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FAM 503

PRIVATE PRACTICE ORGANISATION

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Course code: FAM 503

Course title: Private Practice Organisation

Course credit load: 1 Unit

Series 1: Family Medicine Tools, Comprehensive and Coordinated Care, and the Patient-Centred Approach

- **Part 1.1: Family Medicine Tools in Private Practice**
  - Sub Part 1.1.1: Practice organisation tools
  - Sub Part 1.1.2: Medical records and appointment systems
  - Sub Part 1.1.3: Tools supporting continuity and coordination of care
- **Part 1.2: Comprehensive and Coordinated Care**
  - Sub Part 1.2.1: Concept of comprehensive care
  - Sub Part 1.2.2: Concept of coordinated care
  - Sub Part 1.2.3: Organising a private practice to deliver comprehensive, coordinated care
- **Part 1.3: The Patient-Centred Approach**
  - Sub Part 1.3.1: Concept and principles of the patient-centred approach
  - Sub Part 1.3.2: Patient-centred consultation skills
  - Sub Part 1.3.3: Applying the patient-centred approach in private practice

Introduction

Establishing and running a successful private family practice requires considerably more than clinical skill alone, demanding careful attention to practical **organisation**, and a deliberate commitment to comprehensive, coordinated, patient-centred care even outside the structured environment of a large public hospital. Picture a newly established private family practice, where a simple but well organised appointment and records system, combined with a physician's genuine commitment to seeing each patient as a whole person, makes the difference between a practice patients trust and one they quietly abandon. Understanding these organisational and philosophical foundations is the essential starting point for everything that follows in this course.

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The aim of this Series is to equip you with a clear understanding of family medicine tools relevant to private practice, comprehensive and coordinated care, and the patient-centred approach.

This Series begins with **family medicine tools in private practice**, before turning to **comprehensive and coordinated care**. It concludes with the **patient-centred approach**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 1.1:** describe family medicine tools relevant to organising a private practice
- **SLO 1.2:** describe medical records and appointment systems supporting continuity of care
- **SLO 1.3:** explain the concept of comprehensive care and coordinated care
- **SLO 1.4:** describe how a private practice can be organised to deliver comprehensive, coordinated care
- **SLO 1.5:** define the patient-centred approach and its principles, and
- **SLO 1.6:** describe patient-centred consultation skills and their application in private practice.

1.1 Family Medicine Tools in Private Practice

1.1.1 practice organisation tools

Structuring the day-to-day running of a private practice

Practice organisation tools are the practical systems and instruments a private family practice uses to manage its day-to-day **operations**, including scheduling, patient flow, and staff **coordination**, complementing the clinical family assessment tools, such as the family APGAR and genogram, discussed in an earlier related course.

Well designed practice organisation tools help a small private practice function efficiently despite generally more limited administrative **staffing** than a large public hospital, discussed in an earlier related course, meaning careful attention to practical organisation is particularly important for the **sustainability** of private family practice.

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Fill in the blank: Practice organisation tools are the practical systems a private family practice uses to manage its day-to-day operations, including scheduling and staff _____.

1.1.2 medical records and appointment systems

A well organised **medical records** system, whether paper based or electronic, is essential to supporting continuity of care, discussed in an earlier related course, allowing the family physician to quickly access a patient's relevant history, previous investigations, and ongoing management **plans** at each subsequent visit.

A functioning **appointment system** additionally supports efficient practice organisation, reducing patient waiting times, discussed in relation to comparing facility types in an earlier related course, and allowing the practice to plan appropriate time for different types of consultation, such as longer appointments for complex chronic disease **review**.

Fill in the blank: A functioning appointment system supports efficient practice organisation, reducing patient waiting _____.

1.1.3 tools supporting continuity and coordination of care

Beyond basic records and scheduling, private practices benefit from specific tools supporting **continuity** of care over time, including structured recall systems reminding patients due for chronic disease review or preventive screening, discussed in relation to secondary prevention in an earlier related course, to return for their next scheduled visit.

Tools supporting **coordination** additionally include clear systems for managing referrals, discussed further in a later Series of this course, and communication with other health providers involved in a patient's care, ensuring the private practice remains effectively connected to the broader health system rather than functioning in **isolation**.

Fill in the blank: Tools supporting coordination include clear systems for managing referrals and communication with other health providers, ensuring the practice remains effectively connected to the broader health _____.

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Figure 1.1: A receptionist managing patient appointments and records at a private family practice front desk.

Pilot questions 1.1

1. Define practice organisation tools and give an example. (Linked to SLO 1.1)
2. Explain why careful practice organisation is particularly important for private practice sustainability. (Linked to SLO 1.1)
3. Describe the role of a well organised medical records system. (Linked to SLO 1.2)
4. Explain how a functioning appointment system supports efficient practice organisation. (Linked to SLO 1.2)
5. Describe two tools supporting continuity and coordination of care in a private practice. (Linked to SLO 1.2)

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1.2 Comprehensive and Coordinated Care

1.2.1 concept of comprehensive care

Addressing the full range of a patient's needs

Comprehensive care, discussed as a basic principle of family medicine in an earlier related course, refers to addressing the full range of a patient's health needs, including acute illness,

chronic disease management, and preventive care, discussed in relation to levels of prevention in an earlier related course, rather than a single presenting complaint alone.

Delivering genuinely comprehensive care within a private practice setting requires the physician to actively enquire beyond the patient's stated presenting **complaint**, and to maintain organised records, discussed earlier in this Series, tracking a patient's full range of ongoing health needs over time rather than addressing each visit in complete **isolation**.

Fill in the blank: Delivering genuinely comprehensive care requires the physician to actively enquire beyond the patient's stated presenting _____.

1.2.2 concept of coordinated care

Coordinated care refers to ensuring the various elements of a patient's overall care, including referrals to specialists, discussed further in a later Series of this course, and any care received elsewhere within the health system, discussed in an earlier related course, remain coherent and effectively **communicated** rather than fragmented across different, disconnected providers.

For a private practice specifically, coordinated care generally requires the physician to actively maintain awareness of any care a patient receives outside the practice itself, and to communicate **relevant** information to and from other involved providers, a role of particular importance given private practice's position outside the more formally structured public sector referral system, discussed in relation to health system organisation in an earlier related course.

Fill in the blank: Coordinated care requires the various elements of a patient's overall care to remain coherent and effectively _____ rather than fragmented across disconnected providers.

1.2.3 organising a private practice to deliver comprehensive, coordinated care

Organising a private practice to deliver genuinely comprehensive, coordinated care requires deliberate **structural** choices, including sufficient consultation time to address a patient's full range of concerns, discussed earlier in this Series, and organised systems supporting effective referral and communication, discussed earlier in this Series.

This organisational commitment additionally requires ongoing physician **awareness** that comprehensive, coordinated care, while potentially more time-consuming than addressing a single presenting complaint alone, generally produces better long-term patient outcomes and stronger patient **trust**, an important consideration for the long-term success of a private practice.

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Fill in the blank: Comprehensive, coordinated care, while potentially more time-consuming, generally produces better long-term patient outcomes and stronger patient _____.

Table 1.2: Comparing comprehensive and coordinated care.

Feature	Comprehensive care	Coordinated care
Main focus	Addressing the full range of a patient's needs	Ensuring coherence across different providers
Key requirement	Time and organised records to track needs	Communication systems linking providers
Main risk if absent	Missed or unaddressed health needs	Fragmented, disconnected care

Pilot questions 1.2

1. Define comprehensive care. (Linked to SLO 1.3)
2. Define coordinated care. (Linked to SLO 1.3)
3. Explain why coordinated care is of particular importance for a private practice. (Linked to SLO 1.3)
4. Describe two structural choices supporting comprehensive, coordinated care in a private practice. (Linked to SLO 1.4)
5. Explain why comprehensive, coordinated care generally strengthens patient trust. (Linked to SLO 1.4)

1.3 The Patient-Centred Approach

1.3.1 concept and principles of the patient-centred approach

Placing the individual patient's perspective at the centre of care

The **patient-centred approach**, discussed as a basic principle of family medicine in an earlier related course, places the individual patient's own values, preferences, and concerns at the centre of clinical **decision making**, rather than focusing narrowly on the physician's own clinical priorities alone.

Core principles of the patient-centred approach include genuinely exploring a patient's own **ideas**, concerns, and expectations regarding their presenting complaint, and involving the patient as an active **partner** in decisions regarding their own care, consistent with the illness experience discussed in relation to illness versus disease in an earlier related course.

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Fill in the blank: The patient-centred approach places the individual patient's own values, preferences, and concerns at the centre of clinical _____.

1.3.2 patient-centred consultation skills

Patient-centred consultation skills include active **listening**, allowing the patient to express their concerns without premature interruption, and open, empathetic **questioning**, exploring the patient's own understanding and emotional response to their presenting complaint rather than pursuing a narrowly biomedical line of questioning alone.

Further patient-centred consultation skills include clear, accessible **explanation** of clinical findings and recommendations, avoiding unnecessary technical language, and genuine **shared decision making**, presenting available treatment options and respecting the patient's own informed choice among them, discussed in relation to informed consent in an earlier related course.

Fill in the blank: Further patient-centred consultation skills include clear, accessible explanation of clinical findings and genuine shared decision _____.

1.3.3 applying the patient-centred approach in private practice

Applying the patient-centred approach within a private practice setting is generally facilitated by the greater **continuity** and, often, longer consultation time available compared with busier public sector settings, discussed in relation to comparing facility types in an earlier related course, allowing more genuine opportunity for the relationship-based approach central to patient-centred care.

Consistent application of the patient-centred approach additionally represents an important practical **differentiator** for private practice, since patients generally value, and are often specifically seeking, the more personalised, attentive care experience that genuine patient-centred practice can provide, contributing directly to patient **satisfaction** and practice reputation.

Fill in the blank: Consistent application of the patient-centred approach represents an important practical differentiator for private practice, contributing directly to patient satisfaction and practice _____.

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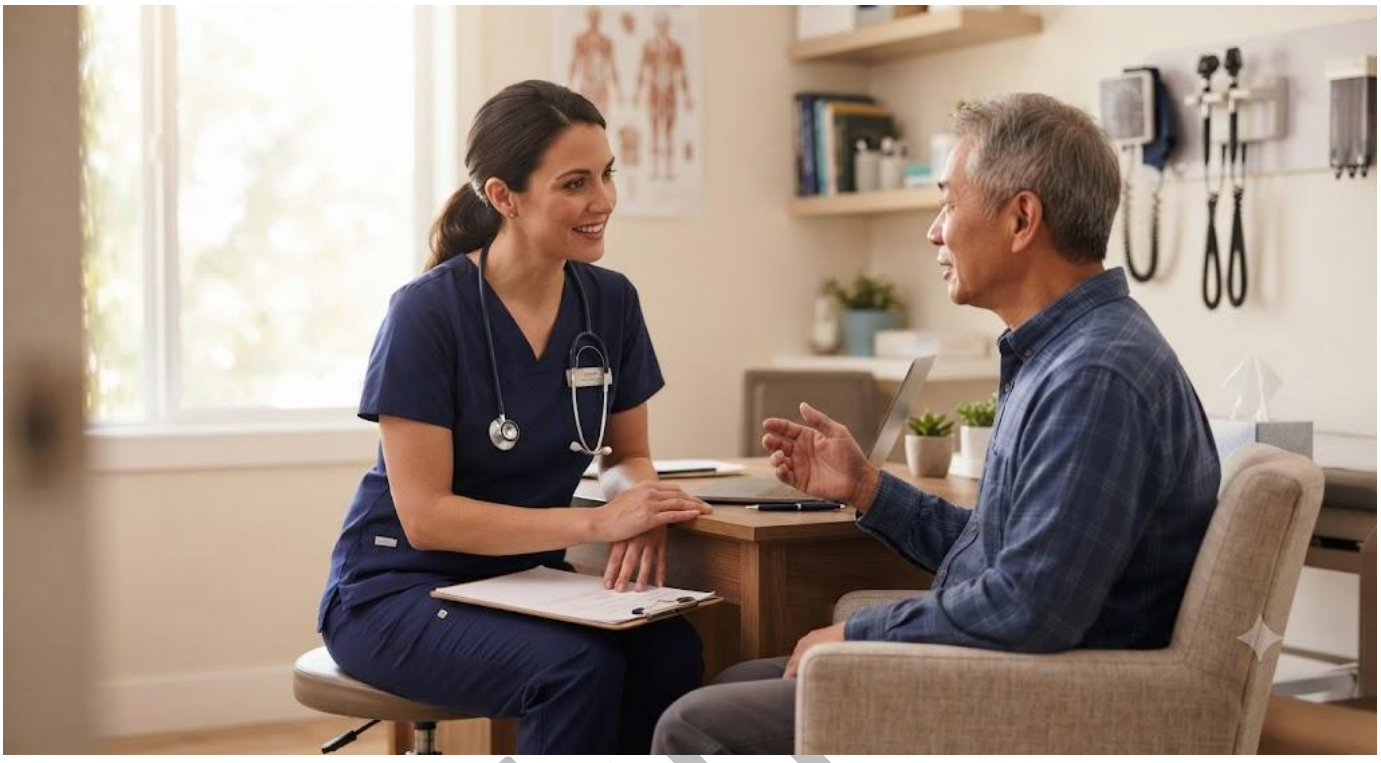

Figure 1.3: A physician engaging in an attentive, empathetic consultation with a patient in a private practice clinic room.

Pilot questions 1.3

1. Define the patient-centred approach. (Linked to SLO 1.5)
2. List two core principles of the patient-centred approach. (Linked to SLO 1.5)
3. Describe two patient-centred consultation skills. (Linked to SLO 1.6)
4. Explain how private practice settings can facilitate the patient-centred approach. (Linked to SLO 1.6)
5. Explain why the patient-centred approach represents an important differentiator for private practice. (Linked to SLO 1.6)

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Series Summary

This opening Series introduced **family medicine tools, comprehensive and coordinated care, and the patient-centred approach** as they apply specifically within private practice organisation, beginning with **family medicine tools in private practice**, practice organisation tools, medical records and appointment systems, and tools supporting continuity and coordination of care, before examining **comprehensive and coordinated care**, their concepts, and how a private practice can be organised to deliver both.

We concluded with the **patient-centred approach**, its concept and principles, specific patient-centred consultation skills, and its application within private practice, where greater continuity and consultation time often facilitate genuinely relationship-based care. Having worked through this Series, you should now possess the conceptual foundation needed to understand primary care management and community-oriented care examined in the next Series of this course.

Glossary of Terms

- **Practice organisation tools:** the practical systems a private practice uses to manage day-to-day operations.
- **Medical records system:** an organised system storing patient history, investigations, and management plans.
- **Appointment system:** a system for scheduling and managing patient consultations.
- **Recall system:** a structured system reminding patients due for review or preventive screening to return.
- **Comprehensive care:** care addressing the full range of a patient's health needs rather than a single complaint.
- **Coordinated care:** ensuring the various elements of a patient's care remain coherent across different providers.
- **Patient-centred approach:** an approach placing the individual patient's values and preferences at the centre of care.
- **Ideas, concerns, and expectations:** the patient's own perspective on their presenting complaint, explored in patient-centred consultation.
- **Shared decision making:** a process in which the physician and patient jointly decide on a course of care.
- **Active listening:** attentively allowing a patient to express their concerns without premature interruption.
- **Continuity of care:** ongoing care provided to the same patient over an extended period.
- **Practice reputation:** the standing and trust a private practice holds among its patients and community.

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Concept Check Questions [Series 1]

Objective questions

1. Practice organisation tools help manage day-to-day operations, including scheduling and staff _____.
2. A functioning appointment system reduces patient waiting _____.
3. Delivering comprehensive care requires enquiring beyond the patient's stated presenting _____.
4. Coordinated care requires the elements of a patient's care to remain coherent and effectively _____.
5. The patient-centred approach places the patient's values and preferences at the centre of clinical _____.

Short-answer questions

6. Describe the role of a well organised medical records system.
7. Define comprehensive care and coordinated care.
8. Explain why coordinated care is of particular importance for a private practice.
9. List two core principles of the patient-centred approach.
10. Describe two patient-centred consultation skills.

Long-answer questions

11. Discuss family medicine tools relevant to organising a private practice. (Linked to SLO 1.1, SLO 1.2)
12. Discuss comprehensive and coordinated care and how a private practice can be organised to deliver both. (Linked to SLO 1.3, SLO 1.4)
13. Discuss the concept and principles of the patient-centred approach. (Linked to SLO 1.5)
14. Discuss patient-centred consultation skills. (Linked to SLO 1.6)
15. Discuss the application of the patient-centred approach in private practice. (Linked to SLO 1.6)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Coordination.
2. Times.
3. Complaint.
4. Communicated.

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5. Decision making.

Short-answer questions

6. It allows the physician to quickly access relevant history, investigations, and management plans at each visit.
7. Comprehensive care addresses the full range of a patient's needs; coordinated care keeps different elements of care coherent across providers.
8. Because private practice sits outside the more formally structured public sector referral system, requiring active coordination effort.
9. Exploring the patient's own ideas, concerns, and expectations, and involving the patient as an active partner in decisions.
10. Active listening, and clear, accessible explanation with shared decision making.

Long-answer questions

11. **Basic response:** Family medicine tools in private practice include practice organisation systems for scheduling and staff coordination, and well organised medical records and appointment systems.

Value-added response: These are complemented by tools supporting continuity, such as recall systems, and coordination, such as referral and communication systems connecting the practice to the broader health system.

12. **Basic response:** Comprehensive care addresses a patient's full range of health needs, while coordinated care ensures different elements of care remain coherent across providers.

Value-added response: Organising a private practice to deliver both requires sufficient consultation time, organised records, and communication systems, recognising that this approach generally produces better outcomes and stronger patient trust.

13. **Basic response:** The patient-centred approach places the individual patient's values, preferences, and concerns at the centre of clinical decision making, exploring their own ideas, concerns, and expectations.

Value-added response: It involves the patient as an active partner in decisions regarding their own care, reflecting the illness experience distinct from disease alone.

14. **Basic response:** Patient-centred consultation skills include active listening, open empathetic questioning, clear accessible explanation, and genuine shared decision making.

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Value-added response: These skills together help ensure the patient's own perspective and choices are respected throughout the clinical encounter.

15. **Basic response:** Private practice settings, with generally greater continuity and consultation time, facilitate genuine patient-centred, relationship-based care.

Value-added response: This consistent application represents an important practical differentiator, since patients value personalised, attentive care, contributing to satisfaction and practice reputation.

Answers to Pilot Questions [Series 1]

Part 1.1

1. Practical systems managing day-to-day practice operations; an appointment system is an example.
2. Because private practices generally have more limited administrative staffing than large public hospitals.
3. It allows the physician to quickly access relevant patient history and management plans at each visit.
4. It reduces waiting times and allows appropriate time allocation for different types of consultation.
5. Recall systems for chronic disease review, and referral and communication systems with other providers.

Part 1.2

1. Care addressing the full range of a patient's health needs, not a single presenting complaint alone.
2. Ensuring the various elements of a patient's care remain coherent and effectively communicated across providers.
3. Because private practice sits outside the more formally structured public sector referral system.
4. Sufficient consultation time, and organised communication systems supporting referral.
5. Because it generally produces better long-term outcomes, which patients recognise and value over time.

Part 1.3

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1. An approach placing the individual patient's values, preferences, and concerns at the centre of care.
2. Exploring the patient's own ideas, concerns, and expectations, and involving them as an active partner.
3. Active listening and open, empathetic questioning.
4. Greater continuity and often longer consultation time facilitate relationship-based, patient-centred care.
5. Because patients value the personalised, attentive care experience it provides, strengthening satisfaction and reputation.

References and Attributions [Series 1]

- McWhinney, I. R., & Freeman, T. (2016). Textbook of Family Medicine (4th ed.). Oxford University Press.
- Stewart, M., et al. (2013). Patient-Centered Medicine: Transforming the Clinical Method (3rd ed.). CRC Press.
- Rakel, R. E., & Rakel, D. P. (2019). Textbook of Family Medicine (9th ed.). Elsevier.
- World Organization of Family Doctors (WONCA) (2011). WONCA Europe definition of general practice/family medicine.

Figures, Plates, Tables, and Boxes

- Figure 1.1: A receptionist managing patient appointments and records at a private family practice front desk. AI-generated using the prompt: "A single clean, realistic illustration of a receptionist managing an appointment book and files at a clinic front desk, calm professional setting, natural lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."
- Table 1.2: Comparing comprehensive and coordinated care. AI-generated using the prompt: "Create a clean reference table titled Comparing Comprehensive and Coordinated Care, listing feature, comprehensive care, and coordinated care. Simple clinical reference table style with outside border."
- Figure 1.3: A physician engaging in an attentive, empathetic consultation with a patient in a private practice clinic room. AI-generated using the prompt: "A single clean, realistic

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clinical illustration of a physician engaged in an attentive consultation with a seated patient in a calm clinic room, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail.

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Series 2: Primary Care Management and Community-Oriented Care

- **Part 2.1: Primary Care Management**
    - Sub Part 2.1.1: Concept and scope of primary care management
    - Sub Part 2.1.2: Clinical decision making in primary care
    - Sub Part 2.1.3: Managing uncertainty in primary care
- **Part 2.2: Principles of Community-Oriented Care**
    - Sub Part 2.2.1: Concept of community-oriented primary care
    - Sub Part 2.2.2: Assessing community health needs
    - Sub Part 2.2.3: Responding to community health needs from a private practice
- **Part 2.3: Integrating Primary Care Management and Community Orientation in Private Practice**
    - Sub Part 2.3.1: Balancing individual patient care with community perspective
    - Sub Part 2.3.2: Practical strategies for community engagement
    - Sub Part 2.3.3: Challenges of community-oriented care in private practice

Introduction

In the last Series, we explored family medicine tools, comprehensive and coordinated care, and the patient-centred approach. We now turn to **primary care management**, the distinctive clinical decision making style required at the first point of contact, and **community-oriented care**, extending the private practice's perspective beyond individual patients to the wider community it serves. Picture a private family physician managing a patient with vague, undifferentiated symptoms, tolerating diagnostic uncertainty while avoiding unnecessary investigation, and, later that week, noticing a cluster of similar presentations that might reflect a genuine community health issue worth addressing more broadly. Understanding this dual focus is the subject of this Series.

The aim of this Series is to equip you with a clear understanding of primary care management, including clinical decision making and managing uncertainty, and community-oriented care.

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This Series begins with **primary care management**, before turning to the **principles of community-oriented care**. It concludes with **integrating primary care management and community orientation in private practice**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 2.1:** define primary care management and describe its scope
- **SLO 2.2:** describe clinical decision making and managing uncertainty in primary care
- **SLO 2.3:** describe the concept of community-oriented primary care and the assessment of community health needs
- **SLO 2.4:** describe how a private practice can respond to community health needs
- **SLO 2.5:** describe how individual patient care is balanced with a community perspective, and
- **SLO 2.6:** describe practical strategies for, and challenges of, community engagement in private practice.

2.1 Primary Care Management

2.1.1 concept and scope of primary care management

Managing the first, unfiltered point of patient contact

Primary care management refers to the distinctive clinical approach required at the first point of patient contact, discussed in relation to patterns of illness in an earlier related course, where the physician must manage a genuinely **unselected** range of presenting complaints without the benefit of prior filtering or referral that characterises specialist practice.

The scope of primary care management encompasses initial assessment and **differentiation** of presenting complaints, ongoing management of established chronic conditions, discussed in an earlier related course, and appropriate **referral** decisions when a presenting problem exceeds the scope of primary care management alone, discussed further in a later Series of this course.

Fill in the blank: Primary care management requires the physician to manage a genuinely unselected range of presenting complaints without prior filtering or _____.

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2.1.2 clinical decision making in primary care

Clinical decision making in primary care generally differs from that in hospital specialist practice, given the typically lower **prevalence** of serious disease among unselected primary care presentations, meaning primary care decision making must appropriately balance the risk of missing a serious condition against the risk of unnecessary **investigation** or referral for the many patients with self-limiting illness.

Effective primary care decision making additionally relies substantially on **longitudinal** assessment over time, using continuity of care, discussed in an earlier related course, to observe how a presenting problem evolves across repeated encounters, rather than requiring every diagnostic uncertainty to be resolved definitively within a single **consultation**.

Fill in the blank: Effective primary care decision making relies substantially on longitudinal assessment over time, observing how a presenting problem evolves across repeated _____.

2.1.3 managing uncertainty in primary care

Diagnostic uncertainty is a genuinely routine, expected feature of primary care practice, given the typically early, undifferentiated stage at which patients present, discussed in relation to illness behaviour in an earlier related course, meaning the primary care physician must become comfortable managing uncertainty rather than expecting immediate diagnostic **certainty** in every encounter.

Managing uncertainty appropriately requires clear **safety netting**, providing the patient with specific guidance regarding symptoms or developments that should prompt earlier **review**, together with appropriately scheduled follow-up, discussed earlier in this Series, allowing genuine reassessment as a presenting problem's clinical picture becomes clearer over time.

Fill in the blank: Managing uncertainty appropriately requires clear safety netting, providing the patient with specific guidance regarding symptoms that should prompt earlier _____.

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Figure 2.1: A private family physician reviewing a patient's evolving symptoms across successive visits.

Pilot questions 2.1

- Define primary care management. (Linked to SLO 2.1)
- Describe the scope of primary care management. (Linked to SLO 2.1)
- Explain how clinical decision making in primary care differs from hospital specialist practice. (Linked to SLO 2.2)
- Explain why diagnostic uncertainty is a routine feature of primary care practice. (Linked to SLO 2.2)
- Define safety netting and describe its role in managing uncertainty. (Linked to SLO 2.2)

2.2 Principles of Community-Oriented Care

2.2.1 concept of community-oriented primary care

Looking beyond the individual patient to the wider community

Community-oriented primary care extends the family physician's focus beyond the individual patient presenting in the consultation room to consider the health needs of the broader

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community, discussed in relation to needs assessment in an earlier related course, from which that practice's patients are drawn.

This orientation reflects a recognition that individual patient presentations, taken **together**, frequently reveal patterns of health need relevant to the wider community, discussed in relation to epidemiological approaches in an earlier related course, meaning a family physician attentive to individual patients is often uniquely positioned to identify broader community health **concerns**.

Fill in the blank: Community-oriented primary care extends the family physician's focus beyond the individual patient to consider the health needs of the broader _____.

2.2.2 assessing community health needs

Assessing community health needs from within a private practice generally relies on systematic review of the practice's own patient **data**, discussed in relation to family medicine tools in an earlier Series of this course, identifying recurring patterns or clusters of presentation that may reflect a genuine shared community **exposure** or risk factor.

This practice-based assessment can usefully be supplemented by awareness of broader community health **data**, discussed in relation to health service evaluation in an earlier related course, and direct engagement with community members and local leaders, providing valuable additional context beyond what practice records alone can reveal.

Fill in the blank: Assessing community health needs relies on systematic review of practice data, identifying recurring patterns that may reflect a shared community exposure or risk _____.

2.2.3 responding to community health needs from a private practice

A private practice can respond to identified community health needs through targeted health **education** initiatives addressing a recognised community concern, discussed in relation to health promotion in an earlier related course, and, where appropriate, collaboration with local public health authorities, discussed in relation to health system organisation in an earlier related course.

Even relatively modest private practice responses, such as consistently reinforcing a specific preventive **message** across many individual consultations, discussed earlier in this Series, can contribute meaningfully to broader community health improvement, illustrating that community orientation need not require large-scale, formal public health **programmes** to have genuine practical value.

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Fill in the blank: Even relatively modest private practice responses to community health needs can contribute meaningfully to broader community health _____.

Table 2.2: Comparing individual patient care and community-oriented care.

Feature	Individual patient care	Community-oriented care
Main focus	The presenting patient's own health needs	Patterns of need across the wider community
Typical evidence source	The individual consultation	Aggregated practice data and community engagement
Typical response	Individual diagnosis and treatment	Health education and collaboration with public health authorities

Pilot questions 2.2

1. Define community-oriented primary care. (Linked to SLO 2.3)
2. Explain why individual patient presentations can reveal broader community health patterns. (Linked to SLO 2.3)
3. Describe how community health needs are assessed from within a private practice. (Linked to SLO 2.3)
4. Describe two ways a private practice can respond to identified community health needs. (Linked to SLO 2.4)
5. Explain why even modest private practice responses can contribute meaningfully to community health. (Linked to SLO 2.4)

2.3 Integrating Primary Care Management and Community Orientation in Private Practice

2.3.1 balancing individual patient care with community perspective

Attending to both the patient in front of you and the wider community

Effective private practice requires the family physician to genuinely **balance** attention to the individual patient's specific needs, discussed earlier in this Series, with awareness of the broader **community** perspective, discussed in the previous Part of this Series, rather than treating these two orientations as mutually exclusive priorities.

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In practice, this balance generally means the individual patient consultation always remains the primary immediate **focus**, while the physician additionally remains alert to broader patterns worth **recognising** and, where appropriate, acting upon across the wider patient population the practice serves.

Fill in the blank: Effective private practice requires the family physician to genuinely balance individual patient needs with awareness of the broader community _____.

2.3.2 practical strategies for community engagement

Practical strategies for community engagement from a private practice include organising occasional community health **talks** or screening events, discussed in relation to health education in an earlier related course, and maintaining constructive working **relationships** with local community leaders and public health authorities.

Further practical strategies include actively encouraging patient **feedback** regarding community health concerns during routine consultations, and participating, where feasible, in relevant local health planning or coordination **activities**, discussed in relation to health planning in an earlier related course, strengthening the practice's connection to its wider community context.

Fill in the blank: Practical strategies for community engagement include actively encouraging patient feedback regarding community health concerns during routine _____.

2.3.3 challenges of community-oriented care in private practice

Community-oriented care within a private practice faces practical **challenges**, including limited physician time available beyond individual patient consultations, discussed earlier in this Series, and, at times, limited practice **resources** for undertaking more formal community health activities beyond individual consultations alone.

Further challenges include the practical difficulty of systematically **aggregating** patterns across individual patient encounters without dedicated data analysis capacity, and, at times, uncertainty regarding the private practice's appropriate **role** relative to formal public sector community health structures, discussed in an earlier related course, requiring thoughtful, realistic engagement rather than attempting to replicate formal public health programme activity.

Fill in the blank: Challenges of community-oriented care include limited physician time and, at times, uncertainty regarding the private practice's appropriate role relative to formal public sector community health _____.

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Figure 2.3: A private family physician giving a brief community health talk at a local venue.

Pilot questions 2.3

1. Explain how a private practice can balance individual patient care with a community perspective. (Linked to SLO 2.5)
2. Describe two practical strategies for community engagement from a private practice. (Linked to SLO 2.6)
3. Describe two challenges facing community-oriented care in private practice. (Linked to SLO 2.6)
4. Explain the practical difficulty of aggregating patterns across individual patient encounters. (Linked to SLO 2.6)
5. Explain why realistic, thoughtful engagement is more appropriate than attempting to replicate formal public health programmes. (Linked to SLO 2.6)

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Series Summary

This Series examined **primary care management and community-oriented care**, beginning with **primary care management**, its distinctive scope managing an unselected range of presenting complaints, the characteristic style of primary care clinical decision making, and the essential skill of managing genuine diagnostic uncertainty, before turning to the **principles of community-oriented care**, extending the practice's focus to the wider community, assessing community health needs, and responding through targeted, realistic private practice initiatives.

We concluded with **integrating primary care management and community orientation in private practice**, balancing individual and community perspectives, practical engagement strategies, and the genuine practical challenges community-oriented care faces within a private practice setting. Having worked through this Series, you should now be equipped to understand the biopsychosocial dimensions of holistic care and communication and interview skills examined in the next Series of this course.

Glossary of Terms

1. **Primary care management:** the distinctive clinical approach required at the first, unfiltered point of patient contact.
2. **Diagnostic uncertainty:** the routine state of not yet having a definitive diagnosis, common in primary care.
3. **Safety netting:** providing guidance on symptoms or developments that should prompt a patient to seek earlier review.
4. **Longitudinal assessment:** observing how a presenting problem evolves across repeated encounters over time.
5. **Community-oriented primary care:** an approach extending a practice's focus to the health needs of its wider community.
6. **Community health needs assessment:** the systematic identification of health needs within a defined community.
7. **Health education:** activities providing information to promote healthy behaviour and disease prevention.
8. **Community engagement:** active, constructive interaction between a practice and the community it serves.
9. **Practice data:** information recorded within a practice's own patient records and consultations.
10. **Aggregation:** the process of combining individual data points to reveal broader patterns.
11. **Public health authority:** a government body responsible for population-level health functions.

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12. **Screening event:** an organised activity offering health screening to members of the public.

Concept Check Questions [Series 2]

Objective questions

1. Primary care management requires managing an unselected range of presenting complaints without prior filtering or _____.
2. Effective primary care decision making relies on longitudinal assessment across repeated _____.
3. Managing uncertainty requires clear safety netting, guiding patients on symptoms that should prompt earlier _____.
4. Community-oriented primary care extends the physician's focus to the health needs of the broader _____.
5. Challenges of community-oriented care include uncertainty regarding the private practice's appropriate role relative to formal public sector community health _____.

Short-answer questions

- Explain how clinical decision making in primary care differs from hospital specialist practice.
- Define safety netting.
- Describe how community health needs are assessed from within a private practice.
- Describe two ways a private practice can respond to identified community health needs.
- Describe two challenges facing community-oriented care in private practice.

Long-answer questions

1. Discuss primary care management, including clinical decision making and managing uncertainty. (Linked to SLO 2.1, SLO 2.2)
2. Discuss the concept of community-oriented primary care and the assessment of community health needs. (Linked to SLO 2.3)
3. Discuss how a private practice can respond to community health needs. (Linked to SLO 2.4)
4. Discuss how individual patient care is balanced with a community perspective in private practice. (Linked to SLO 2.5)
5. Discuss practical strategies for, and challenges of, community engagement in private practice. (Linked to SLO 2.6)

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Answers to Concept Check Questions [Series 2]

Objective questions

6. Referral.
7. Encounters.
8. Review.
9. Community.
10. Structures.

Short-answer questions

11. Primary care sees lower prevalence of serious disease among unselected presentations, requiring a different balance of investigation versus reassurance.
12. Providing patients specific guidance on symptoms or developments that should prompt earlier review.
13. Through systematic review of the practice's own patient data, identifying recurring patterns or clusters.
14. Targeted health education initiatives, and collaboration with local public health authorities.
15. Limited physician time and resources, and difficulty aggregating patterns without dedicated data analysis capacity.

Long-answer questions

16. **Basic response:** Primary care management addresses an unselected range of presenting complaints, with decision making balancing the risk of missing serious disease against unnecessary investigation given typically lower disease prevalence.

Value-added response: Managing uncertainty, a routine feature of primary care, requires clear safety netting and longitudinal assessment across repeated encounters rather than requiring immediate diagnostic certainty.

17. **Basic response:** Community-oriented primary care extends the physician's focus beyond the individual patient to the health needs of the wider community from which patients are drawn.

Value-added response: Assessing these needs relies on systematic review of practice data and can be supplemented by broader community health data and direct community engagement.

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18. **Basic response:** A private practice can respond to community health needs through targeted health education and collaboration with local public health authorities.

Value-added response: Even modest responses, such as consistently reinforcing a preventive message across many consultations, can contribute meaningfully to community health improvement.

19. **Basic response:** Effective private practice balances individual patient needs, which remain the primary immediate focus of each consultation, with ongoing awareness of broader community patterns.

Value-added response: This balance allows the physician to recognise and, where appropriate, act upon patterns worth addressing across the wider patient population served.

20. **Basic response:** Practical community engagement strategies include community health talks, screening events, and relationships with local leaders and public health authorities.

Value-added response: Challenges include limited time and resources, difficulty aggregating patterns without dedicated analysis capacity, and uncertainty about the practice's role relative to formal public health structures.

Answers to Pilot Questions [Series 2]

Part 2.1

11. The distinctive clinical approach required at the first, unfiltered point of patient contact.
12. Initial assessment, ongoing chronic disease management, and appropriate referral decisions.
13. Primary care sees lower prevalence of serious disease among unselected presentations, requiring a different investigation-reassurance balance.
14. Because patients present at an early, undifferentiated stage of illness before a clear diagnostic pattern has emerged.
15. Guidance on symptoms warranting earlier review; it manages uncertainty safely without requiring immediate diagnostic certainty.

Part 2.2

1. An approach extending the physician's focus beyond the individual patient to the wider community's health needs.

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2. Because individual presentations, taken together, can reveal shared exposures or risk factors relevant to the community.
3. Through systematic review of practice data identifying recurring patterns or clusters of presentation.
4. Targeted health education initiatives, and collaboration with local public health authorities.
5. Because consistent reinforcement of preventive messages across many consultations can add up to meaningful community-level impact.

Part 2.3

6. By keeping the individual consultation the primary immediate focus while remaining alert to broader patterns worth addressing.
7. Organising community health talks or screening events, and maintaining relationships with local leaders and public health authorities.
8. Limited physician time and resources, and difficulty aggregating patterns without dedicated data analysis capacity.
9. Individual practices generally lack dedicated data analysis capacity, making systematic pattern recognition difficult.
10. Because private practices generally lack the scale and resources of formal public health programmes, so realistic, targeted engagement is more appropriate.

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14. Park, K. (2021). Park's Textbook of Preventive and Social Medicine (26th ed.). Banarsidas Bhanot.

Figures, Plates, Tables, and Boxes

1. Figure 2.1: A private family physician reviewing a patient's evolving symptoms across successive visits. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician reviewing a patient's medical record showing notes from previous visits at a clinic desk, calm professional setting, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."
2. Table 2.2: Comparing individual patient care and community-oriented care. AI-generated using the prompt: "Create a clean reference table titled Comparing Individual Patient Care and Community-Oriented Care, listing feature, individual patient care, and community-oriented care. Simple clinical reference table style with outside border."
3. Figure 2.3: A private family physician giving a brief community health talk at a local venue. AI-generated using the prompt: "A single clean, realistic illustration of a physician giving a short talk to a small seated community audience at a local venue, calm respectful setting, natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic detail."

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Series 3: Biopsychosocial Dimensions of Holistic Care, and Communication and Interview Skills

- **Part 3.1: Biopsychosocial Dimensions of Holistic Care**
    - Sub Part 3.1.1: The concept of holistic care in private practice
    - Sub Part 3.1.2: Demonstrating the biological dimension in practice
    - Sub Part 3.1.3: Demonstrating the psychological and social dimensions in practice
- **Part 3.2: Communication Skills in Family Practice**
    - Sub Part 3.2.1: Principles of effective clinical communication
    - Sub Part 3.2.2: Verbal and non-verbal communication
    - Sub Part 3.2.3: Barriers to effective communication
- **Part 3.3: Interview Skills in Family Practice**
    - Sub Part 3.3.1: Structuring the patient interview
    - Sub Part 3.3.2: Questioning techniques
    - Sub Part 3.3.3: Closing the consultation effectively

Introduction

In the last Series, we explored primary care management and community-oriented care. We now turn to **demonstrating** the biopsychosocial dimensions of holistic care in actual practice, and the specific **communication and interview skills** that make such holistic, patient-centred care genuinely possible in a busy private practice consultation. Picture a private family physician skilfully weaving questions about a patient's physical symptoms together with gentle enquiry into their emotional state and home circumstances, all within a single, well structured, unhurried consultation. Understanding how to practically demonstrate this holistic approach through effective communication is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of the biopsychosocial dimensions of holistic care, and communication and interview skills.

This Series begins with the **biopsychosocial dimensions of holistic care**, before turning to **communication skills in family practice**. It concludes with **interview skills in family practice**.

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Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 3.1:** describe the concept of holistic care and demonstrate the biological dimension in practice
- **SLO 3.2:** demonstrate the psychological and social dimensions of holistic care in practice
- **SLO 3.3:** describe the principles of effective clinical communication
- **SLO 3.4:** distinguish verbal from non-verbal communication and identify barriers to effective communication
- **SLO 3.5:** describe how to structure the patient interview and appropriate questioning techniques, and
- **SLO 3.6:** describe how to close a consultation effectively.

3.1 Biopsychosocial Dimensions of Holistic Care

3.1.1 the concept of holistic care in private practice

Moving the bio-psychosocial model from theory to practice

Holistic care, grounded in the bio-psychosocial model discussed in an earlier related course, requires the private practice physician to actually **demonstrate**, within the consultation itself, genuine attention to the biological, psychological, and social dimensions of a patient's presentation, rather than treating this model as an abstract theoretical framework alone.

Demonstrating holistic care in a private practice setting requires deliberate, practical **skill**, since genuinely addressing all three dimensions within the time constraints of a typical consultation, discussed in relation to appointment systems in an earlier related course, requires an efficient, structured approach rather than an unfocused, open-ended conversation.

Fill in the blank: Demonstrating holistic care in private practice requires deliberate, practical _____, since addressing all three dimensions within limited consultation time requires an efficient, structured approach.

3.1.2 demonstrating the biological dimension in practice

Demonstrating the **biological dimension** in practice involves thorough, systematic **history taking** and clinical examination directed at the presenting physical complaint, together with

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appropriate investigation where clinically indicated, discussed in relation to primary care management in an earlier Series of this course.

Effective demonstration of the biological dimension additionally requires clear, accurate **communication** of clinical findings back to the patient, discussed further later in this Series, ensuring the biological component of care is not only competently performed but genuinely understood by the patient **themselves**.

Fill in the blank: Effective demonstration of the biological dimension requires clear, accurate communication of clinical findings back to the _____.

3.1.3 demonstrating the psychological and social dimensions in practice

Demonstrating the **psychological dimension** in practice involves directly enquiring about a patient's emotional response to their presenting complaint, discussed in relation to illness behaviour in an earlier related course, using specific, deliberate questions rather than assuming this information will emerge unprompted.

Demonstrating the **social dimension** similarly involves directly enquiring about a patient's family, discussed in an earlier Series of this course, and living or working circumstances relevant to their presenting complaint, since these psychosocial dimensions, though less immediately visible than physical findings, require equally deliberate clinical **attention** to be genuinely addressed.

Fill in the blank: Demonstrating the psychological and social dimensions requires equally deliberate clinical attention, since these are less immediately visible than physical _____.

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Figure 3.1: A private family physician asking a patient about their home circumstances during a consultation.

Pilot questions 3.1

- Explain why holistic care requires practical demonstration, not just theoretical understanding. (Linked to SLO 3.1)
- Describe how a physician demonstrates the biological dimension in practice. (Linked to SLO 3.1)
- Explain why clear communication of clinical findings matters to the biological dimension of care. (Linked to SLO 3.1)
- Describe how a physician demonstrates the psychological dimension in practice. (Linked to SLO 3.2)
- Describe how a physician demonstrates the social dimension in practice. (Linked to SLO 3.2)

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3.2 Communication Skills in Family Practice

3.2.1 principles of effective clinical communication

Building trust through clear, respectful exchange

Effective clinical **communication** rests on several core principles, including **clarity**, expressing information in language the patient can genuinely understand, discussed in relation to the patient-centred approach in an earlier Series of this course, and **respect**, treating the patient as a genuine partner in the consultation rather than a passive recipient of information.

Further principles include **empathy**, genuinely acknowledging the patient's emotional experience, discussed in relation to illness in an earlier related course, and **honesty**, providing accurate information even when discussing difficult findings, since trust built through consistently honest communication represents an essential foundation for the ongoing physician-patient relationship.

Fill in the blank: Effective clinical communication rests on core principles including clarity, respect, empathy, and _____.

3.2.2 verbal and non-verbal communication

Verbal communication encompasses the specific words and language a physician uses during a consultation, requiring careful attention to avoiding unnecessary technical **jargon**, discussed in relation to patient-centred consultation skills in an earlier Series of this course, and using language genuinely accessible to the individual patient.

Non-verbal communication, including eye contact, posture, and tone of **voice**, carries substantial additional communicative weight, often conveying genuine attentiveness or, conversely, disinterest, regardless of the specific words being spoken, meaning physicians must remain conscious of these non-verbal **signals** throughout the consultation.

Fill in the blank: Non-verbal communication, including eye contact, posture, and tone of voice, often conveys genuine attentiveness or, conversely, _____.

3.2.3 barriers to effective communication

Common barriers to effective communication include use of excessive medical **terminology**, discussed earlier in this Series, language or literacy differences between physician and patient, and time **pressure**, discussed in relation to appointment systems in an earlier Series of this

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course, which can discourage a physician from allowing a patient sufficient time to fully express their concerns.

Further barriers include cultural differences in health beliefs and communication style, discussed further in a later Series of this course, and physical or environmental factors, such as inadequate consultation room **privacy**, capable of inhibiting a patient's willingness to openly discuss sensitive personal or family matters.

Fill in the blank: Common barriers to effective communication include time pressure and physical or environmental factors such as inadequate consultation room _____.

Table 3.2: Comparing verbal and non-verbal communication.

Feature	Verbal communication	Non-verbal communication
What it involves	The specific words and language used	Eye contact, posture, and tone of voice
Key requirement	Clear, jargon-free language	Attentive, respectful body language
Risk if poorly managed	Patient misunderstanding of information	Perceived disinterest despite accurate information

Pilot questions 3.2

1. List four principles of effective clinical communication. (Linked to SLO 3.3)
2. Define verbal communication and describe a key requirement for its effective use. (Linked to SLO 3.4)
3. Define non-verbal communication and give two examples. (Linked to SLO 3.4)
4. Describe two barriers to effective clinical communication. (Linked to SLO 3.4)
5. Explain how inadequate consultation room privacy can act as a communication barrier. (Linked to SLO 3.4)

3.3 Interview Skills in Family Practice

3.3.1 structuring the patient interview

A logical sequence supporting efficient, thorough assessment

A well structured patient **interview** generally follows a logical sequence, beginning with an open invitation for the patient to describe their presenting **concern**, discussed in relation to the patient-

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centred approach in an earlier Series of this course, followed by more focused questioning to clarify specific clinical details.

This structured approach additionally generally includes systematic enquiry into relevant past medical, family, discussed in an earlier Series of this course, and social **history**, before concluding with examination and discussion of findings, providing a logical, efficient framework supporting thorough assessment within realistic consultation **time** constraints.

Fill in the blank: A well structured patient interview begins with an open invitation for the patient to describe their presenting _____.

3.3.2 questioning techniques

Effective questioning generally begins with **open questions**, allowing the patient to respond broadly in their own words, before progressively narrowing to more specific **closed questions** seeking precise clinical detail, a technique sometimes described as the funnel approach to clinical interviewing.

Skilled interviewing additionally requires appropriate use of **clarifying questions**, confirming genuine understanding of the patient's meaning, and **summarising**, periodically restating what the patient has said to confirm accuracy and demonstrate genuine attentive **listening** throughout the consultation.

Fill in the blank: Effective questioning generally begins with open questions before progressively narrowing to more specific closed questions, a technique sometimes described as the _____ approach.

3.3.3 closing the consultation effectively

Closing a consultation effectively involves clearly **summarising** the key findings and agreed management plan, ensuring the patient genuinely understands the next steps in their **care**, discussed in relation to shared decision making in an earlier Series of this course.

Effective closure additionally includes explicit **safety netting**, discussed in relation to managing uncertainty in an earlier Series of this course, and confirmation of any necessary follow-up **arrangements**, providing the patient a clear, confident sense of the plan going forward as the consultation concludes.

Fill in the blank: Effective consultation closure includes explicit safety netting and confirmation of any necessary follow-up _____.

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Figure 3.3: A private family physician summarising a consultation plan for a patient before they leave the clinic.

Pilot questions 3.3

1. Describe the logical sequence of a well structured patient interview. (Linked to SLO 3.5)
2. Distinguish open questions from closed questions. (Linked to SLO 3.5)
3. Describe the funnel approach to clinical interviewing. (Linked to SLO 3.5)
4. Define clarifying questions and summarising as interview techniques. (Linked to SLO 3.5)
5. Describe the components of effective consultation closure. (Linked to SLO 3.6)

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Series Summary

This Series examined the **biopsychosocial dimensions of holistic care, and communication and interview skills**, beginning with **holistic care**, the practical demonstration, rather than merely theoretical understanding, of the biological, psychological, and social dimensions within a private practice consultation, before turning to **communication skills**, the core principles of clarity, respect, empathy, and honesty, verbal and non-verbal communication, and common barriers to effective communication.

We concluded with **interview skills**, structuring the patient interview logically, appropriate questioning techniques including the funnel approach, and effective consultation closure incorporating clear summarising, safety netting, and follow-up arrangements. Having worked through this Series, you should now be equipped to understand the interrelation of curative and preventive care and the family physician's place in the national health system examined in the next Series of this course.

Glossary of Terms

1. **Holistic care:** care demonstrating genuine attention to the biological, psychological, and social dimensions of a patient's presentation.
2. **Biological dimension:** the underlying physical pathology addressed through history taking, examination, and investigation.
3. **Psychological dimension:** a patient's emotional response, beliefs, and coping strategies related to their presenting complaint.
4. **Social dimension:** a patient's family, living, and working circumstances relevant to their presenting complaint.
5. **Verbal communication:** the specific words and language used during a clinical consultation.
6. **Non-verbal communication:** eye contact, posture, tone of voice, and other cues accompanying spoken communication.
7. **Communication barrier:** a factor, such as jargon or time pressure, that inhibits effective clinical communication.
8. **Open question:** a question allowing a patient to respond broadly in their own words.
9. **Closed question:** a question seeking specific, precise clinical detail.
10. **Funnel approach:** a questioning technique moving from open to progressively more specific closed questions.
11. **Clarifying question:** a question confirming genuine understanding of a patient's meaning.
12. **Consultation closure:** the final part of a consultation summarising findings, plans, safety netting, and follow-up.

Concept Check Questions [Series 3]

Objective questions

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1. Demonstrating holistic care in private practice requires deliberate, practical _____ given limited consultation time.
2. Effective demonstration of the biological dimension requires clear, accurate communication of clinical findings back to the _____.
3. Effective clinical communication rests on core principles including clarity, respect, empathy, and _____.
4. A questioning technique moving from open to progressively more specific closed questions is called the _____ approach.
5. Effective consultation closure includes explicit safety netting and confirmation of any necessary follow-up _____.

Short-answer questions

- Describe how a physician demonstrates the psychological dimension in practice.
- Define non-verbal communication and give two examples.
- Describe two barriers to effective clinical communication.
- Distinguish open questions from closed questions.
- Describe the components of effective consultation closure.

Long-answer questions

1. Discuss the concept of holistic care and how the biological dimension is demonstrated in practice. (Linked to SLO 3.1)
2. Discuss how the psychological and social dimensions of holistic care are demonstrated in practice. (Linked to SLO 3.2)
3. Discuss the principles of effective clinical communication and verbal and non-verbal communication. (Linked to SLO 3.3, SLO 3.4)
4. Discuss barriers to effective communication. (Linked to SLO 3.4)
5. Discuss structuring the patient interview, questioning techniques, and closing the consultation effectively. (Linked to SLO 3.5, SLO 3.6)

Answers to Concept Check Questions [Series 3]

Objective questions

6. Skill.
7. Patient.
8. Honesty.
9. Funnel.
10. Arrangements.

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Short-answer questions

11. By directly enquiring about the patient's emotional response to their presenting complaint through deliberate questions.
12. Cues such as eye contact, posture, and tone of voice accompanying spoken communication.
13. Excessive medical terminology, and time pressure limiting consultation length.
14. Open questions allow broad responses in the patient's own words; closed questions seek specific, precise detail.
15. Summarising findings and the management plan, explicit safety netting, and confirmation of follow-up arrangements.

Long-answer questions

16. **Basic response:** Holistic care requires demonstrating, not merely theoretically understanding, the biological, psychological, and social dimensions within a consultation.

Value-added response: The biological dimension is demonstrated through thorough history taking, examination, and clear communication of findings back to the patient.

17. **Basic response:** The psychological dimension is demonstrated through direct, deliberate enquiry into the patient's emotional response to their complaint.

Value-added response: The social dimension is demonstrated through direct enquiry into family and living or working circumstances, since these dimensions require equally deliberate attention as physical findings.

18. **Basic response:** Effective clinical communication rests on clarity, respect, empathy, and honesty, encompassing both verbal communication, the words used, and non-verbal communication, including eye contact and tone.

Value-added response: Non-verbal cues carry substantial communicative weight, often conveying attentiveness or disinterest regardless of the words spoken.

19. **Basic response:** Barriers to effective communication include excessive jargon, language or literacy differences, time pressure, cultural differences, and inadequate consultation privacy.

Value-added response: These barriers can inhibit patient understanding or willingness to openly discuss sensitive matters, undermining effective clinical communication.

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20. **Basic response:** A well structured interview begins with an open invitation, narrows through the funnel approach to closed questions, and includes clarifying questions and summarising.

Value-added response: Effective closure summarises findings and plans, provides explicit safety netting, and confirms follow-up arrangements, giving the patient a clear, confident sense of the path forward.

Answers to Pilot Questions [Series 3]

Part 3.1

11. Because time constraints require an efficient, structured approach rather than unfocused conversation to address all three dimensions.
12. Through thorough history taking, clinical examination, and appropriate investigation where indicated.
13. Because the biological component of care must be genuinely understood by the patient, not just competently performed.
14. By directly enquiring about the patient's emotional response through specific, deliberate questions.
15. By directly enquiring about family and living or working circumstances relevant to the presenting complaint.

Part 3.2

1. Clarity, respect, empathy, and honesty.
2. The specific words and language used; requires avoiding unnecessary technical jargon.
3. Cues accompanying spoken communication; eye contact and tone of voice.
4. Excessive medical terminology, and time pressure.
5. It can inhibit a patient's willingness to openly discuss sensitive personal or family matters.

Part 3.3

6. An open invitation to describe the concern, focused questioning, systematic history, then examination and discussion.

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7. Open questions allow broad responses; closed questions seek specific, precise clinical detail.
8. Moving from open to progressively narrower closed questions during the interview.
9. Clarifying questions confirm understanding of patient meaning; summarising restates what the patient has said.
10. Summarising findings and the plan, explicit safety netting, and confirming follow-up arrangements.

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14. Rakel, R. E., & Rakel, D. P. (2019). Textbook of Family Medicine (9th ed.). Elsevier.

Figures, Plates, Tables, and Boxes

1. Figure 3.1: A private family physician asking a patient about their home circumstances during a consultation. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician asking a seated patient a question during a consultation, calm respectful setting, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."
2. Table 3.2: Comparing verbal and non-verbal communication. AI-generated using the prompt: "Create a clean reference table titled Comparing Verbal and Non-Verbal Communication, listing feature, verbal communication, and non-verbal communication. Simple clinical reference table style with outside border."
3. Figure 3.3: A private family physician summarising a consultation plan for a patient before they leave the clinic. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician summarising a plan with a seated patient in a calm clinic room, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."

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Series 4: Curative and Preventive Care, and the Family Physician in the National Health System

- **Part 4.1: Curative and Preventive Care**
    - Sub Part 4.1.1: Concept of curative care
    - Sub Part 4.1.2: Concept of preventive care
    - Sub Part 4.1.3: The interrelation between curative and preventive care
- **Part 4.2: The Family Physician in the National Health System**
    - Sub Part 4.2.1: The family physician's position within the tiered health system
    - Sub Part 4.2.2: The family physician's relationship with public and private sectors
    - Sub Part 4.2.3: The family physician's contribution to national health goals
- **Part 4.3: Integrating Curative-Preventive Balance with the Family Physician's Systemic Role**
    - Sub Part 4.3.1: Balancing curative and preventive activity in private practice
    - Sub Part 4.3.2: The family physician as a bridge between individual and system-level care
    - Sub Part 4.3.3: Practical strategies for strengthening this dual role

Introduction

In the last Series, we explored the biopsychosocial dimensions of holistic care and communication and interview skills. We now turn to the **interrelation of curative and preventive care**, and the **place of the family physician** within the wider national health system. Picture a private family physician treating a patient's acute chest infection, while simultaneously seizing the opportunity to discuss smoking cessation and offer overdue vaccinations, illustrating how curative and preventive activity naturally interweave within a single consultation, and how that same physician's private practice remains genuinely connected to the broader national health system. Understanding this interrelation and connection is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of the interrelation of curative and preventive care, and the place of the family physician in the national health system.

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This Series begins with **curative and preventive care**, before turning to the **family physician in the national health system**. It concludes with **integrating curative-preventive balance with the family physician's systemic role**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 4.1:** describe the concepts of curative care and preventive care
- **SLO 4.2:** describe the interrelation between curative and preventive care
- **SLO 4.3:** describe the family physician's position within the tiered national health system
- **SLO 4.4:** describe the family physician's relationship with public and private sectors and contribution to national health goals
- **SLO 4.5:** describe how curative and preventive activity are balanced in private practice, and
- **SLO 4.6:** describe the family physician's role as a bridge between individual and system-level care.

4.1 Curative and Preventive Care

4.1.1 concept of curative care

Treating an already established illness

Curative care refers to treatment aimed at resolving or managing an already established illness, discussed in relation to illness versus disease in an earlier related course, representing the traditional focus of much clinical practice, and generally corresponding to the biological dimension of holistic care, discussed in an earlier Series of this course.

In private practice specifically, curative care typically represents the most immediately visible, explicitly requested component of a patient's **presentation**, since patients generally seek consultation primarily because of an active symptom or concern requiring **treatment**, discussed in relation to illness behaviour in an earlier related course.

Fill in the blank: Curative care refers to treatment aimed at resolving or managing an already established _____.

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4.1.2 concept of preventive care

Preventive care, discussed in relation to the levels of prevention in an earlier related course, refers to measures aimed at preventing disease before it occurs, or detecting and addressing it at the earliest possible **stage**, rather than waiting for a patient to actively present with a fully developed, symptomatic illness.

Preventive care within private practice includes activities such as immunisation, discussed in an earlier related course, screening for common chronic conditions, discussed in relation to secondary prevention in an earlier related course, and health education promoting healthy behaviour, discussed in relation to modifiable risk factors in an earlier related course.

Fill in the blank: Preventive care refers to measures aimed at preventing disease before it occurs, or detecting and addressing it at the earliest possible _____.

4.1.3 the interrelation between curative and preventive care

Curative and preventive care are genuinely **interrelated** rather than separate, competing activities, since every curative consultation, discussed earlier in this Series, presents a valuable, naturally occurring opportunity for the physician to additionally address relevant preventive **needs**, discussed in the previous sub-Part, without requiring a separate dedicated visit.

This interrelation reflects the comprehensive care principle discussed in an earlier Series of this course, meaning skilled family physicians routinely integrate preventive **activity**, such as opportunistic screening or vaccination, into consultations initially sought for an entirely unrelated curative **concern**, maximising the practical value of every patient encounter.

Fill in the blank: The interrelation between curative and preventive care means skilled family physicians routinely integrate preventive activity into consultations initially sought for an entirely unrelated curative _____.

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Figure 4.1: A family physician offering a vaccination to a patient who initially attended for an unrelated complaint.

Pilot questions 4.1

- Define curative care. (Linked to SLO 4.1)
- Explain why curative care typically represents the most visible component of a private practice presentation. (Linked to SLO 4.1)
- Define preventive care and list two examples relevant to private practice. (Linked to SLO 4.1)
- Explain why curative and preventive care are genuinely interrelated rather than separate activities. (Linked to SLO 4.2)
- Describe an example of integrating preventive activity into a curative consultation. (Linked to SLO 4.2)

4.2 The Family Physician in the National Health System

4.2.1 the family physician's position within the tiered health system

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A key generalist presence at the entry point of care

The family physician generally occupies a position at, or very close to, the **primary** level of Nigeria's tiered health system, discussed in an earlier related course, serving as an accessible first point of contact regardless of whether the physician practises within the public sector or, as this course specifically addresses, a private **practice**.

This positioning means the family physician's clinical decisions carry substantial influence over the efficient functioning of the broader health system, since appropriate management or referral **decisions** made at this initial point of contact directly affect the burden placed on secondary and tertiary facilities, discussed in an earlier related course, further along the system.

Fill in the blank: The family physician generally occupies a position at, or very close to, the primary level of Nigeria's tiered health _____.

4.2.2 the family physician's relationship with public and private sectors

Family physicians practise across both the public and private **sectors**, discussed in relation to the Nigerian health system in an earlier related course, with private practice specifically representing an important complementary source of primary care capacity alongside public sector primary health facilities.

Effective functioning of this dual-sector arrangement generally requires appropriate professional **communication** and, where relevant, referral pathways between private and public sector providers, discussed in relation to two-way referral in a later Series of this course, ensuring patients receive coherent care regardless of which specific sector they initially **access**.

Fill in the blank: Effective functioning of the dual-sector arrangement requires appropriate professional communication and referral pathways, ensuring coherent _____ regardless of which sector a patient accesses.

4.2.3 the family physician's contribution to national health goals

Individual family physicians, whether in public or private practice, collectively contribute meaningfully to national health goals, discussed in relation to national health policy in an earlier related course, through their aggregate impact on disease prevention, discussed earlier in this Series, and early detection and management of common conditions across the population.

This contribution additionally extends to supporting progress toward universal health **coverage**, discussed in relation to healthcare financing in an earlier related course, since accessible,

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competent primary care, whether delivered through public facilities or private practice, represents an essential foundation for any genuinely comprehensive national health **system**.

Fill in the blank: Family physicians contribute to national health goals, including supporting progress toward universal health _____.

Table 4.2: Comparing curative and preventive care within private practice.

Feature	Curative care	Preventive care
Typical trigger	Patient presents with an active symptom	Opportunistically added during a consultation
Main aim	Resolve or manage established illness	Prevent or detect disease early
Relationship	The visible reason for the visit	Integrated alongside the curative visit

Pilot questions 4.2

1. Describe the family physician's position within Nigeria's tiered health system. (Linked to SLO 4.3)
2. Explain how the family physician's decisions affect the broader health system's efficient functioning. (Linked to SLO 4.3)
3. Describe the relationship between private practice and public sector primary health facilities. (Linked to SLO 4.4)
4. Explain why professional communication between private and public sector providers is important. (Linked to SLO 4.4)
5. Describe the family physician's contribution to national health goals. (Linked to SLO 4.4)

4.3 Integrating Curative-Preventive Balance with the Family Physician's Systemic Role

4.3.1 balancing curative and preventive activity in private practice

Achieving genuine integration within realistic consultation time

Achieving genuine **balance** between curative and preventive activity within a private practice requires practical skill, discussed in relation to holistic care in an earlier Series of this course, since consultation time remains **limited**, meaning excessive focus on preventive activity risks inadequately addressing the patient's original, presenting curative concern.

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Practical strategies supporting this balance include maintaining organised **records**, discussed in an earlier Series of this course, flagging patients due for specific preventive interventions, allowing efficient, targeted preventive activity to be added to a curative consultation without requiring extensive additional consultation **time**.

Fill in the blank: Practical strategies supporting curative-preventive balance include maintaining organised records flagging patients due for specific preventive _____.

4.3.2 the family physician as a bridge between individual and system-level care

The family physician functions as a genuine **bridge** connecting individual patient care with the broader health system, discussed earlier in this Series, translating national preventive health priorities, discussed in relation to national health policy in an earlier related course, into concrete action within individual patient consultations.

This bridging role additionally operates in the reverse direction, with individual patient encounters, discussed in relation to community-oriented care in an earlier Series of this course, providing valuable practical insight into how national health priorities are actually experienced and implemented at the individual patient **level**.

Fill in the blank: The family physician's bridging role operates in both directions, with individual patient encounters providing insight into how national health priorities are actually implemented at the individual patient _____.

4.3.3 practical strategies for strengthening this dual role

Strategies for strengthening the family physician's dual curative-preventive and individual-systemic role include ongoing professional **development**, discussed in relation to continuing professional development in an earlier related course, keeping the physician updated on current national preventive health priorities and guidelines.

Further strengthening strategies include active participation in relevant professional and health system **networks**, discussed in relation to WONCA in an earlier Series of this course, and consistent use of the practical organisational tools discussed throughout this course, together supporting the family physician's genuinely effective **dual** role within both individual patient care and the broader national health system.

Fill in the blank: Strengthening the family physician's dual role includes active participation in relevant professional and health system _____.

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Figure 4.3: A family physician reviewing national health guidelines alongside individual patient records at a desk.

Pilot questions 4.3

1. Explain the practical challenge of balancing curative and preventive activity in private practice. (Linked to SLO 4.5)
2. Describe a practical strategy supporting curative-preventive balance. (Linked to SLO 4.5)
3. Explain what it means for the family physician to serve as a bridge between individual and system-level care. (Linked to SLO 4.6)
4. Explain how this bridging role operates in the reverse direction, from individual encounters to system-level insight. (Linked to SLO 4.6)
5. Describe two strategies for strengthening the family physician's dual role. (Linked to SLO 4.6)

Series Summary

This Series examined **curative and preventive care, and the family physician in the national health system**, beginning with **curative and preventive care**, their distinct concepts, and their genuine interrelation within everyday consultations, before turning to the **family physician in**

the national health system, their position within the tiered health system, their relationship across public and private sectors, and their contribution to national health goals.

We concluded with **integrating curative-preventive balance with the family physician's systemic role**, practical strategies for balancing curative and preventive activity, the physician's bidirectional bridging role connecting individual and system-level care, and strategies for strengthening this dual role. Having worked through this Series, you should now be equipped to understand family health beliefs, the two-way referral system, NHIS costs, and home visits examined in the final Series of this course.

Glossary of Terms

1. **Curative care:** treatment aimed at resolving or managing an already established illness.
2. **Preventive care:** measures aimed at preventing disease before it occurs or detecting it at the earliest possible stage.
3. **Opportunistic screening:** screening or preventive activity added to a consultation originally sought for another reason.
4. **Tiered health system:** a health system structured into primary, secondary, and tertiary levels of care.
5. **Dual-sector arrangement:** the coexistence of public and private health service provision within a health system.
6. **Universal health coverage:** access to needed health services without financial hardship for the whole population.
7. **Bridging role:** the family physician's function connecting individual patient care with broader health system priorities.
8. **National health goals:** the overarching health objectives a country seeks to achieve through its health system.
9. **Continuing professional development:** ongoing learning activities maintaining a physician's current knowledge and skills.
10. **Professional network:** a body or association connecting physicians for shared learning and standards.
11. **Consultation time:** the practical duration available for a clinical encounter, a key constraint on care delivery.
12. **Aggregate impact:** the combined effect of many individual physicians' actions across a population.

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Concept Check Questions [Series 4]

Objective questions

1. Curative care refers to treatment aimed at resolving or managing an already established _____.
2. Preventive care refers to measures aimed at preventing disease before it occurs, or detecting it at the earliest possible _____.
3. The family physician generally occupies a position at, or very close to, the primary level of the tiered health _____.
4. Family physicians contribute to national health goals, including supporting progress toward universal health _____.
5. Strengthening the family physician's dual role includes active participation in relevant professional and health system _____.

Short-answer questions

- Explain why curative and preventive care are genuinely interrelated rather than separate activities.
- Explain how the family physician's decisions affect the broader health system's efficient functioning.
- Describe the relationship between private practice and public sector primary health facilities.
- Explain the practical challenge of balancing curative and preventive activity in private practice.
- Explain what it means for the family physician to serve as a bridge between individual and system-level care.

Long-answer questions

1. Discuss the concepts of curative care and preventive care and their interrelation. (Linked to SLO 4.1, SLO 4.2)
2. Discuss the family physician's position within the tiered national health system. (Linked to SLO 4.3)
3. Discuss the family physician's relationship with public and private sectors and contribution to national health goals. (Linked to SLO 4.4)
4. Discuss how curative and preventive activity are balanced in private practice. (Linked to SLO 4.5)
5. Discuss the family physician's role as a bridge between individual and system-level care. (Linked to SLO 4.6)

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Answers to Concept Check Questions [Series 4]

Objective questions

6. Illness.
7. Stage.
8. System.
9. Coverage.
10. Networks.

Short-answer questions

11. Because every curative consultation presents a naturally occurring opportunity to address relevant preventive needs.
12. Appropriate management or referral decisions at the primary level directly affect the burden on secondary and tertiary facilities.
13. Private practice provides an important complementary source of primary care capacity alongside public sector facilities.
14. Consultation time is limited, so excessive preventive focus risks inadequately addressing the patient's original curative concern.
15. The physician translates national health priorities into individual consultations while individual encounters inform system-level understanding.

Long-answer questions

16. **Basic response:** Curative care resolves or manages established illness, while preventive care aims to prevent disease or detect it early, with the two genuinely interrelated rather than separate.

Value-added response: Skilled family physicians routinely integrate preventive activity into consultations originally sought for a curative concern, maximising the value of every patient encounter.

17. **Basic response:** The family physician occupies a position at, or close to, the primary level of the tiered health system, serving as an accessible first point of contact.

Value-added response: This positioning gives the physician's clinical decisions substantial influence over the broader system's efficient functioning, since appropriate management or referral affects downstream facility burden.

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18. **Basic response:** Family physicians practise across both public and private sectors, with private practice representing an important complementary source of primary care capacity.

Value-added response: Effective functioning requires appropriate communication and referral pathways between sectors, and family physicians collectively contribute to national health goals, including universal health coverage.

19. **Basic response:** Balancing curative and preventive activity requires practical skill given limited consultation time, with organised records flagging patients due for preventive intervention supporting efficient integration.

Value-added response: This balance ensures preventive activity does not come at the expense of adequately addressing the patient's original presenting concern.

20. **Basic response:** The family physician bridges individual patient care with the broader health system, translating national preventive priorities into concrete individual action.

Value-added response: This bridging role also operates in reverse, with individual patient encounters providing valuable insight into how national health priorities are actually experienced and implemented.

Answers to Pilot Questions [Series 4]

Part 4.1

11. Treatment aimed at resolving or managing an already established illness.
12. Because patients generally seek consultation primarily because of an active symptom requiring treatment.
13. Measures preventing disease or detecting it early; immunisation and chronic disease screening, among others.
14. Because every curative consultation presents a naturally occurring opportunity to address relevant preventive needs.
15. Offering a vaccination to a patient attending for an unrelated acute complaint.

Part 4.2

1. At, or very close to, the primary level, serving as an accessible first point of contact.
2. Appropriate management or referral decisions directly affect the burden on secondary and tertiary facilities.

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3. Private practice provides an important complementary source of primary care capacity alongside public facilities.
4. Because it ensures patients receive coherent care regardless of which sector they initially access.
5. Through aggregate impact on disease prevention, early detection, and progress toward universal health coverage.

Part 4.3

6. Consultation time is limited, so excessive preventive focus risks inadequately addressing the presenting curative concern.
7. Maintaining organised records flagging patients due for specific preventive interventions.
8. Translating national preventive health priorities into concrete action within individual patient consultations.
9. Individual encounters provide practical insight into how national priorities are actually experienced and implemented.
10. Ongoing professional development, and active participation in relevant professional and health system networks.

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References and Attributions [Series 4]

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12. World Health Organization (1978). Declaration of Alma-Ata: International Conference on Primary Health Care.
13. Federal Ministry of Health, Nigeria (2004). Revised National Health Policy.
14. Rakel, R. E., & Rakel, D. P. (2019). Textbook of Family Medicine (9th ed.). Elsevier.

Figures, Plates, Tables, and Boxes

1. Figure 4.1: A family physician offering a vaccination to a patient who initially attended for an unrelated complaint. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician offering a vaccination to a seated patient during a routine consultation, calm respectful setting, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."
2. Table 4.2: Comparing curative and preventive care within private practice. AI-generated using the prompt: "Create a clean reference table titled Comparing Curative and Preventive Care in Private Practice, listing feature, curative care, and preventive care. Simple clinical reference table style with outside border."
3. Figure 4.3: A family physician reviewing national health guidelines alongside individual patient records at a desk. AI-generated using the prompt: "A single clean, realistic illustration of a physician reviewing documents at an office desk, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

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Series 5: Family Health Beliefs, the Two-Way Referral System, NHIS Costs, and Home Visits

- **Part 5.1: Family Health Beliefs and Their Impact on Health**
    - Sub Part 5.1.1: Concept of family health beliefs
    - Sub Part 5.1.2: Sources and diversity of family health beliefs
    - Sub Part 5.1.3: Impact of family health beliefs on health-seeking behaviour and outcomes
- **Part 5.2: The Two-Way Referral System and NHIS Costs**
    - Sub Part 5.2.1: Concept and operation of the two-way referral system
    - Sub Part 5.2.2: The family physician's role in two-way referral
    - Sub Part 5.2.3: Cost implications of the NHIS to the family physician
- **Part 5.3: Domiciliary and Home Visits**
    - Sub Part 5.3.1: Concept and purpose of domiciliary and home visits
    - Sub Part 5.3.2: Conducting an effective home visit
    - Sub Part 5.3.3: Challenges and benefits of home visits in private practice

Introduction

In the last Series, we explored curative and preventive care and the family physician's place in the national health system. We now conclude this course with **family health beliefs** and their impact on health, the **two-way referral system** connecting private practice to the wider health system, the **cost implications of the NHIS** for the family physician, and the practice of **domiciliary or home visits**. Picture a private family physician visiting a homebound elderly patient, discovering during the home visit a family belief that discourages hospital attendance for a specific condition, information that would never have emerged within the clinic walls alone. Understanding these final practical realities of private practice completes the foundation this course has built.

The aim of this Series is to equip you with a clear understanding of family health beliefs and their impact on health, the two-way referral system, the cost implications of the NHIS to the family physician, and domiciliary and home visits.

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This Series begins with **family health beliefs and their impact on health**, before turning to the **two-way referral system and NHIS costs**. It concludes with **domiciliary and home visits**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 5.1:** describe the concept and sources of family health beliefs
- **SLO 5.2:** describe the impact of family health beliefs on health-seeking behaviour and outcomes
- **SLO 5.3:** describe the two-way referral system and the family physician's role within it
- **SLO 5.4:** describe the cost implications of the NHIS to the family physician
- **SLO 5.5:** describe the concept, purpose, and conduct of domiciliary and home visits, and
- **SLO 5.6:** describe the challenges and benefits of home visits in private practice.

5.1 Family Health Beliefs and Their Impact on Health

5.1.1 concept of family health beliefs

Shared understandings shaping how a family views illness

Family health beliefs refer to the shared understandings, values, and assumptions a family holds regarding the causes, meaning, and appropriate management of illness, discussed in relation to illness behaviour in an earlier related course, generally developed and reinforced across successive **generations** within the family.

These beliefs frequently operate largely **unconsciously**, meaning family members may not readily articulate them unless directly and sensitively **enquired** about, requiring the family physician to actively explore this dimension of the social context discussed in relation to holistic care in an earlier Series of this course, rather than assuming shared biomedical understanding.

Fill in the blank: Family health beliefs are generally developed and reinforced across successive _____ within the family.

5.1.2 sources and diversity of family health beliefs

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Family health beliefs draw on several sources, including broader cultural and religious **traditions**, discussed in relation to sexuality and reproduction ethics in an earlier related course, direct family experience with previous illness episodes, and, increasingly, information encountered through media and social **networks**.

Family health beliefs vary **considerably** both within and between different Nigerian communities, meaning the family physician must remain genuinely attentive to the specific beliefs held by an individual patient's own family, rather than assuming uniformity across an entire cultural or religious **group**.

Fill in the blank: Family health beliefs draw on several sources, including cultural and religious traditions, direct family experience, and media and social _____.

5.1.3 impact of family health beliefs on health-seeking behaviour and outcomes

Family health beliefs can significantly influence **health-seeking behaviour**, discussed in an earlier related course, including whether and how promptly a family member seeks formal medical care, and whether traditional or alternative approaches are pursued alongside, or instead of, conventional treatment **recommendations**.

Where family health beliefs conflict with sound clinical **advice**, the resulting tension can directly affect treatment adherence and clinical outcomes, discussed in relation to treatment adherence in an earlier related course, meaning the family physician must approach such situations with cultural **sensitivity** while still providing clear, accurate clinical guidance.

Fill in the blank: Where family health beliefs conflict with sound clinical advice, the family physician must approach such situations with cultural sensitivity while still providing clear, accurate clinical _____.

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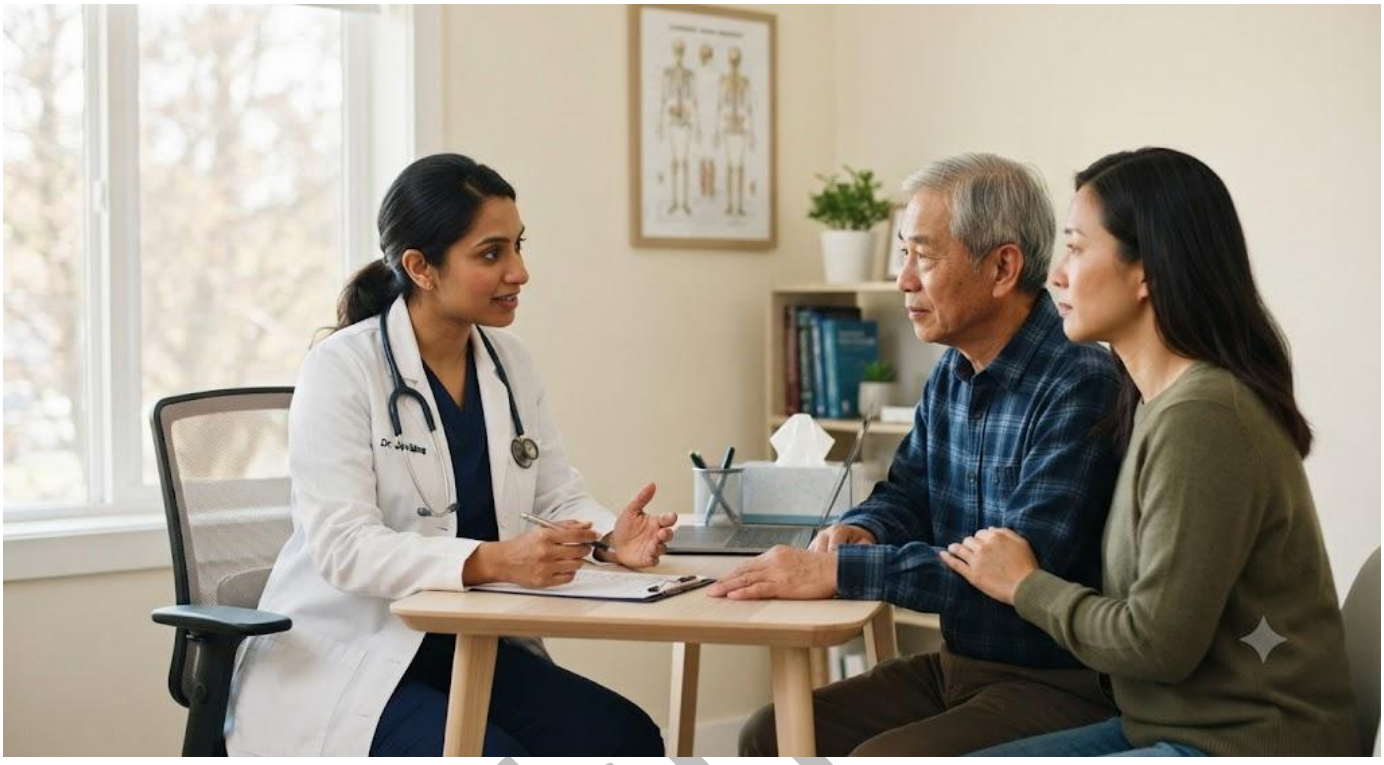

Figure 5.1: A family physician sensitively discussing treatment options with a patient and family member who hold differing views.

Pilot questions 5.1

- Define family health beliefs. (Linked to SLO 5.1)
- Explain why family physicians must actively enquire about family health beliefs. (Linked to SLO 5.1)
- List two sources of family health beliefs. (Linked to SLO 5.1)
- Explain how family health beliefs can influence health-seeking behaviour. (Linked to SLO 5.2)
- Describe how a family physician should approach a conflict between family health beliefs and sound clinical advice. (Linked to SLO 5.2)

5.2 The Two-Way Referral System and NHIS Costs

5.2.1 concept and operation of the two-way referral system

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Referral flowing both toward and back from specialist care

The **two-way referral system** describes a referral arrangement in which patients are referred **forward** from the family physician to specialist or higher level care when clinically indicated, discussed in relation to the tiered health system in an earlier Series of this course, and subsequently referred **back** to the family physician for ongoing follow-up once specialist input is no longer required.

This bidirectional arrangement contrasts with a purely **one-way** referral pattern, in which patients referred to specialist care are simply retained there indefinitely, and instead supports the continuity of care principle discussed in an earlier Series of this course, allowing the family physician to remain genuinely involved in a patient's overall, ongoing **management**.

Fill in the blank: The two-way referral system contrasts with a purely one-way referral pattern, instead supporting the _____ of care principle.

5.2.2 the family physician's role in two-way referral

The family physician's role in the two-way referral system includes making appropriate initial referral **decisions**, discussed in relation to primary care management in an earlier Series of this course, and providing the receiving specialist with clear, relevant clinical **information** supporting efficient specialist assessment.

Equally importantly, the family physician holds responsibility for effectively receiving patients referred **back**, incorporating specialist recommendations into ongoing primary care management, and maintaining the continuity of care that represents one of family medicine's core defining **principles**, discussed in an earlier related course.

Fill in the blank: The family physician holds responsibility for effectively receiving patients referred back and maintaining the continuity of care that represents one of family medicine's core defining _____.

5.2.3 cost implications of the nhis to the family physician

The **NHIS**, discussed in relation to healthcare financing in an earlier related course, carries specific **cost implications** for family physicians participating as providers, including agreed reimbursement rates that may not always fully cover the actual cost of delivering comprehensive, patient-centred care as discussed throughout this course.

Family physicians participating in NHIS arrangements must additionally consider the administrative **cost** and complexity of insurance claims processing, and the potential tension

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between insurance-driven consultation time or service **limits** and the genuinely comprehensive, patient-centred approach this course has emphasised, requiring careful practice financial management.

Fill in the blank: Family physicians participating in NHIS arrangements must consider the administrative cost and complexity of insurance claims _____.

Table 5.2: Comparing one-way and two-way referral.

Feature	One-way referral	Two-way referral
Pattern	Patient remains with specialist indefinitely	Patient returns to family physician after specialist input
Effect on continuity	Fragments ongoing care	Supports continuity of care
Family physician role after referral	Limited or none	Receives patient back and continues management

Pilot questions 5.2

1. Define the two-way referral system. (Linked to SLO 5.3)
2. Distinguish two-way referral from a purely one-way referral pattern. (Linked to SLO 5.3)
3. Describe the family physician's responsibilities when referring a patient forward. (Linked to SLO 5.3)
4. Describe the family physician's responsibilities when receiving a patient referred back. (Linked to SLO 5.3)
5. Describe two cost implications of the NHIS for the family physician. (Linked to SLO 5.4)

5.3 Domiciliary and Home Visits

5.3.1 concept and purpose of domiciliary and home visits

Bringing family medicine into the patient's own home

A **domiciliary**, or home, visit involves the family physician attending a patient directly within their own home environment, generally reserved for patients unable to easily attend the practice, discussed in relation to family medicine tools in an earlier Series of this course, such as those with significant **mobility** limitations or advanced illness.

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The purpose of a home visit extends beyond simple convenience, providing the family physician valuable direct insight into a patient's actual living **conditions**, family support arrangements, discussed in an earlier related course, and social context, information that may not be readily apparent within the clinic setting alone.

Fill in the blank: A domiciliary, or home, visit is generally reserved for patients unable to easily attend the practice, such as those with significant mobility _____.

5.3.2 conducting an effective home visit

Conducting an effective home visit requires careful **preparation**, including confirming the visit arrangement in advance and bringing appropriate equipment and supplies, since home visits generally lack the immediate access to additional resources available within the practice **premises** itself.

During the visit, the physician should apply the same patient-centred, holistic principles discussed throughout this course, while additionally taking the opportunity to directly **observe** relevant environmental and family factors, discussed earlier in this Series, that may be contributing to the patient's presenting health **concern**.

Fill in the blank: During a home visit, the physician should take the opportunity to directly observe relevant environmental and family factors contributing to the patient's presenting health _____.

5.3.3 challenges and benefits of home visits in private practice

Home visits present specific practical **challenges** for private practice, including the considerable time cost relative to office-based consultations, discussed in relation to consultation time earlier in this course, and the practical logistics of travel, particularly given traffic and distance considerations within many urban Nigerian **settings**.

Despite these challenges, home visits offer substantial **benefits**, including the rich contextual information they provide, discussed earlier in this Series, and the meaningful strengthening of the physician-patient relationship and trust that a genuine home visit can foster, often representing a valuable, if selectively used, component of comprehensive private family practice.

Fill in the blank: Despite practical challenges, home visits offer substantial benefits, including rich contextual information and meaningful strengthening of the physician-patient _____.

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Figure 5.3: A family physician conducting a home visit, examining a homebound elderly patient.

Pilot questions 5.3

1. Define a domiciliary or home visit and describe when it is typically used. (Linked to SLO 5.5)
2. Describe the purpose of a home visit beyond simple convenience. (Linked to SLO 5.5)
3. Describe the preparation required for conducting an effective home visit. (Linked to SLO 5.5)
4. Describe two challenges facing home visits in private practice. (Linked to SLO 5.6)
5. Describe two benefits home visits offer despite these challenges. (Linked to SLO 5.6)

Series Summary

This final Series examined **family health beliefs, the two-way referral system, NHIS costs, and home visits**, beginning with **family health beliefs**, their concept, sources, and considerable influence on health-seeking behaviour and treatment outcomes, before turning to the **two-way referral system and NHIS costs**, the bidirectional referral arrangement supporting continuity of

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care, the family physician's specific role within it, and the practical cost implications of NHIS participation.

We concluded with **domiciliary and home visits**, their concept and purpose beyond simple convenience, how to conduct an effective visit, and the challenges and substantial benefits home visits offer within private practice. Having worked through this Series, and indeed this entire course, you should now possess a comprehensive, practically grounded foundation in private practice organisation, from family medicine tools and the patient-centred approach introduced in Series 1 through primary care management, holistic care, curative-preventive balance, and, finally, family beliefs, referral, financing, and home visits addressed throughout FAM 503.

Glossary of Terms

1. **Family health beliefs:** shared understandings a family holds regarding the causes, meaning, and management of illness.
2. **Health-seeking behaviour:** the specific actions taken in response to perceived symptoms, including whether and when to seek care.
3. **Two-way referral system:** a referral arrangement in which patients are referred forward and subsequently referred back to the family physician.
4. **One-way referral:** a referral pattern in which a patient remains with specialist care indefinitely without returning.
5. **Continuity of care:** ongoing care provided to the same patient over an extended period.
6. **NHIS:** the National Health Insurance Scheme, Nigeria's principal formal social health insurance arrangement.
7. **Reimbursement rate:** the agreed payment a provider receives for services delivered under an insurance scheme.
8. **Insurance claims processing:** the administrative process of submitting and settling payment claims under an insurance scheme.
9. **Domiciliary visit:** a home visit conducted by a physician attending a patient in their own home.
10. **Mobility limitation:** a physical constraint restricting a patient's ability to travel to a health facility.
11. **Contextual information:** insight into a patient's living conditions and social circumstances gained through direct observation.
12. **Physician-patient relationship:** the trust-based, fiduciary relationship between a physician and their patient.

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Concept Check Questions [Series 5]

Objective questions

1. Family health beliefs are generally developed and reinforced across successive _____ within the family.
2. The two-way referral system supports the _____ of care principle, unlike a purely one-way pattern.
3. Family physicians must consider the administrative cost and complexity of insurance claims _____.
4. A domiciliary visit is generally reserved for patients unable to easily attend the practice, such as those with significant mobility _____.
5. Home visits offer benefits including rich contextual information and strengthening of the physician-patient _____.

Short-answer questions

- Explain why family physicians must actively enquire about family health beliefs.
- Distinguish two-way referral from a purely one-way referral pattern.
- Describe two cost implications of the NHIS for the family physician.
- Describe the purpose of a home visit beyond simple convenience.
- Describe two challenges facing home visits in private practice.

Long-answer questions

1. Discuss the concept, sources, and impact of family health beliefs on health-seeking behaviour and outcomes. (Linked to SLO 5.1, SLO 5.2)
2. Discuss the two-way referral system and the family physician's role within it. (Linked to SLO 5.3)
3. Discuss the cost implications of the NHIS to the family physician. (Linked to SLO 5.4)
4. Discuss the concept, purpose, and conduct of domiciliary and home visits. (Linked to SLO 5.5)
5. Discuss the challenges and benefits of home visits in private practice. (Linked to SLO 5.6)

Answers to Concept Check Questions [Series 5]

Objective questions

6. Generations.

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7. Continuity.
8. Processing.
9. Limitations.
10. Relationship.

Short-answer questions

11. Because these beliefs often operate unconsciously and are unlikely to be articulated unless directly and sensitively enquired about.
12. Two-way referral returns the patient to the family physician after specialist input; one-way referral retains the patient with the specialist indefinitely.
13. Reimbursement rates that may not fully cover care costs, and the administrative cost of claims processing.
14. It provides insight into a patient's living conditions, family support, and social context not readily apparent in clinic.
15. The considerable time cost relative to office consultations, and the logistics of travel in urban settings.

Long-answer questions

16. **Basic response:** Family health beliefs are shared understandings about illness causes and management, drawing on cultural traditions, family experience, and media, often operating unconsciously.

Value-added response: These beliefs can significantly influence health-seeking behaviour and treatment adherence, requiring the family physician to approach conflicts between beliefs and clinical advice with cultural sensitivity.

17. **Basic response:** The two-way referral system refers patients forward for specialist care and back again for ongoing management, supporting continuity of care unlike a purely one-way pattern.

Value-added response: The family physician's role includes making appropriate referral decisions, providing clear clinical information to specialists, and effectively receiving and continuing management for patients referred back.

18. **Basic response:** NHIS participation carries cost implications including reimbursement rates that may not fully cover comprehensive care costs.

Value-added response: Family physicians must additionally manage the administrative complexity of claims processing and potential tension between insurance-driven limits and genuinely patient-centred care.

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19. **Basic response:** A domiciliary visit involves attending a patient in their own home, generally for those with mobility limitations, providing insight into living conditions and social context beyond simple convenience.

Value-added response: Conducting an effective visit requires careful preparation and application of the same patient-centred, holistic principles used in clinic, while directly observing relevant environmental and family factors.

20. **Basic response:** Home visits present challenges including considerable time cost and travel logistics, particularly in urban Nigerian settings.

Value-added response: Despite these challenges, they offer substantial benefits, including rich contextual information and meaningful strengthening of the physician-patient relationship and trust.

Answers to Pilot Questions [Series 5]

Part 5.1

11. Shared understandings a family holds regarding the causes, meaning, and management of illness.
12. Because these beliefs often operate unconsciously and must be directly and sensitively explored.
13. Cultural and religious traditions, and direct family experience with previous illness.
14. They can affect whether and how promptly care is sought, and whether traditional approaches are pursued instead of or alongside conventional treatment.
15. With cultural sensitivity, while still providing clear, accurate clinical guidance.

Part 5.2

1. A referral arrangement in which patients are referred forward to specialist care and back to the family physician afterward.
2. One-way referral retains the patient with the specialist indefinitely; two-way referral returns the patient for ongoing management.
3. Making appropriate referral decisions and providing clear, relevant clinical information to the receiving specialist.

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4. Incorporating specialist recommendations into ongoing management and maintaining continuity of care.
5. Reimbursement rates that may not fully cover care costs, and the administrative cost of claims processing.

Part 5.3

6. A visit where the physician attends a patient in their home; typically used for patients with significant mobility limitations.
7. It provides direct insight into living conditions, family support, and social context.
8. Confirming the visit in advance and bringing appropriate equipment and supplies.
9. Considerable time cost relative to office consultations, and travel logistics in urban settings.
10. Rich contextual information about the patient's circumstances, and strengthened physician-patient trust.

References and Attributions [Series 5]

11. McWhinney, I. R., & Freeman, T. (2016). Textbook of Family Medicine (4th ed.). Oxford University Press.
12. Kleinman, A. (1988). The Illness Narratives: Suffering, Healing, and the Human Condition. Basic Books.
13. National Health Insurance Authority, Nigeria (2022). NHIA Act and operational guidelines.
14. Rakel, R. E., & Rakel, D. P. (2019). Textbook of Family Medicine (9th ed.). Elsevier.

Figures, Plates, Tables, and Boxes

1. Figure 5.1: A family physician sensitively discussing treatment options with a patient and family member who hold differing views. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician discussing options with a patient and family member seated together, calm respectful setting, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."

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2. Table 5.2: Comparing one-way and two-way referral. AI-generated using the prompt: "Create a clean reference table titled Comparing One-Way and Two-Way Referral, listing feature, one-way referral, and two-way referral. Simple clinical reference table style with outside border."
3. Figure 5.3: A family physician conducting a home visit, examining a homebound elderly patient. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician examining a seated elderly patient within a simple home setting, calm respectful atmosphere, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."

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