Intent Research Scientific Journal-(IRSJ)
ISSN (E): 2980-4612
Volume 2, Issue 9, September-2023
Website: intentresearch.org/index.php/irsj/index

IMPROVING THE EFFECTIVENESS OF COUNSELLING AND CLINICAL EXAMINATION OF PATIENTS IN A FAMILY POLYCLINIC

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Annotation
To date, graduate students of medical universities are experiencing some difficulties in carrying out a comprehensive clinical examination of patients with the interpretation of the data obtained and the differential diagnosis. At the end of the training, the graduate must have the skill of conducting a clinical examination of the patient with the definition and solution of his problems, including preventive measures and medical examinations. In our opinion, in order to correct the above, it is necessary: to modernise and systematise training in medical examination of patients both in a hospital and in a family polyclinic; to determine the specific goals and objectives of the actions performed by students when consulting patients in need of both the 1st, 2nd, and 4th categories of services; and to create criteria for evaluating students for the stages and levels of examination of patients.

The work of a family doctor requires a wide variety of knowledge and skills. This includes clinical experience to correctly assess the situation; knowledge of pathophysiology to understand the causes of deterioration or improvement of the patient's condition; data from clinical studies to assess the prognosis and correct treatment; and knowledge of the deontology and psychology of the patient to help him make arrangements in case of loss of independence. All this knowledge

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will be needed at the same time; knowing one thing in such a situation is absolutely not enough. To feel confident, a family doctor must constantly take care of the completeness of his knowledge; at the right moment, he will be able to select what the patient needs and effectively solve his problems.

Keywords: family polyclinic, structured clinical examination, prevention, medical examination.

The ability to build a conversation with a patient is necessary for a doctor of any specialty. Without a trusting dialogue, neither diagnosis, treatment, nor prevention are possible. A conversation with a patient allows the doctor to solve a number of tasks: to strengthen trusting relationships, to obtain the data necessary to establish a diagnosis, to develop a treatment plan, to inform the patient of the necessary information, and to convince him to give up bad habits and lead a healthy lifestyle.

The ability to conduct a systematic conversation improves the quality of the work of a family doctor, promotes patient satisfaction, and improves the results of prescribed treatment. Studies have shown that most patients prefer a style of conversation in which they are given an active role—that is, when they are given all the necessary information and are given the opportunity to choose the most appropriate treatment option. This is exactly how a conversation should be conducted: listen carefully to the patient, be interested in his opinion, offer treatment options, and leave the choice to him. A patient who actively participates in the conversation will actively participate in the treatment, which increases its effectiveness.

In order for the consultation to be successful, it is necessary to fulfil several conditions: from the very beginning, it is necessary to identify all existing complaints and draw up a dialogue plan; listening to the patient, it is necessary to monitor how and what he says and what his emotional and physical condition is; everything that hinders communication (for example, the patient does not hear well) must be identified in a timely manner.

The tasks of counselling include: obtaining the necessary information; strengthening the relationship with the patient; informing him about the

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diagnosis and treatment; convincing the patient to lead a healthy lifestyle; and getting rid of bad habits.
The stages of counselling include: preparation (to prepare for the doctor himself; to prepare an office; to prepare medical documentation); the beginning of a conversation; drawing up a dialogue plan; a patient's story in free form (answers to open-type questions); clarification of the data obtained (answers to questions of a closed and verification type); simultaneous
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Numerous tasks of the conversation with the patient can be divided into three groups: to collect anamnesis; to strengthen relationships; to provide moral support; and to inform and educate the patient (to tell him about the diagnosis and treatment; to convince him to get rid of bad habits and lead a healthy lifestyle).

The auxiliary medical staff, the doctor's office, and the family doctor himself should be ready to talk to the patient. The situation in the office is very important. During the conversation, strangers should not enter; the phone should not ring. The patient should feel comfortable and calm. It is necessary that he feels at the centre of attention and knows that he can count on effective help. The preliminary preparation of medical documentation greatly facilitates the conversation. Before a repeat meeting, it is necessary to study the latest test results, radiographs, and other data. This will not only improve the conversation but also show the patient that the doctor has not forgotten about him since the last meeting and that he remembers and thinks about him. Trust in such a doctor is much higher. Finally, the family doctor himself needs to prepare for the conversation. No matter how many things are distracting in the middle of the working day, before meeting with the patient, they need to be postponed. Open the outpatient card and fully focus on the upcoming conversation.

The first minutes largely determine all subsequent relationships. The family doctor begins to study the patient from the moment he enters the office. Mood, clothes, and a lot of small signs can tell a lot. These observations can be used immediately: if the patient is very excited, calm him down; if he is scared, try to cheer him up.

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As a rule, the conversation begins with a greeting (if the doctor sees the patient for the first time, he must introduce himself). The tone of the greeting should not be coldly aloof; it should encourage and soothe, not repel. You should ask how the patient would like to be addressed (for example, by name or patronymic) this is a manifestation of respect for his opinion.

After the acquaintance, you need to find out what made the patient go to the doctor. It is better to use open-ended questions, i.e., questions that involve a detailed answer, for example, "Tell me what is bothering you?". It is necessary to give him the opportunity to talk about it as much as he sees fit. Interrupting the patient at the stage of collecting complaints and anamnesis, the doctor shows a lack of interest and haste. In addition, it can lead to the fact that the most important complaint will not be expressed at all or will be expressed at the very end of the meeting. Many people think that patients talk too much and for too long. In fact, the presentation rarely takes more than 90 seconds.

After listening to the patient's story, it is necessary to clarify whether he has forgotten anything. They come to the doctor with an average of three complaints, and the most important one is often not mentioned in the first place. Having found out all the complaints from the very beginning, the doctor gets important benefits. First, he immediately finds out what the patient expects from the reception. Secondly, he gets the opportunity to plan a conversation and determine what should be discussed with the patient immediately and what can be postponed until the next meeting. Having found out all the complaints, you can summarise them by briefly repeating them. This shows the patient that the doctor listened attentively to him and gives the doctor the opportunity to mentally organise his complaints.

At the next stage, it is necessary to outline the range of topics for conversation. If there are too many of them, some of them can be left until the next consultation. The order of discussion should be agreed upon with the patient. He may be particularly concerned about some manifestations, and the doctor may be alerted by others that seem unimportant to the patient.

The best way to find out the history of the disease is to give the patient the opportunity to tell it in his own words. He will highlight what he considers the most important, express an opinion on the causes and consequences, and perhaps draw the doctor's attention to important details that he might have missed.

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Listening to the patient, the doctor analyses the information received, ponders a possible diagnosis, and decides how to confirm or refute it. Along the way, it turns out a lot of important things: where the patient works, where and with whom he lives, and who his loved ones are. All this will be useful when planning treatment.

The personal characteristics of the patient are very important; it is not difficult to identify them at all. The appearance, manner of behavior, and clothing almost immediately show to which social group a person belongs, and sometimes his profession and marital status. At a glance, you can determine the nationality. By what and how the patient says, you can understand his way of thinking and views. Facial expressions, position, and gestures reveal his emotional state, and their change (frowned, covered his eyes with his hand, looked at the floor, suddenly smiled, etc.) speaks about how he relates to what is being discussed. The living conditions of people are very diverse, and it is impossible to list all the circumstances that can contribute to the emergence and development of the disease. There are several factors to consider in all cases: Who does the patient live with, how close are these people, are they indifferent or hostile to him, who supports the family, where does the patient live (on the 5th floor without an elevator, among drug addicts and alcoholics, or in a secluded house in a rural locality); where does he work; social environment; his national composition; and cultural characteristics (this largely determines the attitude to medicine, the tendency to follow medical recommendations, or, on the contrary,

At the end of the interview, the doctor considers and analyses the information received. This stage can be very painful for the patient. He told the doctor everything and is now awaiting sentencing. The doctor should share with the patient all his considerations: what are the most important circumstances he noted, what conclusions he came to, and what is the plan for further actions. When reporting a preliminary diagnosis, it is important to monitor the patient's reaction. He may have his own opinion about the causes of the disease, which does not always coincide with the opinion of the doctor. It is necessary, one way or another, to encourage him to express this opinion.

The treatment plan, as well as the diagnosis, must be discussed with the patient. Moreover, it is desirable that he actively participate in its development. If the patient does not believe in the success of treatment or does not understand what

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he should do, then it is not necessary to count on success. It is absolutely necessary to find out what the patient thinks about the prescribed treatment.

Before proceeding to the final stage of the conversation, you need to find out if the patient has any questions and ask him to briefly repeat the main points, making corrections if necessary. This repetition allows you to make sure that he understood everything correctly and intends to follow the recommendations. This provides additional insurance against failure due to the fact that the patient will not make appointments.

Before saying goodbye, the doctor explains to the patient his priorities (where and when to take tests, etc.). It is necessary to agree on the next consultation and make sure that he can come. In addition, the patient needs to explain how to find out the results of tests and how to contact a doctor in urgent cases. Finally, the family doctor can share his thoughts on the topic of the following conversation: "In a month, we will look at your diary and your condition, and then we will be able to better understand your problem."

Thus, the stages of patient counselling require students to possess a wide variety of knowledge, skills, and abilities: correct assessment of the patient's condition; identification of problems and needs of the patient; understanding the causes of deterioration or improvement of the condition; skills of clinical research; assessment of prognosis and correction of treatment; knowledge of deontology and psychology of the patient.

Observations show that there are some difficulties that students face every day when examining and managing patients: questioning, examination, and examination of patients are not always consistent; there are cases of one-sided communication with patients; the application of practical skills necessary for the curation of patients requires improvement; systematic assessment of students when consulting patients is difficult.

To correct the above shortcomings, we have compiled a sequential phasing of counselling patients with the first category of services in family polyclinics:

1. Received a patient in the family doctor's office with a demonstration of interpersonal communication skills.
2. Carefully collect complaints using open and verification questions.
3. Carefully collect the history of the present disease (anamnesis morbi).
4. Carefully collect the history of life (anamnesis vitae).

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5. Identified and determined the risk factors (controlled and uncontrolled) available to the patient, taking into account complaints, anamnesis, and data obtained in the pre-medical office.
6. After a thorough collection of complaints, an anamnesis of the disease and life identified the patient's problems (main and concomitant).
7. Started an objective examination (the student must demonstrate a competent and consistent study of the patient's condition with the corresponding syndrome).
8. Started making a preliminary diagnosis indicating the category of services of this patient's disease.
9. Make a plan for the examination of this patient (laboratory and instrumental studies in the conditions of a family polyclinic and beyond).
10. Independently performed the necessary amount of research according to category 3.1 of medical care provided by a family doctor.
11. After a comprehensive examination, the student demonstrates knowledge of the interpretation of the obtained objective and laboratory-instrumental data.
12. At this stage, the student demonstrates the differential diagnosis.
13. Established and justified the final diagnosis, indicating the category of services of the disease in this patient.
14. Have you determined what kind of prevention this patient needs?
15. Identified a non-drug treatment with a demonstration and explanation for the patient.
16. Prescribed medication with indication of doses, time, frequency, and duration of administration of the prescribed medication
17. Conducted feedback, determining the date and time of the patient's repeated visit to the family polyclinic to monitor the effectiveness of the prescribed non-drug and drug treatment.
18. Took the patient into account, having previously determined the group of dispensary observation.
19. Addressing the observers, the student demonstrates theoretical knowledge and practical steps for all types of prevention of the corresponding disease.
20. Addressing the observers, the student demonstrates theoretical knowledge and practical steps in the stages of medical examination of the corresponding disease.

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Conclusions:

Structured stages of patient counselling in a family polyclinic will allow teachers of medical universities to teach students an integrated clinical examination with a correct assessment of the condition and identification of problems; improve knowledge, skills, and abilities to effectively solve patients' problems; conduct an appointment, conduct an objective examination, and solve patients' problems, observing the principles of family medicine; be able to timely identify and perform the category medical care services according to the qualification characteristics of a family doctor (1 category; 2 category; category 3.1 and 3.2; category 4); increase the effectiveness of clinical examination of patients and the implementation of therapeutic and preventive measures at the level of primary health care.

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