Outline for Patient-centered case presentation*

- In patient-centered case presentation, you need to present patient's profile followed by the chief complaint.
- Then you have to present your Pre-Diagnostic Interpretation (**PDI**) of that specific chief complaint (before taking your history), based on probability, seriousness, treatability and novelty.
- After that, you need to explore the **HPI** including patient-centered- medicine and biopsychosocial profile explaining your patient's ideas, concerns, expectations, and possible effects of the problem. Finally, this should lead you into your final list of differential diagnoses (**DDx**). Note that your final DDx list might be different from your PDI list.
- At last, you need to come up with a specific **management** plan as summarized by the acronym RAPRIOP.

An example of illness behavior:
Mr. Naser is a 42-year-old teacher. He has chest pain.

Possible ideas

He may think it is from his heart
He may think it could be a result of heavy meal
He may think it could be (bad eye) or (black magic)
He may think it could be trauma

Possible concerns

His main concern could be his work
His main concern could be his image as a distinguished teacher
He might be worried his fitness
He might be worried about his family, what will happen to them if he died

Possible expectations

His main expectation could be just explanation and reassurance
He may expect ECG or X-Ray or cardiac catheterization
He may expect referral for more reassurance
He may expect medical report or just a sick leave

Possible effects of the problem

This problem may affect him physically and prevent him from doing his daily activities
It may affect him socially and make him isolated
It may affect him psychologically and make him anxious and depressed

** Inpatients have a different approach that is not included in this template.*

Appendix 1

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Cognitive skills in history taking.
(Hypothetico-deductive method)
Patient's Interview

Chief Complaint

Why is the patient here today? (An essential question in each consultation)

Duration	File information

The **differential diagnosis** is based on:

1. Probability
2. Seriousness
3. Treatability
4. Novelty

(At least seven differential diagnoses arranged from most likely to least likely)

History

A proper history is the single most crucial step. An ideal history should cover all the following:

A. Socrates (All complaints)

1. Site (can be ignored in certain situations such as dizziness)
2. Onset
3. Timing, Duration, Frequency
4. Character
5. Radiation
6. Exacerbating and reliving factors
7. Severity
8. Associated symptoms (pertinent clues for each one of probability, seriousness, treatability, and novelty)

B. 4 Ds

1. Disease
   - I. Previous similar attacks (Including Dx, Mx)
   - II. Past Medical history (Is it Controlled/Uncontrolled?)
   - III. Past Surgical History (Including complications)

2. Drugs
   - I. For the current disease
   - II. Any other drugs/herbs
   - III. Allergy history
   - IV. Vaccination history
   - V. Addiction

3. Diet
   - I. Appetite
   - II. Any specific diet
   - III. Current weight and significant changes
   - IV. Certain disease (e.g., Celiac disease)
   - V. Hydration

4. Dokhan
    I. Ask about all forms of smoke (If present 5 As)
    II. Marital status
    III. Level of education
    IV. Job
    V. Alcohol consumption (If present CAGE)
    VI. Financial status
    VII. Insurance
    VIII. Psychological status
    IX. Sexual history
    X. Family history and genetics
    XI. Life cycle (teenage until menopause)

Whole patient medicine

Patient Centered Medicine

A. ABC

1. Anxiety
2. Beliefs
3. Concerns

B. FEFI

1. Function
2. Expectation
3. Feelings
4. Ideas

Physical Exam

A. General appearance

1. Mouth breathing
2. Paleness, jaundice, or other discolorations
3. Apparent distress

B. Vital signs

1. Temperature
2. Respiratory rate
3. Heart rate
4. Blood pressure

C. Focused physical examination

Management Plan

A. RAPRIOP

1. **R**eassurance
2. **A**dvice
3. **P**rescription
4. **R**eferral
5. **I**nvestigation
6. **O**bservation
7. **P**revention

Patient- doctor interaction: explaining the DDx; the cause, course, and available management options, and sharing all this info with the patient.
Noting that all the above is taking into consideration the patient's concerns and worries.

This is the ideal approach to Family Medicine patients.

Checklist of Monitoring Communication and Cognitive Skills During the Consultation

By Dr Nada Yasein©, 2023

	score		
	1	*2*	*3*
COMMUNICATION SKILLS			
Interviewing and history			
Introduces self to patient			
Puts patient at ease			
Listens attentively			
Allows patient to elaborate fully			
Uses silence appropriately			
Seeks clarification of words used by patients			
Simple and clear questions			
Identifies reason for consultation (why & why now)			
Recognises verbal and nonverbal cues			
Elicits information from patient or file			
COGNITIVE SKILLS			
Name, age, gender			
Complaint and duration			
Diagnostic process (differential diagnosis)			
Most likely -> least likely			
(Probability, seriousness, treatability, rarity)			
SOCRATES (site and radiation if applicable)			
D1: Disease similar attacks or complaints, past history			
D2: Drugs (for this complaint and past drug history)			
D3: Diet (as appropriate)			
D4: (Dukhan) smoking (+social and psychological history as appropriate)			
Patient-centred Medicine			
Explores worries and expectations			
(Anxieties, beliefs, expectations of the cause & management)			
Well organised information gathering (communication skills)			
CLINICAL SKILLS			
Physical exam			
General: (vital signs, appearance) and local examination			
Elicits physical signs (correctly and sensitively)			
Uses instruments in competent, sensitive way			
Management (RAPRIOP format)			
Appropriate management plan			
Reassurance (explanation and exploration)			
Advice			
Discriminate use of prescription, referral and investigations			
Appropriate follow-up			
Prepared to use time appropriately (5-8 minutes)			
Checks patient understanding			
Attempts to modify help seeking behaviour			
Anticipatory care (A.C.) (as appropriate)			
Opportunistic (health ed & prevention)			
Why A. C. (provides explanation)			
Sensitive in promoting patient cooperation			
Record keeping (documentation)			
Accurate - legible			
Minimum information			
Date - history - exam (measurements)			
Diagnosis, management plan			
SOAP (subjective - objective - assessment - plan)			