

# Family medicine assignment essays examples

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## **Introduction**

Family medicine is a branch of medicine concerned with delivering health care services at the family level. Unlike other medical fields which with the patient individually, family medicine practitioners must incorporate the other family members in the delivery of health services. Family medicine practice is built around addressing the Ideas, Concerns and Expectations (ICEs) of the patient and the family. Family medicine practitioners should be flexible in responding to diverse medical needs of a family. Additionally, family medicine practitioners should be able to reconcile the priority areas of the patient and those derived from medicine and address them in a patient-centered way. This essay discusses the process of delivering care to an asthmatic patient in an outpatient setting. The paper focuses on objectives of family medicine, ICEs and how these can be combined to enhance care delivery.

Family medicine practitioners provide care in the context of the family and must consider the needs of the family members. The process of care delivery involves diagnosis, identifying the family's ICEs, identifying the priority areas, and designing interventions to meet the priority areas. The GP conducted a full medical history and physical examination on Mr. John. The measures conducted included forced expiratory volume in one second (FEV1) and peak expiratory flow rate to enable an accurate classification of Mr. John's asthma. The medical history provided the frequency of asthmatic symptoms while a background check highlighted the areas where lifestyle modification can be used to manage and control the disease. Although he had a symptom frequency of once a week which is consistent with a severity

of mild persistent, Mr. John's night time symptoms occurred at least once a week and he had a FEV1 of 71% which is consistent with a severity level of moderate persistent (Yawn, 2008). Accurate classification of asthma is vital as it affects the priority areas, and determines the prescribed drugs and dosage level (Dekhuijzen et al., 2013).

A complete medical history and physical examination is the first step in family medicine. For this case, I would have concentrated more on the patient living environment to enable identification of the environmental factors which may trigger an asthmatic attack. These triggers include cigarette smoke, dust, spray paint and some allergens such as cat's fur (Brooks, Malo & Gautrin, 2013) Mr. John is exposed to these triggers either at home or in the workplace. Addressing the triggers would reduce the chances of future attacks while pharmacological therapy would control the symptoms of asthma and allow Mr. John to have a normal life (Miravittles et al., 2012). Since his wife smokes and his children keep pets, it would require radical lifestyle changes at the family level.

## **Planning for Continuity of Care**

When planning for continuity of care, family medicine practitioners should evaluate the needs of the whole family, identify priority areas, and recommend interventions that can be implemented at a family level to address the patients ICEs. For Mr. John, the main worry is another asthma attack or development of severe symptoms that may hamper day to day activities. As the breadwinner in the family, Mr. John worries that a severe asthma attack would leave him unable to provide for the family. The symptoms of asthma such as coughing and wheezing reduce his social

interactions. His wife and children go through psychological pressure when they see him suffer. They are worried on how their actions may be making Mr. John's asthma worse especially after the medical examination revealed his asthma severity has moved up from mild persistent to moderate persistent. From these family ICEs, the priority areas identified were relieving and preventing symptoms and allowing normal activities such as work and social interaction.

As the health care provider, my priority areas would be relieving and preventing the symptoms of asthma, restoring and maintaining normal pulmonary function, reducing the cost and inconveniences associated with the disease, and avoid adverse effects from the interventions. Family medicine practitioners have a duty to provide holistic health care services. This was the guiding principle while selecting my priority areas so that they complement those of the patient and family, and provide a holistic approach to the case.

Once the priority areas were identified, the GP invoked the principles asthma management as giving in the hospital policies. These principles include accessing and monitoring asthma severity, patient education, controlling asthma triggers, long term pharmacological plans, self management plan of acute exacerbations, and regular follow up care (Carr & Peters, 2012). Some of these steps can be implemented at a family level. Assessing asthma severity had been done by measuring lung functions as a severity level of "moderate persistent" obtained. Monitoring severity level is vital to addressing the priority area of restoring and maintaining normal pulmonary function and addressing the symptoms of the disease.

Although asthma has no cure, there are pharmacological interventions to control the symptoms. Mr. John had been taking bronchodilators whose prescription is consistent with a severity score of intermittent. However, his actual severity score was mild persistent and he ought to have been prescribed low-dose inhaled corticosteroids. Now that his severity level is moderate persistent, I would recommend an inhaled corticosteroid and a mast cell stabilizer. These classes of drugs have a high efficacy in controlling the symptoms of asthma (Barnes, 2012). To minimize the risk of adverse side effects, I would avoid prescribing long-acting beta-adrenoceptor agonists such as salmeterol which have a high risk of adverse effects when used with corticosteroids (Ortega & Bleecker, 2011). Mr. John was prescribed beclomethasone, an inhaled corticosteroid at a dosage of two puffs per day.

Patient education was an important part of planning for continuity of care when the patient got home. The GP focused the patient education on the management of asthma, self-management during acute asthma exacerbations and controlling asthma triggers. Acute asthma exacerbations are characterized by chest tightness, wheezing and shortness of breath. The patient and the family were educated on how to recognize these symptoms and taking interventions such as use of bronchodilators and corticosteroids to prevent the development of acute severe asthma (asthmaticus) which can be fatal (Shah & Saltoun, 2012). Asthma attacks usually occur after exposure to asthma triggers. Some triggers such as cigarette smoke and allergens such as cat's fur are present at Mr. John's house and may have triggered his asthma attack. These triggers can be eliminated through lifestyle changes

such as Mrs. John quitting smoking and the children avoiding to keep pets. In addition to the GPs education, I would have added further triggers such as work and socially related triggers. Mr. John works in the construction industry where he is exposed to triggers such as dust and spray paint. Additionally, he is a father and plays with his children. Wearing a face mask at work would reduce exposure to triggers and avoiding heavy exercises would reduce the risk of bronchoconstriction and asthma (Bonini, M., Moreira & Bonini, S., 2014). In self management training, I would have focused on the proper way of administering drugs from an inhaler to ensure the patient receives the full dose. This is based on the study by Hamdan et al., (2013) which revealed that proper administration of drugs from an inhaler is important in ensuring drug efficacy.

### **Doctor-centered Care vs. Patient-centered Care**

Doctor-centered care is health care services delivered with an emphasis on the doctor's role and decisions. Since doctors can make medical decisions fast and under pressure, doctor-centered care is timely and effective in addressing the clinical priority areas. The major disadvantage of doctor-centered care in a family medicine setting is the lack of cultural, emotional, and religious sensitivity which reduce its acceptability among patients. According to Starfield, (2011) patient-centered care is fully acceptable to patients since they are the key decision makers on which therapies to receive.

In family medicine practice, the ideal care ought to be a blend of patient-centered care and doctor-centered care. In this case, doctors should educate the family to enable them to make informed decisions which leads to

effective patient care that is acceptable. Blending the two approaches to care delivery is important especially when selecting the priority areas since doctors and patients have different priority areas. For instance, Mr. John and his family priority areas were reducing symptoms and maintaining normal daily activities, while the physician's priorities were maintaining normal pulmonary function and minimizing adverse effects from interventions. Therefore, it is important for family medicine practitioners to be flexible and incorporate the patient's and family's ICEs in care delivery.

## **Conclusion**

Family medicine practitioners provide health care at the family level. Their focus extends beyond the needs of the patient to cover the ICEs of the other family members and highlight the interventions the other family members can take to alleviate health for the patient. In order to provide quality services, family medicine practitioners need to address diverse health needs of a family from controlling symptoms to disease management and knowledge on risk factors. In the case of Mr. John, the family can help by eliminating factors such as cigarette smoking and pets which can trigger his asthma attacks. Additionally, the family should recognize the symptoms of an asthma attack and know how to respond to it.

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