7.1 Principles of patient management

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Introduction

An ever more popular movement towards strengthening the patient's role (the 'consumer approach') and the increasing economic pressure on primary care doctors has stimulated more rational planning of the management of individuals in general practice. (1) The idea of patient management in primary care, however, is not new and has always been about addressing the patient in his/her biomedical as well as social and psychological context.

The evidence for patient management

Patient management aims to shift the focus from the disease to the sick person, (2) or—as Maimonides, the medieval Jewish physician and thinker, put it 800 years earlier—‘the physician should not treat the disease but the patient who is suffering from it’. (3) Such a patient-centred approach is based on a good ('therapeutic') doctor–patient relationship. The quality of the interaction between physician and patient and their expectations may sometimes influence patient outcomes more than specific treatment, for example, with a drug. Moreover, patient-centred practice is associated with increased efficiency of care, involving fewer diagnostic tests and referrals. (4, 5)

Engel (6) was one of the first to develop a systematic approach towards the biopsychosocial model. (7) Drawing on systems theory, this model offers a framework of the patient as 'a whole person' with specific emphasis on subjective experience, thoughts, and emotions related to objective data (e.g. medical findings). Consequently, disorders exist at different hierarchical but closely interacting levels (Fig. 1).

Fig. 1 Levels of the biopsychosocial model.

![Diagram of the biopsychosocial model]

Engel's theoretical assumptions are supported by recent evidence from psychoneuroimmunology. The term psychoneuroimmunology expresses the important links between the central nervous and the immune systems. There is a strong bi-directional relationship between the brain and immune systems. Several studies have confirmed the relationship between stressful life events, immunological changes, and adverse health outcomes such as heart disease, cancer, asthma, or infectious disease (Fig. 2). (8)
Supportive relationships are an important mediator and often improve the immunological condition, whereas bereavement, for example, can result in a temporary down-regulation of the immune response. Also, other factors such as chronic stress modulate a variety of immunological activities.

Since immunological processes are embedded within a larger biological, psychological, and social context, it is—as Engel predicted—impossible to practise 'disease management' without taking the patient's concerns and background into consideration.

**Key principles of patient management**

The consultation is at the centre of primary care. Serial consultations establish long-term relationships with patients and knowledge about them, and form the basis for follow-up. It is essential, especially in patients with chronic conditions, not only to structure each consultation but also to develop a structured long-term plan for clinical management. Such a plan should include

- collaborative definition of problems,
- action planning (targeting, goal setting),
- information,
- patient education and motivational training,
- scheduled follow-up,
- outcome monitoring,
- adherence monitoring,
- stepped therapy,
- specialty consultation and referral.

Management programmes may improve with active patient participation and shared decision-making. There is evidence that most patients want a patient-centred approach, and are less satisfied, less enabled, and may be more burdened by symptoms if they do not get it.

Patient management is also an attempt to overcome clinical inertia: a failure of health care providers to initiate or intensify therapy when indicated. Doctors may thus identify patients and situations in which more intensive management of chronic conditions such as hypertension is appropriate. Moreover, real-world primary care physicians can deliver effective treatment if they are supported by organized systems for patient education, proactive consultation for non-responders, physician education, and patient monitoring, as Katzelnick demonstrated for the management of depression.
Stages and steps of a management plan

A management plan should be based on evidence-based guidelines (if available) for different conditions seen in general practice. The following steps may help to structure a single consultation as well as the long-term doctor–patient relationship (Table 1).

Table 1 Stages and steps of a management plan

<table>
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<th>Stages at first or follow-up consultation</th>
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<td>Active listening</td>
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<td>Eliciting the patients agenda</td>
<td>■ Screening of complaints and medical condition</td>
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<td></td>
<td>■ Hypothesis concerning the patient's reason for encounter</td>
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<td>History/examinations</td>
<td>■ Collecting information about previous diseases (including genetic aspects)</td>
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<tr>
<td>Context</td>
<td>■ Regarding multiple causes and effects of illness</td>
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<td>Information</td>
<td>■ The patient's background as well as occupational, social, and personal situation</td>
<td>Informing the patient</td>
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<td>■ Patient's health beliefs</td>
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<td>■ Assessing resources (e.g. social support and the patient's locus of control)</td>
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<td>■ Discussing the diagnosis with the patient (name, origin, and consequences of the disease)</td>
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<td>Aims of treatment</td>
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<td>■ Pain (control or reduction)</td>
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Establishing a relationship

Development of a sustained partnership is an explicit responsibility of GPs and a typical characteristic of primary care (see also Chapter 5.1). Some role allocations should be taken into account: the patients as experts for their life and specific medical conditions, the GP as counsellor and expert in the application of medical knowledge and skills. Both partners maintain responsibility for the process of treatment. Fostering the doctor–patient relationship is a continuing process pervading all stages of a management plan supported by active listening, encouraging narration, providing explanations, and expressing concern.

Eliciting the patient's agenda

In the first consultation with a new patient or at the beginning of a new illness episode, it is a central task to elicit the patient's agenda. Even in well-established patients, their problems should be reassessed from time to time. One of the most prominent reasons for encounter is the patient’s
need for explanation and not (only) for treatment. (17)

At this stage, the doctor tries to enter the patient's world, get a holistic picture of his or her problems, and obtain the full spectrum of concerns. (18) In addition, information from all levels of the biopsychosocial model (cell–organ, psychological–individual, and family–community) is collected. Information on the patient's symptoms, his or her ideas on the cause of the problem, perception of symptoms, and potential influences on personal and social life are all important. A patient-centred style with open-ended questions as well as the feeling that the doctor listens and understands the problem encourages patients to raise their own concerns and agendas and appears to be most congruent with patient reported quality of primary care. (19)

**Diagnostic procedures**

In the light of the biopsychosocial model, making a diagnosis is not a mere technical procedure but always a combination of, for example, clinical examinations, laboratory tests, and interpretation of results together with the patient. Diagnostic procedures should be guided by evidence-based information, if available.

Pathology is influenced both by biological and psychological processes and illness itself may affect the patient's psychological and physical well-being (referred to as the multiple-cause–multiple-effect model). For a comprehensive understanding, assessment of situational triggers that promote specific events can be included (e.g. using an asthma diary). Considerations of individual and social resources provide clues for the planning of further treatment.

Especially in general practice, making a diagnosis necessitates communication so that both parties come to a common understanding of the problem, instead of labelling the patient (see Chapter 6). Misunderstanding or dysfunctional health beliefs that make the patient feel helpless (e.g. false conviction of the disease being incurable) can be prevented. Giving the patient comprehensive and understandable information and a perspective on the consequences for daily life is part of a management plan.

**Defining and realizing the aims of the treatment**

Doctors usually think that their patients expect treatment of their disease according to the state of the art (if it exists). So, why think and talk about the aim of the treatment? First of all, there are different therapeutic options for many conditions. For example, a minor depression may be treated with antidepressants drugs, natural remedies, or psychotherapy, or similar counselling techniques. All of these options may be effective, at least in some patients. Secondly, many treatment options have side-effects and influence the patient's life and well-being in a negative way. For example, antihypertensives may cause dizziness or impotence in some patients. Therefore, the pros and cons of the treatment have to be balanced. Finally, if treatment options require help from others, the doctor must check whether support is really available.

Talking with the patient about the treatment should also include the different dimensions of therapy. A treatment may either address the underlying causes of a disease or simply aim at symptom control, such as pain relief or coping support.

Co-morbidity can be another reason why treatment aims especially in general practice patients are sometimes difficult to determine—or even to realize. For example, 63 per cent of visits made by patients with hypertension are for a range of other reasons and it makes no sense to limit considerations to a single entity in the illness spectrum of these patients. (20) Furthermore, the patient's autonomy often requires doctors to accept his or her choice even when these options are not evidence based or second best. (14)

The management of many conditions seen in general practice requires patient self-management and motivational training to support behavioural change. (21) Following the doctor's advice is only a
minor aspect of the patient's cooperation. It seems to be more important to learn to what degree a patient's condition may have been influenced by previous behaviour and how to handle it in the future. Patient self-management should be based on action plans, developed by patients as something they want to do. If necessary, doctors should help patients to make an action plan more realistic in order to avoid failure. (22) Doctors' training and support services include instruction in disease management, help for problem-solving as well as behavioural change (e.g. smoking or dietary interventions), and interventions to cope with emotional demands of chronic disease. It may also include advice on how to document experience with treatment so that a better adjustment of medication is possible. There is substantial evidence that structured self-management and behavioural change programmes improve important outcomes in asthma, diabetes, hypertension, arthritis, coronary heart disease, and other chronic diseases. (21) Doctors can help patients manage their chronic condition by effective communication and information. (23)

Stepped care and support by specialists

One important principle of patient management in general practice is the concept of 'individualized stepped care': (10) simpler, less restrictive, less intensive, or less expensive interventions are tried initially, followed by care based on guidelines for patients who have not responded adequately. Stepped-care principles help to allocate limited professional resources. For example, follow-up visits to report the resolution of a problem may not be necessary for every patient. A management plan, however, should include an agreement on this point.

Clinical responsibilities might also be transferred to specialists in certain patients or conditions. (10) A further important task of the general practitioner is to coordinate and integrate specialist care and prevention of the patient who may otherwise get lost in the technological maze of modern hospitals and clinics.

Outcome evaluation

Immediate outcomes from the consultation include patient satisfaction, recall of the physician's explanations and instructions, and changes in the patient's concern about their symptoms. Intermediate outcomes refer to the patient's compliance with the physician's recommendations. Finally, the long-term outcome is the change (or not) in the patient's health status. Health outcomes are gaining prominence as validators of the effectiveness of the physician–patient interaction, particularly as brief summary measures of functional status and general well-being have been developed. (24)

The advantage of validated assessment scales, compared to a spontaneous question of how the patient feels, is the multidimensionality and objectivity of such measures. It is important to know whether and to what degree the patient is satisfied with treatment, time spent, practice organization, or communication skills of the doctor. Chapters 14.2 – 14.6 present and discuss several research tools and outcome measures that are feasible for general practice.

End of treatment; follow-up

In some cases, medical treatment might result in a complete recovery of the patient so that the problem is no longer present. Even in these cases, the doctor should make an agreement with the patient about the evaluation of this aim. In many other cases, follow-up or even life-long consultations will be necessary. On these occasions, the doctor and the patient should talk or check in detail whether the aims have been achieved and what problems still remain. During this time the physician is at the patient's disposal, ready to enter earlier stages of the management plan.

The strength of a management plan

The eight stages in Table 1 represent a logical chain rather than a chronology. The individual stages are strongly interrelated. For example, a good relationship between the doctor and the patient is a prerequisite for eliciting the patient's agenda. At the same time, talking about the patient's problems and health beliefs strengthens this relationship. Talking about how to realize the treatment aims might also support the relationship and may complete the information on the patient's family background and social resources. In some cases, several phases may be compressed or may even be superfluous (e.g. in the management of uncomplicated urinary tract infections or acute respiratory illness).

Future developments

The philosophy of patient management is confronted with, at least, three problems:

1. There appears to be a discrepancy between the strong belief in patient autonomy and the suggestive evidence that many patients do not wish to participate in treatment decisions (even if they may be receptive to greater information exchange). Doctors interested in systematic methods of patient management will recognize that valid and reliable methods of eliciting patient preferences are still being developed. There is plenty of room for future research (e.g. to find out which patients prefer, or dislike, a more active role in the management of their problem).

2. Patient management has the potential to stimulate doctors to a more active approach, which may, however, conflict with patients' resistance to treatment or to the prescription of evidence-based medicines (especially true in the management of asymptomatic patients). Thus, it seems important to allow individualization of care in patient management plans.

3. Successful patient management may require a redesign of practice. Organizational development includes changes in decision-making process, shape and nature of groups, work procedures, job descriptions (allocation of tasks), and the management of patient contact (appointments, follow-ups, telephone contacts, reminders). Patient management may also create new and important roles for nurse practitioners as case managers.

Patient management offers fascinating opportunities for a more powerful, successful, and satisfying treatment of the patient. History tells us that patient management is fairly straightforward whereas the art of its application is intrinsically challenging: 'The doctor is faced with a particular patient, with a particular bodily constitution, and at a particular point in time' (Maimonides).

References


