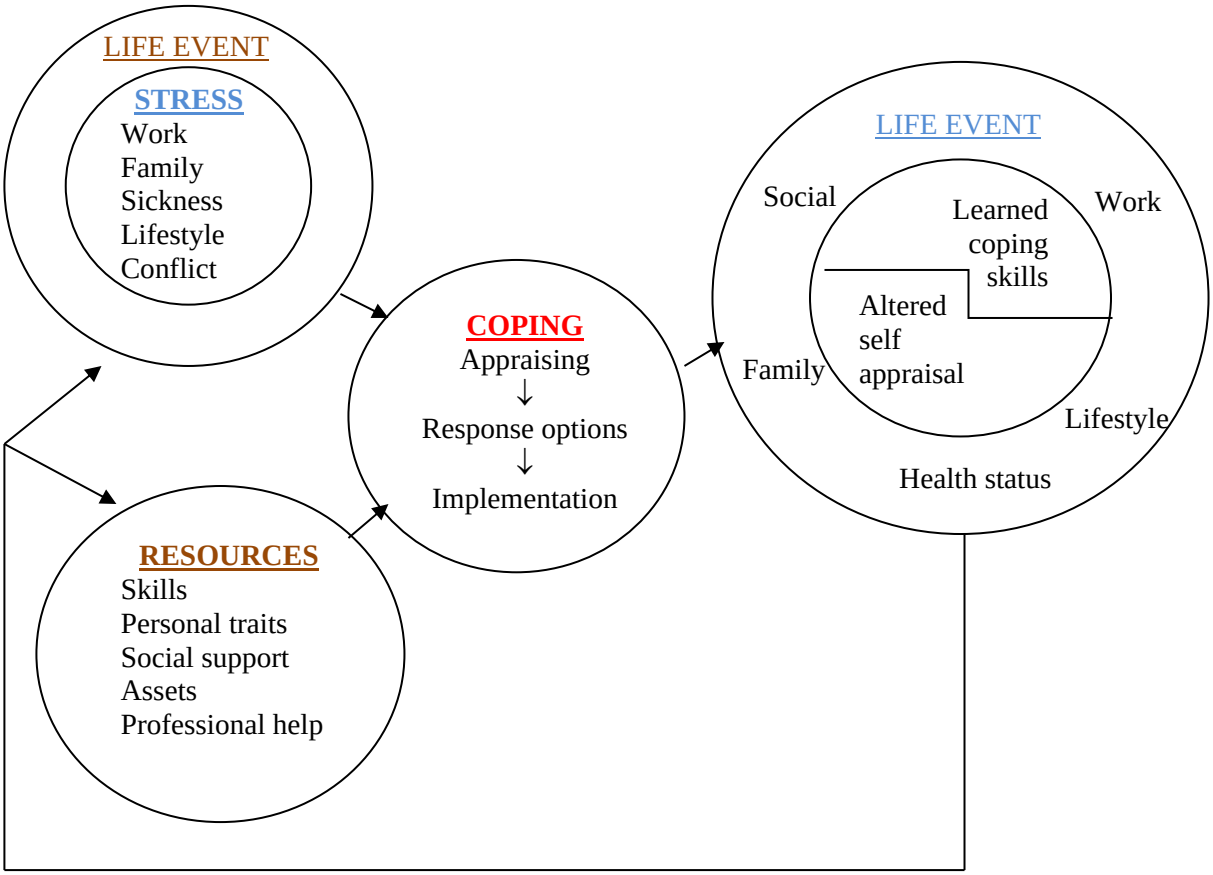
Community	Mobilization of rehabilitation resources
Family	Reduced anxiety, increase understanding
Doctor-patient	Communication, therapeutic relationship
Person	Development of insight, adjustment of life goals, restoration of self respect
Nervous system	Return to normal weight and heart rate, recovered function in knee
Organ (organ system)	Return to normal weight and heart rate, recovered function in knee
Tissue	Muscle strength restored, surgical repair of knee joint
Cell	Healing of knee joint
Molecule	

A Health Belief Model (1950, USA Social Psychologists)



DECISION TO CONSULT

STRESS, LIFE EVENTS AND COPING



THE DEVELOPMENT OF THE PATIENT-DOCTOR RELATIONSHIP

1. Forming the relationship
   - The consultation has always been central to medicine as the main point of interaction with patients. The patient-doctor relationship has moved towards a true *partnership* from traditional *paternalistic* approach.
   - In working towards a partnership family physicians try to develop an open relationship with patients, making sure that they are well informed and involved in any decisions about their treatment.
   - Concordance or adherence used to be unwittingly called compliance and it means that the doctor and patient have discussed, negotiated and mutually agreed on a plan of action rather than the patient 'submitting' to the doctor's ideas.
2. Achieving rapport
3. Addressing patients, respect and titles
4. Patient Enablement or Empowerment
5. Developing partnerships through meeting a patient's ideas, concerns and expectations (ICE)
6. Shared Decision making and the mutual management plan

EMPATHY

Empathy is the ability to put yourself in the patient's place and act accordingly. It is more than just an intellectual appreciation of the patient's situation. It is a blend of understanding and caring, which is evident to the patient in your actions and words.

Empathy supports the therapeutic relationship between patient and doctor. It is the cognitive and behavioural aspect of compassion and care. Empathy can be enhanced by training. It is a key component of a patient-centre approach.

PATIENT SATISFACTION (PS) (ATTRIBUTES CONSIDERED MOST IMPORTANT FOR PS)

What patients want in a physician (Stock Keister et.al., 2004)

- Does not judge
- Understand and supports me
- Is always honest and direct
- Acts as a partner in maintaining my health
- Treats serious and non-serious conditions
- Attends to my emotional as well as physical health
- Truly listens to me
- Encourage me to lead a healthier lifestyle
- Tries to get to know me
- Can help with any problem
- Is someone I can stay with as I grow older

MODULE 6:

SETTING UP A PRACTICE

INTRODUCTION

General Practitioners (GPs) provide primary care, in a personalized manner, on continuing basic with a comprehensive approach to all patients regardless of their age, sex or type of illness and extend the care to their family members taking into account the total environment of the patient.

CHARACTERISTICS OF GENERAL PRACTICE (GP) FAMILY MEDICINE (FM) ARE;

(1) The GP/Family doctor is an effective clinician.
(2) The doctor - patient relationship is central to GP/FM.
(3) GP/FM is person - centered, family - oriented, and community - based.
(4) GP/FD is a resource to a defined practice population.

ART AND SCIENCE OF GENERAL PRACTICE

Considering the above principles and attributes of GP/FM, the quality as well as success in clinical practice not only depend on technical competency (knowledge and skills) but the same weight and age bear on good - doctor patient relationship. General practice is science as well as art. Both qualities are indispensable. Many a times, personality and tact help more than academic ability. Long - term relationship, mutual trust, sympathy, friendship and confidence encourage the doctor and the patient (family) to pull together through many serious illnesses.

SETTING UP A PRACTICE

1. LOCALITY AND LOCATION

A good locality should be chosen considering the population background and catchments area. The location of clinic should be easily approached from various parts of that locality.

2. THE PREMISES

Building is an important criterion. The patient must have a good impression as soon as he enters. The clinic should be in general, tidy, neat and modern. The basic requirements are:

(a) Waiting room
(b) Reception room
(c) Consultation room
(d) Treatment room
(e) Toilet

(a) Waiting room

Generally, the entrance, the waiting room and the reception should be arranged for easier interface. It should be decorated in light colours and look welcoming. It should be adequately ventilated and lighted. The size can vary from (100 - 600 sqft) where (10 - 20) persons can be accommodated.
Ornament (pictures, flowers) and printed information (newspapers, magazines, brochures) will help to make the waiting timeless tedious for persons who are ill or depressed. Opportunity

should be taken to display health education materials - books, pamphlets etc. and also others like posters and models can be displayed. Comfortable seats should be placed.

(b) Reception room

It could be used as a reception for incoming patients, for keeping patient's records, storage of drugs, cash desk, dispensing and stationeries. It needs to be sited so that the receptionist cum nurse is in control of patient entering the waiting room, can contact doctor (carrying the records) and also be available to patient leaving the consultation room to dispense the medicines etc. It should be spacious and need large desk area for stationeries, telephone etc.
In a bigger clinic or at a Group Practice Clinic it is desirable to have a Pharmacy or Dispensary point separately.

(c) Consultation room

The size of consultation room could be (100 sq-ft = 10 ft x 10 ft) or larger where a screened couch can be put. The room can be divided into (3) function zones. Zone (1) is doctor area which needs the best day light and where all his equipment and needs are grouped to be within reach of his chair. It will include desk, swivel chair, worktop, stationeries, and examination instruments. Zone (2) is the patient seating area with sufficient space for an additional accompanying person. Zone (3) is the examination area with couch including drawers, shelves, table or trolley for instruments, injection syringes, place for emergency kit, basin, dust bin, etc. There must be sufficient space for examination from the side.

(d) Treatment room

It could be attached to consultation room or better a separate room (if possible) where could be provide;

(i) Emergency tray
(ii) Minor surgery - dressing, I& D, suturing, etc.
(iii) Minor procedures - catherization, PR exam, SE, VE, Pap smear taking, N/G suction etc..
(iv) Essential laboratory facilities - urine test kit (sugar, albumin, UCG) etc.
(v) Provisional facility for wastage from clinic.

(e) Toilet

It should be conveniently situated with hand washing facility and always kept clean.

3. EQUIPMENT AND INSTRUMENTS

At least minimum facilities should be kept; more can be added depending on growth of practice and interest of GP.

(a) Furniture - for waiting room, reception, consultation room has been described. The chairs, cupboards, desks, the wall and the floor should be kept always clean.
(b) Equipment - Stethoscope, BP apparatus, thermometer, torch, hammer, tongue depressor, inch tape, weighing machine, high stand, etc.
(c) Instruments- Forceps (artery, tooth/ non - tooth) , knives, scissors (straight, curve), suture mate rails (needles, needle - holder), proctoscope, Vaginal speculum, urinary catheters, enema set, kidney trays, bowls, breast pump, stomach wash tube, Ryle's tube, Foreign body removal set (probes, forceps, ear syringes), dressing materials (bandage, sterilized gauze), drip stand sterilizer etc. Instruments needed may vary according to the interest and capability of individual GP.

4. STAFF OF THE PRACTICE

(1) Medical officer/doctor - one in solo, more in group practice.
(2) Practice nurse/dispensary nurse.

(3) Receptionist/Secretary.
(4) Workers - cleaner, watchman etc. Note 1) + 2) must be qualified and fully licensed.

5. SERVICES AVAILABLE

- General Consultation and treatment, Consultation - visiting
- Counseling on STDs, HIV/AIDS, Birth spacing etc..
- Office (minor) surgery.
- Special clinics - well - woman, well - baby, youth friendly clinics, asthma, hypertension diabetes and immunization etc.
- Referral services.

6. LEGAL REQUIREMENT FOR CLINIC REGISTRATION

MODULE 7:

MEDICAL RECORDS

"As a medical student when I entered hospital, I was advised to keep records of all the patients whom I encountered. I was taught that clinical records are a greater educational value than textbooks. Since then, I have kept detailed records of patients who have come under my care."

"PROFESSOR HODGKIN"

1. INTRODUCTORY COMMENTS:

- An effective record keeping system contributes to the standard of care. In fact, this is vital in our daily practice of a family physician. To improve the quality of medical care, GP/family physicians should be able to maintain a good record keeping system,
- Medical records are more than an aide me moiré or a documentation of clinical details just in case medico-legal circumstances arise. Properly kept and used, they allow us to see the problem-solving process from which we can deliver better care.

2. AIM:

To develop a good record keeping system in family practice leading to quality of care.

3. LEARNING OBJECTIVES:

At the end of this learning session, the candidates should be able to

3.1 describe the utility of records and pitfalls

3.2 achieve knowledge on different types of records – the source oriented medical records (SOMR) and problem oriented medical records (POMR) including their components

3.3 initiate in implementation of a problem oriented medical record keeping systems

4. WHAT IS A MEDICAL RECORD?

Record is the statement of facts / written document or stored information. Medical record is the scientific, administrative and legal document in respect of the patient care relating to sequence of events, observations, investigations, diagnosis, treatment planned and carried out.

There are 2 types of records –

1. Records on work of practice (*e.g., patient register; daily prescription book, accounting records*)
2. Medical Records which contain a summary of the patient's clinical condition to enable the attending doctor and nurses to make out at a glance the essentials of an illness and the treatment given

4.1. UTILITY OF RECORDS AND PITFALLS.

UTILITY

(1) The main objective of maintaining medical record is to improve the quality of patient care, avoid omissions, unnecessary repetition of diagnostic tests, procedures and other treatment measures

(2) It helps to maintain the continuity of medical care (Continuing Care)

(3) It also forms the basis to issue necessary medical certificates for the purpose of leave, insurance, employment etc…

(4) It helps to evaluate, self-evaluation, CME, CPD and medical audit.

(5) Record information forms the basics of observation, analysis, inference, proving or disproving the hypothesis (sheet anchor of medical research leading to evidence based GP)
(6) Medical Records further help to determine the morbidity and mortality patterns, public health measures for prevention and control, monitoring of health programmes, their evaluation and planning of the alternate strategies etc…
(7) It acts as a communication tool between one physician and another.

MEDICAL RECORD (PITFALLS)

1. Traditionally GP has been family physician to this patient and has grown with the families under his care and most of the events pertaining to the families under his care having a bearing on health have been stored in his brain. There is reluctance on his part to adopt a change.
2. There is lack of motivation, training, knowledge and skill on part of physician to maintain effective records.
3. For the fear of losing confidentiality of the information and thus
4. For the fear of recorded information being used as evidence against the physician for alleged malpractice.
5. For the fear of records forming the basis of assessment of income and other taxes.
6. For the fear of being blamed by the family/patient for not organizing scientific treatment, investigations, referral and planning of the treatment

PRINCIPLES OF GOOD RECORD KEEPING

1. Data Gathering
2. Recording
3. Retrieval
4. Storage

Data gathering

Not possible for comprehensive information at first visit
Selective information
After DPR – more personal & sensitive information

Help by consistent

- filing
- Indexing
- Logical grouping
- Summary

Recording

- Must be legible and clearly recorded
- Information should be accurate and concise

Retrieval

Storage

- Confidentiality
- Easily retrievable

4.2 SOMR Vs POMR

4.2.1. SOMR (Source Oriented medical Record)

- In this system, the information is recorded chronologically and sequentially as they are available irrespective of the type of data or clinical context.
- The SOMR is still the main format used in in-patient care (Hospital practice) where detailed clinical records from many sources are accumulated as they become available.
- In family practice SOMR is still used but POMR is increasingly implemented.

4.2.2. POMR (Problem oriented Medical Record)

This was first described by Weed LL in 1969 as an attempt to address the deficiencies of SOMR. It consists of 4 elements viz. The master record, the progress notes, the flow charts and the source documents.

POMR has 3 strengths;

- Every item of information has a defined place in clinical contexts,
- Rapid retrieval of information is possible as one knows where exactly the information is recorded.
- Problems stand out whether they are active or inactive; unsolved problems can be seen in context of the whole history

Here we should learn the POMR record system of Singapore which was documented by Prof: Cheong PY, Goh LG and Yeo H (1988). It has 4 elements;

THE MASTER RECORD

- Bio-data
- Problem List
- Report Summaries
- Graphic Space

BIO-DATA – BACKGROUND INFORMATION OF PATIENT AND FAMILY

- Fixed: SEX, DOB, previous illnesses, immunization, family history.
- Changing: Marital status, occupation, address, screening tests.

PROBLEM LIST

- It has 3 columns viz. Active date, the problem and inactive date.

REPORT SUMMARIES

There are table for immunization records and also events. Events are summary information such as referrals, hospitalization etc…

GRAPHIC SPACE

This is meant for the family genogram or significant physical signs which are best drawn

PROGRESS NOTES AND SOURCE DOCUMENTS

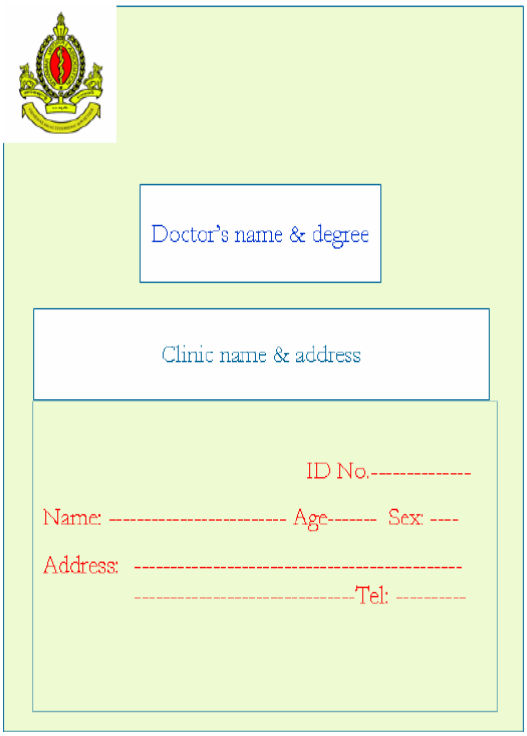
FOUR-COLUMN VERSION

First 2 columns - date and problem number indexed to the problem list
3rd column - SOA (Subjective, Objective, Assessment or Analysis

4th column - plans (P) which are prefixed with D, T or for diagnostic, treatment or therapeutic or Instruction

FLOW CHARTS

Very useful for continuing care for chronic problems (e.g., Hypertension, Diabetes and Bronchial Asthma) or structured consultation such as medical check-ups.



Report Summaries

Date	Event	Result

Genogram

Subjective (S)	Objective (O)	Assessment (A)	Plan (s) (P)

PRACTICE MANAGEMENT (POMR)

Scenario

U Sein Win, 55 years old man presents to your clinic with 2 day history of shortness of breath, frequency of urine and feeling thirsty. He has family history of Diabetes and IHD in his father. He denies any history of smoking and alcohol drinking. He has history of Diabetes for 5 years and Hypertension for 10 years.

Regarding the past history, he gives history of calculus cholecystitis and cholecystectomy done in 1995.And also history of right sided inguinal hernia and operation done in 1990.

On Examination
Height – 1.63 cm , weight – 69 kg
BMI – 26 , Waist / Hip 0.9
No edema , JVP not increased
BP 160/100mmHg, HR 90 / min(sinus rhythm)
VBS all over the lung fields
Abdomen – no significant finding

On investigation

RBS - 350 mg%
Urine RE - sugar present, No pus cell
ECG - within normal limits
CXR - Normal film

Diagnosis- Uncontrolled Diabetes with Hypertension
Treatment given

Gliclazide MR60 - 1 OD
Metformin - 1 BD
Perindopril - 4 mg OD

The next day, he returned your clinic for follow up, He is feeling better.
BP 130/80 mmHg
HR 80 / min(Sinus rhythm)
RBS (2 hour PP) -180 mg%

You are happy with the results, but you have to do further investigations such as lipid profile. You would like to provide Education on Diet and Exercise.

TASK

Please record your findings in a SOAP format of problem oriented medical record.

PROBLEM LISTS

Active	Problems	Inactive
2002	Diabetes	
1997	Hypertension	
	Calcus cholecystitis Cholecystectotomy	1995
	RIH & Operation	1990

Subjective (S)	Objective (O)	Assessment (A)	Plan (P)
Date 1			
SOB	*Ht - 1.63 m*	*DM uncontrolled*	*To control DM, HT*
Frequency of urine	*Wt - 69 kg*	*Hypertension*	
Thirsty	*BMI - 26*	*No IHD*	*GliclazideMR60 1 OD*
Smoking (-)	*WHP - 0.9*	*No Heart failure*	*Metformin 1 BD*
Alcohol (-)	*Oedema (-)*	*No Lung problems*	*Perindopril 4 mg OD*
DM & IHD in father	*JVP - normal*		*To Review tomorrow*
	BP – 160 / 100 mmHg		
	HR – 90 / min, SR		
	VBS – all over		
	Abdomen - soft		
	Move with respiration		
	BS (+)		
	RBS 350 mg %		
	Urine RE , Sugar +		
	Sugar +, Pus cell (-)		
	ECG - NAD		
	CXR - NAD		
Date 2			
Feeling better	*BP - 130 / 80 mmHg*	*DM & HT controlled*	*Same treatment*
Symptoms - decreased	*HR - 80 / min*		*Diet & HE*
	RBS(2 hr PP)180mg%		*Review tomorrow*
			& to continue

OVERVIEW OF PATIENT CONFIDENTIALITY

The doctor-patient relationship (DPR) is based and built on trust and confidentiality of information provided is a cornerstone of this relationship.

FOUR ETHICAL PRINCIPLES (4 'CS')

This applied to 4 conditions in which the family doctor should breach the confidentiality of the patient.

- In the Course of care of the patient
- With the patient's Consent
- Under statutory Compulsion
- In situations with strongly countervailing public interest

IN THE COURSE OF CARE OF THE PATIENT:

- Health Care Provider providing direct care to the patient

- Confidentiality should be based on a need-to know-basis

WITH THE PATIENT'S CONSENT

Consent of the patient can be implied or explicit.

UNDER STATUTORY COMPULSION

Laws in most countries enacted in public interest to compel disclosure and notification of certain diseases.

In situations with strongly countervailing public interest

- The preventing harm to others and preventing crime could exceptionally outweigh both the private and public interest.
- There must be a real and serious risk of some other person or persons suffering harm if the confidence is not broken e.g. SARS, AVIAN FLU, H1N1 Flu

MODULE 8:

EMERGENCY CARE AND THE GP'S HOUSE CALL

INTRODUCTION

Emergency care and house call services are part and parcel of our daily practice and every GP should be prepared to provide these services whenever he or she is called upon emergency care outside the hospital represents one of the most interesting and rewarding areas of medical practice.

AIM

- To improve the candidate's awareness on components and importance of emergency care and house calls under the umbrella of primary care

OBJECTIVES

At the completion of this module the candidates should be:

1. Familiar with the underlying principles of dealing with common emergencies encountered in general practice
2. Able to plan safe and effective emergency care and house called services
3. Able to prepare the house call bag using available resources - the choice of drugs and equipments and their uses.
4. Able to respond effectively to a call for home visit

EMERGENCY CARE, THE GP'S HOUSE CALL AND THE DOCTOR'S BAG

Almost everyone who goes to bed counts upon a full night's rest: like a picket at the outputs, the doctor must be ever on call. (Karl F. Max (1796-1877)

DEFINITION

An event demanding immediate medical attention.
The demand is determined by patients, relatives, neighbors, nurses, police and others, but is sometimes modified by the doctor or his or her staff.
In dealing with a specific emergency, the doctor adopts a different approach instead of taking a history and performing an examination in the usual way, he or she replaces this with a technique of rapid assessment and immediate management. In fact, the diagnosis may be possible on the information available over the telephone.

GENERAL PRINCIPLES CONCERNING THE EMERGENCY CARE AND THE HOUSE CALL SERVICES.

I. BE A GOOD GP

A good GP = a sound basic knowledge + common sense

1. Common things occur commonly
2. The race may not always be to the swift nor the battle to the strong, but it's a good idea to bet that way.
3. When you hear hoof beats think of horse: not zebra.
4. Place your own capabilities and limitations.

II. REALIZE YOUR OWN CAPABILITIES AND LIMITATIONS

1. If what you're doing is working, keep doing it.

2. If what you're doing is not working, stop doing it.
3. If you don't know what to do, don't do anything.

III. QUESTIONS YOU SHOULD ASK YOURSELF BEFORE TREATING ANY PATIENT

Q: Can I treat patient?
A1: Yes - go ahead
A2: No - refer
A3: No sure - call for help
Q: Should I be treating this patient?

- Patient is much safer in more experienced hands if you lack enough practical experience, although you have theoretical knowledge.

IV. HAVE AN ACCESS TO SPECIALIST NETWORK AND HOSPITALS.

- Establish effective communication between the GP and the specialist.

V. TAKE EXTRA CARE WHEN DEALING WITH EXTREME OF AGES, THE VERY YOUNG AND THE VERY OLD.

- Sign and symptoms are very vague & misleading in this age group. And don't be overconfident.

VI. BE PREPARED FOR THE UNEXPECTED

- Sometimes you may be called upon for an apparently trivial c/o like giddiness or fainting but the underlying cause can turn out to be something serious. e.g, silent myocardial infarction.

VII. BEWARE OF MEDICO-LEGAL ISSUES

- Suicide
- Homicide
- RTA
- Death certification

VIII. WHEN TO GET UP AND GO

- It is important to get up and go when the call signals danger.
- The following signs and symptoms make attendance at emergency mandatory
    - Unconsciousness
    - Convulsions
    - Chest pain in an adult especially associated with pallor and sweating.
    - Pallor and sweating in any patient with pain, collapse or injury
    - Collapse especially at toilet
    - Significant haemorrhage
    - Breathlessness including bronchial asthma
    - The agitated patient threatening homicide or suicide (take a policemen or company)
    - Serious accidents

IX. TWELVE GOLDEN RULES

1. Acute chest pain represents myocardial infarction until proved otherwise.
2. Always consider the possibility of hypoglycaemia and opioid over-dosage in the unconscious patient.
3. Always consider the possibility of acute anaphylaxis in patient with past history of allergies.
4. Beware of the asthmatics who cyanosed with a silent chest and tachycardia.
5. Consider ventricular fibrillation or other arrhythmias foremost in as adult with sudden collapse or dizziness.

6. The sudden onset of severe headache adds up to subarachnoid haemorrhage
7. If a patient is found cyanosed always consider upper airway obstruction first.
8. Exclude acute epiglottitis in a child with a sudden onset of respiratory distress and pallor.
9. Consider the possibility of a ruptured intra-abdominal viscus in any person especially a child with persistent post traumatic abdominal pain.
10. Consider intra abdominal bleeding first and foremost in a patient with abdominal pain who collapses at toilet.
11. Always consider the possibility of depression in a post partum woman, presenting with undifferentiated illness or problems in coping with the baby.
12. Always consider ectopic pregnancy in any woman of child bearing age presenting with acute abdominal pain.

SCOPE OF EMERGENCY CARE SEEN IN GENERAL PRACTICE:

Paediatric emergencies	*e.g. Persistent crying, abdominal pain, fits.*
Cardiovascular emergencies	*e.g. chest pain, acute left ventricular failure.*
Respiratory emergencies	*Asthma, pneumothorax*
Gastrointestinal emergencies	*Abdominal pain, haemetemesis, melena.*
Urogenital emergencies	*Acute urinary retention, renal colic,*
Obstetric and gynaecological emergencies	*Antepartum haemorrhage, ectopic pregnancy, twisted ovarian cyst*
Neuromuscular emergencies	*e.g. stroke, transient ischaemic attack, loss of consciousness.*
ENT and eye emergencies	*Foreign bodies, glaucoma, ear ache, epistaxis*
Endocrine emergencies	*Not common, e.g. diabetic ketoacidosis and hypoglycaemic coma*
Bites and stings, burns and scalds	
Forensic emergencies	*e.g. assault or rape*
Psychological or psychiatric emergencies	*e.g. acutely confused, suicidal, extremely anxious, aggressive or violent, acutely psychotic*

DELIVERY OF EMERGENCY CARE

APPROPRIATE PREPARATION

- Equipment and Clinic Organisation
  - Basic equipment and essential drugs. House call bag.
  - Clinic staff trained to recognize emergency situations.
  - Priority treatment for such patients

MANAGEMENT PROTOCOLS

Work out in advance management protocols for the emergencies likely to be encountered. Clinic staff should be familiar with their roles in these protocols.

Acute paediatric problems

- Many are trivial from a purely medical point of view, but parental anxiety can be tremendous, take the parents seriously, assess each case according to severity and treat, reassure or refer as necessary.

Chest pain

- The task of the general practitioner is to identify those that are medical emergencies (e.g. acute myocardial infarction), refer these for further management, and treat the others as appropriate.

Loss of consciousness

- May be potentially life threatening or trivial
- Immediate treatment required e.g. hypoglycaemic coma
- Urgent hospital referral required e.g. head injuries, poisoning
- Non-life threatening causes e.g. vasovagal attack ('faint') and hysterical conversion. Management depends on the particular circumstances. Referral may or may not be necessary.

Acute respiratory distress

- Quick history and clinical assessment.
- Urgent stabilization before referral e.g. acute laryngeal oedema
- Urgent referral required without intervention e.g. acute epiglottitis in children.
- Non-urgent conditions, e.g. hyperventilation.

Severe abdominal pain

- It is worthwhile spending time on a careful history and keeping a high index of suspicion for the unusual.
- Difficult to decide whether to make a visit, or to give advice over the telephone. E.g. renal, biliary or abdominal colic, can be managed as outpatient initially followed by referral if indicated.

Gynaecological emergencies

- Such as ectopic pregnancy and twisted ovarian cyst must be referred immediately following initial stabilization.

Bleeding in pregnancy –

- If ectopic pregnancy is suspected, do not do a pelvic examination and arrange for urgent hospital admission.

Injuries

- Mild to severe. The doctor's task is to quickly assess the severity, amount of bleeding, decide whether to institute first aid measures and refer to the hospital straight away, or whether the patient can be treated in the clinic.

Allergic reactions

- The task of the general practitioner is to treat those conditions that are life threatening e.g. subcutaneous adrenaline in angioedema, arrange for hospital referral those that are potentially severe e.g. early Steven-Johnson syndrome

The disturbed patient/forensic problems

- The family physician often has to decide how to alleviate the crisis over the next 24 hours, rather than trying to find a definitive solution to a long term problem. Cases of alleged rape need to be referred. In the case of sudden death, a post mortem is always prudent.

Patient Education

- It is important that patients are educated as to which situation constitutes an emergency and which doesn't.

SCOPE OF HOUSE CALLS AS SEEN IN GENERAL PRACTICE

ASSESSMENT AND/OR MANAGEMENT OF ACUTE ILLNESSES

- Assessment for home management vs. hospitalization: Home conditions and availability of family support important factors to consider.

ASSESSMENT AND MANAGEMENT OF PATIENTS DISCHARGED FROM HOSPITAL

- e.g. post-surgery or recovering from myocardial infarction and stroke.

MANAGEMENT OF PATIENTS WITH CHRONIC ILLNESS –

- e.g. patients with stroke.

MANAGEMENT OF PATIENTS WITH TERMINAL ILLNESS

- Assessment of home conditions and family function
- Opportunity for the doctor to meet family members, observe interactions among them, provide family counseling.
- To allay patient or caller anxiety
- To allay anxiety alone is sometimes a good enough reason to make a home visit.

DOING A HOUSE CALL

PREPARATION

Personal preparation: The doctor's readiness.

- The doctor must be prepared personally to do house calls.
- Should be contactable.
- Appropriate vocational training.
- Ensure the doctor's safety as far as is possible.

Clinic organization: *Staff readiness.*

- Clinic staff trained to recognize an urgent call.
- Good to document details of all requests for house calls, any advice given, and whether or not a visit was made.

THE HOUSE CALL BAG

- A matter of personal choice, also depend upon the type of practice. The doctor's bag needs to be stocked and ready at all times, contents should be checked and updated regularly.

HANDLING A REQUEST FOR HOUSE CALL

- Establish identity of the caller, contact telephone number, name of the patient, and location.
- Collect only enough information to decide whether a visit is necessary and if necessary, how quickly; whether any extra equipment needed; and whether to call for an ambulance at the same time.

THE DOCTOR'S BAG

Essential requirements for the bag

- sturdiness: disposable single use items
- lockable: light, port able equipment
- uncluttered

- regular checks to ensure non-expired drugs
- ready interior access - storage in cool place (not boot of car)

Recommended Contents & Stationery

- Drugs
- Equipment
- Stationery
- Miscellaneous items

Drugs

Oral

- Analgesics
- Antihistamines
- Antibiotics
- Sedatives
- Antidiarrhoeal agents
- Glyceryl trinitrate
- Antiemetics
- Soluble aspirin (for myocardial infarction)

Sprays

- Salbutamol aerosol
- Glyceryl trinitrate

Suppositories

- Paracetamol
- Diclofenac

Equipment

- Arenoid sphygmomanometer
- Stethoscope
- Diagnostic set (auriscope + ophthalmoscope)
- Tongue depressors
- Tourniquet
- Scissors
- Syringes 2, 5, 10, 20 ml
- Needles 19, 21, 23, 25 G
- Scalp vein (butterfly) needles
- Examination glove
- IV cannulae 16, 18, 20 G
- Alcohol swabs
- Micropore tape
- Thermometer
- Artery forceps
- Torch
- Patellar hammer
- Oral airway
- Scalpel

Stationery

- Practice letterhead & envelops
- Prescription pads
- X-ray, pathology referral forms
- Dangerous drugs record books, Pens

Miscellaneous items

- The doctor's bag check list
- Dosage details of drugs all age groups
- Important telephone numbers
- Handbook of emergency medicine

Drug	Presentation	Indication
1. Adrenaline	1 mg/ml	Hypersensitivity reactions & anaphylactic shock, VF (to assist CPR)
2. Atropine sulphate	0.6 mg/ml	Bradycardia, ureteric colic, worm colic, organophosphate poisoning
3. Benzyl penicillin	600 mg with 2ml water	Meningococcaemia, pneumonia (adults), Leptospirosis
4. Chlorpheniramine maleate	Burmeton 10 mg	Allergy, anaphylaxis
5. Dexamethasone	4 mg/ml	Acute severe asthma, increased ICP
6. Diazepam	10 mg/2ml	Status epilepticus and any convulsion such as eclampsia, sedation in acute anxiety & severe tension headache, psychiatric emergency
7. Ergometrine maleate	0.25 mg/ml	Uterine bleeding, abortion or PPH
8. Frusemide	Lasix 20mg/2ml	LVF, acute pulmonary oedema
9. Glucose, 50%, 25%	5g/10ml	Hypoglycaemia
10. Haloperidol	Serenace 2mg/ml	Psychiatric emergencies usch as severe agitation, psychosis
11. Hydrocortisone sodium succinate	Solucortef, 100mg/2ml, 250mg/2ml	Analphylactic shock, acute severe asthma, Addisonina crisis, thyroid crisis, acute allergies
12. Hyoscine butylbromide	Buscopan 20mg/ml	*Ureteric and biliary colics, acute pancreatitis
13. Lignocaine	Xylocard 100mg/5ml	Ventricular arrhythmias especially VT and VF
14. Metoclopramide or Prochlorperazine	Maxolon 10mg/ml Stemetil 12.5mg/ml	Severe vomiting (e.g. Meniere's disease, gastritis), acute labyrinthitis, migraine
15. Morphine sulphate	15mg/ml	Acute pulmonary oedema, relief of severe pain (not due to muscular spasm) such as MI
16. Pethidine	100mg/2ml	Severe pain such as ureteric and biliary colic
17. Naloxone	Narcan 0.4mg/ml	Opiate overdose
18. Vitamin K	10mg/ml	Anticoagulant overdose with haemorrhage, haemorrhagic disease or newborn
19. Salbutamol	Ventolin 0.5mg/ml	Bronchial asthma, other bronchospasm
20. Water for injection	5 ml	Diluent

*May be useful as an alternative drug

Picture: Doctor's bag (call bag)

HOSPITAL AT HOME CARE

Hospital-at-home care is an alternative type of care, most probably suitable for terminally ill elders

- Patients allocated to hospital-at-home care had a significantly reduced risk of death at six months.
- They conclude that admission-avoidance hospital-at-home can provide an effective alternative for certain older patients.
- The degree of patient selection may reflect the high levels of satisfaction, with those taking part preferring to be treated at home.

Note: Permission already obtained from this patient and his family

MODULE 9:

CONTINUING MEDICAL EDUCATION FOR GENERAL PRACTITIONERS

"Education is a life-long process"

"Socrates"

"All doctors in whatever branch of medicine (including GP) must have the opportunity and the time for continuing education in order to keep up to date in their own field and to remain reasonably well acquainted with developments in others"

"Scottish Council for P/G Medical Education (1973-74)

OBJECTIVE

- To help doctors to provide optimal care by changing their behaviour to reflect advances in knowledge base and practice of medicine.

This is accomplished both by imparting new information and by reaffirming that the existing information used by the physician is the most appropriate at that time.

DEFINITION

Continuing medical education (CME) is a process of gaining professional experiences from the time of initial graduation throughout the course of life-long career.

The prime purpose of CME activities is thus to enhance the competence and performance of general practitioner (GP), by providing clinically useful information, skills and attitude which could be translated into better patient care thus improving the health of population.

CME programme includes lectures, seminars, symposia, workshops, panel discussions, clinical meetings, conferences, on various topic - clinical, administrative and medico-legal issues by family physician and or for by eminent specialists.

WHY CME IN GENERAL PRACTICE?

Medical science as a whole and general practice in particular is growing, changing, expanding broader and deeper and ever pervading into social life. The GP must exercise continuous learning in theoretical, therapeutic and management skills and to meet the changing demands of the society.

Community expects on GP to be knowledgeable, skillful, understanding and readily available. The qualities of physician which actually make him a GP/ family physician (FP) like courtesy, compassion, communication, organization of collected information, identification of patient's problems, a good listener and counsellor etc. are not taught during his undergraduate years. To be able to do GP/FP sincerely, GP needs to be turned in the following spectrums:

- multidisplinary (internal medicine, surgery, O&G, child health, psychiatry, etc.)
- multidimentional approach (preventive, promotive, curative, rehabilitative)
- multifaceted subject (socio-economic, cultural, psychosomatic, knowledge, skill, attitude, value)

General practitioner sticks neither on one particular disease nor organ entity but it rather focused on the sick person as a whole. GP attends all ages (from to tomb) and both sexes. For its breath life-long continuing self-directed learning is essential in general practice. Through long term and close contact with the patient and his family, GP becomes a friend, a guide, advisor and coordinator in managing patient's sufferings.

No practitioner should be engaged in clinical practice unless he has had training appropriate to his responsibilities and unless he maintains and enhance his skills, through regular assessment and CME.

General family practice is the point of first contact for majority of patients. GP has often to deal with problem complexes or undifferentiated cases. He has also to response to house calls, accident and emergency cases in the clinic, on the road or in the hospital. He must be able to make a total assessment

of the patient's condition without subjecting unnecessary investigations, procedures and treatment or referral.

One shall also notice the fact that, in five years' time, the average medical graduate would have forgotten half the amount of the facts he had so laboriously swatted up during his final exams from the remaining half, 50% could be out of date and of no relevance to contemporary medical thinking. If he is lucky enough he is still left with 25% medical knowledge he can use.

General medical practitioners (public or private) accounting nearly 75% of the total medical force, form the back-bone of the profession.

It is mandatory to improve the quality of GPs by proper CME. With proper CME GPs will be more acceptable, accessible and affordable for quality and cost- effective care to the vast majority of the people irrespective of their age, sex and nature of disease.

THE NEED OF CME

1. To maintain standard of care and improve quality of care
2. To be able to apply new knowledge's
3. For adapting to change health needs
4. To correct the weakness/ inadequacy in initial training
5. To use resources more economically
6. To fulfill the need of health workers own desire to learn.

PRINCIPLES OF CME

1. Should respond to needs of health system/needs of people
2. Should also answer the needs of the health workers
3. Should form a bridge between training and practice
4. Should be accessible to all. (Universality)
5. Should be consistent at all levels, fully determined in content, duration and frequency, not sporadically (consistency).
6. Should be a permanent progressive learning process, learners participate on a regular sequential basis (sequentially)
7. Should be monitored and supervised with reviews and guidance.
8. Should be participants offered with accreditation certificates.

There are four concepts to be considered regarding the need of continuing medical education (CME) for general practitioners (GPs)

1. Every individual GP needs CME to improve his competency for better performance in his day to day practice.
2. Provision of CME is the most important role of medical colleges (Institutions) and professional organizations in order to maintain standard, raise quality and keep uniformity in medical practice.
3. Community demands quality and cost effectiveness in health care service and for that CME is a necessity.
4. Governments also support CME programmes for health care providers especially at primary care level to achieve optimal health care delivery.

STANDARD AND QUALITY IN MEDICAL PRACTICE

The process of standard and quality assurance in medical care and medical practice is intended to ensure that medical practitioners attain adequate level of education and professional training.

Medical colleges and professional organizations are responsible to organize, orientate and educate medical practitioners in line of community need and demands. It clearly shows that, to maintain standard, quality and uniformity among medical practitioners, CME is a must.

Both CME and research together with educational (training) programme and field of practice will identify general practice as a distinct discipline.

STRATEGIC CONSIDERATIONS

1. CME programs should be centrally developed (to mind standard, uniformity and quality but decentralized in implementation.)
2. The training should be conducted in such a way that their (GPs) daily practice sessions are not disturbed (Part-time, distance learning)
3. CME programs should be equitable access to all GPs throughout the country.
4. The course content should be based on learner's need, GP-oriented, GP friendly.
5. Make use of cooperation of all partners and resources within and without profession.

REFERENCES:

1. *Miller, G.E (1967) Continuing Education for what? J.Med Ed (42)*
2. *Collected reports of the Scottish Council for P/G Med Education 1973-1984 (33).*
3. *Departments of family medicine in medical colleges is a necessity. IMA CGP publication 1989 (12)*
4. *Dr. H.S Wong, Singapore family physicina 1988, vol XIV, NOH*
5. *Dr. Rajakumar (Past president of WONCA, Chairman of CGP Malaysia) (Family medicine education workshop Manila 1993).*
6. *Making medical practice and education more relevant to people's needs WHO-WONCA 1994 Conference, in Ontario, Canada, page (7)*
7. *Improving the performance of health centers in district health system WHO-Geneva 1997, Page (1)*
8. *Abbatt & Mejia, continuing education for health workers WHO, Geneva 1988.*
9. *Dr. Tin Aye, Continuing Medical Education for General Practitioners.*
    a. *MMJ: Volume 42, Number 3,4, December, 1998.*
    b. *MMJ: Volume 43, Number 1,2, June, 1999.*
    c. *MMJ: Volume 43, Number 3,4, December 1999.*
10. *Continuing the education of health workers - F R Abbatt, A Mejia WHO 1988.*

MODULE 10:

CONTINUING PROFESSIONAL DEVELOPMENT

DEFINITION

"The aim of continuing professional development (CPD) is to sustain the professional development of general practitioners and help them to provide high quality patient care throughout their careers."

(Oxford handbook of General Practice, Page 62, 2002)

General practitioner, to be able to accept the new, wider and changing roles and functions to master new jobs and skills, should be always thinking how to improve himself in all relevant fields as a professional and also as a working citizen. Thus, CPD may include a mixture of various educational activities e.g.

1. Further training in related specialties - psychiatry, pediatrics, acute and emergency medicine, behavioural Science, management of STDs and HIV/AIDS, reproductive health research etc.
2. English (and other) Language proficiency, art of presentation and public speaking, etc.
3. Philosophy- Psychology, Counselling Skills, etc.
4. Business, administration and management
5. Technical, computer use in general practice, minor surgery, etc.
6. Training in teaching, research, writing papers, etc.
7. As organizers in professional organizations, etc.

Unlike CME which is more or less limited to continuing medical educational activities, CPD on the other hand, encompasses any subject which may be useful in the professional life of a general practitioner allowing to develop to his maximal potential.

These activities may be formal (leading to certificate/ degree) or informal (trainings, scientific, meetings, seminars, workshops etc..). In many parts of the world, where GP/FM is recognized as a special discipline and where colleges of general practitioners/ departments of family medicine are well established in medical education the different kinds of CPD programs are provided for GPs. If a GP has time, interest and money, apart from his vocational training, he can attend and obtain many other related certificates (DCH, Diploma in Obstetrics & Gynaecology, geriatrics) Diploma in Reproductive Health, Diploma in Dermatology etc..

In CPD, required knowledge and skill is based upon the need of the learner, grounded in practice and thus has a personal value for the learner. As such the newly acquired knowledge and skill is more meaningful and is readily absorbed into practice. CPD comprises purposeful, systematic activity by individuals and their organizations to maintain and develop the knowledge, skills and attributes which are needed for effective professional practice. In fact, it is a process life-long learning and professional development.

In conclusion, a saying of Greek Argonauts is worthy to be mentioned here "the essential thing is not to live, the essential thing is to navigate (sail)."

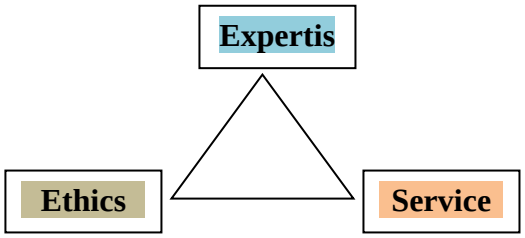
A PROFESSIONAL

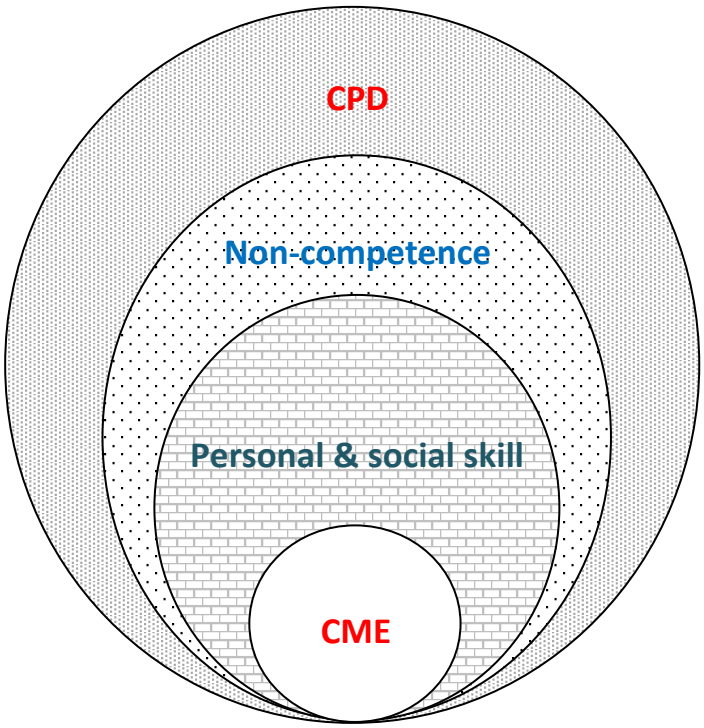
A professional is a person who possesses a body of knowledge and skill for a particular task. He is also a member of the professional society and has to uphold ethics. He has privilege to practice his own professional occupation. At the same time, he has the obligation to serve the society and should be accountable for him professional conduct and performance. A professional always updates his knowledge and improves his skill and excels in his performance. A true professional, unlike an amateur produces a good quality work. A professional always self-audit and self-correct his short comings. He keeps his patients and the people's health needs above his own interest.

In short “a profession is an occupation requiring specialized knowledge and skills with which a person earns his living.”

Three Pillars of Profession

Expertise
Ethics
Service



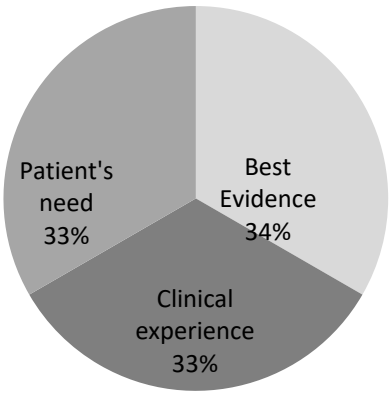


MODULE 11:

TOWARDS EVIDENCE- BASED DECISION MAKING IN FAMILY PRACTICE

DEFINITION OF EVIDENCE-BASED MEDICINE (EBM):

The integration of best research evidence with clinical expertise and patient value
Evidence-based practice is a systematic process primarily aimed at improving the care of patients.



THE BEST RESEARCH EVIDENCE

Clinically relevant
Patient-centered research about:

- Diagnostic tests
- Prognostic markers
- Therapeutic / preventive regimens
- Clinical Guidelines

CLINICAL EXPERTISE

- Ability to use our clinical skills & past experience to rapidly identify:
  - Each patient's unique health state.
  - Their individual risks and benefits of potential interventions.
  - Their personal values and expectations.
  - Availability of resources in the community

PATIENT VALUES

- The unique preferences, concerns, and expectations each patient brings to a clinical encounter.
- These must be integrated into clinical decisions if they are to serve the patient.

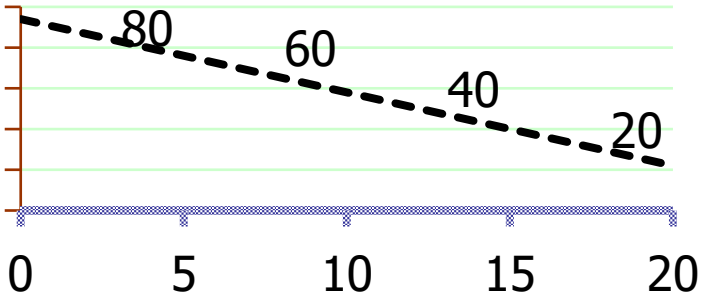
LIMITATIONS OF CURRENT CLINICAL PRACTICE

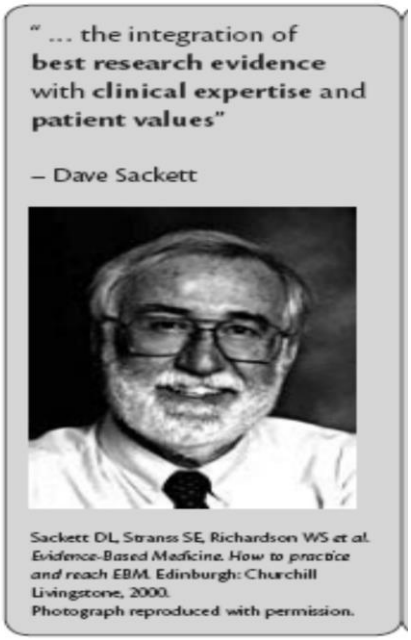
- **Variation in current practice**
  - ***Practice patterns of local "opinion leaders"***

- ***Advertising***
- ***Pharmaceutical representatives***
- ***Specialists who may see a different spectrum of patients***

UPDATING KNOWLEDGE

The following chart shows knowledge of hypertension management typically decrease after 20 years of practice.





Father of EBM

FIVE STEPS OF EBM (5 AS)

1. **Framing a focused question (ASK)**
2. **Searching thoroughly for research-derived evidence (ACQUIRE)**
3. **Appraising the evidence for its validity and relevance (APPRAISE)**
4. **Seeking and incorporating the user's values and preferences (APPLY)**
5. **Evaluating effectiveness through planned review against agreed success criteria (ASSESS)**

Step 1: ASK—formulating clinical questions: in order to practice evidence-based medicine, the initial step involves converting a clinical encounter into a clinical question.
A useful approach to formatting a clinical question is using PICO framework.
1. **P**---patient/population: which patients or population group of patients are you interested in?
2. **I**—intervention: which intervention/treatment is being evaluated?
3. **C**---comparison/control: what is/are the main alternative/s compared to the intervention
4. **O**—outcome: what is the most important outcome for the patient?

Evidence-based medicine is relevant for three other key domains: Etiology, Diagnosis, and Prognosis

Clinical Encounter:

UHM, 40 yr-old patient with chronic dyspepsia, who has no other sinister features that suggest malignancy, prefers to have non-invasive investigations to establish the diagnosis. His chronic dyspepsia has responded well to H2antagonists in the past. You think that his condition may be associated with H: pylori, but he refuses to have invasive procedures done to confirm the diagnosis.

PICO question

In a 40 yr-old patient with chronic dyspepsia (PATIENT), what are the sensitivity, specificity and predictive value of a non-invasive test (INTERVENTION) compared to that of a gold standard endoscopic biopsy (COMPARISON) in terms of diagnosing H.pylori (OUTCOME)?

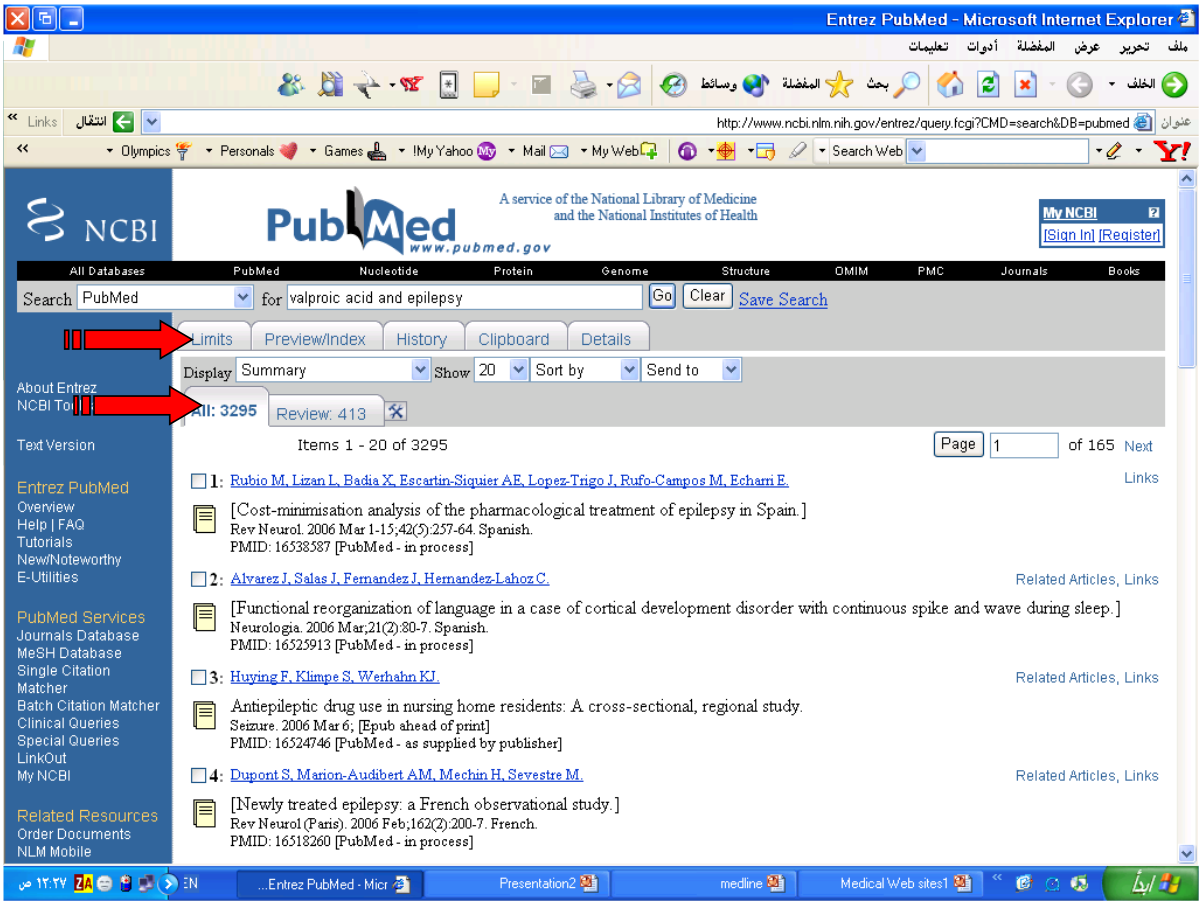
Step 2: ACQUIRE----identifying relevance evidence from EBM resources:

- ✓ www.ovid.com MEDLINE/MEDLINE in process
- ✓ www.cochrane.org CDSR,DARE,CENTRAL
- ✓ www.acpjc.org
- ✓ www.clinicalevidence.com
- ✓ www.nim.nih.gov
- ✓ EMBASE
- ✓ PUBMED

Evidence should be identified using systematic, transparent and reproducible database searches. While a number of medical databases exist; the particular source used to identify evidence of clinical effectiveness will depend on clinical question.

You can use the following criteria to search the MEDLINE database:

- A keyword or phrase from your focused question(for example, H.pylori)
- The MeSH term (medical subject heading), which are the terms used to index the articles
- The title (the search will look for words in the title of the paper)
- The author (the last name and initial)
- The name of the journal (for example, Myanmar Medical journal)
- The type of publication (for example, randomized controlled trial)



CLASSIFICATION OF EVIDENCE

- Grade 1: meta-analysis/systematic review of multiple well designed RCTs
- Grade 2: at least one RCT with definitive results
- Grade 3: published well designed trials without randomization, cohort or matched case controlled study
- Grade 4: well-designed non-experimental studies from more than one center or research groups including cross sectional surveys and case reports
- Grade 5: expert opinion, reports of consensus

Table 1. Levels of evidence and grades of recommendation

Grade of recommendation	Level of evidence	Therapy/prevention, aetiology/harm	Prognosis	Diagnosis	Economic alanysis
A	1a	SR (with homogeneity) of RCTs	SR (with homogeneity) of inception cohort studies; or a CPG validated on a test set	SR (with homogeneity) of level 1 diagnostic studies; or a CPG validated on a test set	SR (with homogeneity) of level 1 economic studies
	1b	Individual RCT (with narrow confidence interval)	Individual inception cohort study with ≥ 80% follow-up	Independent blind comparison of an appropriate spectrum of consecutive patients, all of whom have undergone both the diagnostic test and the reference standard	Analysis comparing all (critically validated) alternative outcomes against appropriate cost measurement, and including a sensitivity analysis incorporating clinically sensible variations in important variables
	1c	All or none	All or none case series	Absolute SpPins and SnNouts	Clearly as good or better, but cheaper. Clearly as bad or worse but more expensive. Clearly better or worse at the same cost.
B	2a	SR (with homogeneity) of cohort studies	SR (with homogeneity) of either retrospective cohort studies or untreated control groups in RCTs	SR (with homogeneity) of level ≥2 economic studies	
	2b	Individual cohort study (including low-quality RCT; e.g. <80% B follow-up	Retrospective cohort study or follow-up of untreated control patients, in an RCT, or CPG not validated in a test set	Independent blind comparison but either in non-consecutive patients or confined to a narrow spectrum of study individuals (or both), all of whom have undergone both the diagnostic test and the reference standard; or a diagnostic CPG not validated in a test set	Analysis comparing a limited number of alternative outcomes against appropriate cost measurement, and including a sensitivity analysis incorporating clinically sensible variations in important variables
	2c	"Outcomes" research	"Outcomes" research		
	3a	SR (with homogeneity) of case-control studies			
	3b	Individual case-control study		Independent blind comparison of an appropriate spectrum, but the reference standard was not applied to all study patients	Analysis without accurate cost measurement, but including a sensitivity analysis incorporating clinically sensible variations in important variables
C	4	Case series (and poor-quality cohort and case-control studies)	Case series (and poor-quality prognostic cohort studies)	Reference standard was not applied independently or not applied blindly	Analysis with no sensitivity analysis
D	5	Expert opinion without explicit critical appraisal or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principle"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on economic theory

STRENGTH OF RECOMMENDATION (SOR)

A. Consistent, good quality patient orient evidence
B. Inconsistent or limited-quality patient oriented evidence
C. Consensus, disease-oriented evidence, usual practice, expert opinion, or case series

Step 3: APPRAISE: it is the process of systematically examining the available evidence to judge its validity and relevance in a particular context. The appraiser should make and objective assessment of the study quality and potential for bias.

- **Accessibility**: Can I easily obtain or retrieve the study?
- **Internal validity**: Is it close to the truth? Is it accurate? Can I believe it? Any bias, chances, confounding, causality?
- **External validity**: Can the results be generalized to my practice population?
- **Applicability**: Are the results applicable to and acceptable to my specific patient?
- **Statistical Significance**: are the results of the study valid?
- **Clinical significance**: what were the results?
- **Personal significance:** will the results help me in caring for my patients?

Step 4: APPLY having already critically appraised the evidence, extracted the most useful results and determined whether they are important, you must decide whether this evidence can be applied to your individual patient or population. There are important points to determine whether
Your patient has similar characteristics to those subjects enrolled in the studies from which the evidence was obtained.

- The outcomes considered in the evidence are clinically important to your patient.
- The study results are applicable to your patent.
- The evidence regarding risks is available.
- An economic analysis has been performed.

This process requires a partnership between the doctor and the patient. If at the end of the process the decision is made not to apply the available evidence, that decision should be a shared and conscious one.

Step 5: ASSESS
Evaluate the effectiveness and efficiency of the process

- Are you asking any questions at all?
- What is your success rate in asking answerable questions?
- How is your searching going?
- Are you critically appraising your search results?
- Are you applying your evidence in clinical practice?

DOE DISEASE-ORIENTED EVIDENCE (INTERMEDIATE OUTCOMES)

- A test result/A physiological number

POEM PATIENT-ORIENTED EVIDENCE (FINAL OUTCOMES)

- that Matters to the Patient

Will I die? Will I suffer? My quality of life?

Disease/con.	DOE evidence	POEM evidence
Doxazosin use for hypertension	Decrease BP	Increase mortality in African Americans
Anti-arrhythmic after MI	Suppress arrhythmias	Increase mortality
Sleeping infants on their stomach	Anatomy and physiology decrease aspiration	Increase SIDS
Vitamin E prevention of heart disease	Reduce levels of free radicals	No change in mortality
PPI and H2 receptor blocker for NUD	Significantly reduce gastric pH levels	Little or no improvement in symptoms
HRT to prevent heart disease	Reduce LDL, increase HDL	Increase CV events
Beta blockers in heart failure	Reduce cardiac output	Reduce mortality in moderate to severe heart failure

EVIDENCE BASED DIAGNOSIS

- Sensitivity (true positive rate)-TP/(TP+FN) --- Snout
- Specificity (false negative rate)-FN/(TP+FN) ---- Spin
- Positive Predictive value (PPV)
- Negative Predictive value (NPV)
- Likely hood Ratio (LR)

Ways of expressing summary results

- The risk decreases from 10% to 8% (AR)
- Risk reduction is 20% (RRR)
- Risk decreases by 2% (ARR)
- One heart attack or stroke is prevented among 50 patients (NNT)
- Every 50 patients,49 will not receive benefit (NNT, negative spin)

Table: The accuracy of right lower quadrant tenderness in the diagnosis of appendicitis

	Primary care settings Appendicitis		Tertiary care settings Appendicitis	
	Yes (%)	No (%)	Yes (%)	No (%)
Right lower quadrant tenderness				
Present	84	11	81	84
Absent	16	89	19	16
Total	100	100	100	100
Frequency of appendicitis	14%		63%	
Frequency of positive sign	21%		82%	
Sensitivity	84%		81%	
Specificity	89%		16%	
LR+	7.6		1	
LR-	0.2		1	

- Pre-test probability----Probability of disease before test is performed. May use prevalence of disease.
- Post-test probability----predictive value of the test

Table: Examples of pre-test probabilities

Symptoms or clinical problems	Source	Work-up	Disease probabilities
Anaemia of chronic disease	90 adults admitted to a general medical ward of a county hospital of North America[a]	Clinical examination blood testing selected other testing	Infection 36% Malignant 19% Inflammation 6% Other 24%

Dizziness >2 weeks	100 adult patients seen in primary care sites in one North American city[b]	Clinical examination neurological Ophthalmologic and psychological testing selected other testing	Vertigo 54& Psychiatric 16% Multicausal 12% Other 19% Unknown 8%
Dyspnoea >4 weeks unexplained by exam9in. radiograph and spirometry	72 adults referred to outpatient pulmonary clinic in North America[c]	Standardized examination, testing and treatment	Respiratory 36% Cardiac 14% Hyperventilation 19% Other 12% Unexplained 19%
Epilepsy, new onset in adults	333 adults presenting to a major urban emergency department in North America (excluded alcohol, head trauma, hypoglycemia)[d]	Standardized examination, testing (including head CT), and treatment	Unknown 44% Stroke 11% Tumour 7% Infection 17% Metabolic 5% Other 16%
Palpitations	190 patients from acute care sites in on North American city[e]	Clinical examination, cardiac and psychological testing, selected other tests	Cardiac 43% Psychiatric 31% Miscellaneous 10% Unknown 16%
Raynaud's phenomenon	Literature review of published reports of secondary diseases in 639 patients with Raynaud's from various settings[f]	Variable. usually clinical examination, selected serology and follow-up	Only 12.6% had or developed "secondary disorders" (e.g. systemic sclerosis, MCTD, SLE, etc.)
[a]Am J Med 1969, 87: 638-44 [c]Chest 1991; 100: 1293-9 [e]Am J Med 1996; 100: 138-48		[b]Ann Intern Med 1992; 117: 898-904 [d]Ann Emerg Med 1994; 24: 1108-14 [f]Arch Intern Med 1998; 158: 595-600	

Case Study 1 (low pre-test probability)

- *A 31 –yr-old woman presents with a 3-week h/o intermittent chest pain unrelated to activity, unrelieved by rest and is non-radiating. The onset of pain is usually associated with food intake. No CVD risk factors.*
- *Pre-tp of CAD-10%*
- *With a low prevalence and relatively high specificity, NPV is high. Therefore, NPV of 96%, if test (-)—true negative—exclude CAD.*

Case study 2 (moderate pre-test probability)

- *A 41-yr-old female who has a background H/O h/T and smoking presents with a 2-week H/O central, stabbing chest pain. It is sometimes precipitated by moderate exertion and there is costochondral tenderness.*
- *Her Pre-tp of CAD-50%*
- *With a moderate prevalence of 50% and relatively high sensitivity and specificity, both PPV and NPV are high.*
- *It is likely that patient need an Angiogram if exercise stress test-EST(+)*
- *It is unlikely that patient would need angiogram if EST (-).But 29% probability (100-NPV%)-angiogram may be warranted if resources are available. And enough clinical suspicion.*

Case study 3 (high pretest probability)

- *A 65-yr-old male with background h/o hypertension presents with a 6 week-H/O intermittent central crushing chest pain that radiates to his jaw. It is usually precipitated by mild exertion and relieved by GTN or rest.*
- *His pre-tp of CAD—90%*

- *With a high prevalence and high PPV (96%), only 4% who test + will not have CAD.*
- *NPV is only 21%, who test- will actually have CAD.*
- *If pre-tp is high, EST doesn't help with clinical decision making.*
- *If very high pre-tp of 90%, perform angiogram*

From pretest probability to post-test probability: Bayes' theorem

- *Post test odds = pretest odds times likely hood ratio*
- *X = O x LR*
  - *X = post test odds, O = pretest odds, LR = likely hood ratio*
- *Post test probability = pretest probability* x *test sensitivity/pretest probability* x *test sensitivity + (1-pre tp)* x *test false positive rate*

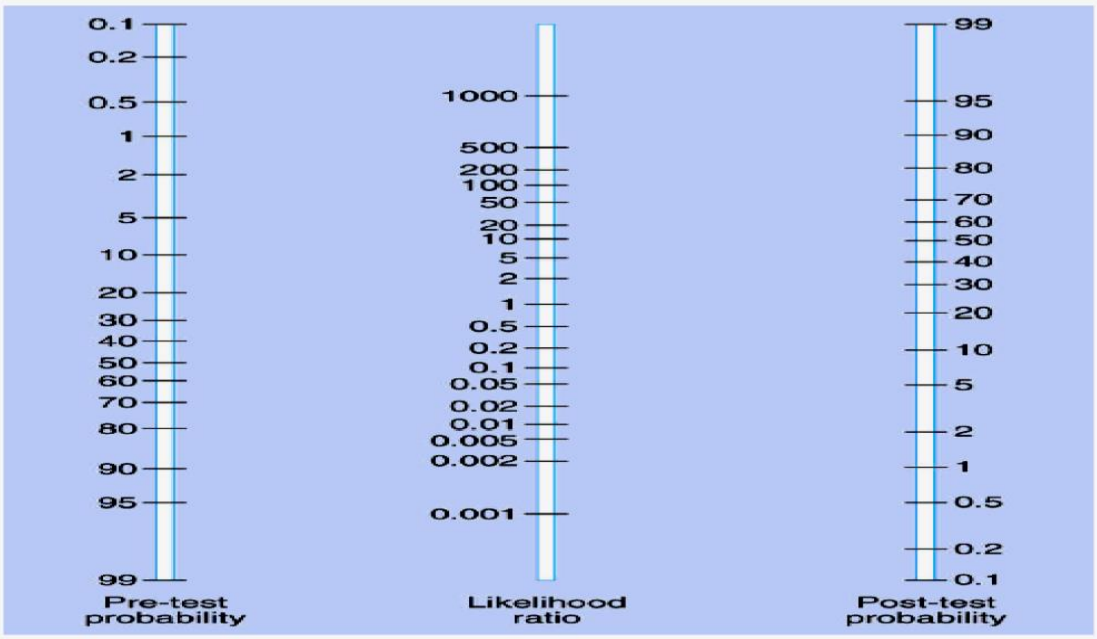
Estimation of post-test probability from pre-test probability and likelihood ratio goes as follows:[2]

- Pretest odds = (Pretest probability / (1 - Pretest probability)
- Posttest odds = Pretest odds * Likelihood ratio

In equation above, *positive post-test probability* is calculated using the *likelihood ratio positive*, and the *negative post-test probability* is calculated using the *likelihood ratio negative*.

- Posttest probability = Posttest odds / (Posttest odds + 1)
- Posttest probability = $\frac{Posttest\ odds}{Posttest\ odds+1} = \frac{Pretest\ odds \times likelihood\ ratio}{(Pretest\ odds \times likelihood\ ratio)+1}$

Figure 3.1 A likelihood ratio nomogram.



- *LR >1 indicates that the test result is associated with the presence of the disease.*
- *LR <0.1 indicates that the test result is associated with the absence of disease.*

EVIDENCE_BASED CLINICAL DECISION MAKING

Please study this following scenario:

U Hla (42) presents to you with classical clinical features of acute maxillary sinusitis: nasal obstruction, purulent discharge and pain and tenderness over his maxillary sinuses. X Rays of his sinuses reveal

mucosal thickening consistent with maxillary sinusitis. This is his first episode, which you ascribe to a recent viral respiratory tract infection.

Example of evidence-based decision making in patient with maxillary sinusitis:

1.Evidence What is the diagnostic accuracy and predictive value of clinical signs, nasopharyngeal swabs and x-rays? What are the efficacy, effectiveness and safety of the following advice and medication? • Nasal douches and steam inhalation • Decongestants • Analgesics • Antibiotics(e.g. Amoxicillin 7-10 days) if symptom persists **Evidence is needed ideally from relevant, high-quality systematic reviews; EBM guidelines or RCTs**
2. Resources-cost effectiveness What are the costs of medication or other treatments? Do the potential benefits of the treatment outweigh the harms and cost?
3. Patient preferences What are the possible side-effects of the medication? What is important to the patient? What other options is the patient interested in?

The family physician has a duty of beneficence towards patients, which involves making sure patients understand information and assisting them in making appropriate health choices based on sound research evidence. Evidence therefore is but one component of the decision making process and is necessary, but not sufficient for delivering high quality patient care.

Further reading:

1. *Evidence-Based Medicine: Reading and writing Medical Papers by Kaura, Mosby Elsevier,2013*
2. *Handbook of Family Medicine,2nd Ed, edited by Bob Mash, Oxford university Press SA, 2006*
3. *Evidence-Based of clinical diagnosis, edited by Knottnerus, BMJ publishing group, 2002.*
4. *Making right decision in Family medicine, CME lecture notes, by Dr Win Lwin Thein, 2018*

MODULE 12:

TERMINAL CARE, PALLIATIVE CARE AND CARE OF CANCER PATIENTS IN GENERAL PRACTICE

TERMINAL CARE

DEFINITION

Terminal Care refers to the management of the patient in whom the advent of death is felt to be certain and not too far off and for whom medical effort has turned from active therapy to concentrate on the relief of symptoms, support of both patient and family.
Terminal Care applies not only to malignant disease but it should also apply to terminal phase of chronic disease. (e.g. HIV/AIDS, end stage of renal failure)

CONCEPTS OF DEATH AND DEFINITIONS

Death is still a fearful and frightening, event and the fear of death is universal. What has changed his own way of coping and dealing with death and dying and without dying patients.
Our duty is composed 2 parts

- Part (1) Dealing with dying patient and family
- Part (2) to confirm the diagnosis of death and give bereavement counselling to his/her family

MEDICAL DEFINITION

It is usually based on cessation of respiratory (or) circulatory function. The most acceptable criterion of genuine and complete death occurs when the categories of cardiac arrest, respiratory cessation, brain death and complete loss of vital sign are satisfied and this condition remain permanently through rigor mortis and physical decay.

DEATH AND THE PATIENT

The thought in the mind of a dying patient usually passes through different stages and at each stages the patient and his relatives have to adjust to the changing circumstances.
There are five stages through which a patient may progress before achieving acceptance of death.

Stage 1. **Denial (No! not me!):** Feeling of denial accompanied by self –pity, irritability and isolation from others

Stage 2. **Anger (Why me?):** Anger about what is appending and grief for what is being lost. Anger displaced and projected to environment.

Stage 3 **Bargaining (Yes, it is me, but...):** negotiating with hospital staff or secretly with God to postpone death

Stage 4. **Depression ('It is me'):** feeling of depression, fear of being dead, of process of dying of pain, of leaving loved ones and happy associations

Stage 5. **Acceptance:** last stage, reached when patients find peace

- Not in all patients
- Help us to identify needs of dying patients and respond appropriately to them, contributing towards acceptance.

DEATH WITH DIGNITY

- It implies that highest possible quality of life will be maintained.
- dying person's rights and wishes be respected by caregivers.
- Give the chance to maintain his self-esteem and sense of integrity. e.g. Dying at home as familiar surroundings help the patient maintain a sense identity.
- The dying person is permitted to retain some control
- Has the freedom to choose his her style of dying
- To discuss death openly
- Allowed to prepare for dying in his/her own way
- Dying patient's care focuses on maintaining quality of life
- Intervention when the prognosis is hopeless, is inappropriate if it violates the patient's wishes
- Ethical Considerations
- Principle of truth-telling, beneficence, autonomy, proportionately and distributive justice.
- Help patients make difficult decisions about care including withdrawal of support
- Others: patient have right to stop unwanted medical treatment including artificial nutrition and hydration

FOUR CARDINAL PRINCIPLE OF TERMINAL CARE

- Patient autonomy (respect for the patient as a person)
- Beneficence (do good)
- Non-maleficence (Minimize harm)
- Justice (fair use of available resource)

The four cardinal principle need to be applied against a background of respect for life and acceptance of ultimate inevitability of death

In practice, there comprise three dichotomies which need to be applied in a balanced manner. Three dichotomies are

- the potential benefits of treatment must be balanced against the potential burden
- striving to preserve life but when biologically futile, providing comfort on dying
- individual need are balanced against those of society

WHEN SHOULD BE THE END-OF-LIFE DISCUSSION BE INITIATED?

1. **Urgent indications**
   - Imminent death –talk about wanting to die
   - Inquiries about hospice or palliative care
   - Recently hospitalised for severe progressive illness
   - Severe suffering and poor prognosis
2. **Routine indications**.
   - Discussing prognosis
   - Discussing treatment with low probability of success
   - Discussing hopes and fear
   - Physician would not be surprised if patient died in 6.12 months

EUTHANASIA

Literal meaning-Death without suffering

1. Active Euthanasia - refers to physician talking an active role in the death of patient. (e.g. giving a lethal dose)
2. Passive euthanasia- means taking no further measures (or therapy) that the patient does not desire. (e.g. giving solucortef)

DNAR ORDERS

Initially DNR (Do Not Resuscitate)
Now DNAR (Do Not Attempt Resuscitations)
CPR can restore people to vigorous health.

DUTY OF PHYSICIAN

- Inform about possible consequences of surviving CPR attempt like fracture ribs, lacerated internal organ and likelihood of requiring aggressive interventions such ICU care.
- Encourage patients and families to make proactive decision about what is wanted in end of life care.
- physician should write DNAR orders and reasons for them in medical record.

Factors to consider

- Nature of Emergency
- General condition of patient
- Disease state and prognosis
- Concomitant pathologies
- Symptomatology
- Effectiveness and toxicity of available t/m
- Patients' and carers, wishes

CARE OF DYING PATIENT

Aim

- to make the person as comfortable as possible
- to pursue cure of potentially reversible disease provide comfort and help the patient prepare for death.

TREATMENT PLANNING FOR A TERMINAL ILLNESS

Discussing Terminal Treatment Guidelines in the Ambulatory Setting

1. While taking a routine genogram, ask, "who in your family do you turn to for support?" Follow up by asking, "Should you become seriously ill or injured, would that be the person you would like me to consult regarding treatment decisions?"
2. Ask about the patient's values, and then his or her wishes for treatment.
3. Be as specific as possible.
4. Encourage the patient to discuss his or her wishes with family members.
5. Introduce the idea of a "living will," which should:
    a. Consider specific possibilities, such as respiratory support, nutritional support, antibiotics, and resuscitation.
    b. Name a healthcare proxy who can have final authority, in consultation with other family members, to make unforeseen treatment decisions.
    c. Contain the signatures of two witnesses.
    d. Be updated yearly and/or prior to any hospitalization.
    e. Be copied and given to family members, with a copy in the chart

Guidelines for Terminal Treatment Planning with the Patient

1. Set attainable goals
2. Help the patient:
    a. Reminisce about life; emphasize accomplishments and positive memories.
    b. Identify valued personal characteristics.
    c. Let go of unfinished business.

    d. Participate in decision making about treatment; let go of the need to control what cannot be controlled.
    e. Forgive oneself, and ask for forgiveness.
    f. Express love directly to loved ones.
    g. Discuss beliefs about spirituality, the meaning of his or her life, in particular, any afterlife.
3. Encourage the use of meaningful religious rites and rituals.
4. Assess for clinical depression (vs grieving), and suicidality; consider antidepressants if warranted

Guidelines for Terminal Treatment Planning at a Family Conference

1. Ask the patient or family if they want their priest, minister, or rabbi to attend the meeting.
2. Begin the conference by asking about less-difficult issues, then move on to more highly charged issues.
3. What are the treatment options?
    - What does the treatment offer the patient?
    - What are the probabilities of success and failure?
    - Will the treatment cause additional illness?
4. Solicit questions to help decide how much and what kind of medical information the patient and family want. Be as straightforward as possible and acknowledge any personal biases. Be careful not to medicalize what are actually ethical issues.
5. Describe and encourage the use of hospice care.
6. Help the patient and/or family weigh potentially good outcomes against potentially undesirable ones.
7. Help both patient and family stay focused on the patient's personal goals as primary.
8. Be as no anxious as possible.
9. Use clear, jargon-free language. Be a supportive, active listener. Track others' communications and clarify confusing statements made by any participant.
10. Model an ability to tolerate the ambiguity and uncertainty that accompanies. Address such relevant medical issues as: all these decisions.
11. Communicate a willingness to sustain contact with the patient and the family regardless of their treatment decisions.

Principles for Terminal Treatment Planning at a Family Conference in Which a Patient Is Unable to Participate

1. Keep the care, comfort, and concern for the patient primary.
2. Include all available family in the conference.
3. Hold the conference at the patient's bedside.
4. Remind the family that their job is to decide what the patient would wish to have done, rather than what they themselves would want.
5. Recognize the family's pain, and acknowledge the difficulty of the process.

Notifying the Family About a Death

1. Encourage the family to be present at the time of death, if at all possible.
2. When the family is expecting the death of one of its members, ask how they would prefer to be notified if they are not present.
3. Notify the family immediately at the time of death:
    a. With an expected death, call on the family as previously agreed.
    b. With an unexpected death, ask the family as a whole to come to the hospital and discuss the events leading up to the death.
4. Think about what you want to say before making the call: Many people remember the exact words spoken by whoever told them of the death.

5. While being sympathetic and sensitive, avoid euphemisms: Use the words “death, dying, and dead.”
6. Say, “You have my sympathy,” rather than, “I am sorry,” which could be construed as an apology.
7. Give the family the opportunity to view the body and say their goodbyes.
    a. Arrange for the viewing to occur in a private room.
    b. Make sure the body has been cleaned and prepared.
    c. Offer to have a member of the healthcare team stay with the family.
    d. Allow them to remain with the deceased as long as they wish.
8. Meet with the family.
    a. Before or after the viewing to show concern and facilitate a healthy early grieving process.
    b. Provide information about the cause of death: Solicit and answer any questions.
    c. Answer any questions about autopsy or organ donations.
    d. Use active listening skills: Expect expressions of intense emotions.
    e. Make yourself available as a support for the family: Offer to have follow-up meetings, either to discuss autopsy results or questions about the deceased that will likely arise in the future.
    f. Remind the family to call their funeral director.
    g. Encourage the family to include children, especially those older than
2. 5 years, in the funeral and other family gatherings.
9. With an unanticipated or traumatic death, consider making a home visit soon thereafter: With an anticipated death, send a sympathy card to the family and/or attend the calling hours or funeral.
10. With an anticipated death, telephone the family 1–2 weeks after the death to inquire about them, answer any questions, and encourage any necessary follow up.

Primary Care Grief Counselling

1. With a traumatic death, schedule an office visit soon after the funeral, and consider rapid referral to a family therapist: With an anticipated death, schedule an office visit at within 1 month with interested family members to review the death and the autopsy results.
2. Encourage family members to talk about the circumstances surrounding the death, recall memories, and openly discuss feelings of sadness, anger, and guilt.
3. Inquire about any significant changes in financial status.
4. Normalize signs of grieving during the first year (e.g., crying spells, lack of energy, and preoccupation with the deceased).
5. Avoid the use of such psychotropic medication as sedatives or hypnotics, except when previously prescribed or when a family has a serious sleep disturbance.
6. Monitor the medical status of the recently bereaved: Encourage family members to come in for a health evaluation at 6 months to evaluate any increased risk for illness or delayed difficulties with grieving.
7. Refer interested family members to community-based self-help support groups.
8. Monitor family members for signs of unresolved grief reaction; refer if necessary.

THE NEED OF DYING PATIENT AND CARE

Psychological Care

- Give explanation about the symptom and the disease
- Counselling of patient have to provide psychosocial and spiritual support

Physical Care

- Symptomatic treatment for comfort
- Symptom control
- Pain control

Social Care

- Religion and culture of patient can and do influence and determine the expectation and ability to cope with terminal illness and death

Care of family

- Timely, frequent and consistent communication
- Focusing on patients' wishes
- Being aware of family conflict
- Accommodating family's grief
- Refocusing hope
- Encouraging planning
- Remaining available
- Following up with family after death
- Role of family physicians
- 1st to know the terminal illness
- Final one to take care of the patient
- Prepared to give empathic care and medical expertise
- Don't forget the family
- Provide emotional support
- Listen to family's concerns
- Encourage family members to stay with patient
- Refer family to community resources, e.g. Hospice
- Reassure family that everything reasonable was done before death
- Reassure family that you will do all possible to provide comfort
- Facilitate the issuing of the death certificate and instruct the family the procedure of reporting death
- Visiting the family just before and immediately after death of the patient may be great confidence booster to the family
- It is the family physician's responsibility to provide coherent management by offering treatment, guidance, and safe conduct throughout the course of disease

Bereavement

- The family doctor is the best person to provide skilled and compassionate bereavement support.

Specialist/Hospitals

- The need for specialist is usually early, to make confirm the diagnosis, to give all management possible to cure (or) to alleviate disease.

Hospice care

- Is an approach to provide a caring environment for meeting the physical and emotional needs of the terminally ill.
- Focus on the patient and family rather than disease.
- Provide comfort and pain relief rather than treating illness e.g. treat patient with morphine and antipyretics rather than antibiotics, for the dying
- Individualised attention, human contact, interdisciplinary team approach
- Advise increase patient's satisfaction, ease the family's anxiety, reduce the costs.

Home care

- Is provision of care and support service by formal and informal caregiver in home, in order to promote restore and maintain a person's maximal level of comfort, function and health including care toward a dignified death.

- Specialist home care nurse licence with primary health care and offer advice on treatment and care. They provide support for the whole family, more patients are able to remain at home until death.

Task after death

The pronouncement and death certificate

- Confirm and verify death
- Note finding and time of death in patient's chart
- Provide words of sympathy and reassurance, time for questions and initial grief and quite private room for family
- Reporting
- Death certificate should contain:
    - Major cause of death
    - Contributory cause
    - Associated conditions

Autopsy and organ donation

- Law specify that physician who declares a patient dead must not be involved with a patient who is waiting for a donor organ
- Patients and family have their right to limit autopsy or organ donation

Follow up and grieving

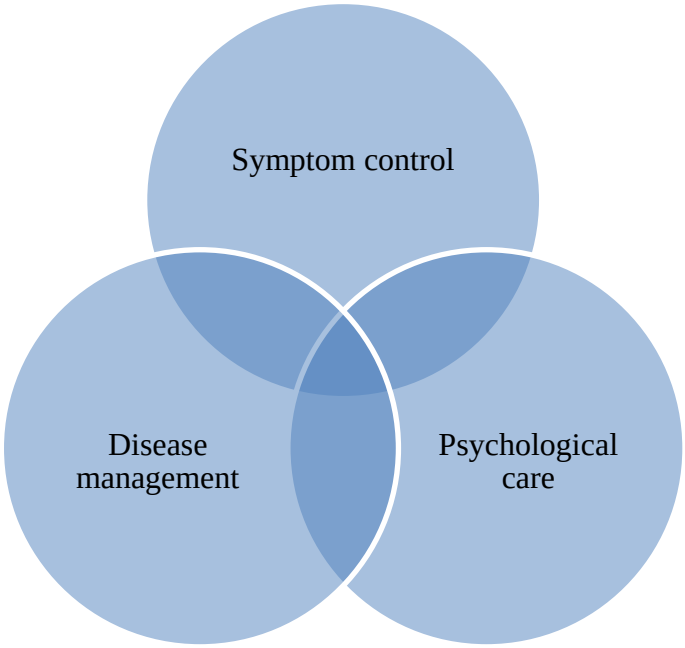
- Following up family and reassure the nature of normal grief and identify complicated grief or depression
- Recommend support groups and counselling
- for physicians ,grieving the loss of patient is normal
- attending the funeral of the patient is satisfying personal experience that is almost universally appreciated by families and that may be the final element in caring well for people at the end- of- life.

PALLIATIVE CARE

DEFINITION

Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual.

PRINCIPLES OF PALLIATIVE CARE



WHAT IS PALLIATIVE CARE?

- Palliative care is the active, holistic care of patients with advanced, progressive illness
- Palliative care is all about looking after people with illnesses that cannot be cured, relieving their suffering and supporting them through difficult times
- Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount.
- The goal of palliative care is achievement of the best quality of life for patients and their families.

WHY DO WE NEED PALLIATIVE CARE?

To help people suffering from:

- Cancer
- HIV
- Progressive neurological illnesses
- Severe kidney or heart failure
- End-stage lung disease
- Other life-limiting illnesses

WHAT IS DIFFERENT ABOUT PALLIATIVE CARE?

The holistic approach to problems

- Physical
- Psychological

- Social
- Spiritual

DIFFERENT MODELS OF PALLIATIVE CARE DELIVERY INCLUDE

- Palliative care within home base care
- Palliative care clinic
- Day care support
- Hospital palliative care team
- Inpatient unit

THE MANAGEMENT OF PAIN

DEFINITION OF PAIN

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage**.**

ASSESSMENT OF PAIN

A. Key components of a pain assessment

- Description of the onset and duration of the pain
- Description of the pain e.g. location, quality, pattern, character
- Rating of pain intensity
- Description of aggravating and relieving factors
- Description of associated symptoms and signs
- Description of the effects of pain on functioning and quality of life
- Description of current pain management regimen and assessment of effectiveness
- Summary of the past history of pain management
- Identification of the patient's goals of treatment
- Physical examination
- Diagnostic testing, where appropriate

S *Site of pain* Where? Any radiation? Numbness where pain felt? Pattern of involvement?

O *Onset* When did it start? How did it start? What started it? Change over time?

C *Character of pain* Type of pain — burning, shooting, stabbing, dull etc.; pattern of pain, e.g. colicky, constant, etc.

R *Radiation* Does the pain go anywhere else?

A *Associated features* Are there any skin or joint changes, e.g. bruising, redness, or swelling?

T *Timing/pattern* Is it worse at any time of day? Is it associated with any particular activities, e.g. movement, urination, eating, passing stool, coughing?

E *Exacerbating and relieving factors*

S *Severity* Record, especially if the pain is chronic and you want to measure change over time. Consider a patient diary.

Ask about:

Pain intensity, e.g. none-mild-moderate-severe; rank on a 1–10 scale.

• Record interference with sleep or usual activities.

• Pain relief e.g. none-slight-moderate-good-complete
Onset When did it start? How did it start? What started it? Change over time?

PAIN ASSESSMENT TOOLS

- **Visual analogue scales (VAS)**
  No pain_____ Worst pain
- **Categorical verbal rating scales (VRS)**
  None Mild Moderate Severe
- **Categorical numerical rating scales (NRS)**
  0___1____2___3__4___5__6_____7___8____9_____10
  No pain Worst pain

PAIN CLASSIFICATION

1. Nociceptive pain

may result from injury to somatic structures (somatic pain) or injury to visceral structures (visceral pain) Pain which is transmitted by an undamaged nervous system and is usually opioid-responsive.

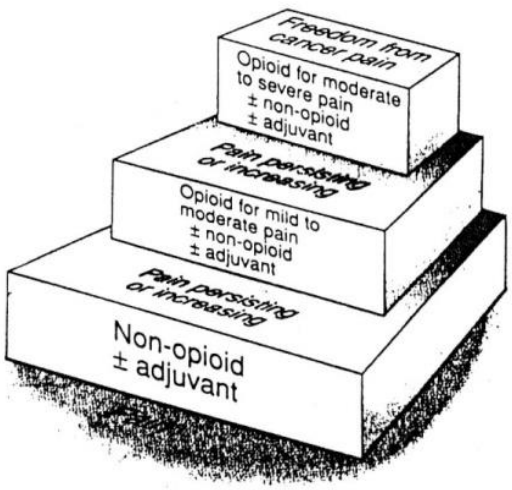
2. Neuropathic pain

is caused by injury to the peripheral and/ or CNS. Pain which is transmitted by a damaged nervous system and which is usually opioid-sensitive.

PRINCIPLES OF PAIN MANAGEMENT

- WHO three –step analgesic ladder.
- The WHO method can be summarized in five phrases:
  - by the mouth
  - by the clock
  - by the ladder
  - for the individual
  - attention to detail

WHO ANALGESIC LADDER



Classification of analgesics

- ❑ **Non-opioids**
  aspirin, paracetamol, and NSAIDs
- ❑ **Opioids**
  opioids for mild to moderate pain
  opioids for moderate to severe pain
- ❑ **Adjuvant analgesics**

Adjuvant analgesic	Use
Antidepressant	Neuropathic pain
Anticonvulsant	Neuropathic pain
Antispasmodic	Pain due to colic
Bisphosphonate	Pain due to bone metastases
Corticosteroid	Pain due to oedema or nerve compression
Muscle relaxant	Pain due to muscle spasm or cramp
NMDA- receptor blocker	Neuropathic pain

Step 1:Non-opioid ±adjuvants

- Patients with mild pain
  For example –patient with mild neuropathic pain – paracetamol 500 mg-1 g q 6-8 hr regularly (maximum daily dose 4g) in combination with amitriptyline 25-75 mg o.d

Step 2: Opioid for mild –moderate pain + non-opioid ± adjuvants

For example –a patient with moderate neuropathic pain

codeine 30-60 mg q 6 hr in combination with paracetamol 1 g q 6 hr and amitriptyline 25-75 mg o.d

Step 3: strong opioid+ non-opioid ± adjuvants

Oral morphine, in either immediate-release (i/r) or modified-release (m/r) form is the opioid of choice for treating moderate or severe cancer pain.

Step 1 analgesics

- Aspirin, paracetamol and NSAIDs
- Non-specific COX inhibitors, such as aspirin, ibuprofen and diclofenac, inhibit both coenzymes
- Newer NSAIDs inhibit COX-2 only are associated with reduced GI effects.

Step 2 Analgesics:

- **Codeine phosphate**
  is available in tablet and syrup formulations.
  dose of 30-60 mg po. 4-hour maximum dose of 240 mg in 24 hours.
- **Tramadol**
  Tramadol displays weak opioid activity and it is also a noradrenaline and selective serotonin-reuptake inhibitor (SSRI)
  Adverse effects include nausea, vomiting, dizziness and drowsiness.
  Preparations: caps:50mg, injection 100mg/2ml
  Starting dose: 50 mg qds. po. or 100 mg bd. po (12 h m/r)

Step 3 Analgesics:

Starting morphine

- Opioids are safe, effective and appropriate drugs for the management of cancer pain.
- Use immediate-release morphine (oramorph or sevredol) to titrate the dose needed for pain relief.
- If moving from step 2 give 5-10 mg 4 hourly and PRN
- If step 2 has not been used (opioid naïve), in the elderly or those with renal impairment, use smaller doses (2.5 – 5 mg) with closer monitoring.
- Reassess pain control regularly
- If pain not controlled, titrate the dose by 30-50% every 2-3 days (or sooner if necessary) to achieve pain relief
- Increase the PRN dose in line with the increase in the background analgesia
- If pain is not responding consider an alternative strong opioid or seek specialist help

Symptoms and signs of opioid toxicity

- Drowsiness
- Hallucinations(most commonly visual)
- Confusion
- Vomiting
- Myoclonus
- Pinpoint pupils

- Respiratory depression

Alternative opioids

- Diamorphine
- Fentanyl
- Buprenorphine
- Methadone
- Oxycodone
- Hydromorphone

NEUROPATHIC PAIN

- The medical treatment of neuropathic pain is unsatisfactory and pain can prove difficult to control.

➢ **Drugs for painful polyneuropathy**

- Amitriptyline, clomipramine, imipramine (tricyclic antidepressant)
- Venlafaxine
- Duloxetine
- Oxcarbazepine
- Lamotrigine
- Gabapentin
- Oxycodone
- Tramadol

MANAGEMENT OF SPECIFIC PROBLEMS

- **Malignant bone pain**
    1. Radiotherapy
    2. Bisphosphonates

TREATMENT OF OTHER CAUSES OF POORLY CONTROLLED PAIN

pain	Possible co-analgesics
Headache due to cerebral oedema	Dexamethasone
Painful wound	Metronidazole
Intestinal colic	Hyoscine butylbromide or hydrobromide
Gastric mucosa	Lansoprazole
Gastric distension	Asilone+domperidone
Skeletal muscle spasm	Baclofen/diazepam
Cardiac pain	Nitrates/nifedipine
Oesphageal spasm	Nitrates /nifedipine

COMPLEMENTARY THERAPIES AND OTHER NON-PHARMACOLOGICAL PAIN INTERVENTIONS

Complementary therapies	Other non-pharmacological interventions
Acupuncture Reflexology Aromatherapy Art therapy Music therapy Touch therapy	Positioning Catheterization Reassurance Good communication Diversional therapy TENS Splinting of a fracture limb Psychological support

- **Alternative medical therapy** –Acupuncture, Homeotherapy
- **Mind-body therapies** –Relaxation therapy, Hypnotherapy, Guided imagery and visualisation, Meditation, spiritual healing
- **Creative therapies** –Art and Music therapies
- **Biologically-based practices** –Herbal medicine, Aromatherapy
- **Manipulative and body-based therapies** –Massage, Reflexology

COMMON SYMPTOMS CONTROL

GASTROINTESTINAL SYMPTOMS

- Oral problems –Coated tongue/dirty mouth (e.g. Fluconazole 50 mg od x 7 days)
  -Dirty mouth, sore mouth and difficulty swallowing
  -painful mouth and stomatitis (e.g. benzydamine mouth wash)
  -Ulceration of oral mucosa (e.g. genelog)
  -Drooling (e.g. hyocine)
- Nausea and vomiting (e.g. domperidone 10 mg tds pre-meal)
- Constipation (e.g. laxative, enema)
- Diarrhoea (e.g. loparamide)
- Intestinal obstruction (e.g. refer for surgery if appropriate)
- Hiccup (mexilon, dexamethasone)
- Anorexia/cahexia/asthenia (dexamethasone 2-4 mg od)
- Dyspepsia
- Gastrointestinal bleeding
- Bowel stoma care

RESPIRATORY SYMPTOMS

- **Breathlessness**
- **Cough**
- **Breathlessness**

  Principle of management

  –general measure
  -treatment of reversible causes
  -Disease-specific treatment
  -Symptomatic management-including pharmacological and non-pharmacological measure
  Management of treatable causes e.g.
  lung tumour → radiotherapy or chemotherapy
  bronchospasm → bronchodilators, corticosteroids
  anaemia → blood transfusion, iron, erythropoietin
  Cough → pharyngeal irritation → simple linctus
  → bronchial irritation → nebulized bupivacaine

SKIN PROBLEMS IN PALLIATIVE CARE

Wound care =bacterial ,fungal skin infections, abscesses
Pruritus(itch)

ANXIETY AND SLEEPLESSNESS

GENITOURINARY SYSTEM

= urinary retention, bladder spasms

PSYCHOSOCIAL SUPPORT AND SPIRITUAL SUPPORT

The spiritual aspects of an illness concern the human experiences of sickness(dis-ease) and search for meaning within it.

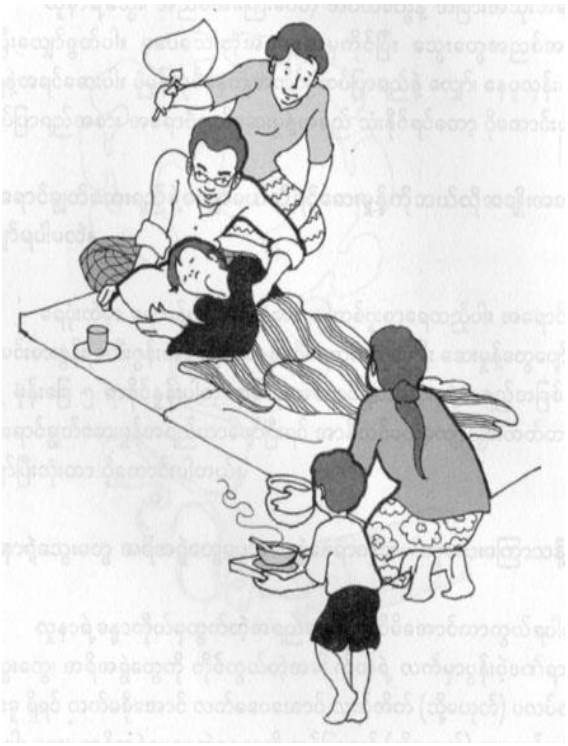
- Emotional and spiritual support
- Counselling
- Assist by hospice organization, social workers, chaplain, volunteers
- Important issues by consultation of breaking bad news
- Revealing of diagnosis, &prognosis
- Reaction to and copying with knowledge of diagnosis and prognosis
- Refusal or concern about treatment.
- Fears of dying-separation anxiety
- Placement issues-hospice, home
- Bereavement issues

SPIRITUAL ASSESSMENT/ SUPPORT

- ❑ **H**ope
- ❑ **O**rganised religion
- ❑ **P**ersonal issues
- ❑ **E**ffect on our care

- What sources of **H**ope, strength, comfort, meaning, peace, love and connection does the patient have?
- What role does **O**rganized religion play in the patient's life?
- What is the patient **P**ersonal spirituality and practice?
- What will be the **E**ffects of these factors on the patient's medical care and end-of-life decisions?

SUPPORTIVE CARE OF CANCER PATIENTS AT HOME AND AT HOSPICE



At home

- monitoring of symptoms
- dealing with emergencies
- daily self-care needs
- when death is near-what they need to do
- after death-what to do, whom to call, how to obtain death certificate

Hospices services

- Inpatient hospices, nursing homes
- Have a social workers, chaplain, volunteers
- Can assist with preparation of a legacy, financial issues& support for bereaved family members

At hospital

- To protect the patient from end-of-life suffering.
- Admitted for terminal care.
- To control refractory symptoms.

REFERENCE

1. *Diploma in Family Medicine module*
2. *Oxford handbook of General Practice, 4th Edition*

CARE OF CANCER PATIENTS IN GENERAL PRACTICE

DEFINITION

It is the approach that improves the quality of life of patients and their families facing the problems associated with life threatening illnesses, through prevention, relief of suffering by means of early identification assessment treatment of pain, other problems (physical, psychological, spiritual)

ROLE OF GENERAL PRACTITIONER

1. Primary Prevention

   Health education to public for cancer awareness.
   Screening procedures

2. Early Diagnosis

   Awareness of cancer warning signs
   Diagnostic procedure

3. Support for the patients and their families during the process of diagnosis and treatments
4. Continuing care after treatment when patients need surveillance, support and all possible relief from any residual disabilities
5. Diagnosis of recurrence
6. Care and guidance of patients in the palliative and terminal phase including bereavement counseling
7. Treatment of cancer Surgery, Radiotherapy, Hormonal therapy, Immunotherapy, Molecular targeted therapy, Gene therapy are used.
8. GP should know early recognition and timely referral of common oncologic emergencies e.g. superior vena cava obstruction, Pericardia effusion, spinal cord compression, hypercalcemia, and hyponatremia.

COMMON PROBLEMS IN PATIENTS WITH CANCER AND HOME CARE OF TERMINALLY ILL PATIENTS:

- Pain management
- Lymphoedema
- Skin care
- Fungating malignant ulcers
- Stoma care
- Bleeding
- Mucositis
- Nutrition and cancer treatment

PAIN MANAGEMENT

CANCER PAIN

Cancer pain is mediated by inflammatory signalling mechanism related to tissue injury by cancer.
Chronic cancer pain is commonly mediated by prolonged firing of nociceptive C fibres.

Assessment of pain

Position, quality, radiation, severity, timing, understanding and values.

Severity

Numerical rating scale is used to quantify the severity of pain, rating scale is 0-10
None =0. Mild =1-3.Moderate =4-6.Severe =7-10

Categories of pain

- Visceral pain, arise from internal organs, peritoneum or pleural cavity
- Somatic pain, arise from skin, muscle, bone, joint or ligaments
- Neuropathic pain, signal is generated by damaged nervous system

WHO analgesic ladder

Step 1 = Non opioid + or - adjuvant
Step 2 = weak opioid + or - non opioid + or - adjuvant
Step 3 = strong opioid + or - non opioid + or - adjuvant

Non-opioid analgesics

Acetaminophan and non-steroidal antinflammatory drugs (NSAID)

- Effective for mild to moderate somatic or visceral pain
- Side effect of acetaminophen is potential hepatotoxicity.
- NSAID must be used with caution in renal impairment, peptic ulcer disease and elderly.

OPIOID ANALGESICS

Classification

1. Weak opioids (Codeine, tramadol)

   Used for mild to moderate episodic or constant pain, Involve in pain management of WHO analgesic ladder step 2

2. Strong opioids (Morphine, Hydromorphine, Oxycodone, Fentanyl, Methadone)

   Used for Moderate to severe pain, involve in pain management of WHO analgesic ladder step 3

Weak Opioids

Codeine
Naturally occurring opium alkaloid. Oral or parenteral formulations, combination with acetaminophen or caffeine.
Dose is 15mg, 30mg, 60mg. (Major side effects: Constipation)
Tramadol
Dual mechanism of action, through opioid receptor, Inhibition of serotonin & norepinephrine reuptake.
Oral or parentral form, 50 mg, 100 mg. Maximum dose 300 mg/day

Strong Opioids

Morphine Injection Morphine
Hydromorphine

- Semi-synthetic morphine derivative, (5 times potent than morphine, Oral, rectal, injection form**)**

Oxycodone

- Semi-synthetic morphine congener
- Fixed combination with acetaminophen (available only as oral)

Fentanyl

- Synthetic opioid and 100 times potent than morphine, rapid onset & short half life (buccal, sublingual, parenteral)
- Used in Palliative care as transdermal skin patch (TD). TD patch provide analgesics for 72 hrs
- Choice for patients with renal insufficiency
- Less constipation than opioids

Transdermal Fentanyl (TD)

- Indicated in following situations

Compromised oral route, Head & Neck Cancer, Oesophageal, gastric and bowel obstruction, variable level of consciousness, Poor compliance with oral form and other opioid have adverse effects

Methadone

Synthetic opioid

Oral opioid

Regular dosing

- Appropriate dose is the lowest dose that achieve desired effect with few side-effects
- To provide the patients with serum drug levels that is in the therapeutic range, but below sedation threshold.

Immediate release form

- Oral morphine, hydromorphone, oxycodone
- Onset of action within 45-60 min, half-life is 4-6 hrs
- Dosing interval of 4 hrs is good starting point
- Opioid-naïve patient, good starting dose might be as follows

Morphine 5-10 mg by mouth every 4 hrs, Hydromorphone 1 mg by mouth every 4 hrs, Oxycodone 2.5 mg by mouth every 4 hrs.

Slow release long-acting preparation

- Usually start after dose titration
- Onset of action peak is 3-4 hrs.
- These medications are administered every 12hrs.
- Initially use same total daily dose of mediation when switch from immediate-release to slow-release opioid preparation, for example: Oramorph: 30, 60, 100mg tab

Break though dosing

- Break through pain and break through dosing.
- Break through dose is half of regularly scheduled 4-hrly dose or 10% of total daily opioid dose.
- Breakthrough medication is immediate release formulation.
- Number of breaks through doses should be monitored.
- Re-evaluation of regular opioid dose should be undertaken when there have three breakthroughs dose a day.

Common side-effects of opioids

Some side effects are idiosyncratic. Develop when initiating an opioid or when there is escalation in dose

GI side effects

Nausea, vomiting and constipation. Prokinetic agent such as metoclopramide or domperidone can be used in opioid involved nausea.

CNS side effects

Sedation, confusion, respiratory depression

Other side effects

Non-cardiogenic pulmonary oedema, Xerostomia, Urinary retention, SIADH, Endocrine, Hypothyroidism, hypercalcaemia, pruritus

OPIOID ROTATION
(Switching opioids)

- Opioid rotation may be undertaken for following reasons
- Patient may require change of route of administration, pain is escalating or under suboptimal control and Dose of current opioid is causing unacceptable side effects

Opioids in renal failure

Both Fentanyl and Methadone are considered opioid for patients with renal impairment or who are on dialysis.

Other routes of opioid administration

Regular subcutaneous delivery of opioid (every 4hrs), continuously administered with pump, Intravenous route, TD Fentanyl

MANAGEMENT OF BONE PAIN

- NSAID, COX2 inhibitor, corticosteroid, bisphosphonate and calcitonin are used according to severity.
- External beam radiotherapy is considered when there is no adequate pain control with analgesic.
- Orthopaedic intervention is considered in situation when pain is difficult to control with other measures.

MANAGEMENT OF NEUROPATHIC PAIN

Tricyclic antidepressant (TCAs), serotonin-norepinephrine reuptake inhibitors (SNRIs), Anticonvulsants, Topical lidocaine, conventional opioid analgesics, methadone, corticosteroid and NMDA antagonists

SUPERIOR VENA CAVA OBSTRUCTION (SVC OBSTRUCTION)

Definition

SVC obstruction restrict the venous return from upper body resulting in oedema of arm and face, distention of neck and arm vein, headache and dusky blue skin discoloration over the upper chest, arms and face.

Aetiology

Malignant aetiology

a. Lung Cancer
   Account for 75% of malignancy causing SVC Obstruction.

b. Non-Hodgkin Lymphoma
Account for 10-15% of cases of Malignant SVC obstruction.

c. Other Malignant aetiology
Those include thymoma, mediastinal germ cell neoplasm and solid tumor with mediastinal lymph node metastases.

Benign aetiology

a. Mediastinal fibrosis and chronic infections
Those include fibrosing mediastinitis such as TB, Aspergillosis, lymphatic filariasis, idiopathic fibrosing mediastinitis and RT to mediastinum.

b. Thrombosis of Vena cava such as central line, polycythemia, Bachet syndrome & Idiopathic.
c. Benign mediastinal tumor such as thymoma, goitre, sarcoidosis and aortic aneurysm.

Diagnosis

1. Symptoms
Shortness of breath (50% of patients), neck and facial swelling (40%), Sensation of choking, fullness in head, headache and rarely convulsion

2. Signs
Thoracic vein distension (65%), neck vein distension & oedema of face (55%), tachypnoea (40%), plethora of face and cyanosis (15%), oedema of upper extremities (10%), paralysis of vocal cord or Horner Syndrome.

3. Radiographs
a. Chest radiograph
Demonstration a mass in 90% of patients, usually located in right superior mediastinum in 75% of cases.

b. Chest CT
Contrast enhanced CT can detect area of obstruction, degree of occlusion and presence of collateral veins.

c. Superior Venogram
Bilateral upper extremities venogram and MR venography are used for identification of SVC obstruction and extent of thrombus formation.

4. Histological diagnosis
a. Cytology of sputum positive in 60% of patients with SVC obstruction due to lung cancer.
b. Lymph node Biopsy of palpable lymph node can be helpful
c. Transthoracic fine needle aspiration can be used for peripheral lesion.
d. Video assisted thoracoscopic surgery usually results in definite histological diagnosis.
e. Mediastinoscopy is performed in helping selected group of patients.

Management

1. Endovascular Stents
- Percutaneous placement of stent give symptomatic relieve in 90% to 100% patient.
- This stent is placed via subclavian or femoral vein under local anaesthesia.
- Two indications are SVC obstruction with previously undiagnosed non-small cell carcinoma, that was followed by RT and recurrent SVC obstruction previously treated with RT.
- Short term anticoagulant with warfarin or dual antiplatelet for 3months after stent replacement.

2. Radiotherapy (RT)

- RT is indicated for SVC obstruction caused by NSCLC and combine with chemo in SVC obstruction caused by SCLC and lymphoma.
- Total dose varies between 3000& 5000 CGy. RT is associated with complete relief of symptoms within two weeks in 70% of patient.
- Median Survival is 10 month for SCLC and 3-5 months for NSCLC.

3. Chemotherapy

- Chemotherapies indicated in patient with NHL, SCLC, germ cell tumor, Breast cancer with SVC obstruction.

4. Supportive treatment

- Oxygen administered for hypoxia. Head should be raised to reduce hydrostatic pressure. Corticosteroid is indicated to reduce Brain oedema. Diuretic may be helpful.

5. Anticoagulants and antifibrolytic

- These agents may be helpful in SVC thrombosis.

6. Surgical decompression

- By passing SVC obstruction by using saphenous venous graft or sapheno-axillary vein bypass, which can be done under local anaesthesia.

GASTROINTESTINAL SYSTEM

NAUSEA/VOMITING

Causes

1. Higher center stimulation
2. Direct vomiting center stimulation
3. Vagal and sympathetic stimulation
4. Vestibular nerve stimulation

Management

1. Due to higher center stimulation (counseling, explanation, listening)
2. Direct vomiting center stimulation due to radiotherapy, raised intracranial pressure (Cyclizine, Dexamethasone)
3. Vagal, Sympathetic (Cough, constipation, bronchial secretion) Due to gastric stasis domperidone, metoclopramide, erythromycin
4. Chemoreceptor trigger zone (Haloperidol, Levomepromazine)
5. Vestibular stimulation (Cyclizine, Hyoscine patch)
6. Others (Acupuncture, Ginger)

MOUTH ULCERS AND MOUTH CARE

Mouth problems are common occurring in 90% of patients
Appropriate and effective oral assessment should be carried out

- Is the mouth dry or painful or infected
- Nutritional status of patient
- Tongue condition, Type of saliva and lip,

- Mental state of the patients, ability and willingness to participate in their care
- Uses of medications opioids may cause dry mouth
- (Steroids may cause oral candidiasis)
- Management and prevention (Health Education)
- Regular tooth and denture brushing twice daily
- Regular use of antibacterial antifungal mouth wash
- Check of fit of dentures
- Regular dental check

SKIN PROBLEMS

- Bed sores: Due to pressure necrosis of skin. Immobile patients are high risk especially in shoulder blades, elbow, buttock, knees, ankles and heels.
- To prevent bed sores, carer should use protective mattresses, cushions, incontinence advice on positioning and movement.
- Treat any sores that develop aggressively and admit if not resolving.

MANAGEMENT

- Use aids to movement where appropriate
- Discuss management with patient and home care.
- Turn the patient every 2, 3 hours
- In incontinent patients protect vulnerable skin with zinc and castor oil cream and consider catheterization
- If nutritional state is poor, advice on nutritious diet.

MONONEUROPATHY

DEFINITION

Mononeuropathy means lesions of individual peripheral (including cranial) nerves which may be due to trauma, Diabetes, Leprosy, cancer, and sarcoidosis.

MANAGEMENT PLAN

History taking

When we do history taking, we should discuss the severity of pain, underlying cause of pain, why a particular pharmacological treatment is being offered, the importance of dosage titration, other physical, psychological therapies and surgery.
To consider referring the person to specialist clinic if their pain is severe, their pain limits their lifestyle, daily activities. Regular clinical reviews need to assess and monitor the effectiveness of treatment, to assess pain control, physical well-being.

Clinical examination.

Sensory lost, numbness, tingling, burning sensation on extremities and certain areas, e.g. Median nerve C5-T1 sensory lost on lateral 3 fingers and palm, wasting of thenar muscles. Ulnar C7-T1 weakness, wasting of hypothenar eminence.
Sciatic L4-S2 Weakness of hamstrings and all muscles below knee,
Loss of sensation below knee laterally.

Common mononeuropathies are…..

1. Bell's palsy.
2. Autonomic neuropathy
3. Herpes zoster oticus (Ramsay hunt Syndrome)

Causes of mononeuropathy

- 30% idiopathic,
- Diabetes, B2 Folic vitamin deficiency,
- Drugs chemotherapy, HIV medicines.
- Poisons, Insecticides.
- Chronic kidney, Liver disease
- Injuries, Connective tissue diseases.
- Cancers, Alcohol.

Treatment

- Treat underlying cause
- Advise patients to stand slowly, raise the head of the bed at night, Eat little or often
- Reduce alcohol, Nonsteroids, noninflammatory drugs, Anticonvulsant, antidepressant drugs
- Treatment of underlying disease: Diabetes

ALTERNATIVE TO PAIN MANAGEMENT

Electrical stimulation
Physical therapy
Acupuncture
Massage therapy
Relaxation therapy

OTHER PERIPHERAL NEUROPATHY

Mononeuropathy: Carpel tunnel syndrome, Ulnar nerve palsy, Radial nerve

REFERENCE

- Oxford Handbook General Practice, 4th Edition
- John Murtagh's General Practice, 10th Edition

MODULE 13:

FAMILY VIOLENCE

- Family violence includes child abuse, intimate partner violence, and elder mistreatment.
- Estimating the true prevalence of family violence is challenging, because it occurs in the privacy of the home and not all cases come to medical or professional attention, but it appears to be a common under-reporting problem in Myanmar.
- All forms of family violence can have serious physical and mental health consequences. It is important that the family physician be alert to signs that might suggest family violence and understand approaches to managing the problem.

CHILD MALTREATMENT

- Child maltreatment includes physical abuse, sexual abuse, psychological abuse, and neglect.
- Child maltreatment often presents with symptoms of inattention, school failure, disruptive symptoms, anxiety, depression, failure to thrive, and a broad range of somatic symptoms (ranging from the physical pain of a broken bone to psychogenic symptoms such as recurrent abdominal pain).

Sexual Abuse

- Sexual abuse includes all forms of sexual contact (oral-genital, genital, anal) involving a child in which there is age or developmental discordance between the child and the perpetrator. It also includes noncontact abuse such as exhibitionism, voyeurism, and use of a child to produce pornography.
- Child sexual abuse usually presents with child disclosure. However, presentations may vary and include acute sexual trauma, sexually transmitted diseases, pregnancy, extremes of sexualized behavior, and somatic symptoms such as dysuria and enuresis.
- Interviewing children for evidence of sexual abuse requires special skill and training. That does not preclude the family physician from taking a thorough medical history of a child, including open-ended and nonleading questions about various types of trauma and the etiology of specific findings. In this nonthreatening and familiar setting, a child may disclose abuse. These disclosures are admissible in court.
- When possible, medical history documentation of a disclosure should include direct quotations of questions asked by the provider and responses of the victim.

Neglect

- Neglect alone accounts for more than one third of the annual child maltreatment fatalities. Neglect can be thought of as failing to meet the basic needs of a child.
- These needs include adequate supervision, food, clothing, shelter, medical care, education, and love. Neglect, unlike physical and sexual abuse, often manifests as a pattern of chronic unmet needs, sometimes along one domain, but often along multiple domains. Situations due to poverty are excluded from reporting laws in some states. However, the family physician should avoid this judgment if he or she recognizes inadequate care that may jeopardize the health or development of a child.
- The cause of neglect may not be malevolent, but the risk to the child remains the same. For example, a poor single father may leave his 2-year-old child home alone sleeping at night to work a second-shift job.

- Even though his circumstances drove him to this omission of care, the child is still at risk of significant harm.

Psychological Abuse

- Psychological abuse of children is common; however, it is the least often substantiated type of abuse because of social norms and the challenges of proving both intent of the parent and harm to the child.

The followings are the examples:

- Threatening to leave or abandon a child,
- Threatening to kick a child out of the home
- Locking a child out of the house
- Calling a name like stupid, ugly, or useless
- It is difficult to determine when such behavior is abusive, as it is common, often chronic, and harm is difficult to measure or prove.

Assessment

PHYSICAL ABUSE

- In considering an injury for suspicion of abuse, many physicians use the practical 24-hour rule. That is, if a mark lasts 24 hours, it is considered a significant injury.
- Red marks from spanking (with open hand, paddle, or switch) that resolve in_24 hours do not rise to the level of concern for injury by protective services in most jurisdictions.
- In evaluating any injury to a child, a detailed history should be obtained and carefully documented. In the case of suspicious injuries, detailed drawings or photographs can be helpful.
- The injury should be carefully matched to the reported mechanism. Does the skin mark resemble a known pattern of injury? Loops, teeth marks, and linear welts (from belts or switches) are common patterns in abusive injuries.
- Studies have shown that pre-mobile children rarely bruise: fewer than 1% of children no yet cruising have bruises thought to be due to unintentional injury.
- Certain skeletal injuries are highly suggestive of abuse. Children younger than age 2 years with rib fractures (in the absence of a high impact trauma history or metabolic bone disease) are nearly always the result of abuse.
- Likewise, metaphyseal corner fractures of the long bones are usually from abuse in children younger than age 2. Inflicted head injury is the most common cause of death from child physical abuse.
- Children younger than age 2 with other significant abusive injuries should be evaluated with brain imaging (computed tomography or magnetic resonance imaging) to identify occult brain injury and a skeletal survey to evaluate for bony injuries.
- The most important factor in identifying physical abuse is a high index of suspicion. Clinicians with special training or experience in child abuse can be helpful in clarifying mechanisms in ambiguous injuries.
- These clinicians will also help search for alternative explanations for disease and injury patterns (e.g., coagulopathy, metabolic bone disease).

- Detailed documentation of history and physical exam is essential for protective service and legal investigation. Table 46.1 lists injuries that are suspicious for abuse and deserve careful history taking and documentation.

Table: Suspicious Injuries for Child Abuse
Bruises in non-weight-bearing child
Numerous bruises
Bruises over fleshy body parts (i.e., buttocks, thighs, cheeks)
Scalds (especially symmetric, perineal, clear margins)
Rib fractures
Metaphyseal fractures in children younger than age 2 years
Brain injuries (especially subdural haemorrhage)
Pattern skin injuries (i.e., iron, stove eye, loop, cigarette burn)
Oral injuries (especially labial frenulum laceration in non-weight bearing child)

SEXUAL ABUSE

- The physical examination for child sexual abuse should include visual inspection of the genitals and anus in supine frog-leg and knee-chest positions.
- This exam may be aided by the use of specialized instruments such as lighting devices and a colposcope for magnification.
- Instruments such as probes or specula should never be inserted into a prepubertal vagina without anesthesia or conscious sedation.
- Photodocumentation can be helpful for legal reference, but accurate pen and paper diagrams can be used when photocolposcopy is unavailable.
- Routine cultures for sexually transmitted diseases are not necessary in the absence of symptoms.
- Clinicians unskilled in the physical exam for sexual abuse should seek expert consultation. In the case of uncertain findings, photodocumentation or expert consultation can clarify equivocal findings.
- In the overwhelming majority of cases of chronic or past sexual abuse, physical exam findings will be either normal or nonspecific, making the history critical in determining sexual abuse victimization.

NEGLECT

- Neglect may come to the family physician’s attention in the form of medical nonadherence, failure or delay in seeking medical care, failure to thrive, unmanaged obesity, behaviour problems, school failure, poor hygiene, or homelessness.
- In identifying a child suspected of being neglected, asking nonjudgmental questions about resources can help identify sources of problems and potential solutions.
- Because neglect often manifests as a chronic pattern, the physician must have a way to follow children over time.
- If a child failing to thrive does not return as scheduled, the physician should have a system in place to call the patient, reschedule the appointment, and identify barriers to follow through.
- When a pattern of omissions in care (or a single egregious episode) rises to the level of harm or significant risk of harm, the physician is obligated to report the case to protective services.

PSYCHOLOGICAL ABUSE

- The diagnosis of psychological abuse is often made only through long-term observation of parent–child interaction. This can be facilitated by querying other adults involved in the life of the child (e.g., teachers, coaches).
- Symptoms of psychological abuse include: aggressiveness, impulsivity, depression, hyperactivity, school failure, inattention, disturbances of conduct, anxiety, eating disorders, and somatic symptoms.
- In the evaluation of children with disorders of behavior and development, parents may be witnessed belittling children in cruel ways ("he's stupid just like his daddy" or "she drives me crazy").
- Discussing destructive behaviour and role modelling positive behaviour can help ameliorate a difficult visit and begin to help a parent identify problem parenting. However, in the setting of this type of abusive behavior, a child struggling at home or school will be very difficult to treat with any measure of success.
- When such behavior is observed over time or seems to be correlated with behavioural symptoms, the treating physician should consider a referral for family therapy or to protective services.

Management

- It is important for the parent involved to understand that the report is not placing blame or making judgment, but carrying out a legal responsibility. This helps to absolve some of the guilt that a physician may feel in making a report to child protective services.
- It is not required by law that a person reporting must inform the parent of the report to be made; however, this can set the stage for an open dialog and continued support of a family. How this is framed will depend on the nature of the suspected maltreatment and the suspected perpetrator. Attention to careful documentation of history (both questions asked and responses in quotes) and careful documentation of injuries with drawings or photo documentation is critical.
- In many cases, a physician caring for a child suspected to be a victim of abuse or neglect may need to make a safety plan in conjunction with social services while the child is in the clinic, emergency room, or hospital.
- Ongoing evaluation will often include ancillary studies (i.e., skeletal survey, head computed tomography, coagulation studies). In many communities, the family physician will have access to a provider with special skill and training in the evaluation of children suspected to be maltreatment victims.

INTIMATE PARTNER VIOLENCE (formerly called Domestic Violence)

- Intimate partner violence (IPV), which includes physical, emotional and sexual harm by a current or former partner or spouse, is a common problem with serious physical and mental health consequences for victims and their children.
- Although women are most commonly affected, IPV affects both men and women and occurs in married and unmarried couples, affecting both heterosexual and same-sex couples.
- The Centers for Disease Control and Prevention defines IPV according to the following categories:
- **Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching;

pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.

- **Sexual violence** is divided into three categories:
  - (i) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;
  - (ii) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure); and
  - (iii) abusive sexual contact.
- **Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources.
- Although IPV affects all ages, races, ethnicities, and socioeconomic strata, young women and individuals with low incomes are at greatest risk.
- A prior history of IPV, child abuse victimization, or sexual assault is all associated with increased risk of IPV, as is a history of alcohol or other drug use and separated or divorced marital status.
- In addition to the toll that IPV takes on individuals and their families, the cost of IPV to society is large. Because victims of IPV tend to have high rates of physical and mental health morbidity, they are frequent users of the health care system.
- For this reason, rates of IPV seen in primary care practices and emergency departments are even higher than those seen in the general population. One study of women enrolled in health maintenance organizations demonstrated that 44% of adult female patients reported IPV in their lifetimes and 8% had experienced IPV in the past year. Intimate partner violence is thus a condition that family physicians can expect to encounter frequently over the course of their careers.

Common Presentations

- IPV influences multiple aspects of physical and mental health, affecting victims' health for many years, even after abuse. Negative health effects occur whether abuse is physical, sexual, or emotional.

INJURIES

- The most direct health effect of IPV is injury. Certain patterns of injury, such as injuries to the head, neck, breast, or abdomen, should raise suspicion of intentional injury. Facial trauma, for example an orbital fracture or dental injury, is particularly suggestive.
- Fractures, sprains, or dislocations of the extremities account for about one quarter of IPV-related injuries. Victims of IPV also suffer long-term sequelae of injury, such as symptoms of traumatic brain injury or problems with swallowing and speech.
- The most serious direct consequence of IPV is mortality: more than 1,000 women are killed by intimate partners in the United States annually. Myanmar data is not known.

OTHER PHYSICAL HEALTH EFFECTS

- Many of the health effects of IPV are not directly attributable to trauma. Concerns related to sexual health, such as sexually transmitted infections, cervical dysplasia, and unplanned pregnancy, are more common in victims of IPV.
- In addition, victims of IPV are at increased risk for cardiovascular disease and stroke. Functional gastrointestinal disorders such as irritable bowel syndrome and a variety of chronic pain complaints, such as arthritis, migraine, fibromyalgia, chronic fatigue syndrome, and temporomandibular joint syndrome are all more common in victims of IPV.
- Patients with IPV may present with multiple somatic complaints, such as stomach pain, back pain, menstrual problems, headaches, chest pain, dizziness, fainting spells, palpitations, shortness of breath, constipation, generalized fatigue, and insomnia.
- The reason that IPV increases risk for such a wide range of conditions is unknown but may be related to the direct consequences of trauma, the long-term accumulated effects of chronic stress, and high prevalence of risky health behaviours.
- Interestingly these complex symptoms are commonly brought to GP/FP's daily practice. That is why we should consider IPV in case of undifferentiated symptoms. (See Chapter 2)

IPV AND PREGNANCY

- IPV often continues throughout pregnancy, increasing risk for complications such as spontaneous abortion, hypertensive disorders of pregnancy, vaginal bleeding, placental abruption, severe nausea and vomiting, dehydration, diabetes, urinary tract infection, and premature rupture of membranes.
- Victims of IPV are often delayed in seeking prenatal care, and the possibility of IPV should be considered in women who receive late or no prenatal care. IPV-related homicide is the leading cause of maternal mortality, accounting for 13% to 24% of all deaths in pregnancy.
- Infants of mothers who experience IPV during pregnancy also are at risk for medical complications, including low birth weight, prematurity, and perinatal death.

MENTAL HEALTH

- IPV, whether it is physical, sexual, or emotional, also has mental health consequences. Victims of IPV commonly experience depression, suicidal thoughts and attempts, and posttraumatic stress disorder.
- Tobacco, alcohol, and illicit drug abuse are common , and victims of IPV are more likely to engage in risky sexual behaviours.
- Women who are abused are more likely to engage in disordered eating patterns. Adverse mental health consequences, such as depression, oppositional defiant disorder, developmental delay, school failure, or future violent behavior, are also seen in children who witness IPV.

Assessment

- Assessing for IPV in the clinical setting can fall into one of two categories: clinicians may inquire about IPV in all patients at risk regardless of clinical suspicion **(a universal screening approach),** or they may confine inquiries to situations in which there is some suspicion that violence is occurring or in which knowledge of violence would be relevant to the presenting complaint.

- Although routine screening for IPV is recommended by some organizations, the United States Preventive Services Task Force (USPSTF) states that there is insufficient evidence to recommend for or against routinely screening women for IPV.
- This recommendation was based on the lack of evidence regarding accuracy of IPV screening questionnaires, and more importantly, the lack evidence that primary care based interventions are helpful in preventing the negative consequences of IPV.
- Recent systematic reviews have confirmed that there is not yet strong evidence of effectiveness of any intervention, although some strategies show promise in mitigating the effects of IPV.
- After the USPSTF recommendation was published, a randomized controlled trial of screening for IPV in health care settings did not support a significant benefit from screening.
- The USPSTF does state, however, that "all clinicians examining children and adults should be alert to physical and behavioral signs and symptoms associated with abuse or neglect. Patients in whom abuse is suspected should receive proper following points
  1.documentation of the incident and physical findings
  2. treatment for physical injuries
  3. arrangement for skilled counselling by a mental health professional
  4. the telephone number of local crisis centers, shelters, and protective service agencies"
- . In other words, although there may be weak evidence for *screening* for IPV, clinicians should still maintain an index of suspicion for IPV, remaining alert to situations suggestive IPV and providing appropriate treatment resources for patients in whom IPV is detected.
- When patients present with issues consistent with IPV
- (Table 46.2), clinicians should consider inquiring about IPV, not only because intervention may be beneficial but also because knowledge of IPV could influence the treatment plan and help the clinician understand barriers to treatment adherence.

Table: Situations that should raise suspicion for Intimate Partner Violence

Injuries to the face or trunk
Pattern of injury not consistent with explanation given
Frequent somatic complaints
Chronic pain syndromes
Recurrent sexual health concerns
Late entry into prenatal care
Frequent late or missed appointments
Substance abuse
Frequent mental health complaints

- Women with a history of IPV often have frequent primary care and emergency room visits and may be perceived to overuse the health care system. They often report strained relationships with their physicians.
- However, what physicians perceive as poor adherence to medical recommendations and lack of motivation may in fact be related to the abuse a patient is experiencing. Interference with receipt of health care may be part of the control that abusers exert in their partners' lives.
- Primary care physicians who diagnose IPV, and therefore begin to understand the barriers that their abused patients face, may be able to form more effective therapeutic relationships.
- Identifying IPV also provides an important opportunity for providing the patient with empathic support and reassurance that the violence is not her fault; educating her regarding the dynamics

of IPV and the future risks it poses to her and her children; and opening the door to future conversations.

- Several questionnaires for assessing for IPV have been validated in a variety of populations and patient care settings and are practical for use in the primary care setting (Table 46.3).

Table: Tools to Assess for Intimate Partner Violence

Test	Sensitivity (%)	Specificity (%)
Abuse Assessment Screen	93	55
1. Have you ever been emotionally or physically abused by your partner or someone important to you?		
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?		
3. Since you've been pregnant, have you been slapped, kicked, or otherwise physically hurt by someone? If YES, who?		
4. Within the last year, has anyone forced you to have sexual activities? If YES, who?		
5. Are you afraid of your partner or anyone you listed above?		
Any YES answer considered positive for abuse		
HITS	86-96	91-99
1. How often does your partner physically HURT you?		
2. How often does your partner INSULT or talk down to you?		
3. How often does your partner THREATEN you with physical harm?		
4. How often does your partner SCREAM or curse at you?		
Each question is answered on a 5 point scale: 1=never, 2=rarely, 3=sometimes, 4=fairly often, 5=frequently Score ≥10 considered positive for abuse		
Partner Violence Screen	65-71	80-84
1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?		
2. Do you feel safe in your current relationship?		
3. Is there a partner from a previous relationship who is making you feel unsafe now?		
Yes answer to question 1 if perpetrator is current or former partner, no answer to question 2 or yes answer to question 3 considered a positive test		
WAST short	92	100
1. In general, how would you describe your relationship?		
• A lot of tension		
• Some tension		
• No tension		
1. Do you and your partner work out arguments with:		
• Great difficulty?		
• Some difficulty?		
• No difficulty?		
"A lot of tension" on question 1 or "great difficulty" on question 2 considered a positive test		

Table: Intimate Partner Violence Red Flags indicating Increased Risk for Serious Injury or Homicide

Increasing frequency or severity of violence
Recent use of or threats with a weapon
Homicide or suicide threat
Hostage taking or stalking
Alcohol or drug use
Recent separation from or threats to leave partner

- It must be kept in mind with each of these questionnaires, however, that what is considered a "positive" test depends on how IPV is defined, and sensitivity and specificity of the test depend on what criterion standard is used to define a true positive or negative test.
- Because it is difficult to objectively confirm the presence of IPV, determining accuracy of specific questions can be problematic.

- Regardless of whether a clinician uses a structured instrument or simply asks questions informally in the context of a patient interview, several principles are important to follow. Physicians should ensure a private setting, without friends or family members (other than children under age three) present.
- They should assure patients of confidentiality, but notify them if any reporting requirements apply. Language should be direct and nonjudgmental. It is often helpful to preface questions about IPV with statements that normalize the inquiry; for example, "Because violence is a common problem, I routinely ask my patients about it," or "Many people with [condition] have worse symptoms if they have been physically, emotionally, or sexually abused in the past."
- If any language barriers are present, physicians should use the assistance of an interpreter, ideally one who has been trained to ask about IPV.

Management

- When IPV is detected in the clinical setting, it is important that clinicians respond in a way that builds trust and sets the stage for an ongoing therapeutic relationship.
- Key components of an initial interaction should include validation of the patient's concerns, education regarding the dynamics and consequences of IPV, safety assessment, and referral to local resources.
- It is important to realize that IPV is usually a chronic problem that will not be solved in the one or two visits, but rather can be worked on over time. Because intervening on IPV is a complex and slow process, with outcomes that are often difficult to measure objectively, the evidence base for most health care–based interventions IPV is weak.
- Recommendations for management of intimate partner violence in the clinical setting are therefore largely based on expert opinion. An initial response to a disclosure of IPV should include listening to the patient empathically and non-judgmentally, expressing a concern for her health and safety, and affirming a commitment to help her address the problem.
- Women who have long been subjected to abuse may have very low self-esteem and may believe that the abuse is their fault. Physicians can help counter this belief, reassuring patients that although partner violence is a common problem, it is unacceptable and not the fault of the victim.
- It is also important to convey to victims of IPV a respect for their choices regarding how to respond to the violence. Taking control and attempting to steer a patient toward a specific course of action, for example leaving an abusive partner, can actually replicate a pattern of abuse, disempowering a patient who already has very little control over the circumstances of her life.
- Victims of IPV may have a clearer understanding than clinicians about the dynamics of their relationships and what courses of action may result in increased danger. If patients need to move slowly, scheduling frequent office visits can be helpful, providing ongoing support and addressing medical problems.
- It is, however, important that clinicians provide patients with education on the dynamics of partner violence and potential effects on victims and their children.
- Patients should be helped to understand that once violent dynamics are established in a relationship, the violence generally continues and escalates over time.
- In a nonjudgmental way, physicians can convey concern to patients regarding the negative physical and mental effects that IPV may have on patients and their children.

- Although addressing IPV is usually a long-term, ongoing process, physicians should be alert to potential crisis situations that could indicate imminent danger to patients' health or safety (Table 46.4).
- Even if none of these risk factors is currently present, assessing for them can help educate patients regarding what situations to be alert for that could indicate increased risk. It can be useful to offer patients a handout or brochure on safety planning and go over it with them.
- Finally, physicians should provide victims of IPV with referral to local resources that can provide advocacy and support.
- Family physicians should be familiar with the organizations in their communities that can provide assistance to victims of IPV, including organizations' capacity to accommodate specific populations such as immigrants; specific ethnic or cultural groups; teens; lesbian, gay, bisexual, or transgender clients; or people with disabilities.
- Resources might include community-based advocacy groups, shelters, law enforcement agencies, social workers, or support systems within the healthcare setting.
- If immediate concerns for safety exist, the physician can offer for the patient to contact these resources from the office. A follow-up visit should be scheduled, and IPV should be readdressed at future visits.

ELDER MISTREATMENT

- Elder abuse is a less well-understood phenomenon than child abuse and IPV, but a growing body of research suggests that it is a common problem with potential for serious morbidity and mortality.
- A recent panel convened by the National Academy of Sciences to outline a research agenda in the field defined elder mistreatment as "(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm".
- Elder mistreatment includes physical abuse, psychological abuse, sexual abuse, financial exploitation, and neglect. Elder self-neglect, or the failure of an elderly person to meet his or her own basic needs or protect his or her health and safety, is also sometimes considered to be a type of elder mistreatment. Recent population-based studies suggest that between 2% and 11% of older adults report having been subject to some form of abuse in the past year.
- Neglect is most commonly reported, followed by emotional mistreatment, physical mistreatment, and sexual mistreatment. A minority of these events are ever brought to the attention of physicians or adult protective services agencies.
- Elder mistreatment, however, is difficult to measure, so the accuracy of prevalence estimates is unclear.
- Population-based research has generally relied on self-report of abuse from cognitively intact, community dwelling individuals and is therefore unable to accurately estimate the prevalence of mistreatment in vulnerable elders who suffer from dementia or live in long-term care facilities.
- Family caregivers and long-term care staff report even higher levels of abuse than do the elders themselves. In surveys of long-term care staff, 10% admit to physical abuse of residents, 40% admit to psychological abuse, and, impressively, 80% report having witnessed abuse.
- By any of these measures elder mistreatment is a common enough problem that any family physician who cares for elderly patients in outpatient, inpatient, or long-term care settings will encounter elder abuse frequently in clinical practice.

- Although the causes of elder mistreatment are not well understood, several patient, caregiver, social, and environmental factors are markers of increased risk.
- Elders who live with their caregivers are more likely to be victims of mistreatment; probably simply from tensions that arise when there are greater opportunities for contact. Social isolation of both elders and their caregivers also appears to increase risk for mistreatment.
- Patients with dementia, in particular patients who have disruptive behavior or aggression, are at increased risk. Research on the role of physical frailty and dependence play in risk of abuse has been inconsistent.
- Caregiver factors that increase risk of mistreatment include mental illness, especially depression and alcohol abuse, and financial dependency on the elder.
- Factors that increase risk of abuse in long-term care facilities include inadequate staffing and staff training, staff burnout, and aggressive behavior by residents. Elder mistreatment has been linked to adverse health outcomes, including increased depression, hospitalizations, nursing home placement, and mortality.

Assessment

- As with child maltreatment and intimate partner violence, the USPSTF states that there is insufficient evidence to recommend for or against routine screening for elder abuse, because of the lack of clear evidence that we can accurately identify and effectively intervene upon elder abuse in the clinical setting.
- The lack of evidence for universal screening, however, does not obviate the need for remaining alert to signs of elder mistreatment and appropriately treating when elder mistreatment is identified.
- Unlike some of the patterns of injury that are clearly suggestive of child maltreatment—for example, the retinal hemorrhages and metaphyseal corner fractures of shaken baby syndrome—there is no clear constellation of symptoms that is suggestive of elder mistreatment.
- Falls and fractures are common in the frail elderly, and skin may be fragile and bruise easily. Weight loss may be a symptom of late stages of many illnesses seen in the elderly, but could also be a sign of neglect.
- Identification of elder mistreatment is also complicated by the fact that elderly individuals with cognitive impairment, who are particularly vulnerable, may not be able to give accurate accounts of abuse or neglect.
- Mistrust of caregivers can be part of the dementia process itself; it may be difficult to distinguish between financial exploitation and appropriate efforts by caregivers to take control of finances for an elder who is no longer able to manage independently.
- Although there is no pattern of presenting symptoms that is specific to abuse, providers should remain alert to bruises or burns in unusual locations or injuries that are not consistent with the explanation offered. Injuries to wrists or ankles could be an indication of use of restraints.
- Genital or breast injuries should raise suspicion of sexual abuse. Findings that should raise suspicion for neglect include dehydration or malnutrition, pressure ulcers, poor hygiene, or medical non-adherence.
- Several instruments have been developed to assess for elder mistreatment, but none have been well validated across different clinical settings and with different patient populations.
- In the absence of clear evidence for specific approaches to identifying elder mistreatment, several principles may guide clinicians who are attempting to determine whether abuse and/or neglect are occurring.

- If mistreatment is suspected, the patient should be questioned and examined in private, away from caregivers. General questions about home environment and safety can be followed with more direct questions about whether the patient has been hurt or threatened, food or medicines have been denied, the patient has been made to feel guilty about asking for help, personal belongings have been taken away, or unwanted touch has occurred.
- Any affirmative answers should be followed up with questions about details about the circumstances and frequency of potential abuse. Answers and physical findings should be documented carefully.
- For patients who have cognitive impairment, assessment of decision-making capacity is important, because it will guide an approach to intervention.
- Caregivers may also be questioned directly about abuse or neglect, but physicians must be careful to avoid alienating caregivers, who could in turn restrict access to the elderly patient.
- It may be helpful to precede direct inquiries with permissive statements, such as “Caring for your father must be stressful. How do you manage?” If a caregiver does disclose abuse or neglect, the physician should be careful to refrain from passing judgment.

Management

- There is a paucity of evidence to support any specific approach to intervening on elder mistreatment.
- Research on effective interventions is difficult for a number of reasons: elder mistreatment encompasses a heterogeneous group of problems with diverse causes; interventions for elder abuse are generally multifactorial and multidisciplinary and are difficult to standardize in the context of a controlled trial; elderly patients often have several serious comorbidities, including cognitive impairment, that make comparing outcomes across individual patients difficult; and access to patients may be limited by their caregivers.
- The most appropriate strategy for intervention will be determined by the nature of the abuse or neglect and the circumstances of the individual patient.
- Strategies for managing elder mistreatment should be tailored to the specific situation. Lack of social support appears to be a risk factor for most types of abuse, so connecting elders with resources that can provide social support is likely to be beneficial in most situations.
- If abuse is thought primarily due to caregiver burden or mental health concerns, interventions can be targeted toward caregivers. These interventions might include caregiver education regarding what constitutes abuse, referral to respite care resources, connection with social support, and psychotherapy or pharmacotherapy to address mental health concerns.
- If abuse is a response to or is perpetrated by an aggressive patient with dementia, interventions to address behavior in the patient with dementia are indicated. If the abuse is a continuation of longstanding intimate partner violence, referral local IPV support organizations may be helpful.
- For patients who lack capacity for decision-making, pursuing guardianship may be necessary. Ideally, physicians should enlist the assistance of a multidisciplinary team (which might include physicians, nurses, government agencies, social workers, legal professionals, and law enforcement personnel) with expertise in various aspects of elder mistreatment.

Reference

Essentials of Family Medicine ,6th edition: Phillip D Sloane et al, Lippincott Williams & Walkins,2012