Letter to the Editor
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Holistic care from health professionals: Applying a scale to provide the most appropriate healthcare

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Dear Editor,

Having allied health professionals connect with our patients can provide a clearer picture of the key issues as perceived by the patient and their actual condition. Allied health professionals with their specific training and knowledge can add value to management plans for both general and specialist medical practitioners. As a rheumatologist, I have valued the contributions of physiotherapists, occupational therapists, podiatrists, nurses, social workers and orthotists among others, to the overall management of my patients. Their input reflects enhancement in the care of patients with chronic diseases, rather than replacement or competition.

When dealing with patients with chronic diseases, we need some form of 'assessment language' crossing all disciplines so that the best outcomes can be determined for each patient. We now have a number of scales to assess the success of treatment which caters for a medical model.[1] However, these have been designed to provide consistent patient information for clinical trials and do not easily translate to daily clinical practice. The following overall assessment scale that combines physical and emotional states of a patient was designed by the author to help target specific health professional intervention in clinical practice. This helps produce a composite score (E,P) with the coordinates helping determine the best mix of health professional input taking into consideration objective diagnostic features. This scale has only been used in clinical practice when patients with complex clinical features were assessed. This has not as yet been tested in a large clinical trial.

As we can all attest, there are patients who have severe physical disabilities who have superb intrinsic coping strategies; while at the other end of the spectrum, there are patients with mild disabilities who have variable pain amplification syndromes that place increasing demands on health professionals and costs to the community including disability support.

For example, a patient that I consulted on with neck pain, had recently been extensively assessed by a community physiotherapist. She had been seen by other medical and physiotherapy practitioners in the preceding three months and her severe symptoms were attributed to depression following the recent death of her mother. While the patient had no clinical signs other than neck stiffness, we both agreed that she displayed strong emotional coping strategies but was in distress with pain that needed urgent evaluation (Scale 1,5). Her accelerated investigations showed an unusually aggressive spinal tumour that had not as yet caused neurological signs. The combined assessment of medical and allied health professionals had in this situation, triggered appropriate early surgical referral for treatment. There is a need for this type of scale to inform appropriate clinical practice.

Whether in general practice or in a specialised care environment, having the collective input of the right health professionals, can optimise delivery of holistic care.[2] If we do not address their needs, patients will go to alternative health professionals. Patients who need more emotional support should have access to the right type of health professional help while those with physical disabilities and active disease would need more medical management. The family doctor should both be informed, connected and central to the overall management in this multidisciplinary context.[3]

Sincerely,
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2. Wagner EH. The role of patient care teams in chronic disease management. BMJ 2000; 320:569-572.
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EMOTIONAL/PHYSICAL SCALE

Score	Emotional need (E)	Pain/Physical disability (P)
0	Emotionally coping well with condition (e.g. pain, stiffness, deformity).	No pain/physical disability. Coping well with condition.
1	Coping with condition with occasional need for emotional support from family/friends.	Mild pain/physical disability. Coping well with activities of daily living (ADLs)
2	Coping with condition but often needs emotional support from family/friends.	Mild pain/physical disability with occasional need for allied health services.
3	Needs some health professional help with coping and emotional support from family/friends.	Mild to moderate pain/physical disability. Coping, but with occasional allied health support e.g. hydrotherapy, splints).
4	Needs more help with coping and occasional structured allied health support (e.g. cognitive behavioural therapy)	Moderately severe pain/physical disability. Coping, but with regular need for allied health services.
5	Needs allied health support to cope with condition regularly which can be provided at outpatient visits 3–4 monthly.	Moderately severe pain/physical disability. May need home and walking aids as back-up.
6	Needs allied health support to cope with condition regularly; which needs to be provided at discharge and monthly in the community.	Moderately severe pain/physical disability. Occasionally needs walking aids and some home appliances.
7	Needs allied health support to cope with condition regularly at discharge and weekly in the community.	Severe pain/physical disability. Occasionally needs walking aids. Will benefit from home modifications and appliances
8	Poor coping mechanisms and needs consideration of respite care and regular community visits and possible therapeutic assistance with occasional drug and non-drug interventions.	Severe pain/physical disability. Regularly needs walking aids and some home modifications and appliances.
9	Very poor coping mechanisms and needs consideration of respite care and community visits and definite therapeutic assistance with drug and non-drug interventions.	Severe pain/physical disability. May mobilise with wheelchair. Home modifications.
10	Needs structured care in the community even with consideration of alternative accommodation.	Bed bound with attendant needs; including consideration of full nursing support.

Examples: (E,P)

Patient A (7,3): High emotional need, mild to moderate pain/physical disability – healthcare role of GP, psychologist, cognitive behavioural therapist, occupational therapist.

Patient B (1,5): Low emotional need, moderate pain/physical disability – healthcare role of GP, specialist, physiotherapist, occupational therapist to optimise treatment and function.

Patient C (9,7): High emotional need, severe pain/physical disability – multidisciplinary care with coordination by GP in community; with specialists in supportive role.

In 21st century patient care, we need to allow the most appropriate health professionals to connect with patients to deliver the best outcomes.