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Internal Medicine. Propaedeutics as an introduction to the clinic of internal medicine.

*Basic concepts. Medical ethics and
deontology in the clinic of internal medicine.*

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2015

Aim of practical medicine

- prevention of disease
- treatment of disease
- alleviation of the patient 's suffering

Health is a state of complete physical, mental and social well-being and not only the absence of disease or infirmity.

World Health Organization (WHO), 1946

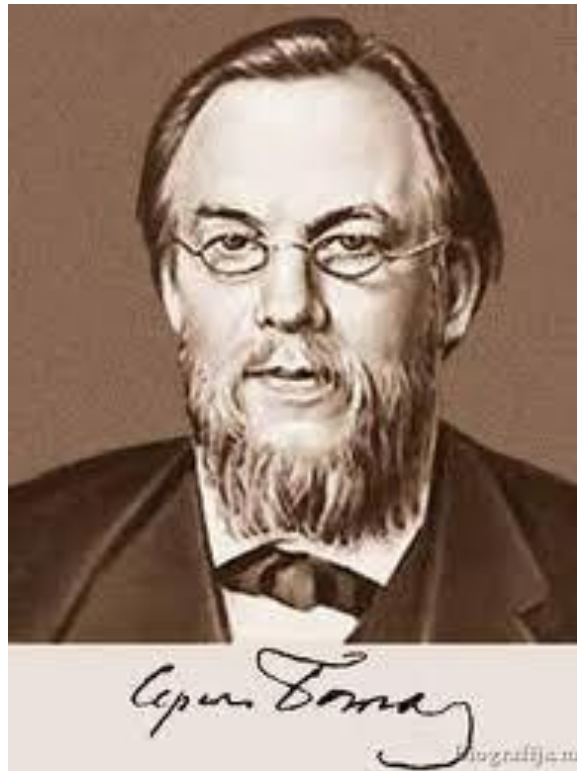
Disease is an anatomical or functional disorder caused by a pathogenic or an extraordinary stimulus and all changes in the organism that occur in response to this stimulus.

Internal diseases classification

- By etiology
- By localization
- Diseases in which the leading role plays the pathogenesis of the disease, not the cause, which may not be known
- Disease, encompass with special morphological and functional properties - tumors

*The concept of disease is closely contacts to its cause,
which is always exclusively due to the external
environment, acting either directly on the diseased
body or through his closest or distant parents.*

S.P. Botkin



Causes of the disease

- 1) Mechanical (opened and closed injuries)
- 2) Physical (high or low temperature, light)
- 3) Chemical (spoiled foods, poisons)
- 4) Biological (microorganisms)
- 5) Psychogenic
- 6) Genetic (hereditary)

Disease

- Acute disease
- Chronic disease
- Complication of the disease
- Relapse of the disease
- Main disease
- Concomitant disease
- Competitive disease

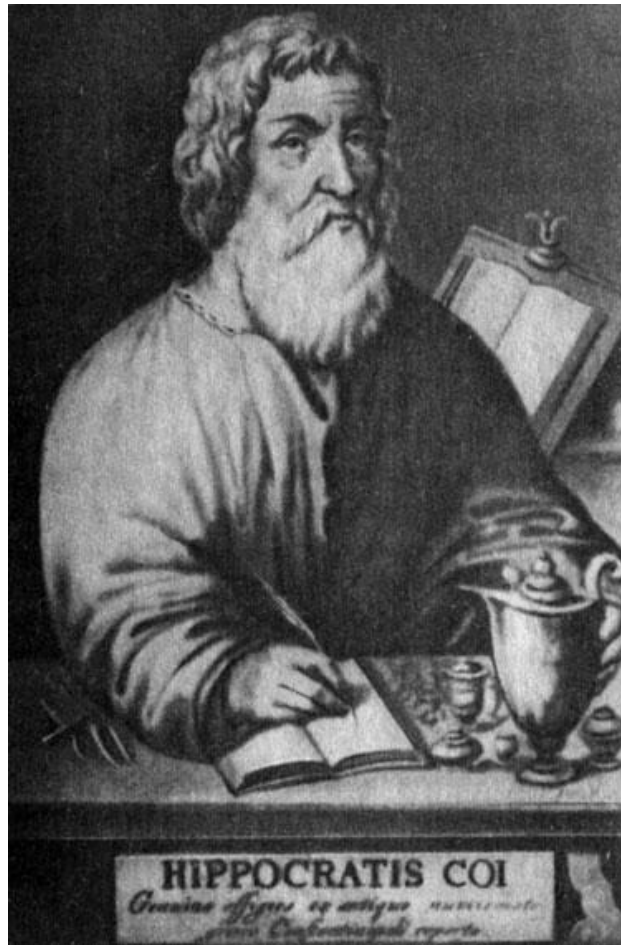
Outcomes

- Recovery
- Chronic condition
- Death

Qui bene dignoscit bene curat

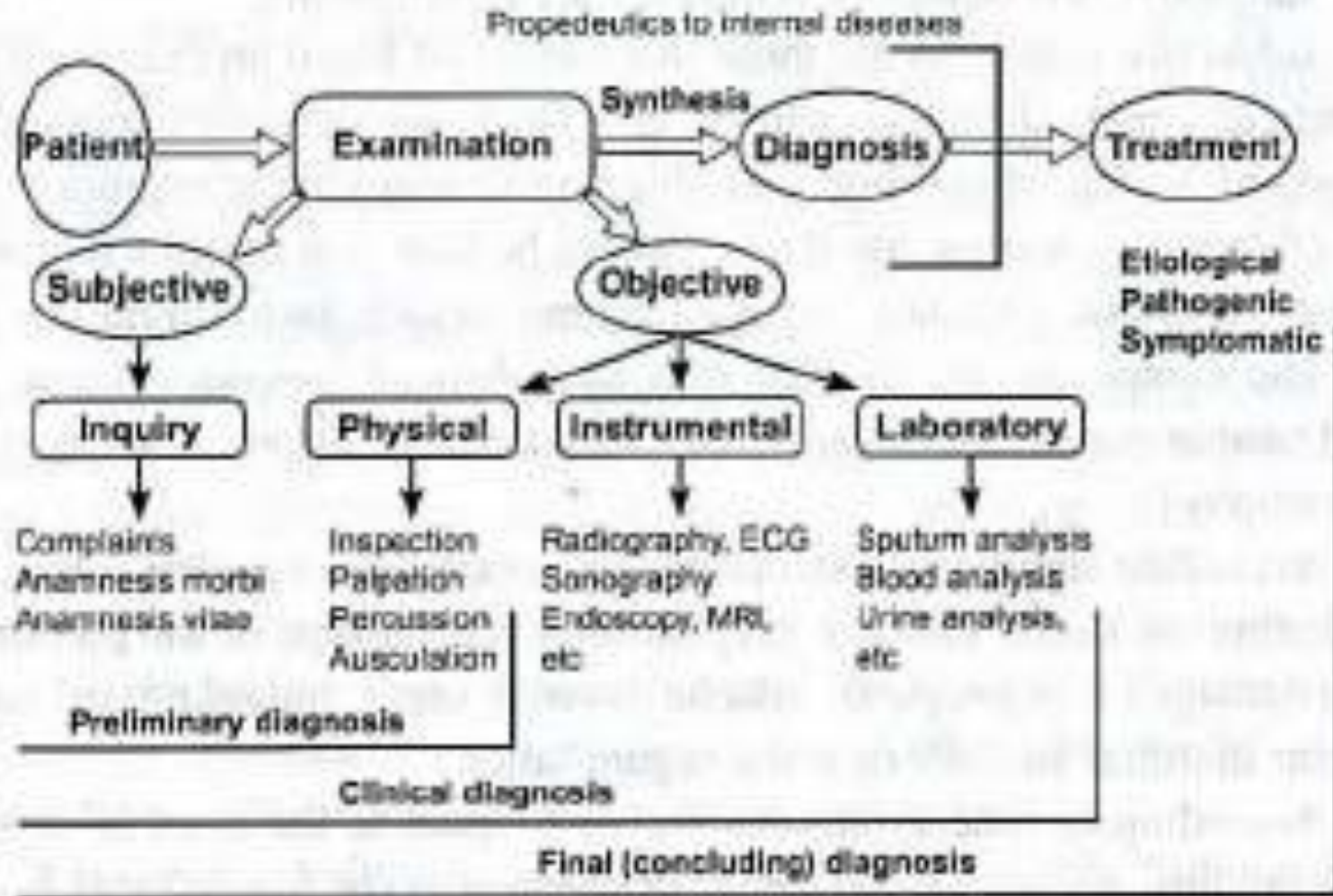
Who diagnoses well that well-treats

Hippocrates



- **Propaedeutics** or **propedeutics** is a historical term for an **introductory course** into a discipline: art, science, etc.
- Etymology: pro- + Greek: *paideutikós*,

The algorithm of a clinical diagnostics



Diagnosis

- **Medical diagnosis** refers to the process of attempting to determine and/or identify a possible disease or disorder and the opinion reached by this process.



Diagnosis

- Preliminary diagnosis
- Clinical (working) diagnosis
- Final (concluding) diagnosis :
 - underlying disease
 - complications
 - concomitant [coexistent] disease, associated illness

Diagnosis structure

1. The main disease
2. Complication of the main disease
3. Concomitant (concurrent) disease

- Semiology (Greek *semion* - sign) is a study of diagnostic value of symptoms and signs.

- A **symptom** (from Greek *symptoma* – “*that which happens*”) is a departure from normal function or feeling which is noticed by a patient, indicating the presence of disease or abnormality. A symptom is subjective, observed by the patient, and not measured.

A **medical sign** is an objective indication of some medical fact or characteristic that may be detected by a physician during a physical examination of a patient.

Signs and symptoms

- Pathological
- Compensatory
- Specific or pathognomic
- Nonspecific
- Early
- Late
- Favorable
- Unfavorable

- In medicine a **syndrome** is the association of several clinically recognizable features, signs (observed by a physician), symptoms (reported by the patient), characteristics that often occur together, so that the presence of one or more features alerts the physician to the possible presence of the others. Specific syndromes tend to have a range of possible etiologies or diseases that could create such a set of circumstances.

Treatment

- Etiological
- Pathogenic
- Symptomatic

Treatment

- **Palliative care** is a holistic, multi-disciplinary approach that includes specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

It is necessary to treat not the disease,
but the patient.

M.Y.Mudrov



Write-ups



The Medical History serves several purposes:

- It is an important reference document that gives concise information about a patient's history and exam findings at the time of admission. In addition, it outlines a plan for addressing the issues which prompted the hospitalization/visit. This information should be presented in a logical fashion that prominently features all data immediately relevant to the patient's condition.
- It is a means of communicating information to all providers who are involved in the care of a particular patient.
- It is an important medical-legal document.

The Medical History is not:

- An instrument designed to torture Medical Students and Interns.
- Meant to cover unrelated bits of historical information.
- Should neither require the killing of more than one tree nor the use of more than one pen to write!

Medical History

- Interviewing
- Physical examination
- Data of additional examination methods
- Diagnosis
- The course of the disease (*decursus morbi*)
- Treatment
- Epicrisis

The standard framework of interviewing (history taking)

- Identifying Data
- Chief complaint(s)
- Anamnesis morbi
- Anamnesis vitae
- Review of Systems

Identifying Data

- Full name
- Age
- Birthplace
- Address
- Professional occupation and workplace

random|plakid

Chief complaint

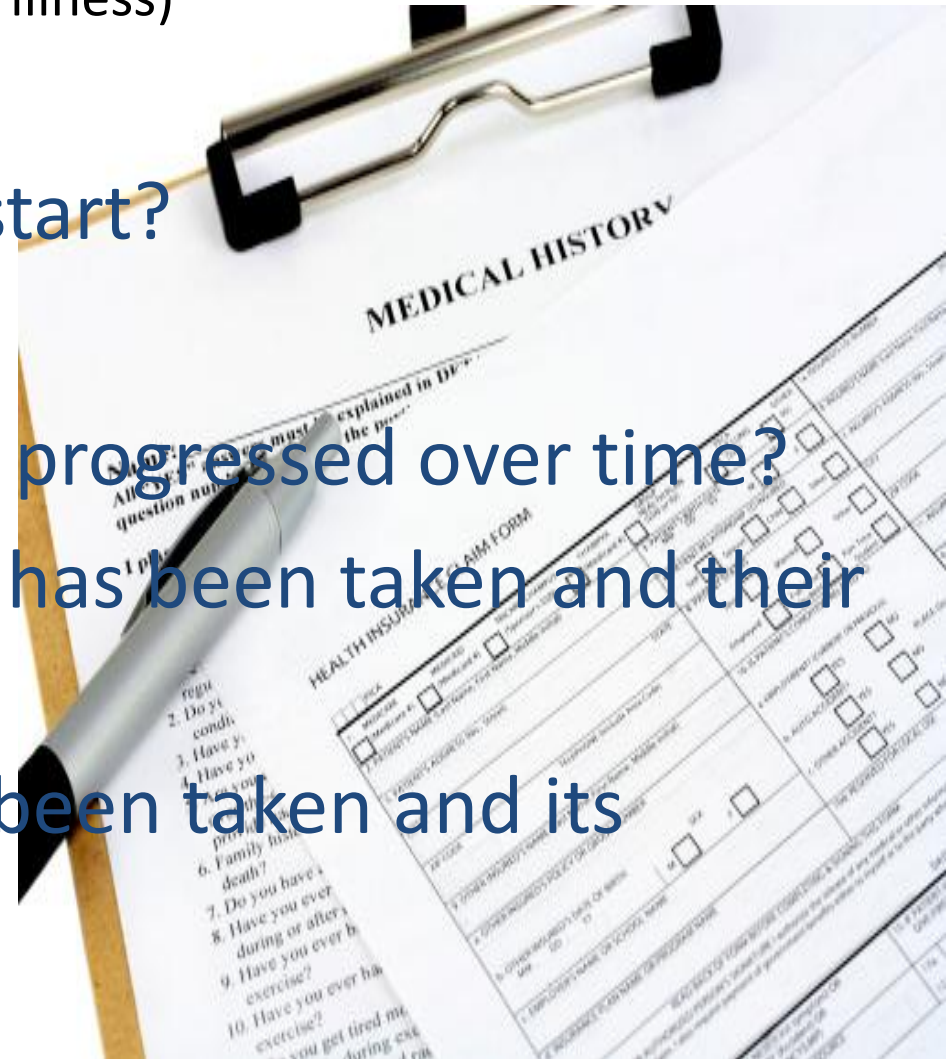
- chief symptom in patient's own words
- it should be no more than a single sentence.
- several symptoms should be present as a list



Anamnesis morbi

(present illness)

1. When did the illness start?
2. How did it start?
3. How has the problem progressed over time?
4. What kind of analysis has been taken and their results?
5. What treatment has been taken and its effect?



Anamnesis vitae

- **General biographic(al) data** (*birthplace, level of health at birth and in childhood, time of puberty coming*)
- **Social and living conditions** (*living conditions, marital status, dietary habits, degree of physical activity, Military Service*)
- **Occupation** (*Adverse working conditions and job hazard – dust, noise, vibration, working regime*)
- **Illness in the past** (*Children's infectious diseases, Repeated tonsillitis, Diabetes, Rheumatic fever, Operations, Injuries*)

Anamnesis vitae

- **Family history** (*Parents, Close relatives, Familial occurrence of certain diseases*)
- **Gynecological anamnesis in women**(*Menstruation, Menopause, Number of children, Hormone contraceptives*)
- **Allergic anamnesis** (*Drug allergy, Pollinosis, Food allergy, Allergy to adhesive plaster, contrast media*)
- **Drug history** (*List of permanently taken medications - Eye-drops, Sleeping pills, Over the counter drugs, Vitamin supplements, Herbal remedies*)

Review of Systems

- General symptoms - weight change (loss or gain), change in appetite (loss or gain), fever, apathy, flaccidity, malaise.
- Respiratory symptoms - cough, sputum, haemoptysis, shortness of breath, wheeze, chest pain.
- Cardiovascular symptoms - shortness of breath on exertion, paroxysmal nocturnal dyspnoea, chest pain, palpitations, ankle swelling, orthopnoea, claudication.
- Gastrointestinal symptoms - indigestion, pyrosis, abdominal pain, nausea, vomiting, a change in bowel habit, constipation, diarrhoea, pathological substances in the faeces , melena, dysphagia, biliary colic, icterus
- Genito-urinary symptoms - urinary frequency, polyuria, oliguria, dysuria, haematuria, nocturia, renal colic, menstrual problems, impotence.
- Neurological symptoms - headaches, dizziness, tingling, weakness, tremor, fits, faints, funny turns, black-outs, sphincter disturbance, sleep disturbance, irritability or indifference to environment, activity of sense organs
- Locomotor symptoms –aches, pains, joints stiffness, swelling.
- Skin symptoms - lumps, bumps, ulcers, rashes, itch.

Sources of information

- Relatives/cohabitants.
- Close friends/room-mates.
- The general practitioner or other members of the primary care team.
- The pharmacist.
- The warden (if in sheltered accommodation).
- The staff at the nursing or residential home.
- Anyone who witnessed the event.

Example

- Patient F., unconscious on admission. From the words of his wife, suddenly fainted during lunch.
- Patient B., excited, aggressive, refusing to answer questions. From the words of the medical staff change of mood came after a visit of relatives.

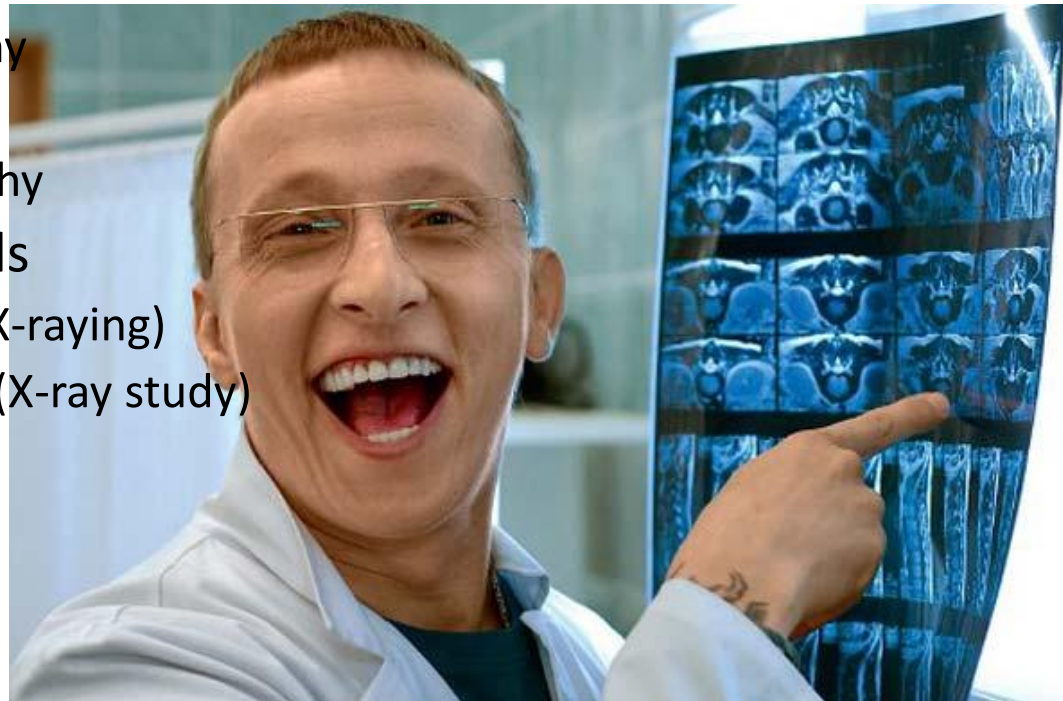
Physical examination

(Status praesens)

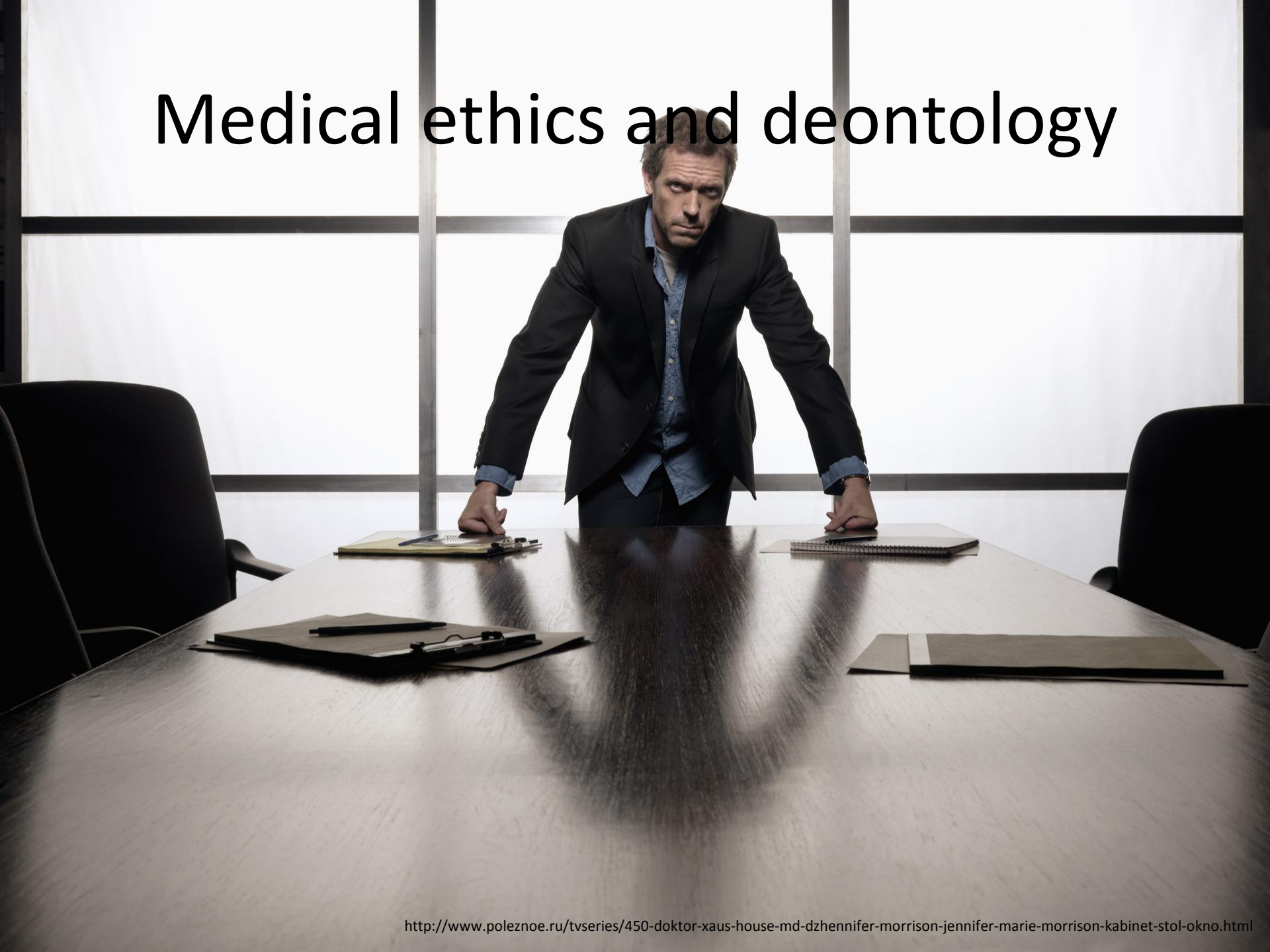
- General survey (level of consciousness, position, constitution, fatness, skin and its appendages)
- Local survey (face, neck, peripheral lymph nodes, muscles, bones, joints)
- Examination by organs and systems
 - overview
 - palpation
 - percussion
 - auscultation
 - measurements

Additional examination methods

- Laboratory tests
- Instrumental methods
 - ❖ Endoscopy, biopsy, cytological analysis
 - ❖ Functional methods
 - ❖ Electrocardiography
 - ❖ Spirography
 - ❖ Pneumotachography
 - ❖ Roentgenologic methods
 - ❖ Roentgenoscopy (X-raying)
 - ❖ Roentgenography (X-ray study)
 - ❖ Tomography
 - ❖ Ultrasonic methods



Medical ethics and deontology



Medical ethics and deontology in the clinic of internal medicine

Physicians frequently confront ethical issues in clinical practice that are perplexing, time-consuming, and emotionally draining. Experience, common sense, and simply being a good person do not guarantee that physicians can identify or resolve ethical dilemmas. Knowledge about common ethical dilemmas is also essential.

Medical ethics and deontology

Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. As a scholarly discipline, medical ethics encompasses its practical application in clinical settings as well as work on its history, philosophy, theology, and sociology.

Deontological ethics or **deontology** (from Greek *deon*, "obligation, duty"; and *-logia*) is an approach to ethics that judges the morality of an action based on the action's adherence to a rule or rules. Deontologists look at rules and duties.

FUNDAMENTAL ETHICAL GUIDELINES

Physicians should follow two fundamental but frequently conflicting ethical guidelines: *respecting patient autonomy* and *acting in the patient's best interests*.

RESPECTING PATIENT AUTONOMY

Treating patients with respect requires doctors to accept the medical decisions of persons who are informed and acting freely. Individuals place different values on health, medical care, and risk. In most clinical settings different goals and approaches are possible, outcomes are uncertain, and an intervention may cause both benefits and harms. Thus competent, informed patients may refuse recommended interventions and choose among reasonable alternatives.

Informed Consent

- For patients to make informed decisions, physicians need to discuss with them the nature of the proposed care, the alternatives, the risks and benefits of each, and the likely consequences, and to obtain the patient's agreement to care. Informed consent involves more than obtaining signatures on consent forms. Physicians need to educate patients, answer questions, make recommendations, and help them deliberate. Avoid to overwhelm patients with medical jargon, needlessly complicated explanations, or too much information at once.

Non-disclosure of Information

Physicians may consider withholding a serious diagnosis, misrepresenting it, or limiting discussions of prognosis or risks because they fear that a patient will develop severe anxiety or depression or refuse needed care. Generally, physicians should provide relevant information, while adjusting the pace of disclosure, offering empathy and hope, and helping patients cope with bad news.

Emergency Care

- Informed consent is not required when patients cannot give consent and when delay of treatment would place their lives or health in peril. People are presumed to want such emergency care unless they have previously indicated otherwise.

Futile Interventions

- Autonomy does not entitle patients to insist on whatever care they want. Physicians are not obligated to provide futile interventions that have no physiologic rationale or have already failed.
- But physicians should be wary of using the term “futile” in looser senses to justify unilateral decisions to forego interventions when they believe that the probability of success is too low, no worthwhile goals can be achieved, the patient’s quality of life is unacceptable, or the costs are too high. Such looser usages of the term are problematic because they may be inconsistent and mask important value judgments.

Maintaining Confidentiality

- Confidentiality respects patients' autonomy and privacy. Maintaining a secret record of personal information shows respect for the individual's autonomy and their right to control their own information. There is also an element of beneficence where releasing the protected information may cause harm. However, maintaining confidentiality is not an absolute rule.

Confidentiality

Breaking confidentiality

- With the consent of the individual concerned.
- If disclosure is in the patient's interest but consent cannot be gained.
- If required by law.
- When there is a statutory duty such as reporting of births, deaths, and abortions and in cases of certain communicable diseases.
- If it is overwhelmingly in the public interest.
- If it is necessary for national security or where prevention or detection of a crime may be prejudiced or delayed.
- In certain situations related to medical research.

Avoiding Deception

- Health care providers sometimes consider using lies or deception in order to protect the patient from bad news or to obtain benefits for the patient. Lying refers to statements that the speaker knows are false and that are intended to mislead the listener.
- The person who is deceived cannot make informed decisions if they receive misleading information. Furthermore, deception undermines physicians' credibility and trustworthiness.

THE END