What is the best way to interact with doctors?
(STARS Syncope and RAS Patient Day)

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What is a clinician? Philip Tumulty

A clinician is one whose prime function is to manage a sick person with the purpose of alleviating the total effect of his illness. The multifocal character of the impact of illness upon the patient and his family is stressed. Clinical evidence is the material with which the physician works, and a meticulous history and physical examination are paramount. The availability of more specific forms of therapy requires a clinician to be more of a scientist and, at the same time, more expert in clinical methods. Ability to listen and to talk, so that valid clinical evidence is gathered, anxieties are dissipated, and understanding and motivation are instilled, are the clinicians' greatest assets.

Opening lecture to the third-year students in their course, "Introduction to Clinical Medicine," at Johns Hopkins University School of Medicine, 1970
Why are we discussing this topic?

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3. Syncope is not a rash
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Fig. 1. Algorithm for the diagnostic management of syncope. TLOC: transient loss of consciousness, HT: hyperventilation test, HUTT: head-up tilt test, EPS: electrophysiological study, CSM: carotid sinus massage, NMS: neurally mediated syncope, ILR: implanted loop recorder, EEG: electroencephalography.
Tachycardia (VT)
Bradycardia (CHB)
Structural (AS/HCM)
Channelopathies

Echo
ECG
24h tape
“Other Ix” – CMR, reveal, ajmaline or adrenaline challenge,
Electrophysiology Study, CT coronary angiogram
Blood loss
Dehydration
Orthostatic intolerance (OI) = inability to maintain adequate BP on standing
a) Early OI, initial BP drop, then recovery
b) Delayed OI, common in elderly due to inability to maintain compensatory reflexes
c) POTS
Primary and secondary autonomic failure syndromes

Multiple syst atrophy

Parkinsons

Diabetes, Amyloid

Alcohol, diuretics, vasodilators
Situational (cough, sneeze, micturition, post-prandial/exercise, laugh)

Carotid sinus syncope

Vasovagal (mediated by emotional stress, fear, pain, blood phobia, **orthostatic stress**)

Pathophysiological basis of the classification
Typical history-taking sequence

Demographics
Presenting complaint
History of presenting complaint
Past Medical History
  • DHx + Allergies
Social history
  • EtOH + smoking
Family history
Systems Review:
  - chest, abdomen, brain, musculoskeletal, endocrine, others
  - In effect: SOB, “asthma/COPD, liver disease, stroke, arthritis, BP, DM, thyroid”
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All in 25 minutes (+ dictation)
What does a typical doctor like in a consult?

1. Clear consult – with answers given to FIT diagnosis
2. Clear hard facts
3. Limited differential diagnoses
4. Rapid diagnosis
5. Clear treatment plan
6. Ideal single visit – discharge back to GP
7. Within 20 minutes (first consult), 10 mins (follow up)
What does a typical doctor dislike in a consult?

1. Knight’s move thinking/communication
Why we are direct questions...

Doctor, may I please tell you my story?

Just answer my questions!
What does a typical doctor **D**ISlike in a consult?

1. Knight’s move thinking/communication
2. Vague history, uncertain recollection of facts
What does a typical doctor dislike in a consult?

1. Knight’s move thinking/communication
2. Vague history, uncertain recollection of facts
3. Ah/yes but…
What does a patient want?

• A clear and accurate diagnosis
• A clear and effective treatment plan
• To be heard
• Reassurance
• Empathy
So how do you get what you want?


Let's align agendas!

What a doctor wants

• Clear consult – with answers given to FIT diagnosis
• Clear hard facts
• Limited differential diagnoses
• Rapid diagnosis

What a patient wants

• A clear and accurate diagnosis
 Lets align agendas!

**What a doctor wants**
- Clear consult – with answers given to FIT diagnosis
- Clear hard facts
- Limited differential diagnoses
- Rapid diagnosis
- Clear treatment plan

**What a patient wants**
- A clear and accurate diagnosis
- A clear and effective treatment plan
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What a patient wants

- A clear and accurate diagnosis
- A clear and effective treatment plan
- Reassurance?
Let's align agendas!

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What a patient wants

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• A clear and effective treatment plan
• Reassurance
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Top tips

1. Be friendly / engaging – your are likely to elicit a similar response
2. Be concise
3. Be factual – bring your medications, BP/HR readings
4. “The strongest memory is weaker than the faintest ink…” so write down questions / comments / facts
5. Personality
A helpful start
The Blackouts Checklist

Sometimes during a consultation it can be hard to remember everything. The checklist is designed for you to complete. If you have a friend or family member (witness) who has been with you during a blackout or fall, it is VITAL to ask for their help in filling out parts of the form. Please ensure your witness completes their sections of the Checklist. This will help your GP to refer you to the appropriate specialist to make the right diagnosis.

Preparing your own CHECKLIST

To give the doctors the best chance of making the right referral or diagnosis you should provide as many details as possible about your blackout(s) or fall(s).

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
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1. List any medication(s) you are currently taking:  

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2. Do you experience blackout, falls or both? (Tick as appropriate)  
- Blackouts  
- Falls  
- Blackouts and Falls  

If you experience falls, are they unexplained or due to a slip or trip?  
- Unexplained  
- Slip or trip  

3. Do you always lose consciousness? Please ask a witness (Tick as appropriate)  
- Yes  
- No  

How long are you unconscious for?  

4. How frequent are your blackout or falls? (Tick as appropriate)  
- Daily  
- Weekly  
- Less frequent than every two weeks  

5. Before a blackout or fall did you have any warning signs? (Tick as appropriate)  
- Light-headedness  
- Looking pale  
- Change in hearing  
- Sweating  
- Palpitations  
- Other (give details below)  
- Nausea  
- Greying out or dots in vision  

6. Is there anything that triggers your blackout or fall? (Tick as appropriate; if one trigger occurred at one time and another at another time, tick both)  
- Pain or a fright  
- Lack of sleep  
- Anxiety  
- Being very hot  
- Not eating  
- Stressful situation  
- Going from sitting or lying to standing  
- Exercise  
- Alcohol  
- Flashing lights  
- Standing for a long time  
- Other (give details below)
Describe what happens during your blackout or fall. Please include whether your episodes are identical on each occasion or if there are differences.
If you are not conscious or cannot remember to ask someone who was with you at the time to describe what happened.

Your description

Friend or family description

**WITNESS:** Do the individual’s limbs move whilst they are unconscious? Do they jerk about randomly or rhythmically?
- [ ] Randomly
- [ ] Rhythmically

**WITNESS:** Do the individual’s arms move around their head?
- [ ] Yes
- [ ] No

**WITNESS:** Are the individual’s eyes opened or closed?
- [ ] Don’t know
- [ ] Open
- [ ] Closed
If open, how do their eyes move?

After your blackout

**WITNESS:** Following the individual’s blackout or fall, how long before they regain consciousness?

After the blackout or fall are you confused on coming around? How long does the feeling last?

How do you feel after a blackout or fall?

Are your blackouts or falls affecting your daily activities or quality of life?
- [ ] Yes
- [ ] No

Family history

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If there is, who/what relation?</th>
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<tbody>
<tr>
<td>Is there a history of loss of consciousness in your family?</td>
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<tr>
<td>Is there a history of deafness in your family?</td>
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<td>Has anyone suffered a sudden cardiac death in your family?</td>
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<tr>
<td>Have there been any sudden deaths in the family under 55 years?</td>
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<tr>
<td>Is the cause known?</td>
<td></td>
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Any other questions you would like to ask the doctor or specialist:
Top top top tip
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