

Clinical Management in the CSA

The Art Of Managing Uncertainty – Are you committed to the cause?

We will start with another Chinese proverb, hopefully by the end of this article you will appreciate its significance.

“Claiming certainty without corroborating evidence is stupid”

- Han Fei Zi, Warring States Period

In this article I will look to deal with the following CSA statements:

CLINICAL MANAGEMENT SKILLS

Reasons for failing:

6. **Does not make an appropriate working diagnosis or identify range of differential possibilities**
7. **Does not develop a management plan (prescribing +/- referral) that is appropriate and in line with current best practice**
8. **Follow-up arrangements and safety netting are inadequate**
9. **Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options**
10. **Does not attempt to promote good health at opportune times in the consultation**

The above statements encompass the 2nd half of the consultation and from a time management point of view you will require about 4 minutes to wrap up this domain. If you are still taking a history at 8 minutes – you are in CSA no man’s land!

One of the biggest concerns that I hear from GP trainees on my course is what to do when you don’t know what the diagnosis is. Conversely, although often equally anxiety generating is when you may know what the diagnosis is but feel afraid to commit in case you are wrong. However one of the biggest CSA myths that trainees have is that you need to know exactly what is going on and have a precise diagnosis by the end of the 10 minute station.

In real life this is rarely the case and it also does not apply in the CSA. What matters is that you are able to justify your actions appropriately in order to reach a diagnosis and act on red flags when developing a management plan. What perhaps becomes more apparent in the CSA is that you will not be able to ‘hide’ behind unjustified investigations proposed out of context or snub the responsibility of decision making, deciding instead to pass the buck onto somebody else.

What you are being assessed on is the taking on of responsibility and justification of your decision making process which always depends upon making a commitment. This is best demonstrated by talking through an example.

A favourite challenging OSCE case of mine on the undergraduate finals circuit is optic neuritis, typified by a young woman presenting with unilateral eye pain and visual disturbance.

The diagnosis of optic neuritis and possible multiple sclerosis is often realized by candidates fairly early on in the station. After taking the history and examination of the patient, the worried and anxious patient asks if she will lose her vision, whether she will go blind and what is going on?

So what would you say and what would you do?

Would you say? :

1. "I don't know what is going on. We will do some blood tests to see if anything comes back abnormal."
2. "I don't know what is going on (although you really do), so I am going to refer you to the specialist to find out."
3. "It is difficult to know at this point whether you will lose your vision but there is a possibility you may have multiple sclerosis. I am going to refer you urgently to a specialist."
4. "I appreciate your anxiety but I am here to help. I feel that this is something that we urgently need to look into. I am concerned about the pain and visual loss in your eye - these are serious symptoms and we need to find out today as to what is causing them."

So which option might you choose? Option 3 shows a commitment to a working diagnosis but is this something you would say immediately in a real life situation or is this jumping into the deep end of the pool? You may be right but you might also be wrong. Consider committing by starting in the shallow end of the pool and then moving your way sensitively towards the deep end in response to how your patient reacts. Address the patient's concern – make that commitment. Option 4 allows this and you have time to tread water according to what comes back in response to your approach. Option 1 and 2 show little commitment, you have not really tipped a toe into the water and it is likely that you will be perceived to have shown and displayed an anxiety about how to deal with the uncertain and walked away from the pool completely. If you really don't know what to do, if you don't know how to swim - what is it in the history and examination in terms of 'red flags' which makes this an urgent presentation? How do you justify an equally reactive, sensitive but appropriate and urgent response? That is what you are being assessed on.

So what if in the CSA the patient then asks me what I am worried about and pushes me for a diagnosis?

Then demonstrate self awareness - be sincere, sensitive, transparent and most of all supportive. Tailor your language and wait to see what comes back.

Consider the following conversation developing between the patient and doctor in an exam situation. There are several levels of commitment which develop throughout this interaction:

Patient: 'So what do you think is going on?'

GP: 'I am not entirely sure, but I am concerned about your symptoms.'

Patient: 'What are you concerned about? Is it serious?'

GP: 'I am afraid that there is a possibility it might be serious. We need to find out today what is causing your visual symptoms.'

Patient: 'Have you no idea what is going on?'

GP: 'Well having listened to your story and examined you, I am concerned that you may have some inflammation to the back of your eye?'

Patient: 'Inflammation? What do you mean? What causes that?'

GP: 'It is called an optic neuritis. There can be several things which can cause this. We need to find out what the cause is in your case.'

Patient: 'I have heard about this condition. My friend had it several years ago and it lead on to multiple sclerosis. She died from that. Does that mean I will get multiple sclerosis!? Am I going to go blind?'

GP: 'I appreciate you are worried. Multiple sclerosis is a cause of optic neuritis, but in the first instance we need to diagnose whether this is indeed optic neuritis. I know that you scared but I am here to help you and we will find out exactly what is going on. I ring the specialists now and get you seen.'

So how has this particular GP shown commitment? Well firstly there has been a commitment to the fact that this is a potentially serious diagnosis and requires urgent attention. Secondly red flags have been recognized and an appropriate management plan proposed. Thirdly when pushed to commit further, the GP has approached the potential diagnosis sensitively and not jumped into the deep end.

Asking questions in context and reacting appropriately are paramount in passing the CSA. This also applies to how one reacts to finding out whether a patient is a smoker or drinks more than the recommended limit of units per week. Often nervous trainees will ask 'health promotion' questions rigidly and then go on to talk inappropriately at patients, rather than with, about health promotion. Again this has to be natural and at an opportune moment in the consultation. There is no 'tick box' or 'extra brownie point' for talking about smoking cessation out of context.

In summary, aim to cover the following points in the 2nd half of the CSA consultation:

In the remaining 4 minutes:

Informed Decision Making

- Share your findings
- Always readdress patient health beliefs and expectations
- Make a commitment based on the probability of what is likely to be happening

- Propose a working diagnosis in user friendly language as the consultation evolves
- Consider how the problem might develop
- Discuss sensible patient centred management options
- Address concerns sensitively and sincerely

Clinical Management

- Justify Management Plans - act appropriately when presented with red flags and consider evidence based treatments
- Health promotion only when appropriate
- Safety net and follow up

In my last article of this series, I will look at how to form and practice in a study group in the lead up to the exams.

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