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# History of the rosary pdf

Advertisement The content of the history required in primary care consultations is very variable and will depend on the presenting symptoms, patient concerns and the past medical, psychological and social history. However the general framework for history taking is as follows[1]:Presenting complaint.History of presenting complaint, including investigations, treatment and referrals already arranged and provided.Past medical history: significant past diseases/illnesses; surgery, including complications; trauma.Medication history: now and past, prescribed and over-the-counter medicines, allergies.Family history: especially parents, siblings and children.Social history: smoking, alcohol, recreational drugs, accommodation and living arrangements, marital status, baseline functioning, occupation, pets and hobbies.Systems review: cardiovascular system, respiratory system, gastrointestinal system, nervous system, musculoskeletal system, genitourinary system.There are several consultation models which are useful to frame (and remember) your questions. Medical schools in the UK often use the Calgary-Cambridge model[2, 3].It is widely taught that diagnosis is revealed in the patient's history. 'Listen to your patient; they are telling you the diagnosis' is a much quoted aphorism[4].The basis of a true history is good communication between doctor and patient. The patient may not be looking for a diagnosis when giving their history and the doctor's search for one under such circumstances is likely to be fruitless. The patient's problem, whether it has a medical diagnosis attached or not, needs to be identified.It is important for doctors to acquire good consultation skills which go beyond prescriptive history taking learned as part of the comprehensive and systematic clerking process outlined in textbooks. A good history is one which reveals the patient's ideas, concerns and expectations as well as any accompanying diagnosis. The doctor's agenda, incorporating lists of detailed questions, should not dominate the history taking. Listening is at the heart of good history taking. Without the patient's perspective, the history is likely to be much less revealing and less useful to the doctor who is attempting to help the patient.Often the history alone does reveal a diagnosis. Sometimes it is all that is required to make the diagnosis. A good example is with the complaint of headache where the diagnosis can be made from the description of the headache and perhaps some further questions. For example, in cluster headache the history is very characteristic and reveals the diagnosis without the need for examination or investigations.To obtain a true, representative account of what is troubling a patient and how it has evolved over time, is not an easy task. It takes practice, patience, understanding and concentration. The history is a sharing of experience between patient and doctor. A consultation can allow a patient to unburden himself or herself. They may be upset about their condition or with the frustrations of life and it is important to allow patients to give vent to these feelings. The importance of the lament and how it may be transformed from the grumbles of a heartsink patient, to a useful diagnostic and therapeutic tool for both patient and physician, has been discussed in an excellent paper[5].The skills required to obtain the patient's true story can be learned and go beyond knowing what questions to ask. Indeed 'questions' may need to be avoided, as they limit the patient to 'answers'. There is a lot written about consultation skills and different models of consulting. These have been developed through consultation analysis and now form an important part of undergraduate medical training and GP training in the Curriculum for Speciality Training for General Practice. There are many examples of aspects of consulting which may assist history taking for doctors working with patients in all specialties.The layout of the consulting room can assist good consulting. It can facilitate establishing rapport with patients by, for example, allowing for good eye contact, enabling easy access to computers or notes and avoiding 'distance' between the doctor and patient.Take care with the opening greeting, as this can set the scene for what follows. It may assist or inhibit rapport. Generally, it helps to be warm and welcoming so as to put the patient at ease. Good eye contact, shaking hands with the patient and showing an active interest in the patient should help to establish trust and encourage honest and open communication.Take care not to let the computer intrude on the consultation. This can be difficult when there is useful information available on a screen. Make use of the time before and after consultations to obtain information from the computer. Let the patient tell you the story they have been storing up for you. This can be encouraged by active listening.This implies that the doctor is seen to be interested and attentive by the patient.Give the patient a chance to tell you their pre-constructed narrative, rather than diving in with a series of questions to delineate detail (such as the exact frequency and colour of their diarrhoea). This approach affords a better chance of obtaining a true 'flavour' of their experience of an illness, its temporal development and the relative importance to the patient of the symptoms that they have (which ultimately is what, from their viewpoint, you'll be attempting to cure, not 'the diagnosis', about which most patients do not really care).It is important to be able to ask discriminating, delineating questions about particular symptoms to verify their actual nature and give enough information to support the process of reaching a diagnosis; however, timing is everything. Get down a record of each of the major symptoms in the order that they are presented to you by the patient. Then go back to this overall picture and break down any aspects of the history that you need to from there. This is a much better way of doing things than interrupting (and probably losing for ever) the patient's initial narrative.Listening does not just involve using your ears. Also use facial expression, body language and verbal fluency to help understand what is really troubling someone and to suggest other areas in which the history might need to proceed. This is very useful where there is a psychological origin for physical symptoms, of which the patient may be unconscious, but you could get at if you noticed that talking about a certain aspect of their story makes them uncomfortable or hesitant. Remember that speech is not the only means of communicating, especially where someone has a poor command of the language in which you are taking the history, or has hearing impairment. Make full use of communication aids such as translators, sign-language interpreters, picture boards, and drawings done by the patient showing where the pain is, when this is a more appropriate form of discourse.Some patients do not come readily prepared with a narrative of their illness and, in this situation, it is unavoidable to use questioning and clarification of details to 'draw out' the history. However, if your prompting sparks off a narrative then try to hear it out if it seems to be relevant. Try to avoid interrupting if at all possible.These are seen as the gold standard of historical inquiry. They do not suggest a 'right' answer to the patient and give them a chance to express what is on their mind. Your question should not be able to be answered with 'yes' or 'no'. A broad example is: 'What's been bothering you?' There are other similar open questions but it may be effective just to let the patient start speaking sometimes.Open questions can be used to obtain specific information about a particular symptom as well. For example: 'Tell me about your cough.' Or: 'How are your waterworks bothering you?' Open questions cannot always be used, as sometimes you will need to delve deeper and obtain discriminating features about which the patient would not be aware. However, they should be kept foremost in the mind as a way to broach a subject or an unexplored symptom.Sometimes it is necessary to 'pin down' exactly what a patient means by a particular statement. In this case, if the information you are after cannot be obtained through open questioning then give the patient some options to indicate what information you need. For instance, if a male patient complains of 'passing blood' and it is difficult to tell what he means, even after being given a chance to expand on the subject, you could ask: 'Is that in your water or your motions?' This technique must be used with care as there is a danger of getting the answer you wanted rather than what the patient meant (he might be having nosebleeds). Try to avoid using specific medical terms such as 'coffee grounds' (one of the options you might give if trying to find out if a patient is vomiting blood). If you can use an open question such as: 'What colour was the vomit?', rather than suggesting options, it is more likely to give you a true picture of what the patient has experienced; however, sometimes questions suggesting possible answers cannot be avoided.These are best avoided if at all possible. They tend to lead the patient down an avenue that is framed by your own assumptions. For instance, a male patient presents with episodic chest pain. You know he is a smoker and overweight so you start asking questions that would help you to decide if it's angina. So you ask: 'Is it worse when you're walking?'; 'Is it worse in cold or windy weather?' The patient is not sure of the answer, not having thought of the influence of exercise or the weather on his pain, but answers yes, remembering a cold day when walking the dog when the pain was bad. You may be off on the wrong track and find it hard to get back from there. It is much better to ask an open question such as: 'Have you noticed anything that makes your pain worse?' When the patient answers: 'Pork pies', you are on firmer ground in suspecting that this may be chest pain of gastrointestinal origin.After taking the history, it's useful to give the patient a run-down of what they've told you as you understand it. For example: 'So, Michael, from what I understand you've been losing weight, feeling sick, had trouble swallowing - particularly meat - and the whole thing's been getting you down. Is that right?' If there is a nod of approval or expressed agreement with the story then it's fairly certain you're getting what the patient wanted to tell you. If not, then you may need to try another approach. This technique can avoid incorrect assumptions by the doctor. It's always a good idea to ask the patient if there's anything they want to ask you at the end of a consultation. This can help you to impart further information if there's something they haven't understood and it can reveal something that's been troubling them that hasn't been touched upon or got to the bottom of. It is an opportunity to confirm that a shared understanding has been reached between doctor and patient.Try to let patients tell you their story freely.When you use questions, try to keep them as open as possible.Use all your senses to 'listen'.Check that what you think is wrong is what your patient thinks is wrong.Keep an open mind and always ask yourself if you're making assumptions.Be prepared to reconsider the causes of symptoms that you or a colleague have decided upon. In 1993, the Administration for Children and Families (ACF) began working with state public assistance agencies (SPAs) and other federal agencies to develop information-sharing projects to verify the circumstances of public assistance clients. ACF identified information-sharing opportunities and coordinated activities to take advantage of those opportunities. As a result, ACF is able to provide the Department of Veterans Affairs (VA) compensation and pension payment records as well as interstate public assistance benefit information. Between 1993 and 1997, ACF provided 29 state public assistance agencies with VA compensation and benefit information to establish client eligibility and benefits. Of these, five reported actual and projected program savings, and the other 24 indicated that the information proved useful when verifying client circumstances. In September 1997, ACF also provided VA information to 16 states on possible duplicate interstate public assistance payments (AFDC/TANF, Medicaid, Food Stamps, SSI and other federal and state public assistance programs). States participating in this initiative signed state-to-state agreements for the exchange of information on active cases only. Sample copies of the VA and federal computer matching agreements and state model agreements can be found under PARIS Agreements. In May 2002, PARIS received approval for a new match with active and retired federal civilian employees and active and retired military. The Qualifying Individual (QI) Program Supplemental Funding Act of 2008 was signed in October 2008. The QI Act requires states to have a Medicaid eligibility determination system that provides for data matching through PARIS (or any successor system), including matching with medical assistance programs operated by other states. With this system in place, states receive Medicaid Federal matching funds for reimbursement of state costs to administer the Medicaid State plan. The Department of Health and Human Services' Center for Medicare and Medicaid Services issued a state Medicaid directors' letter on June 21, 2010 to announce this information to the states. Now all 50 states, the District of Columbia and Puerto Rico participate in the program. The Department of Defense's Defense Manpower Data Center (DMDC) provides computer resources to support PARIS development and operation. DMDC produces a match file based on Social Security Numbers (SSN). Some states apply filters to the matched records to ensure precious staff time is spent on the records with the greatest potential for savings. States currently apply filters based on individual goals and needs. For example, Pennsylvania filters on birth date and surname to identify possible SSN-only errors. Maryland goes a step further by looking at the benefit amount and length of overlap. Many States filter out cases lacking opening dates. After applying the filters, the matches are then cleared by the state. Some states use local benefit office staff, fraud investigators, or both to clear the matches. States are expected to verify the matched individual's continued eligibility for benefits in their state and take whatever case action is appropriate. There are currently no mandated match clearance procedures. A vital component of the multi-state match process is the need for a telephone contact system. States need to quickly communicate with one another for a number of reasons: To confirm an action that was taken To obtain benefit history data for overpayment processing To resolve data discrepancies Some states have established a central or county point of contact. The file submitted to DMDC has fields for contact information. States should be prepared for the volume of calls they may receive as a result of other states following up on matched records. A list of all current PARIS board members is found at the Board of Directors. Members of the PARIS Board of Directors are available to discuss any general questions or entertain suggestions you might have for improving the process. The majority of PARIS states allow staff 30-45 days to complete their work on a match and some allow staff up to 90 days; there is no required completion deadline. At the Oct. 30, 2008 ACF Honor Awards Program, the assistant secretary of the Administration for Children and Families presented an award to the PARIS Project. "As a part of ACF's scorecard, Proud to Be Reporting and the President's Management Agenda, PARIS is a leader in the Administration's Improper Payments Program that have translated into documented savings totaling \$300 million." PARIS was recognized by the HHS Secretary in its 2006 Honor Awards Program At the June 29, 2006 HHS Honor Awards Program, the Secretary of the U.S. Department of Health and Human Services presented an award recognizing the PARIS project as a "true Federal-State Partnership Program under the President's Management Agenda that helped save millions of dollars through the identification of improper payments."

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