

The Art of Medicine

Past, Present and Future

Art of Medicine- the present

- Golden diagnostic and therapeutic age
- We are now over reliant on technology and increasingly IT dependent
- Maintenance/ Acquisition of top class clinical skills essential
- Strive to acquire knowledge and skills that improve patient care –
Not just CME points

Laboratory advances

- LE cell test – now ANA , ENAs and plethora of autoantibody tests
- Thyroid function tests- now done almost routinely ; previously Dr Baguant at VH- selected patients- radioisotopes
- Molecular typing of tumours – personalized treatment
- PCR and rapid tests for COVID 19
- What question do you want answered ?

Imaging

- Ultrasound imaging of abdomen- Glasgow 1978
- CT scanning- 1979- “ anatomical “ pictures – brain scans – cerebral angiograms through carotid puncture became a rarity
- MRIs – added more value , no radiation
- But value of imaging lost if poor clinical information

Therapeutics

- Antibiotics – soon back to pneumonia resolving by lysis or crisis if not careful
- Asthma treatment - from salbutamol and cromoglycate to inhaled corticosteroids and biologicals- but no teaching of inhaler technique
- Biologicals- momabs, ximabs, zumabs , umabs that have revolutionized the treatment of so many diseases, including tocilizumab for rheumatoid disease and COVID 19
- Machine : CPAP, BIPAP

Current failures

- Overreliant / hooked to technology – Prof Abraham Verghese, Stanford Medical School – the **i-patient** after seeing residents stuck around their computers

Allowing our clinical common sense and skills to atrophy

The Stanford 25

Do we really need

- An echocardiogram for every praecordial systolic murmur in a 70 year old ?
- A CT / MRI brain for every headache in the Emergency Department ?
- An ultrasound of the abdomen for every patient with abdominal pain
- A full battery of blood tests for every patient admitted to a medical ward ?

The basics – room for improvement

- Poor History = Poor diagnosis
- Listen to the patient – they are telling you the diagnosis – **Who ?**
- Lip service only- chest pain , cough histories poorly taken
- Examination- very often omitted or obvious signs missed eg patient burning with fever, lymphadenopathy , oral lesions.
- Recent experience with residents- patient with crackles, **bronchial breathing**
- Diabetic Feet not examined = **AMPUTATIONS**

Formulating a diagnosis and a treatment plan

- Needs basic medical knowledge and **reading** up about the current problem if unsure – most residents spend very little time on this.
- $WD (Ib) + LU (BB) = K$
- Treatment - sometimes unable to **decide** about simple things- is it lack of knowledge, lack of confidence or lack of delegation from the senior ?

End of life issues

- How to break bad news
- Discuss with patient and family when treatment becomes futile-needs training. Frightening for the novice (JHD)
- Do not start or continue needless treatment (ICU, chemo-immunotherapy) that will prolong suffering and bankrupt the family or the health system
- Palliative care

What can be done

- Junior doctors
- Consultants and other senior clinicians MUST **teach** clinical skills
- Health care Institutions, public and private – help doctors develop **a culture of excellence**
- Regulator- **Medical Council of Mauritius**
- ALL HAVE A ROLE TO PLAY



What is Entrustable Professional Activity (EPA)?

Traditional CME outcome measures

- The traditional credit-hour has served to document participation in CME but **falls short in showing translation to maintained competence or improved performance.**
- With the movement toward more **self-directed, practice-based learning**, critics have argued for a system of relative value that provides **higher-value credit** for those **activities** that show **improved practice.**

Continuing medical education (SKILLS)

- Properly structured
- Behaviour changing / skills enhancing
- Patient wellbeing orientated

Table 1

Alignment of educational interventions in the context of **learning by health professionals**

Continuum of learning or change ⁸	Awareness	Agreement	Adoption	Adherence
Elements of change ⁹	Predisposing elements	Enabling strategies		Reinforcing elements
Possible roles for educational interventions	Conferences, lectures, rounds, print materials	Small-group learning activity; interactivity in lectures	Workshop; materials distributed at conferences; audit and feedback	Audit and feedback; reminders

Investigate and manage difficult-to-treat asthma in adults and adolescents

Consider referring to specialist or severe asthma clinic at any stage

DIAGNOSIS:
"Difficult-to-treat asthma"

1 Confirm the diagnosis
(asthma/differential diagnoses)

3 Optimize management,
including:

4 Review response after ~3-6 months

For adolescents and adults with symptoms and/or exacerbations despite medium or high dose ICS-LABA, or taking maintenance OCS

2 Look for factors contributing to symptoms, exacerbations and poor quality of life:

- Incorrect inhaler technique
- Suboptimal adherence
- Comorbidities including obesity, GERD, chronic rhinosinusitis, OSA
- Modifiable risk factors and triggers at home or work, including smoking, environmental exposures, allergen exposure (if sensitized); medications such as beta-blockers and NSAIDs
- Overuse of SABA relievers
- Medication side effects
- Anxiety, depression and social difficulties

- Asthma education
- Optimize treatment (e.g. check and correct inhaler technique and adherence; switch to ICS-formoterol maintenance and reliever therapy, if available)
- Consider non-pharmacological interventions (e.g. smoking cessation, exercise, weight loss, mucus clearance, influenza and COVID-19 vaccination)
- Treat comorbidities and modifiable risk factors
- Consider non-biologic add-on therapy (e.g. LABA, LAMA, LM/LTRA, if not used)
- Consider trial of high dose ICS-LABA, if not used

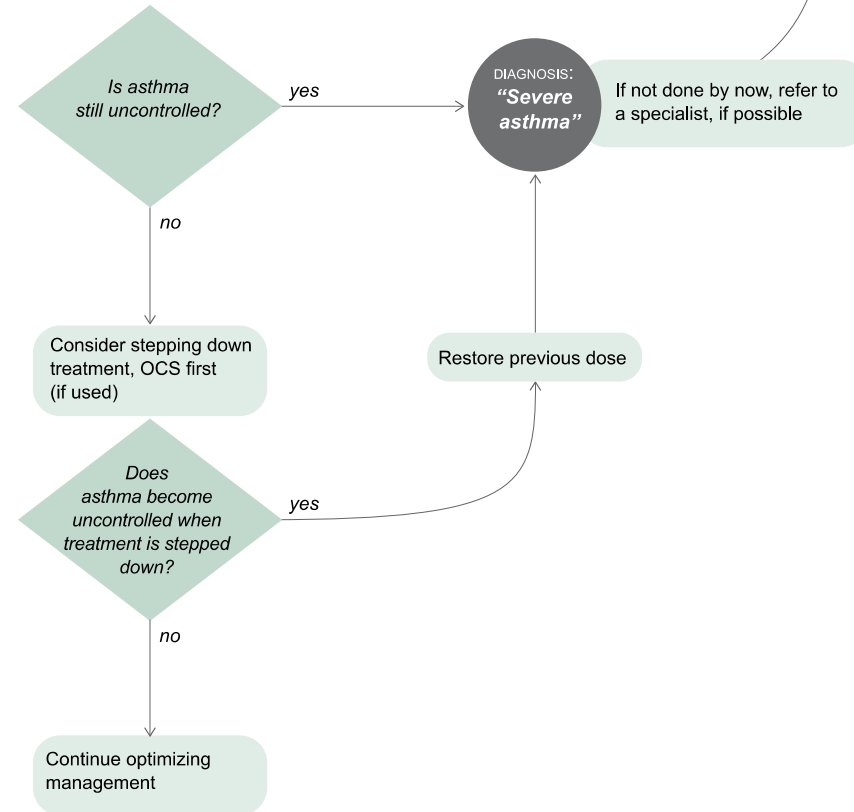


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Outcomes for continuing education/continuing professional development³¹

Level	Outcome	Metrics or indicators
1	Participation	Attendance
2	Satisfaction	Satisfaction of participant
3	Learning	Changes in knowledge, skills or attitude
4	Performance	Changes in performance in practice
5	Patient-specific health	Changes in health status of patient
6	Population-specific health	Changes in health status of population

Homework

- Read what Annick sent you about CME
- Look up Stanford 25
- Medscape

Feedback

- Satisfaction ?
- Did you learn something new ?
- Will it change your practice ?
- Would you recommend it to colleagues ?