

1. manages multiple complaints

2. considers impact of acute complaint(s) on co-morbidities

3. handles uncertainty

Medical Complexity parts 1,2 and 3

Considering the 'implications of co-morbidity' is dependant on our clinical expertise i.e. you need some knowledge and cannot just rely on the patient's perspective alone.

Examples of the effect of acute & chronic problems on each other

1. where chronic Rx can't be absorbed (e.g. in acute diarrhoea)
2. where chronic Rx might become less active (e.g. theophylline by carbamazepine)
3. where the side effects of chronic Rx are made worse (e.g. erythromycin for acne plus antihistamine for hayfever >>> arrhythmias)
4. where the chronic condition can become temporarily worse e.g. diabetic given antibiotics for cellulitic leg

TIP: remember that co-morbidities are common in elderly, deprived and some ethnic groups

TIP: look at the PMH (esp significant active problems), also look at last 3 consultations and the medication screen

TIP: with any presentation, a sk yourself, is this a new acute problem or could it be an exacerbation of a chronic condition

TIP: but at the same time beware: don't assume it is a result of a chronic condition e.g. early signs of lung Ca might be masked by exacerbations of COPD

TIP: always try to screen for what other problems the patient would like to talk about so you can prioritise and allocate time appropriate to the problem(s); try not to be too inflexible with multiple complaints before you have screened for them all first

TIP: look at medication and try to avoid polypharmacy and streamline where possible to aid concordance

TIP: look in the records (PMH) and proactively ask the patient about co-morbidities

TIP: acute illnesses don't just affect physical co-morbidities; remember the effect on mental health too (most acute illnesses make them worse) - explore!

TIP: ensure good record keeping to aid communication

TIP: communicate with key colleagues to keep them informed e.g. regular doctor, COPD nurse

NFD: only looks at problems in isolation, does not look beyond the acute problem esp in terms of management

C: screens for multiple complaints and manages more than one problem, considers acute and chronic complaints together and their effect on each other; also explores psycho-social impact of illness as this affects management

E: orchestrates the WHOLE management

3. handles uncertainty

Doctors may be 'coping with uncertainty' simply by being blasé about it. This is why the term 'unavoidable' is important because these type of docs would inappropriately tolerate uncertainty when it is avoidable and should be acted upon

C: able to tolerate UNAVOIDABLE uncertainty; i.e. knows when to wait and when to act; copes with the pressure uncertainty imposes on us: AN IMPORTANT DOMAIN

E: anticipates and uses STRATEGIES for MANAGING uncertainty

TIP: always consider the possibilities (differential diagnoses)

TIP: always exclude the dangerous possibilities (need to know your red flags!)

TIP: provide adequate safety nets and thoroughly check the patient understands them

TIP: make a judgement on the 'blanks' and act on what is probable rather than what is definitive

TIP: what do you think is the likely outcome? Are there any outcomes that can have adverse effects that you can minimise by anticipating?

TIP: what can you advise in terms of preventing, reducing or aid coping with certain outcomes? Establishing the patient's I,C,E can help with this.

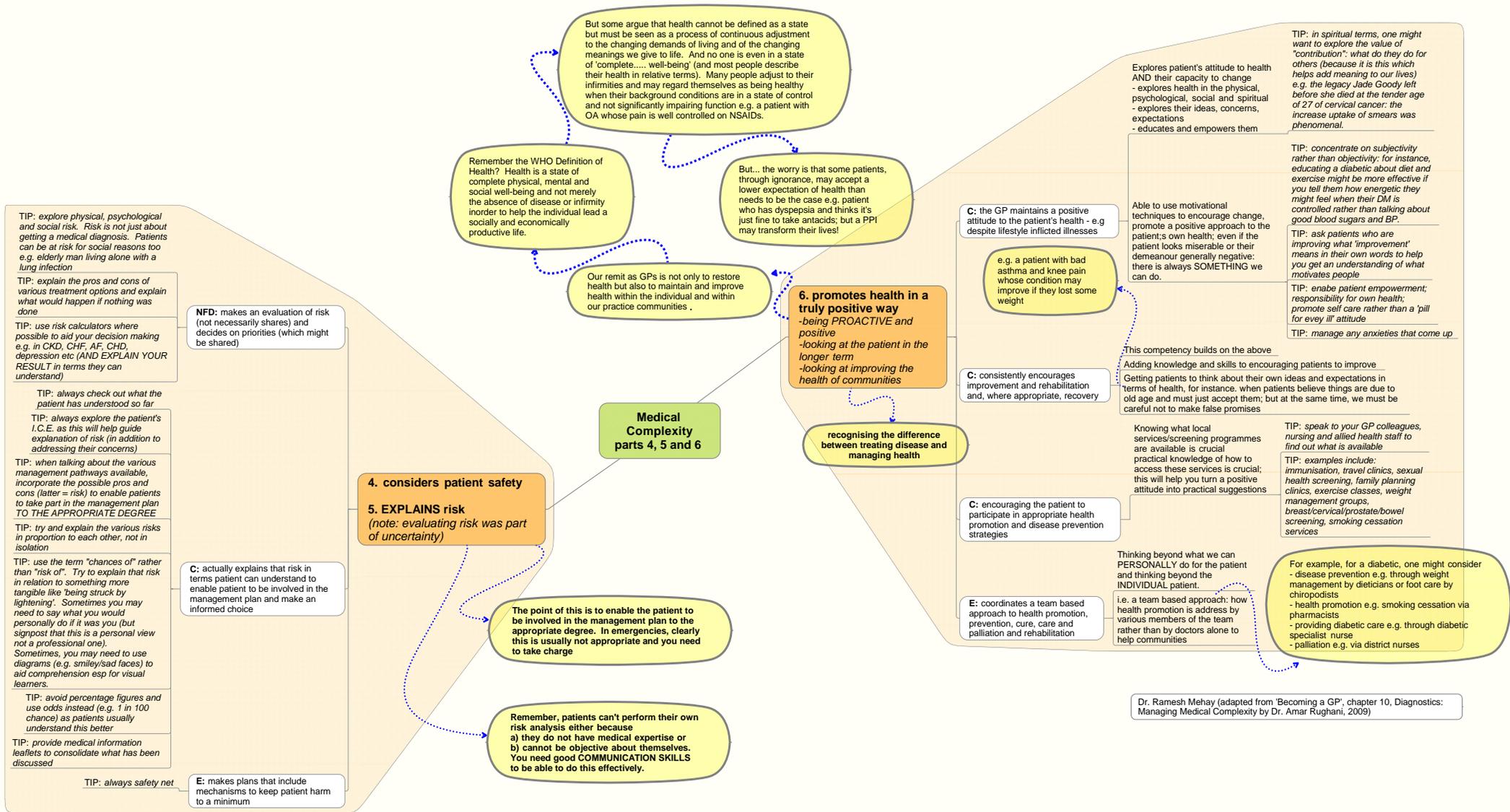
TIP: go through the natural history of the condition or the way in which it might evolve with the patient: it promotes shared understanding AND educates them about deviations from the expected and what they ought to do

TIP: the patient will have uncertainties too so try and manage those e.g. "I was wondering whether I needed an x-ray because...."

TIP: provide follow ups

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Managing Medical Complexity - what does it mean? (parts 1,2 and 3)



Managing Medical Complexity - what does it mean? (parts 4,5 and 6)