WHMC311

Session 2

Tutorial

Naturopathic Medicine Department
Professional Communication

- Effective communication between health care practitioners is essential for integrative health care for clients.

- It ensures risk minimisation with regard to conventional and CAM interactions and client safety events = *Primum Non Nocere*

  (Pierantozzi, 2013)
Referral

Referral Letter

- Use SBAR or similar convention
- Summarise key medical facts
- Use medical language and conventions
- Report accurately
- Be reasonable with your requests
- Provide a rationale

(Pierantozzi, 2013, Arthur, 2014)
# Professional Communication

## Table 1: SBAR (Adapted from (Safer Healthcare 2009, Monroe 2006))

<table>
<thead>
<tr>
<th>S</th>
<th>Describe the SITUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Introduce yourself</td>
</tr>
<tr>
<td></td>
<td>• Identify the patient and the reason for your call</td>
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<tr>
<td></td>
<td>• Describe your concern</td>
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<tr>
<td></td>
<td>• The situation I am concerned about is ..................................................</td>
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<tr>
<td></td>
<td>• I wish to inform you of ...........(e.g. current treatment/s, management plan and possible treatment interactions, changes to patient status, referral to assume the care of the patient for a problem)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Provide BACKGROUND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What is the relevant supporting background information</td>
</tr>
<tr>
<td></td>
<td>• Chief complaint/presenting symptoms</td>
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<tr>
<td></td>
<td>• Current status</td>
</tr>
<tr>
<td></td>
<td>• Relevant history, examination and/or test results</td>
</tr>
<tr>
<td></td>
<td>• Current treatments and/or management plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>Provide client ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• State what you think is going on</td>
</tr>
<tr>
<td></td>
<td>• The problem seems to be...........</td>
</tr>
<tr>
<td></td>
<td>• I am not sure what the problem is, but the client/patient is deteriorating</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Make RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What should be done?</td>
</tr>
<tr>
<td></td>
<td>• What is your recommendation?</td>
</tr>
</tbody>
</table>

(Pierantozzi, 2013)
Best Practice

- If a client is referred to you by another practitioner, medical or complementary it is standard practice to follow up with the referring practitioner.

- If the client is part of an integrative team of practitioners you may provide your client with a report to share or communicate with all parties.
Clinical Decision Making

- Case taking: S.O.A.P.

- Assessment - Naturopathic principles (First do no harm – integrative pharmacology), Therapeutic order, Process of disease and healing, Naturopathic diagnostics

- Treatment
  - S.M.A.R.T. - Short and long term goals
  - Actions
  - Treatment – building a formula, posology
Clinical Notes

- Nora is a 27 year old female patient who weights 52Kg, and is 170m tall.

- She informs you that she has had treatment for a GORD in the past (when she was 25) and feels the treatment prescribed was not effective. She had antisecretory therapy and *H. pylori* eradication for three months.

- She presents with chronic heartburn like discomfort centred in the upper abdomen, bloating and discomfort with large meals.
Clinical Notes

- GIT
  - Bloating, belching, burning and flatulence immediately after meals
  - Undigested food in stool

- NS
  - Stress
  - Fatigue – unrelated to sleep
  - Anxiety
Clinical Notes

- Diet: she can only eat small meals and feels full quickly
  - Breakfast - Gluten free muesli, almonds, dairy free (soy based) yoghurt
  - Lunch - Vegetable wrap or sushi
  - Dinner - loves spicy curries with rice. Vegetarian but tends to avoid legumes due to intolerances. Enjoys gluten free white wraps with salad.
  - Snacks - chocolate
- Avoids intolerances – gluten, dairy, many fruits, legumes, many grains and nuts, most alcohol
Clinical Notes

- Family History:
  - Mother - Depression, bi-polar disorder, IBS
  - Father - High blood pressure, High cholesterol

- Medical History:
  - Treated for gastric ulcer at 25 years old but symptoms still apparent
  - Depression and anxiety diagnosed at 21 during hospitalisation; various medications given over the years
  - Endometriosis
Clinical Notes

- **Medications:**
  - OCP- Yasmin (Endometriosis)
  - Efexor
  - Antacids and Panadol for pain

- Past history includes insomnia, stress, fatigue, depression and anxiety, cold hands and feet
Clinical Notes

- Weak, peeling, and cracked fingernails
- No coat on tongue
- Quivering tongue

Image Source: David Stelfox
Case Study Process

- What is your naturopathic understanding of this case?
- What are your short term therapeutic goals?
- What herbal actions would you consider to support these goals?
- What herbs would you consider and why?
- Prescribe a herbal mix for this client.
- What is your rational for
  - Prescribing these herbs?
  - Choosing them over other potentially useful herbs?
- What other considerations might you suggest to help this patient?
- Write a referral letter as part of your treatment plan
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