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Volume 2 • Issue 6 • 2018

Scientia Ricerca

Editorial

Chronicle of Medicine and Surgery

ISSN: 2576-8298

Additional Demands in the General Medicine Practice

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Received: August 25, 2018; **Published:** September 04, 2018

Volume 2 Issue 6 September 2018

Communication is an important component of patient care and clinical reasoning. Communication is central to human experience, and it provides the vehicle through which we share ideas, coordinate actions, and build social structures. The doctor-patient communication, the doctor-patient clinical interview and the doctor-patient relationship are concepts that are very close and understood at the same time. The Interview is a technique or a channel and place of communication, where the patient doctor relationship is produced and developed. The doctor's relationship with the patient is the true core of his clinical practice. The communication in the patient physician relationship is delimited by the clinical framework. The objective of the interview and the medical examination is to allow the doctor to understand the complaints, symptoms, physical signs of the patient and integrate them into a panoramic and coherent picture. The communication and the doctor-patient relationship is fundamental both for the diagnosis and for the treatment. So, all care activities are influenced, directly or indirectly, by the interpersonal relationship [1].

When general practitioners use communication with the patient appropriately, the consultation is more useful. In this way, the diagnosis can be made more easily, the level of patient satisfaction and the therapeutic compliance improves. To achieve this, physician must use communication skills, biomedical knowledge and clinical judgment [1].

Patients communicate their desires and expectations largely by making requests. Patients report make more than one request in majority of encounters; requests for medical information, examination, and tests or procedures were most common. It has been suggested that in the phase of ascertaining and studying the specific demand of the patient, the general practitioner makes a delimitation of the reasons for consultation. Here, the patient usually presents several problems, and there is a response from the doctor, which indicates which of them are accepted, to pass to an adequate assessment, physical examination or complementary procedures [2].

Thus, it must be taken into account that, if it is allowed, the patient sometimes asks about 3 or 4 simultaneous problems that he thinks are different, although the doctor may be able to integrate them. However, physicians' opening questions (e.g., what can I do for you today?) normally elicit only a single concern, and the expression and exploration of additional concerns is frequently abbreviated, if not absent. Patients' first concerns are solicited by physicians at the beginnings of encounters. A challenge to health care is how to get patients' additional concerns raised as topics of discussion. If patients' additional concerns are addressed, it tends to occur at the end of encounters [3]. In practice, physicians rarely ask these questions about "additional concerns" and tend to do so close to the ends of visits, when additional concerns cannot effectively be dealt with [4].

Consultation closure is defined as the final phase of the medical visit in which the doctor and patient shift perspective to the future, finalize plans, and say goodbye. Closing moments of medical interview may be contained in opening sequences in general practice consultations. The actual nature of a consultation is negotiated locally by the participants rather than decided externally before it takes place. A consultation is a dynamic process, and its nature is the participants' own achievement. It has often been observed that patients present new concerns during the closing of the medical interview (hence the expressions 'doorknob concerns', and 'by the way') [5,6].

An additional or additive demand is the reason for consultation that is added to the first one once it is finalized. It is, without a doubt, a distorting factor in the care relationship, as well as a frequent source of errors, since on some occasion we may not give importance to the new demand, either because of the laziness of a new exploration, or because we think that as it is something that the patient says in passing and without giving much importance, and so it will surely not be important.

However, although some additional demands seem to occur in a random manner and to be a superfluous request, most of them, however, may contain the issues that most concern the patient or are rated as more important by the physician. Additional demands with some psychosocial content are the most frequent and important. But, its aspect of commonplace demands, make it difficult to take them into account. Family doctor never should underestimate any demand in closing moments of medical interview of the patient, especially if its content is partly psychosocial, since that may be the real and important motive that led him or her to the consultation [6].

So, how can we handle the additional demands? Set an agenda early in the visit helps to avoid late-arising concerns that may be the most important issues to the patient ("by the way, I've been having these chest pains …"). On the other hand, the skills of not interrupting the patient's opening statement, and by using facilitating comments (e.g., "is there anything else" or "uh-huh"), rather than immediately pursuing details of individual symptoms, could help to the physician to having a better opportunity to discover the full range of patient concerns [7].

Despite our efforts, 30-80% of our patients' expectations are not detected. In addition, the structuring of the clinical encounter may be adequate, but its usefulness is limited by the lack of flexibility [8]. On the other hand, half of the doctors redirect the initial discourse of the patient very early on (in 16 seconds) and this are significantly associated with new concerns by the patient at the time of closing and with longer goodbyes [9]. Patients desire opportunities to present concerns in their own time and terms regardless of how extensively they act on this opportunity. Visits should be opened with general inquiries (e.g., what can I do for you today?) versus closed-ended requests for confirmation (e.g., Sore throat, huh?) [10].

Consequently, a pragmatic, unstructured and strategic interview can be proposed: from where the doctor and the patient can go, in zigzag, "through the field instead of going the path", taking advantage of the opportunities, as the appearance of additional demands [1,6].

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