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Treating the person, not just the disease

Written by Tara Maltman-Just on September 1, 2013 for Drugstore Canada

By focusing on one tree, we can fail to notice the forest

Good community pharmacists are detail-oriented. We need a keen ability to multitask, analyze data and come to a logical outcome. However, like any healthcare professionals with extensive disease-management training, we run the risk of assuming our patients fit into a mold or model of disease that we know so well.

Unfortunately, many patients report feeling left behind in the current healthcare system. They feel rushed at routine appointments, or must wait months to see specialists. They may have seen many practitioners, tried multiple therapies—but never had meaningful results.

As front-line clinicians, pharmacists have an opportunity to change that. But only if we listen. We need to train ourselves to listen when our patients tell us that their medications are not working or making them feel worse. Because what patients are doing when they confide this type of information is *asking us for help*.

The cornerstone of a successful patient outcome is personalized care. This may seem simple or obvious—of course we provide "personalized" counsel, right? Did you already answer yes? If I know my fellow pharmacists, some of you may be analyzing (in an endearing fashion, of course) the definitions of "personalized" and "care" and checking off the boxes that meet that definition.

*At the end of the day, a patient is not the 'number;' and not 'the disease'; **but a unique person whose observations count.***

In many ways, I'm challenging us as pharmacists to set aside those checklists—*those details that can be distracting*—for just a moment and instead, use what brought us into the profession: our vision—*the big picture that really matters.* Which is, simply. that we want to help people. And the best way to do that is by understanding what season of life they are in. To explain what I mean, let's look at a couple of examples:

Example 1

A case of hypercholesterolemia and high BMI …

When this male patient comes in for a refill, we're tempted to advise on the specific management of hypercholesterolemia: *Watch for any muscle pain with this statin. Don't take it with grapefruit juice.* Perhaps we would tell him it's a good idea to exercise— aim for 5-7 times a week—and lose weight.

Instead, we first decide to ask a few more questions:
When were you diagnosed? When did your doctor first note issues with cholesterol? The patient mentions that he gained a lot of weight a few years ago.

What contributed to the weight gain? His son died in a car accident three years ago. He's struggling financially as he's having difficulty focusing on his job. He rarely leaves the house. He doesn't feel like cooking his own food. He says he wants to exercise, but he has no energy, no motivation, no zest for life. In fact, he can barely get out of bed. He is depressed and grieving. He divorced after the loss of his son and has no family or source of supports nearby. He starts to cry.

Further investigation with him and his healthcare team reveals not only extended stress impacting his social connections and physiologic control of cortisol, sex hormones and thyroid hormones, but also a drug-induced nutrient depletion of Coenzyme Q10 by the statin, further limiting his energy and excessively lowering his cholesterol, the building block of sex hormones, which further impairs his body's already-reduced production of much-needed testosterone critical for weight management, mood and zest for life.

... becomes a real case of a man with hope and renewed vigor, through social supports and treatment of underlying health issues and drug-induced nutrient depletions.

Would a suggestion to lose weight have made any positive impact on this man? Was that the advice he needed in his season of life? There are more trees in his 'foret' than the high LDL tree, the low HDL tree and the high BMI tree in this forest! Sadly, this type of disease-focused care is all too common. A patient of mine received a call from his doctor's receptionist telling him his cholesterol was high, so he should lose 10 pounds. He wasn't overweight. I trust we'd all agree, that's not a good example of personalized care.

Example 2

A case of 'well-managed hypothyroidism in a depressed patient ...

When this patient comes to refill T4 (levothyroxine), she says she doesn't think it's working because she is more depressed than ever, despite a normal TSH of 4.0.

We're tempted to advise on the specific treatment guidelines for hypothyroidism and thyroid replacement: *Your labs show you're within range, so don't worry. See, it's less than 4.5. Just make sure you take it consistently in the morning, on an empty stomach, away from calcium, so it can absorb best.* Perhaps we suggest she contact the doctor about titrating up the dose of antidepressant.

What if, first we decide to ask a few more questions:
When did your depression begin? Thirty years ago. *When did you start thyroid replacement?* Two years ago. *What were the symptoms you had before it was prescribed?* Worsened depression, irritability, hair loss, fatigue, constipation, eczema for five years already, since menopause. *Any family history of thyroid issues?* More autoimmune disease, and some depression, "but once I admit depression, I may as well not mention anything else; they always tell me I'm just depressed," she says.

Our research and consultation with her healthcare team reveals
that we need to adjust the dose of thyroid replacement to optimize TSH, per the 2002 American Association of Clinical Endocrinologists guidelines to treat TSH above 3.0. Further investigation unveils that she feels like she's been typecast as "depressed-only", but our readiness to listen fosters trust. Our recommendation to complete an updated full thyroid panel shows elevated anti-TPO levels, enabling her doctor to diagnose Hashimoto's thyroiditis. This can now be treated accordingly.

... now becomes a true case of effective treatment by identification of immune-modulated Hashimoto's thyroiditis and personalized care.

This person's 'forest' include all types of trees: the TSH tree, the new-and-improved TSH tree, the despondent tree, the history of depression and autoimmune disorders— and the tree of hope. But it is only when we look at the forest that we see the entire picture and are able to help effectively.

Patients know their own bodies best

I believe that our patients know their own bodies best. If something feels "off," even in the face of normal test results, it is vital that we take tha t to heart. At the end of the day, each patient is not a "number"; and not a "disease"; but a unique person whose observations count.

Once we take the time to truly listen, we begin to understand. This makes us well-primed to work with them and their healthcare team to help them feel their best moving forward.

Finding the forest through the trees takes an ability to focus on both the big picture and the little picture. And to understand that both matter.

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