

# 9 Diagnostics: Clinical management

This performance area is about the recognition and management of common medical conditions in primary care.

In the previous two sections, data-gathering and making diagnoses/making decisions, we have learned about a number of behaviours that are needed to solve problems. These abilities are invaluable, because they can be applied to all problems, medical and non-medical, clinical and non-clinical and are particularly helpful for problems that, as in primary care, are more complex and don't have a single 'correct' solution.

In this chapter, we will move on and specifically apply these abilities to clinical problems that present in primary care.

## Tip: learning from the curriculum

The GP curriculum describes elements of clinical management in the section 'primary care management'. Specifically, it advises:

### Managing primary contact with patients, dealing with unselected problems requires:

- Knowledge of the epidemiology of problems presenting in primary care
- Mastering an approach that allows easy access for patients with unselected problems
- An organisational approach to the management of chronic conditions
- Knowledge of conditions encountered in primary care and their treatment.

### Covering the full range of health conditions requires:

- Knowledge of preventative activities required in the practice of primary care
- Skills in acute, chronic, preventative, palliative and emergency care
- Clinical skills in history-taking, physical examination and use of ancillary tests to diagnose conditions presented by patients in primary care
- Skills in therapeutics, including drug and non-drug approaches to treatment of these conditions
- The ability to prioritise problems.



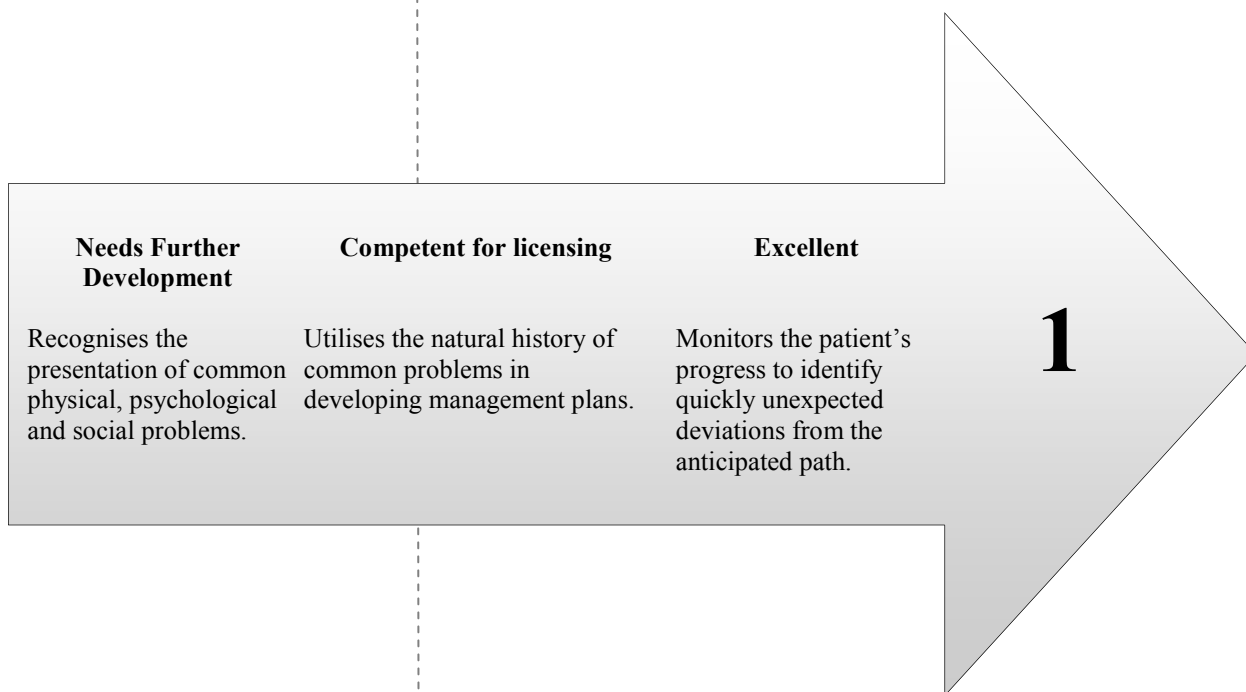
**Joined up?**  
See p14



The behavioural traits that underpin ‘clinical management’ have been shown on page 60. This is a good time to refer back to them.

The ‘clinical expertise’ behaviours are needed particularly for the initial work-up of the clinical problem that then leads to a management plan being formulated. As we will see in this chapter, ‘clinical management’ also covers *referral*, for which empathy & sensitivity skills are needed when working with colleagues. It also covers the *follow-up* of the patient's problem whether it be a routine or emergency issue, including the provision of continuity of care. For this, the ‘organisation skills’ are particularly important. Such skills are also used in the related area of practice management and administration (see page 118). This illustrates how deeper features are generic because they are put to use in a variety of contexts.

There are seven major themes in the clinical management domain, each represented by a competency progression, which we will now discuss one by one:



**This first progression is principally about learning to recognize the pattern of common problems. We move from:**

Recognizing how common problems come to light in the community



Understanding how these problems usually evolve and making use of this information to suggest appropriate treatment and follow-up plans



Ensuring, through advice and follow-up arrangements, that significant worsening or a failure to improve are brought to our attention.

Looking at each of the word pictures in turn:

**Recognises the presentation of common physical, psychological and social problems.**

This word picture refers to physical, psychological and social problems but should not be confused with ‘holistic approach’, where the competency is about being able to attend to these. Here, we are concerned with the ability to *recognise* common problems in these areas, particularly in the early stages. At the start of training, it's hard to know what is common and what isn't and this doesn't really become apparent until we are immersed in general practice. However, there are some ways that we can help ourselves (see box on the right)

What's common? Epidemiological data suggests that in rank order, the following types of disease tend to present most frequently. Note that the fifth most common condition in the community is a ragbag of ill-defined diseases, where no obvious pattern emerges.

1. Respiratory System diseases
2. Musculoskeletal Connective Tissue diseases
3. Skin & Subcutaneous Tissue diseases
4. Nervous System Sense organs diseases
5. Symptoms Signs of Ill defined diseases
6. Circulatory System diseases
7. Infectious Parasitic diseases

### What's common in our locality?

In addition to knowing what the national figures suggest about prevalence, we also need to know how this translates to our local community. Getting to know our practice profile is important and the practice data manager can help to build up a picture of the types of patient in practice and in particular, how the profile differs from the fictional ‘national average’.

For example, the age/sex profile of practices in Brighton (young people, young families) will be very different from Eastbourne (sometimes called Costa Geriatrica!). If our clientele are predominantly university students, we are very unlikely to become familiar with chronic disease management. Conversely, we are much more likely to have to manage eating disorders, so we should be on the lookout for them.

The locality may have pockets of patients with special needs, for example residential homes for the elderly, those with learning disabilities and with mental health problems.

Local employment and industry will influence the type of illnesses we deal with, so it helps to find out who the major employers are and (perhaps from the occupational health departments or local public health doctors) if there are any particular illnesses that we should be alert to. Employment rates are also a factor, with unemployment or changes in employment leading to psychological morbidity.



### Tip: how can we learn to recognize common conditions?

Firstly, the curriculum identifies ‘common and/or important conditions’ in the clinical curriculum statements. This establishes the priorities and is a goldmine from which to develop our knowledge base.

Use techniques such as undertaking knowledge tests to find out where our gaps are and therefore our learning needs.

Keep a learning log of conditions that we are unsure of. What do these suggest about our patient's unmet needs and therefore our educational needs?

Learn to be curious. When seeing a patient, we should briefly look back over recent entries and identify how a condition first came to light. Also we should look at how the condition evolved as this can teach us about the natural history.



### Local prevalence

What other factors can you think of that might affect the prevalence of disease and also the frequency of presentation?

Look at the data from your local commissioning group if you have one. Does this suggest any unusual characteristics about the practice that may relate to this issue?

Try sharing what you have learned with the practice team. This might stimulate interest as it is rare for doctors to a formally talk about this interesting topic.



### With physical problems, what is the range of conditions we need to understand?

The curriculum describes the need for GPs to cover the 'full range of health conditions', which comprise:

- Skills in acute, chronic, preventative, palliative and emergency care
- Clinical skills in history taking, physical examination and use of ancillary tests to diagnose conditions presented in primary care
- Skills in therapeutics including drug and non-drug approaches to treatment of these conditions

In some areas, the ethnic profile may be associated with a different prevalence of certain conditions, such as CHD in diabetes in south Asians. In addition, the health beliefs and expectations of different cultures can vary considerably from the textbook norms.

This competency refers to common physical, social and psychological conditions. Therefore, we need to recognize common conditions in all three categories. What does 'common' mean? Here are some examples:

#### Physical:

Here are some examples of common and/or important conditions listed in the curriculum statement for the respiratory system:

- Upper respiratory tract infections: Sore throats and colds, tonsillitis, peritonsillar abscess, epiglottitis, laryngitis and tracheitis
- Lower respiratory tract infections: Influenza, bronchiolitis, bronchitis and pneumonia (of any cause)
- Acute non-infective respiratory problems: Allergy and anaphylaxis, hypersensitivity pneumonitis, pulmonary embolus, pneumothorax, aspiration of a foreign body
- Chronic lower respiratory problems: Chronic cough, asthma, chronic obstructive pulmonary disease (COPD), tuberculosis, cystic fibrosis, chronic interstitial lung diseases
- Lung cancer

#### Psychological:

The most common primary care mental health problems are depression, eating disorders, and anxiety disorders, ADHD, post-traumatic stress disorder, alcohol and drug misuse

#### Social:

Some situations, such as poverty, delinquency, unemployment, lack of adequate housing or care in the community are defined as social problems, whilst others, like white collar crime, fail to be classified in the same way and therefore attract little attention.

Interestingly, these problems are often defined in such a way that the focus is largely on the individual rather than the system. In general practice, many of the social problems that doctors deal with relate to relationship and behavioural difficulties and the fallout from these.

#### How is this indicator related to holistic practice?

Although we have given examples of physical, psychological & social problems under three separate headings, they don't usually occur separately in real life. As GPs, we need to be alert to the fact that problems in one of these areas tend to be associated with or to lead on to problems in the other two.

For example a young teenage boy with acne may attend for treatment. We may address the skin problem but then go on to explore the patient's feelings about his condition and ask about his mood. We could also ask about impact upon schooling. It might transpire that the patient is being harassed at school and has been truanting as a result. This simple example shows how the domains should not be thought of in isolation of each other. They are connected. The same boy could have been brought in by his parents with emotional distress or have been brought with the social problem of truanting. Careful enquiry would then have revealed the skin condition to be a significant common factor.

Looking at patients' problems in this way is an example of holistic practice, which is one of the expert skills of GPs. This approach helps us to identify significant problems that are related to each other and deal with them appropriately. It also helps us to anticipate and prevent a problem in another

domain, before it occurs. For instance, dealing effectively with acne may reduce the chances of depression in the adolescent and possibly the chances of being bullied.

Significant or serious conditions often start out masquerading as common or minor ones. For example, Polymyalgia may in the early stages be diagnosed as arthritis. Hypothyroidism may initially be thought to be post-viral fatigue. Most if not all significant conditions have, especially in the early stages, a differential diagnosis that includes common disorders.

Therefore, knowing about common conditions is important if we are to diagnose serious ones. This is because knowing how common conditions develop and resolve helps us to recognise when the patient's problem is beginning to fall outside this pattern.

**Utilises the natural history of common problems in developing management plans.**

Having recognized what we think is a common condition, the next step is to think about the differential diagnosis and ask whether there are any significant or serious conditions with which the common condition might be confused. Asking about the red flag symptoms or signs of serious disease can be vital. Although it may feel like a tedious exercise, thinking of a common condition as being a 'diagnosis of exclusion' can keep our actions safe.

For example in a middle-aged man with a two week history of a hoarse voice, a diagnosis of a viral infection may be made. In the course of reaching this diagnosis and devising a management plan, we might investigate the differential diagnosis by asking about dysphagia (oesophageal cancer), cigarette smoking (laryngeal pathology) and asthma (oral thrush from the use of steroid inhaler). If the answers are negative, we can use our knowledge of viral laryngeal infections to decide the appropriate follow-up period. In this example, the patient might be asked to return if symptoms are still persisting after a further two weeks.

**Improving our understanding of natural history**

From the records, look back on the management of common conditions such as respiratory and musculoskeletal problems. Some problems will be acute and self-limiting and from these we can learn the time taken for the condition to reach its peak and then resolve.

Other conditions, such as arthritis, are chronic. We may learn many things about the natural history such as how commonly exacerbations occur, which joints are most affected, factors that exacerbate or relieve the condition and how patients fare when managed in different ways, including using their own remedies. Information about these factors can help us to formulate appropriate management plans, for example advising whether medication might help or not.

Understanding the natural history also helps us to judge whether treatment is essential, desirable, optional, unnecessary or potentially harmful. For example, many symptoms such as coryza are within normal experience and therefore do not need to be medicalised.

Explanation about the natural history is important in demedicalising symptoms and also helps patients to understand the management plan, the safety net and what actions they might take. For example when to get a deferred prescription



**Red flags**

We looked at the importance of red flags in the previous section 'making diagnoses' (see page 72). It is vital to think about common symptoms like headache, dizziness, back pain and indigestion.

What are the serious conditions and their red flag symptoms and signs that you should check for in relation to each of these?

There are national guidelines for many common symptoms that will help you to answer this question.



**Assessor's corner**

For assessors, looking at the follow up plans that doctors make is a quick way of telling whether the doctor's understanding of natural history is sound.

This understanding can also be probed directly in case-based discussions.

dispensed, contact a doctor, go to hospital or return to the GP if their progress is not as good as expected.

**Monitors the patient's progress to identify quickly unexpected deviations from the anticipated path.**

Unlike in secondary care, where we exclude more serious disease through a large number of tests performed at one point in time, in primary care we exclude by collecting information through tests and observation over a period of time, looking for deviations from an expected path of recovery.

We could say that time is the GPs 'MRI scan'.

This competency is about the management and follow-up plans that we make, rather than our clinical skills per se. Earlier on, we talked about the deeper features. The organisation and planning abilities are the most relevant to this area of performance and we use them to think ahead and construct appropriate safety nets. Safety nets, like all nets, have holes. It is therefore important, for any given problem, not to rely on one net but to put in place a number that between them can reduce the chance of a serious problem slipping through without being caught.

The follow-up arrangements should allow serious conditions to be identified and acted upon early enough to avoid putting the patient at undue risk.

For example, suppose a college student presents with migraine headaches having not had any for some time. The clinical assessment reveals associated nausea and mild photophobia, but no other positive findings. Although migraine is possible, indeed probable, there is a risk of meningitis especially in the student group and the patient may be asked to return shortly to check that no new and suspicious findings are present.

It is through such reviews that we learn more about the natural history of the problem, the likelihood of other conditions being present and the evolution of more serious conditions. This information helps us to make better decisions and improve our management plans.

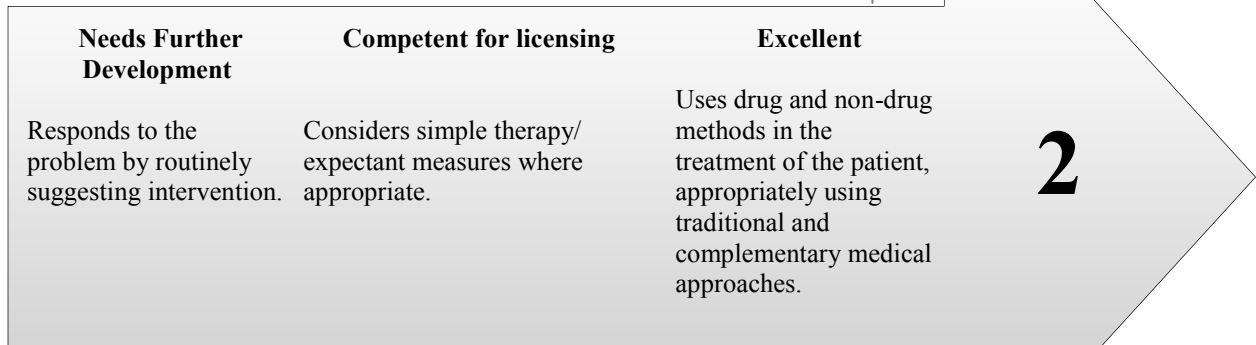
'Monitoring the patient's progress' is not entirely a doctor-based activity and is increasingly undertaken by the team.

Good record keeping in which our thoughts are made clear is a vital part of ensuring that other health professionals understand our thoughts on what the 'anticipated path' is and therefore recognise when unexpected deviations occur. To reduce risk to patients even further, it can be really helpful to record our thoughts as to *what may need to be done* if deviations occur. For example, a GP treating a patient with chronic cough may write 'consider chest x-ray if symptoms not cleared within the next two weeks'. Sometimes, doctors can be reticent to write in this way, particularly when they are training, inexperienced, are not regular members of the practice team or are worried that their thoughts might make them look foolish. That would be a shame because it's the thoughts that flow from the patient encounter that are often more valuable than the record of the encounter itself.

So far, we have talked in terms of acute conditions, but this competency also applies to the management of chronic conditions. For these, there will usually need to be more systematic surveillance accompanied by a programme of patient education and support. Coronary heart disease is a good example in which we see doctors orchestrating management as a team-based activity, involving the patient and family.

For coronary disease, an example of an 'unexpected deviation' may be an

exacerbation of chest pain or breathlessness which occurs without warning and may suggest an acute event. We might construct a safety net for the patient without knowing whether and when it might be used but for coronary disease such a net might include education, information leaflets, an emergency supply of GTN and instructions on the circumstances in which an ambulance should be called.



**Having recognized the problem, this progression describes how we change from an interventionist approach (common and important in secondary care) to an approach that uses conventional treatment (drug and non-drug), complementary therapy and where appropriate, no treatment at all.**



We recognise a problem, but instead of (where appropriate) watching and waiting to see how the condition evolves, we take action and intervene, for example with a prescription or a referral.



In addition to being able to recommend when to watch and wait, we are also able to recommend simple remedies and self-help and monitor the situation rather than intervene.



We are able to think of 'treatment' in a broad sense and are able to accept non-drug and complementary approaches and recommend them appropriately.

Looking at each of the word pictures in turn:

### **Responds to the problem by routinely suggesting intervention.**

Doctors who are relatively inexperienced in primary care tend to respond in this way. This is not surprising, because in the hospital context it is not appropriate to 'watch and wait' as the job of the hospital specialist is to banish uncertainty by gathering data and taking action. In primary care, patient problems are unfiltered, presenting to us without having first been assessed by another doctor. It's quite possible that the problem with which the patient presents isn't actually 'medical' or amenable to a doctor's skills. Part of our skill is being able to recognise when this might be the case.

'Intervention' means taking some form of direct action that might include ordering tests and investigations, referring a patient or recommending treatment.

### **Considers simple therapy/expectant measures where appropriate.**

If we are unable to do anything more than routinely intervene (do tests/prescribe/refer), this means that we have not yet learned that in primary care, problems often need to be given time to evolve and become discernible before appropriate intervention can be recommended. During the waiting phase, it may well be appropriate to suggest simple measures (e.g. cough linctus) whilst we are waiting to see whether the condition resolves as expected.

In addition to medication and simple remedies, a broader palette of options is needed in primary care partly because many problems will not have a satisfactory 'traditional' medical solution. There may not be a 'pill for every ill' and many ills need no treatment at all.

Part of this competency therefore, is knowing when *not* to prescribe, for example when not to give antibiotics for a cough. To be effective, this ability needs to be linked with good communication skills so that the patient understands the pros and cons of treatment and is able to accept the recommendation not to treat.

Simple treatments include traditional remedies such as steam inhalation, basic medications such as painkillers and over-the-counter (OTC) preparations. The latter used to be mainly simple (i.e. not prescription-only) medications but with changes to prescribing regulations and the community pharmacists role, this is no longer the case and an increasing number of complex preparations are available without a doctor consultation. It is therefore increasingly important to check what OTC drugs the patient may have taken.

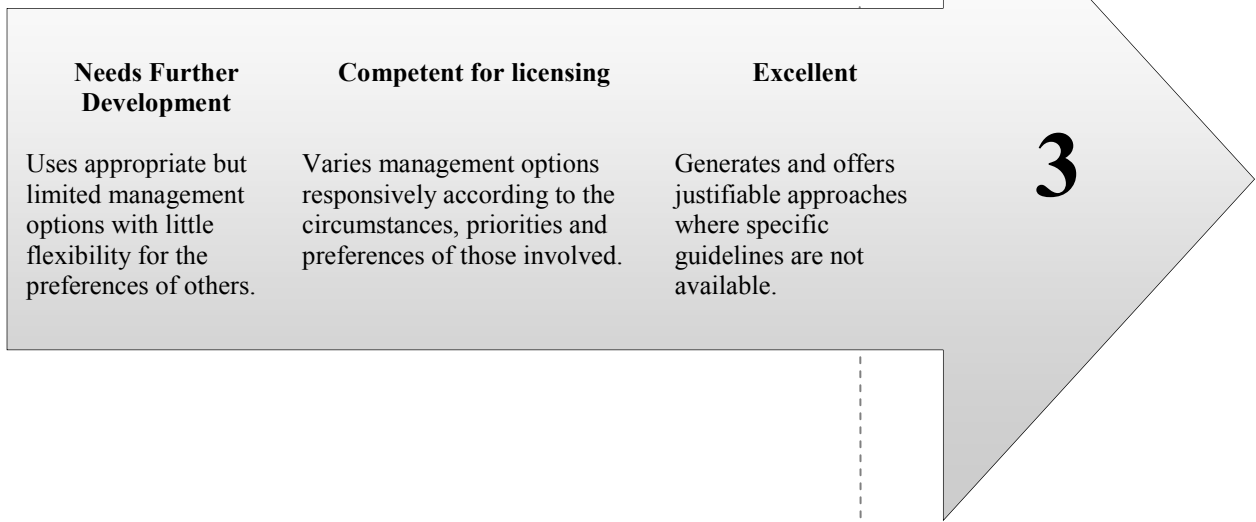
'Considering simple therapy' also includes trying to recommend the simplest of the appropriate options. For example, there may be no need for strong painkillers or combination therapies when a less potent drug or a single medication would do.

Simple treatments are not a separate class of management but are often an initial part of a management process that might later lead on to a higher degree of medical intervention. For example, patients with dyspepsia may begin with OTC antacids but later move on to acid-suppression, breath testing and possible gastroscopy. Note that nowadays most of the steps in this example of a continuum of simple to complex measures, can be implemented by or with the pharmacist, which is an example of their enhanced role.



**Uses drug and non-drug methods in the treatment of the patient, appropriately using traditional and complementary medical approaches.**

In primary care, many forms of help are available. These may include giving explanations, using non-drug interventions such as lifestyle advice or physiotherapy and where appropriate, supporting the patient in the use of complementary therapy. With the latter it may be that doctors do not make a formal recommendation or referral, but that where the patient wishes to go down this route and harm is unlikely, we do not stand in the way and may even facilitate this action.



**For many educators, this is a particularly important progression in the domain of clinical management.** In particular, the ‘competent’ descriptor is significant as we shall describe later.

This progression describes how we start off with a safe but limited and relatively rigid range of options, become more flexible and responsive with an increasing range of approaches and finally, create new approaches where alternatives are not available.

**We move from:**

Initially having only a limited range of options, although making use of these appropriately. The narrowness of these options means that we have little choice on offer, which in turn makes us less flexible and adaptable to what the patient wants.



Building up, through experience, a wider range of management options which when coupled with the wish to be flexible, allows us to respond to what the patient needs.



Being able to think for ourselves and suggest approaches that are *tailored* to the situation. Although these approaches may not have an explicit evidence-based, perhaps because there are no guidelines that directly address the problem, they



### Question: Why is the ability to tailor plans important?

The ability to tailor plans rather than seek to impose an inflexible option means that plans are much more likely to be followed.

Because concordance is improved, **treatment** is likely to be more effective, **waste** (from for example unused medication or non-attendance at hospital appointments) is reduced and the **adverse consequences** of less appropriate treatment, avoided. Can you see how the ability to tailor plans is therefore linked with good risk management?

Importantly, tailored plans show that we have *interest* and *respect* for the patient's thoughts and preferences. This improves trust and the doctor-patient relationship generally, which itself makes future plans easier to negotiate. This can be vital when the plan concerns a problem in which uncertainty or the risk of conflict are significant.

can still be justified.

Looking at each of the word pictures in turn:

**Uses appropriate but limited management options with little flexibility for the preferences of others.**

This progression is interesting because it is partly about acting *appropriately* but also about being able to *tailor* plans, modifying them in response to the thoughts of others, in particular the patient.

You may think that the knowledge and skill base of the GP is fairly standard stuff and will come through experience. This may be the case, but we have to remember that primary care is different from what we have experienced in secondary care. Patients come with *problems* rather than symptoms or signs, which means that we first have to clarify the problem, remembering to think of social and psychological problems as well as clinical ones.

Additionally, we have to tailor our plans. Look at the box on the left to read why this is important. Tailored plans are like tailored (rather than 'off the peg') suits. Patients feel much more comfortable in them and are more likely to wear them and come back to the tailor when the next plan needs designing!

In addition to our clinical abilities, the other major feature of this competency is the *interest* that we take in the patient and the desire we have to respond to their needs. To continue with the clothing analogy, in order to produce a custom-made suit, we have to know the patient's measurements; in other words we have to be interested enough to know what the patient's *requirements* are.

At the 'NFD' level we show little flexibility for patient's needs and this can be due to a number of reasons:

- Firstly, we may not *know enough* to be able to adapt our plans even if we wanted to. Doctors often take refuge in being rigid (for example sticking to their plans and telling patients what to do) when they can't think of suitable alternatives.
- Secondly, we may simply not see the value of tailoring plans or of being flexible. In other words, even if we have the skills to offer a range of options, we may not have the *right attitude*.
- Thirdly, we may not have the *skills to negotiate* a plan with the patient. Tailoring is not the same as just doing what the patient wants, and negotiation skills are needed when there might be conflict.

If you have difficulty with this competency, ask yourself whether the problem lies with your clinical skills, your attitude, your communication (especially negotiation) skills or a combination of these.

These areas work in synergy, which means that improving any one of them will improve the whole. For example, if you have better clinical skills you will feel more confident in offering a wider range of options and this will improve your attitude to being flexible with patients. Here's an interesting point; even if you feel that you don't have many options to offer, if you have the attitude of sharing the plan with the patient, *they* are likely to generate suitable options that had not occurred to you. To use a cliché, the patient is part of the solution as well as part of the problem!

**Varies management options responsively according to the circumstances, priorities and preferences of those involved.**

Why do educators consider this to be such an important competency? The reason is that it embodies the observation and responsiveness that GPs need to

show in their clinical practice.

In the same way as we must not assume that our initial working diagnosis is the right one, we must also not assume that the initial management plan will remain the best one as time goes on.

We need to continually look at how well the plan is working from both our own and the patient's perspective, checking out whether other options become important as the situation changes and therefore whether the plan needs to change.

**Generates and offers justifiable approaches where specific guidelines are not available.**

Compared to 'NFD', at the 'competent' level we still produce appropriate management options but the menu of possible choices that we generate and offer becomes much broader.

This competency overlaps with the ones listed below, which come from the performance area of 'Making a diagnosis/making decisions':

- *Thinks flexibly around problems, generating functional solutions.*
- *No longer relies on rules alone but is able to use and justify discretionary judgement in situations of uncertainty.*

It is worth re-reading the explanation of these competencies from page 76.

The current competency refers to being able to generate approaches when guidelines are not available. It is not about the quality and legitimacy of the guidelines (which are covered in the Making a diagnosis/making decisions') but about our mindset.

At this level of performance, we have moved beyond tailoring existing guidance and are able to be creative when no recommended option seems to be available from the books or guidelines. Of course, this does not mean that we are allowed to behave idiosyncratically. Whatever approaches we suggest must be justifiable on the basis of accepted medical practice. 'Generating' the approach does not necessarily mean that we have to come up with an original suggestion. In real life, we don't wait for inspiration but we usually discuss the case with GP colleagues or hospital specialists, whose thoughts may prompt new ideas.

### **Question: In what way is 'generating approaches' related to risk management?**

This competency takes us and our patients into uncertain territory. By definition, a recommended approach is not available, which means that we must evaluate the risk associated with the approaches that are generated. This requires a good deal of experience with risk management and, preferably, experience with this type of problem; the latter is not always available. It also requires considerable expertise with communication skills.

For example, we may need to explain the situation, the degree of uncertainty and the possible risks of using an approach that may be a modification of an existing approach, or something entirely new.

Care needs to be taken not to simply accept the patient's willingness to put their trust in us, but to try to explain so that the patient can make an informed choice. We also need to be careful not to *insist* upon an informed choice if the patient (or their advocate) is unwilling or unable to engage in the process.

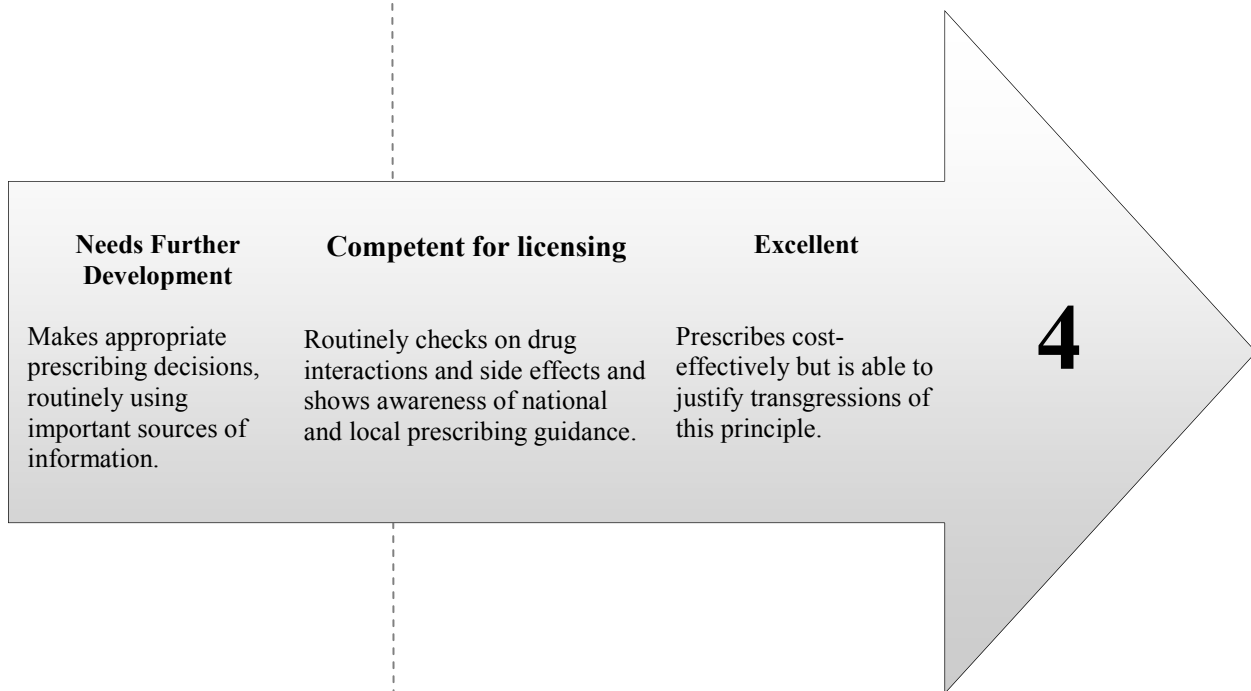


### **Varying plans responsively**

It is common for doctors to suggest changes to the plan, but much less common for patients to be asked without first being made aware of the doctor's thoughts.

We will often have clinical reasons for suggesting changes, but (because we are not the patient) we won't know the impact that the plan is having on the patient's life. This is a vital piece in the jigsaw.

Try asking patients how things are going and how, if at all, they wish to modify the plan *before* you make suggestions of your own.



**This indicator is specifically concerned with prescribing and describes how we move from:**

Prescribing safely, using appropriate sources of information and doing so routinely and dependably, rather than occasionally and inconsistently.



Prescribing in accordance with guidelines, protocols and computer prompts. Establishing which side-effects and interactions might occur and routinely checking for the presence or absence of these with the patient.



Being aware of cost issues, seeking to prescribe the most cost-effective of the available and appropriate alternatives. Being prepared to prescribe less frugally, or outside the formulary, when appropriate.

Looking at each of the word pictures in turn:

**Makes appropriate prescribing decisions, routinely using important sources of information.**

The key behaviour in this indicator is our routine use of guidance. *Why is this important?* In other areas of clinical performance such as the knowledge of appropriate investigations and the patterns that may suggest particular diagnoses, the knowledge base is relatively stable and the mechanisms of CPD are usually adequate to maintain safe practice.

However, with prescribing, changes occur much more frequently and the effects of ‘getting it wrong’ through side-effects, interactions and the wrong choice of drug can be more immediate, profound and sometimes dangerous. Because of the range of drugs and their associated features and the multiple combinations of medication, we need to be in the habit of *not* relying on our memories when prescribing as much as we do for other areas of clinical care.

The important sources of information in general practice are textbooks such as the British National formulary, whether in paper form or online, and the numerous computer prompts on practice systems that warn of side-effects, significant drug interactions and recommended drug options. Doctors who are not competent tend to either fail to check on appropriate prescribing options, to disregard prompts or both. Even if their prescribing is safe to begin with, such behaviour will result over a fairly short timescale, in unsafe practice.

**Routinely checks on drug interactions and side effects and shows awareness of national and local prescribing guidance.**

This competency refers to the habit of checking the literature to decide on which drug to prescribe and this leads us on to the next competency.

It takes the previous one forward in two ways:

- Firstly we not only use the literature to decide what to prescribe but also, when initiating medication and when following up the patient, we discuss side-effects and check on interactions. Checking is important because adverse effects may take time to show themselves, for example the dry cough with ACEI or muscle pain with statins. Very often, patients find the information sheets that come with their drugs overwhelming and frightening. As a result, they often rely on doctors to advise on important interactions.
- Secondly, we go beyond checking on individual drugs and pay heed to national guidelines, often related to particular conditions such as asthma, and to local prescribing guidance such as the practice formulary.

**Prescribes cost-effectively but is able to justify transgressions of this principle.**

Prescribing cost-effectively is clearly important because of the finite resources of the health service and the opportunity-costs that inefficient prescribing creates. There are many measures that we can take to keep costs down, including prescribing generically wherever appropriate (it isn't always), prescribing from a limited list of cost-effective drugs, establishing patient preferences so that prescribed medication is likely to be taken and managing repeat prescriptions to prevent stockpiling and wastage.



**Question: what factors might influence the management plan?**

First and foremost, the ideas, concerns and expectations of the patient could have a direct bearing. These will determine the patient's preferences for what should be done and will help us to suggest which option, from a list of appropriate alternatives, might best fit these preferences.

We need empathy and sensitivity to take an interest in the patient's perspective, coupled with good communication skills to elicit the patient's preferences.

We also have our own priorities and these should be shared as they may result in the patient modifying their own preferences until an accommodation is reached. This process is at the heart of negotiation.

Beyond doctor and patient, there are other factors that may influence the plan. On the patient's side, the priorities and preferences of significant people such as family or employers may modify the patient's thinking.

On our side, beyond the clinical assessment our preferences may be influenced by the availability of resources, the direction given by guidelines and personal factors such as personal biases formed by previous clinical experiences.

### Question: When might you knowingly prescribe less cost-effectively?

The main aim is not to keep costs to a minimum but to keep *cost-effectiveness* to a maximum. It is pointless using cheap drugs if they do not treat the patient's problem or are in some way unacceptable to the patient. Good GPs move from being a doctor-centred to being appropriately patient-centred. Therefore, the most common reason for prescribing less cost-effectively is because this is the best way of addressing the patient's needs. For example, the patient may have a preference for a particular formulation, such as paracetamol capsules rather than tablets. They may have co morbidity such as dyspepsia, which may make an enteric-coated preparation preferable.

The drug may have to fit in with a *lifestyle* choice, such as when gelatin-free products are needed for vegetarians and vegans. Occasionally, patients may not be happy with taking tablets several times a day when a modified - release preparation is available, as for example with diclofenac. Similarly, patients may hear of combination preparations that they would prefer to separate items.

Another issue is the variability between generic preparations of the same drug. Often, being dispensed drugs that are the same but look different is merely an inconvenience. However, when it causes confusion, there may be risk attached. Occasionally, patients are adamant that some generic preparations cause side-effects when compared to others and there may then be a case for prescribing a trade name to guarantee consistency in what the patient receives.

Nowadays, when faced with situations such as those described, it is not unreasonable for doctors to discuss the need for cost containment with patients. Many patients are willing to help the NHS to save money when this is possible, but it is our duty to weigh up the risks and benefits of doing so. Balancing this is the realisation that patient choice matters: there is no more expensive drug than one that isn't taken!

#### Needs Further Development

Performs up to, but does not exceed, the limits of their own competence.

#### Competent for licensing

Refers appropriately and coordinates care with other professionals in primary care and with other specialists.

#### Excellent

Identifies and encourages the development of new resources where these are needed.

5

**This progression concerns our ability to make use of and then improve the help that is available to our patients. We move from:**

Being able and willing to use our personal abilities to the fullest, in the interests of the patient, whilst not going beyond what we are capable of.



Bringing in and coordinating other resources, particularly other healthcare workers to assist in the management of the patient's problem.



Recognizing gaps in the primary care service and addressing these when they are significant.

Looking at each of the word pictures in turn:

**Performs up to, but does not exceed, the limits of their own competence.**

This competency involves two significant elements. Firstly, we have to be willing to accept responsibility for 'doing the job' i.e. not leaving things undone or passing the buck inappropriately. Secondly, we need a reliable system for checking our own competence.

**Question: How could you check that you are not exceeding your limit of competence?**

Firstly, this can be done by reflecting on your actions and their outcomes. Prospectively, a log diary of situations in which you were *uncertain* will allow you to look back on the outcomes and decide whether your management was appropriate. Keeping a record of *referrals* will help you to gauge the frequency of referral to different specialties and whether these indicate over- or under-referral. It will help you to gauge appropriateness in terms of whether more could have been done to investigate the problem before referral, whether the appropriate specialty was chosen and whether the advice or intervention the hospital provided could have been offered by a GP.

Secondly, to develop insight into performance, comparisons need to be made, particularly against actions of competent colleagues with whom you work. Talking through cases and looking at how others deal with similar problems can help you to do this. In parallel with this, the competence framework of the MRCGP allows you to make comparisons with the national standards described.

Thirdly, feedback from colleagues is invaluable and this can either be informal through case review or formalised through structured assessments. Powerful but less palatable feedback comes from significant events and complaints, which may indicate areas in which you may *not have done* certain things that a competent doctor should have done or in which you have gone beyond your competence by *doing certain things* that you may not have had the judgement or skills to do.

The mechanisms of checking our competence, described in the box are invaluable and may confirm that we are acting within our limits. However, acting within the *comfort zone* may not be good enough if our limits do not extend as far as needed for a competent GP. Checking on competence may flag up areas of under-performance that may need addressing, with significant events and patient safety issues being examples that may require urgent attention.

**Refers appropriately and co-ordinates care with other professionals in primary care and with other specialists.**

In this competency, we move beyond being reliant upon our own skills and make use of other health professionals within the primary health care team and from secondary care. In addition to referral, we *coordinate* the activities of those to whom we refer by:

- *Monitoring* who is doing what, keeping individuals informed of what they need to know
- *Reviewing* the patient periodically to gauge response to treatment
- Looking for *evolution* of the patient's condition
- Modifying management, safety netting and monitoring for the unexpected.

Unfortunately, good communication with the patient is not as widespread in some branches of the health service as it is in primary care. This needs to change and an important part of the GPs review of the patient is to *explain* what has happened and what has been found by other professionals and to *check* the patient's understanding and elicit their concerns.

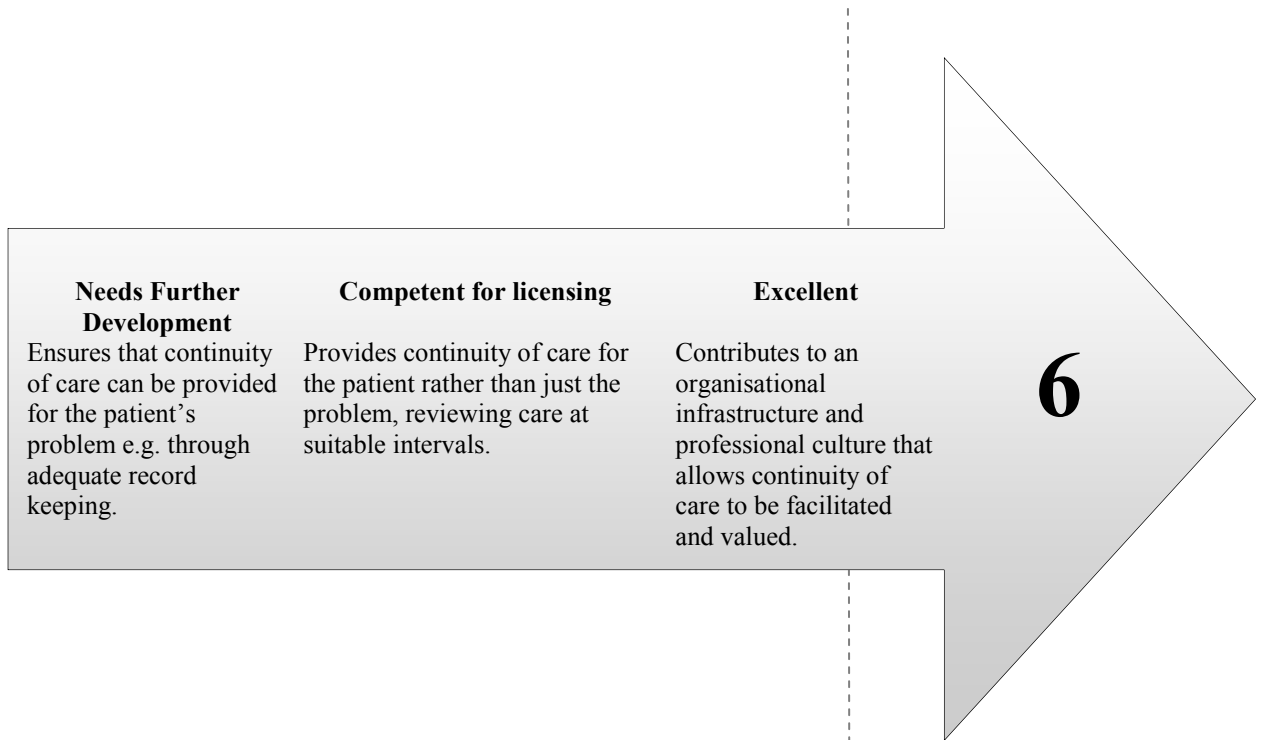
**Identifies and encourages the development of new resources where these are needed.**

This competency is in the excellent category and is not a skill that we usually have the opportunity to demonstrate. It overlaps with 'community orientation' and it is worth reading the section on page 135.

It is a continuation of the GP mindset of looking for ways in which to help manage the patient's problem. Sometimes, doctors identify a patient need, but find that either a resource to meet the need does not exist, or else that it exists but is not accessible. For example, patients with suspected heart failure cannot be adequately diagnosed on clinical grounds alone. Usually, an echocardiogram is needed and in some regions, this investigation is directly accessible by GPs, preventing significant delays that might have an adverse effect on the patient's health.

Using this example, a doctor who performs at this level might act as patient-advocate for both the individual and for his community of patients by campaigning for the provision of an open-access echocardiogram service. Nowadays, there are mechanisms for GPs to have a direct influence on service provision in the locality through commissioning processes.





**Having dealt with the ways in which we can provide help for the patient by using our own skill and by involving others, this progression illustrates the importance of providing personal continuity of care. We move from:**

Ensuring that those who follow us in managing the patient's problem are adequately informed, particularly through good record keeping.



Taking steps to personally review the patient, keeping an overview of their health, an interest in their thoughts and experience and developing an understanding of the patient as a *person*.



Modifying attitudes and the working environment so that continuity of care can be understood, valued and made the best use of.

Looking at each of the word pictures in turn:

**Ensures that continuity of care can be provided for the patient's problem e.g. through adequate record keeping.**

Continuity of care is highly valued by GPs and patients, but why is it considered worthwhile? The interest and responsibility we take in the patient's health over a significant period of time helps us to develop a relationship of trust. This allows for more open and honest communication, more concordant management plans and therefore a more effective use of medical time in optimising the patient's health.

Additionally, the relationship of trust means that there is greater tolerance and flexibility on both sides. This is important because virtually all patients develop



### Question: How might record-keeping assist continuity of care?

Notes can assist continuity of care by recording the basics (history, examination, investigation) and also the patient's thoughts, preferences and responses.

They also record our own thoughts including working diagnosis, management plan, safety netting and anticipatory thinking (thinking ahead).

*Coding* the diagnoses and significant problems is particularly important as this allows stages of a particular journey to be electronically linked, presented and understood. This also improves patient safety.

Our management plan and anticipatory thinking are at their best when they suggest to a third party what response to management we were looking for, when and by whom the patient should be followed up and what we were planning to do next time.

This ensures that the richness of information gained from dialogue with the patient is not lost, the danger being that if it is not recorded, not only can it not be used but it may not be *elicited* again.

significant conditions at some time in their lives and most such conditions have innocuous beginnings, which can be misdiagnosed as minor ailments. In a trusting relationship, doctors may be less *fearful* of (although they should be no less *alert* for) situations where the patient's problem is evolving in a way that was not expected. Where the nature of the problem or the best management plan are unclear, if we have the patient's trust we may be more willing to watch and wait or use our professional judgement. In effect, having trust means that patients are more willing to accept short-term risks that may mean that over-investigation, over-treatment or inappropriate referral are avoided.

Continuity of care also means that we can tailor plans better because we understand how the patient's mind and body are likely to respond. For the same reason of trust, the patient is more likely to concord with a plan and to be more tolerant and forgiving when things go wrong.

Lastly, continuity of care means that we are better able to understand the patient's context, which includes their family, and thereby support them better. At this basic level of competence, we have to demonstrate that we can provide continuity of care for the patient's problem throughout record-keeping and follow-up arrangements.

**Provides continuity of care for the patient rather than just the problem, reviewing care at suitable intervals.**

In this competency, we move beyond good *technical* medicine and no longer see the patient in terms of their problem, but as a *person*.

The competent GP is proactive with follow-up arrangements and rather than leave the patient to make an unguided choice (or worse, regularly advise the patient to see some other doctor), encourages the patient to return to him or her. This does not mean that we should review every problem, as this would be unnecessary and impossible. However, there are ways in which we can maintain the thread of continuity over the years with the patient. For example, we might follow through significant problems with which we are involved. We might also encourage the patient to come back to us for routine medication reviews at which time we could briefly look through significant problems in the records with which other doctors have been involved.

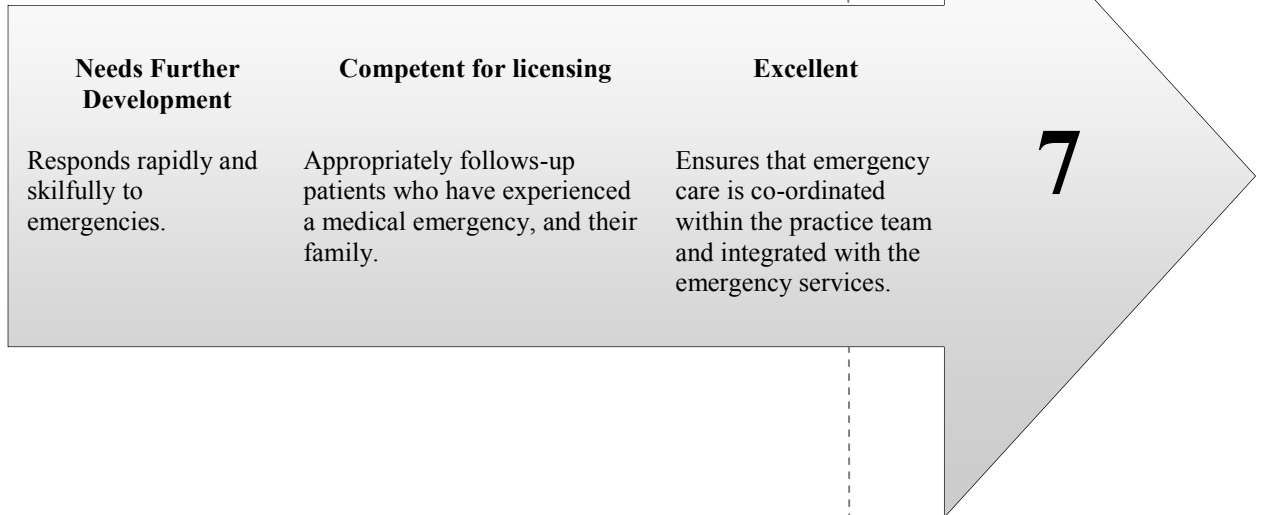
The opportunities to undertake medication reviews are becoming less as nurses take over some of these duties, particularly in chronic disease management. This might mean that we have to make greater use of opportunistic situations to update ourselves on the patient's story, for example on home visits. Of course there are some situations in which all doctors would try to provide personal continuity, most notably with palliative care.

**Contributes to an organisational infrastructure and professional culture that allows continuity of care to be facilitated and valued.**

As with many of the 'excellent' competencies, this is difficult to achieve for doctors who are only members of the practice team for a relatively short time. Nevertheless, it is possible for doctors in training to show that they value continuity of care and to make it easier for others to engage with this. For example, trainees can keep the 'usual doctor' updated when they have been involved in a patient's care, particularly about significant issues. This can be done easily through conversation or by leaving a paper or electronic note. Additionally, trainees can keep the sort of medical records that encourage continuity as described in the box on the left.

Acting in these ways are practical examples of how continuity of care can be

facilitated.



**This progression is specifically about one aspect of clinical management, namely dealing with emergencies. We move from:**

Being competent in handling emergency situations in primary care



Being able to deal with the aftermath of an emergency both with the patient and with their family



Ensuring that emergency care is a coordinated team-based activity

Looking at each of the word pictures in turn:

**Responds rapidly and skilfully to emergencies.**

The out-of-hours competency framework covers the skills required to meet this behaviour. We need to be biomedically competent with dealing with emergencies ranging from CPR to psychiatric emergencies. We also need to be adequately prepared, including having the requisite equipment and drugs, which are replenished and kept in date.

Emergency care is stressful and our reactions should be appropriate and proportionate, so that medical conditions that are less serious are not admitted as emergencies and conditions that are true emergencies are recognised.

In addition, we should be able to use the appropriate emergency services



### Tip: emergency care

With some emergencies, in particular cardio-respiratory collapse, regular training and occasional drills are needed so that in a real emergency, very little 'thinking' is required by those involved because the necessary actions have become reflex.

This is important because thinking under pressure is difficult and is easy to get wrong because of the emotions involved.

including domiciliary emergency care workers, 'Hospital at home' services, social services, psychiatric crisis teams and so on. We should also be capable of keeping others (and ourselves) calm in a crisis. This is difficult, but comes with experience.

**Appropriately follows-up patients who have experienced a medical emergency, and their family.**

Part of our holistic mindset is to consider the wider context and in particular, the impact of an emergency on the patients life, work, relationships and family members. An emergency will be a significant event in these peoples' lives and following-up the emergency has a number of functions including talking it through, hearing thoughts, identifying concerns and providing information and education. We can help the patient to understand what happened, what the implications are and what to do in the event of a future emergency. As a by-product, this also can reduce the likelihood of complaint, whether on not complaint was justified.

It may be that treatment changes have been made or further investigations are planned and part of the follow-up is to ensure that the required changes have been carried through.

Following-up the patient is also an example of maintaining continuity of care and supporting the patient and family at a difficult time. Emergencies are usually significant events for the medical professionals involved and lessons can be learned from informal reflection or formal significant event meetings. The latter can help to ascertain whether the emergency could have been avoided or anticipated (perhaps through better clinical management or patient education) and whether any practice training needs have been flagged up, such as CPR training or how to deal with a confused and aggressive patient.

**Ensures that emergency care is co-ordinated within the practice team and integrated with the emergency services.**

This competency requires doctors to think about emergency care as a team-based activity. Emergencies may be primarily physical, psychological or social. For example, the team might respond to a collapse in surgery, a patient who telephones in a suicidal state or a bruised child who might be a victim of physical abuse. Each of these problems requires coordinated activity so that drama is kept to a minimum, urgent attention is given, confidentiality and dignity are preserved and 'normal service' to other patients is maintained as far as possible.

Integration with emergency services requires the team to have knowledge of who or what is the appropriate service to contact, to learn from the outcomes of emergencies and modify the future use of emergency services where required.

We have now covered the process of decision-making and looked in detail at the various facets of clinical management. As we become proficient with these areas, it becomes possible to grapple with the hardest area of all, 'managing medical complexity' which is described in the following chapter.