

Examination in the Clinical Skills Assessment

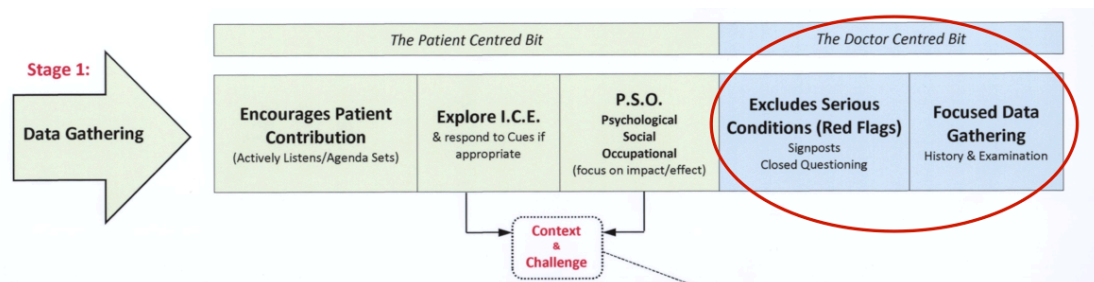
The following discussion document represents my personal views, based on over 30yrs in practice and many years of teaching and assessment. This is not RCGP policy and should not be taken as such. I hope however, that you will find this helpful. It is certainly the approach that I take when teaching skills for the CSA.

I think it's important for us to think about why we examine patients.
For me, I think there are three key reasons:

1. To gather Data to help with decision making or test a hypothesis
2. As part of 'Clinical Management' (Patient's expect to be examined and examination can be used from a therapeutic point of view and to reassure)
3. Because that's what good doctors do (that's what we have been trained to do all of our professional lives, from medical school onwards)

These are all good reasons why we examine patients but we need to try and gain insight into why we examine. The majority of candidates in the CSA struggle because they spent too much time gathering data.

The diagram below is taken from a flow chart that I use for teaching and looks at elements of Data gathering in the consultation. The box that we are thinking about is within the red circle 'Focused Data Gathering'. You will see that I've put 'History and Examination' beneath this, in smaller case. There is good reason for this. We were all taught as medical students to take a history first and then examine patients, usually in that sequence. This works well when we have a lot of time, but in General Practice we have to be more efficient in our data gathering because of time constraints in the consultation (I realise that this is not always the case, but when we are discussing data gathering in the CSA, this is certainly important).



There are three key elements to examination:

- What we examine
- When we examine
- How we examine

For someone who presents with a headache, do we always examine all 12 cranial nerves?

- Which ones do we test and why?
- Which ones do we miss out and why?

For someone with back pain do we always test straight leg raising? What about perianal sensation?

Many doctors would certainly advocate testing all aspects from a medico legal point of view, and while I accept this argument, it will mean that you will probably run into time difficulties in the CSA

So how do you decide what to do?

Well, some of this comes down to 'Risk Management and Safety Netting'
There are risks when you 'miss out' aspects of a full examination in a consultation. History is so important and formulating a hypothesis that you are then going to explore in a consultation depends very much on 'Probability and Pattern Recognition' (a subject for another discussion paper, but essentially thinking about the most likely diagnosis and looking for patterns in the history and examination that support this).

A 'tailored safety net' is the way that I ensure that if I miss something the patient will hopefully flag this up to me at a later stage

Taking a good history is key. There are many of my consultations where I don't physically examine a patient and usually if I do it is just to confirm what I already think, or it forms part of 'Clinical management' (.....the doctor didn't even examine me).

Going back to our patient with the headache:

Do we always look at the fundi? – Is this to help with data gathering or does it form part of clinical management? How often does fundoscopy help with our decision-making?

If I took your ophthalmoscope away for a day, would that stop you from making decisions and giving good care? What about your auroscope / or your stethoscope. Think about what we examine and why.

Do you always have to look in a sore ear?

If it's red / if it's not red, does that influence your decision making – and how?

Can you deal with a painful ear on the telephone, just using the history and no examination? How do you manage risk or safety net in these situations? Do you really have to see it to make a decision?

These are key areas to think about. I'm not saying don't examine patients, but I want you to think about the reasons why we examine. If examining someone's fundi is partly to help reassure a patient that you know what you're doing, and if it helps with the clinical management, that's fine, do it, but be aware that this may not simply be part of Data Gathering.

I often say to trainees – 'What if I said you can only examine 3 aspects of this patient, which are they and why?If you were only able to touch a patient 3-4 times and you had to explain why you were doing it each time, how would that focus your decision making?'

This helps us think about what is important in our decision-making when it comes to examination. If we think about the four quadrants of the abdomen, which ones give us the most information and how do we decide which areas to concentrate on (the history is key).

If we examine a patient's chest, do we always percuss and listen for vocal resonance – some doctors always do this, some never do this, and some will do this when they feel it's an important part of the Data Gathering in a particular case.

So how do we decide?

Choice of examination and timing are really important

Think of the question 'what factors influence your decision making'. If parts of the examination are an integral part of your decision making then do it early. Don't slavishly follow the history examination sequence like a medical student.

If someone presents with a left sided headache and possible GCA (Giant Cell Arteritis), when would you touch their temporal artery? Do you wait until you have asked all the relevant history questions, only to find that it's not tender?

Do you touch it as soon as is reasonably ok to do so to help with your decision making (if it is or isn't tender then the rest of the consultation takes a different path – so how do you decide when to do it – it's an integral part of your decision making in this example, not just random information gathering)

In the CSA, and in consultations generally:

Always think of the most serious condition (and examine with this in mind)

Then think of the most likely (and examine with this in mind)

Well's Criteria, which we use for the diagnosis of DVT, is a good example of 'Focused data gathering' telling you the most important aspects of the history and examination to help you decide what to do. It even gives you a scoring system to help you.

BUT, the most important aspect of Well's score is the last question, which scores 'minus 2' (Is there a more likely diagnosis). Always think of the more likely diagnosis when consulting and examine for that too (e.g. it may be a calf strain and the examination will be different)

In the CSA:

If you're going to examine someone, make sure you do it properly, especially examinations that you may not practice regularly (e.g. use of a PF meter or visual field testing)

Choice of examination is so important in the exam

Always explain to the patient what you are doing

Notes from the Website:

Equipment

You should bring your doctor's bag containing the usual diagnostic equipment with you, including:

- BNF/BNF for children
- Stethoscope
- Ophthalmoscope
- Auroscope
- Tape measure
- Peak flow meter and disposable mouthpieces

There is no need to bring a sphygmomanometer

You may examine a patient if you feel it is appropriate to the consultation, but intimate examinations should not be carried out. If the role player feels that a proposed examination would be personally intrusive they will decline the examination. If you decide that a physical examination forms an important part of your assessment of the case, you should examine the patient and your technique may be marked. You will not normally find abnormal physical signs, but you should examine the patient in such a way that you would find them if they were present. Occasionally the examiner or the role player will give you the results of an examination after you have sought permission to perform it instead of agreeing to the examination.

The two key areas that relate to Examination in the CSA exam are Data Gathering and Interpersonal Skills (IPS). The negative indicators are:

Data Gathering - Negative Indicators:

- Appears unsure of how to operate/use instruments
- Appears disorganised / unsystematic in the application of the instruments or the conduct of physical examinations

Interpersonal Skills - Negative Indicators

- When conducting examinations, appears unprofessional and at risk of hurting or embarrassing the patient

Guidance from the RCGP Website

Does not undertake physical examination competently, or use instruments proficiently

Examiners felt that you could improve your physical examination skills. You should be able to demonstrate the appropriate and fluent use of instruments, in a way that does not distress patients, with their full understanding of what you are doing and their consent.

Suggestions:

Improving these skills is a matter of practice and it pays to spend time developing a systematic method that you can repeat over and over again. Before doing so, take advice and make sure that your technique is correct; otherwise you will simply be reinforcing bad habits. Once correct techniques are practised and become fluent, your approach will appear competent and confident to the examiner

You should always explain what you are proposing to do in an examination to the patient, and why you are doing it. In the case of intimate examinations (and they do occur in the CSA), you should make absolutely sure you have gained informed consent and offered a chaperone

So, in Summary:

- Think about the reasons why we examine patients
- Think about the factors that influence your decision –making (CbD is good for this)
- Practice examining to ensure that you are proficient
- Tailor your examination to the problem / patient in front of you
- Always think of the most serious diagnosis, and then the more likely, and examine accordingly
- Choice of examination and Timing are really important
- ‘Tailored Safety netting’ is vital as part of risk management

I hope this helps

Chris