Clinical decision making when the history is not your own ……

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Who is in your team?

Agree 3 things you are likely to have in common as a group of allied health professionals i.e what do paramedics or pharmacists have in common?

Previous practice ?

What is the GPST's previous experience of working with allied health professionals?

Communicate competence?

Does the GPST understand the concept of working to the top of licence and what does this mean for the people in your team?

Review roles?

Does the GPST understand how the roles within the team relate to each other and support each other?

4 Scenarios

- Para medic – routine review of a housevisit
- Practice nurse – request for patients as cases
- Pharmacist – polypharmacy review request
- Adv Physio practioner - request for medication

Self awareness when discussing cases with other professionals

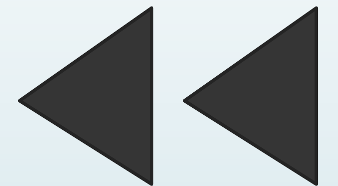
Discomfort processing

Me

You

Other

Responding



PAUSE

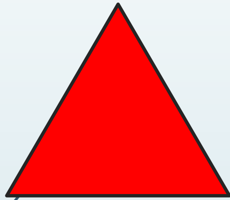
PLAY

REWIND

Avoid EJECT and FAST FORWARD

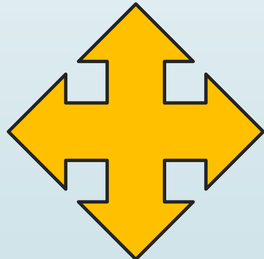
A Marshall Marinker approach

- In discussion with a colleague about a case where decision making is needed.



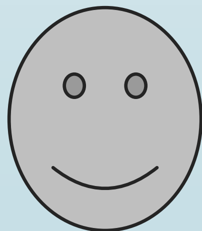
MARGINALISE DANGER

Identify the key things not to miss. Exclude immediate serious symptoms and signs that require intervention.



EXPLORE PROBABILITY

Contextualising the patients complaints checking for symptoms and signs that could point to a diagnosis and help clarify a plan



MANAGE UNCERTAINTY

Acknowledging that a range of possible outcomes may remain. Discuss how to actively manage that uncertainty usually by effective safety netting and/or follow up

The Monorail “mistake”

- **Involves going from one idea equating to another, ignoring qualifying factors**

The magnitude “mistake”

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- **Information is considered as given without the order of magnitude informing the conclusion**

The Misfit "mistake"

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- **A combination of information is considered and recognised as something it is not.**

The Miss out “mistake

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- **Considers only part of a situation and doesn’t give value or misses out key information when forming conclusion**

	Examples	Characteristics
	"PR bleeding = cancer" "Tool number = plan"	Protocol driven Knowledge gaps Lacks exp in diff diagnosis Prev neg experiences
	Pain Time frame of symptoms Value/behavioural statements	Poor quantification hx Directed by patient anxiety Forms quick opinions
	Medical complexity Childhood illness pattern recognition Acute illness	Feels overwhelmed easily Poor hx structure Type 1 instead type 2 Uncertainty skills needed
	Red flags which change management Psycho social context Examination findings	Knowledge gaps Weak on holistic approach Confidence examining

Recognising the "hinter/hoper"

(Encouraging empowerment and clarity in case discussion)

- **S** **Situation** that poses a dilemma or requires a response
- **B** **Background** information that contextualises **S**
- **A** **Assessment** any investigations examination
- **R** **Recommendation** **what do you think should happen? What do you think the solution is?**

How can we prepare GPSTs for good clinical decision making when the history is not their own?

Greater emphasis on knowing team roles and competencies early in training. Understanding how the needs of patients are met by the team and that this may vary with availability and experience.

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What does it mean to be training the Expert Generalist for the future?

Greater emphasis on listening to colleagues in the context of case discussion where the GP may not have seen the patient. Knowing when, where and how to explore information presented is likely to be an increasingly important role.

Thank you – resources reference

Books

Mapping uncertainty in Medicine – Danczak Lea and Murphy

Practical Thinking – Edward de Bono

Blink – power of thinking without thinking – Malcolm Gladwell

Link to PN roles in Primary care

https://www.nes.scot.nhs.uk/media/4235323/cnod6.pdf