

Becoming a GP

The learning and assessment
guide for the nMRCGP

Sample
pages

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For
trainees
trainers
assessors

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10 Diagnostics: Managing medical complexity

This performance area is about aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty and risk, and the approach to health rather than just illness.

In the previous three sections of ‘diagnostics’ we have learned the theory of decision-making through data-gathering & making diagnoses/making decisions. We have then gone on to apply these skills to the primary care context in ‘clinical management’.

In the final section on ‘diagnostics’, we move beyond the straightforward problems described in clinical management and look at some of the difficult areas where GP expertise comes into its own. It takes years of experience to master the competencies described here, but a basic ability to understand the concepts and apply them is required for licensing. The reason is that if they are not there in rudimentary form, there is no foundation on which to build this vital area of expertise.

Learning from the curriculum

The GP curriculum describes the elements of ‘managing medical complexity’ in the section ‘*comprehensive approach*’

Simultaneously managing multiple complaints and pathologies, both acute and chronic health problems requires:

- An understanding of the concept of co-morbidity in a patient
- The skill to manage the concurrent health problems experienced by a patient through identification, exploration, negotiation, acceptance and prioritisation
- The *skill* to seek, and the *attitude* to use, the best evidence in practice.

Promoting health and wellbeing by applying health promotion and disease prevention strategies appropriately requires:

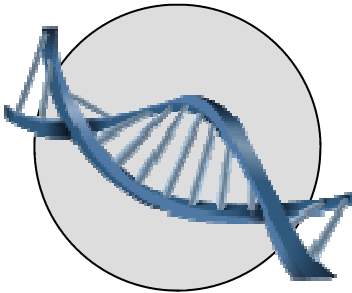
- The ability to understand the concept of health
- The ability to promote health on an individual basis as part of the consultation
- The ability to promote health through a health promotion or disease prevention programme within the primary care setting
- Understanding the role of the GP in health promotion activities in the community
- Understanding and recognising the importance of ethical tensions between the needs of the individual and the community, and acting appropriately.

Managing and coordinating health promotion, prevention, cure, care, rehabilitation and palliation requires:

- Understanding the complex nature of health problems in general practice
- Understanding the variety of possible approaches
- The ability to use different approaches in an individual patient and to modify these according to an individual's needs
- The ability to coordinate teamwork in primary care.

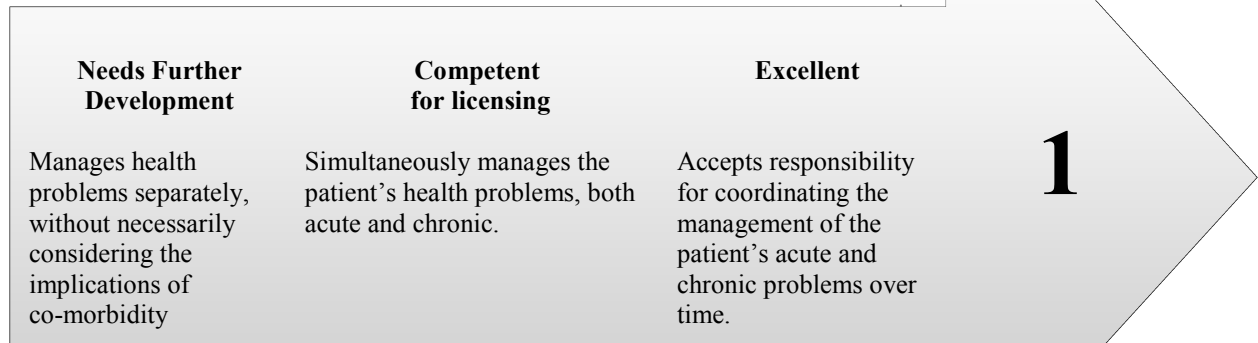
This section more than any other in the competence framework, describes the particular expertise of GPs. In many proposed health service reforms, particularly those in which GPs lose continuity of care with a registered list of their own patients, 'medical complexity' is at risk. This may result in:

- An inability to manage the list of problems with which patients often come, which can lead to lack of appropriate prioritisation based on risk. In addition, the patient's main agenda item may not be recognised. This may lead to patient dissatisfaction, higher consultation rates and increased work-related stress.
- An inability to effectively promote health, which means that patients are not sufficiently encouraged or educated in how to take some responsibility for their own health. Patients therefore become less effective partners in keeping their side of the bargain in a shared management plan.
- Lack of health promotion interventions means that there may be additional treatment costs for conditions that should have been prevented.
- If doctors do not show a sustained and positive attitude to a patient's health, there may also be slower recovery rates for those patients already under treatment.



Which Aspects of our DNA, our deeper features, are particularly important in managing medical complexity? If we look back at the competencies for the 'Diagnostics' section (see page 60), we see that clinical expertise, problem-solving skills and empathy & sensitivity are important.

There are four major themes in the managing medical complexity domain, each represented by a competence progression, which we will now discuss one by one:



The first progression is principally about learning to deal with simultaneous problems and in particular, dealing with an acute problem against the background of other conditions. We move from:

Managing problems in isolation of each other without considering the potential effects of one problem on another.



Managing new and existing problems together.



Taking responsibility for orchestrating ongoing management and ensuring that the infrastructure for managing acute and chronic problems in the longer term is adequate.

Looking at each of the word pictures in turn:

Manages health problems separately, without necessarily considering the implications of co-morbidity

Doctors who perform at this basic level tend to be able to identify the patient's problem, but not to look beyond it when they come to develop the management plan. This competency overlaps with holistic care, in which good GPs explore the impact of the patient's problem and try to understand physical, psychological and social aspects before discussing management with the patient. On top of this, in 'managing complexity', we try to gauge how the problem impacts upon other *ongoing* problems and how ongoing problems might have a bearing on the *current* problem or problems. This is what is meant by understanding the 'implications of co-morbidity'.

As we can see, whereas the holistic dimension is patient-orientated and therefore dependent upon the ability to communicate with people, co-morbidity adds a dimension that is dependent on our clinical expertise.



Tip: How to deal with patients who come with multiple problems

Patients who come with a list are a fact of life! However, we should avoid an inflexible approach such as routinely insisting upon a maximum number of problems per consultation. There may be better ways of managing the situation. Patients will often test out their GPs before disclosing their hidden agenda/major problem. It's best not to try to deal with *everything*, as this can be exhausting, will make you run late and get stressed. One method is to get the patient to briefly outline the problems at the start of the consultation at which point it may become apparent whether the problems might be linked and which of these might be more urgent (or more serious) than others. The patient's impression of what's urgent may not be the same as our own and good negotiation skills are required!

The term 'co-morbidity' sounds like a complicated concept, but it's not and is often recognised independently by patients. For example, when we prescribe for an acute condition it is quite common for patients to ask, 'Will these be okay with my other drugs?' However, patients find it difficult particularly when they are ill, to differentiate between the impact of *different* conditions on their health. Teasing these effects apart is therefore not just a technical skill, but a challenge to our communication skills in helping the patient to understand what we are asking and why.

Tip: learning to manage co-morbidity

Don't forget to think about the past medical history. It pays dividends to spend a couple of minutes before the patient comes in just to look at: the *list of significant problems* (particularly those coded as being active), the last two or three *consultations* and the *medication* the patient is taking.

An acute illness may be an exacerbation of a chronic disease. Therefore, patients with chronic disease are more likely to have acute illnesses than those patients without this background medical history.

However, acute illness is not always an exacerbation although it is easy to make that assumption. For example, epigastric pain in a patient with peptic ulcer may be a manifestation of ischaemic heart disease. Of equal concern are the situations where the chronic disease can mask the *evolution* of a serious problem. For example, the early signs of bronchogenic carcinoma may be misdiagnosed as exacerbations of COPD. Chronic disease may also influence the *presentation*. Immunocompromised patients may have more severe local & systemic symptoms than might otherwise be expected.

Co-morbidities are often co-chronic, for example diabetics may also be hypertensive. Such patients are subject to polypharmacy and part of management is to streamline the medication to keep it as simple as possible and encourage concordance. Remember that co-morbidity is more common in the elderly, the deprived and in some ethnic groups.

Simultaneously manages the patient's health problems, both acute and chronic.

At this level of performance, we are able to manage co-morbidity *and* are also able to manage more than one problem in the consultation. Even more significantly, we understand the importance of thinking beyond the acute problem by checking for the presence of chronic disease both in the records and by asking the patient. Here are some examples of the impact of an acute condition on the chronic.



Effect on a chronic condition when an acute condition occurs or is treated	Example
Chronic disease medication can't be absorbed	Diarrhoea or vomiting may prevent absorption. Drug interaction between acute and chronic drugs may interfere with absorption
Action or chronic medication interfered with	Chronic medication may become less or more active, for example theophylline levels are decreased by carbamazepine.
Side-effects of chronic treatment are precipitated	In a teenager taking erythromycin for acne, an antihistamine given for hayfever may precipitate arrhythmias.
Chronic condition temporarily becomes worse	For example, a diabetic with cellulitis of the leg might be expected to suffer a temporary deterioration in diabetic control because of the infection. This might even make the patient symptomatic from the diabetes.

Tip: managing chronic disease

Most major chronic diseases are protocolised, with many being devolved to nurse-run clinics. It is worth finding out how chronic care is organized within the practice. Here are some questions to answer:

- How are patients identified? How are they referred to the clinic?
- What happens within the clinic both with respect to the chronic disease and with other chronic complaints from which the patient suffers?
- Are these dealt with together or separately?
- How is the 'usual doctor' kept informed of the patient's progress?
- What happens if an acute problem is picked up in clinic: to whom is it referred?

Understanding the mechanism of chronic disease management will help you to determine your role in both looking after chronic diseases and in dealing with acute intercurrent problems.

Coping with multiple problems simultaneously requires us to identify the other problems going on, usually from the records, and discuss priorities with the patient. The *impact* of one problem upon another, the *risk* this creates along with the patient's *agenda* usually dictate what needs to be done first.

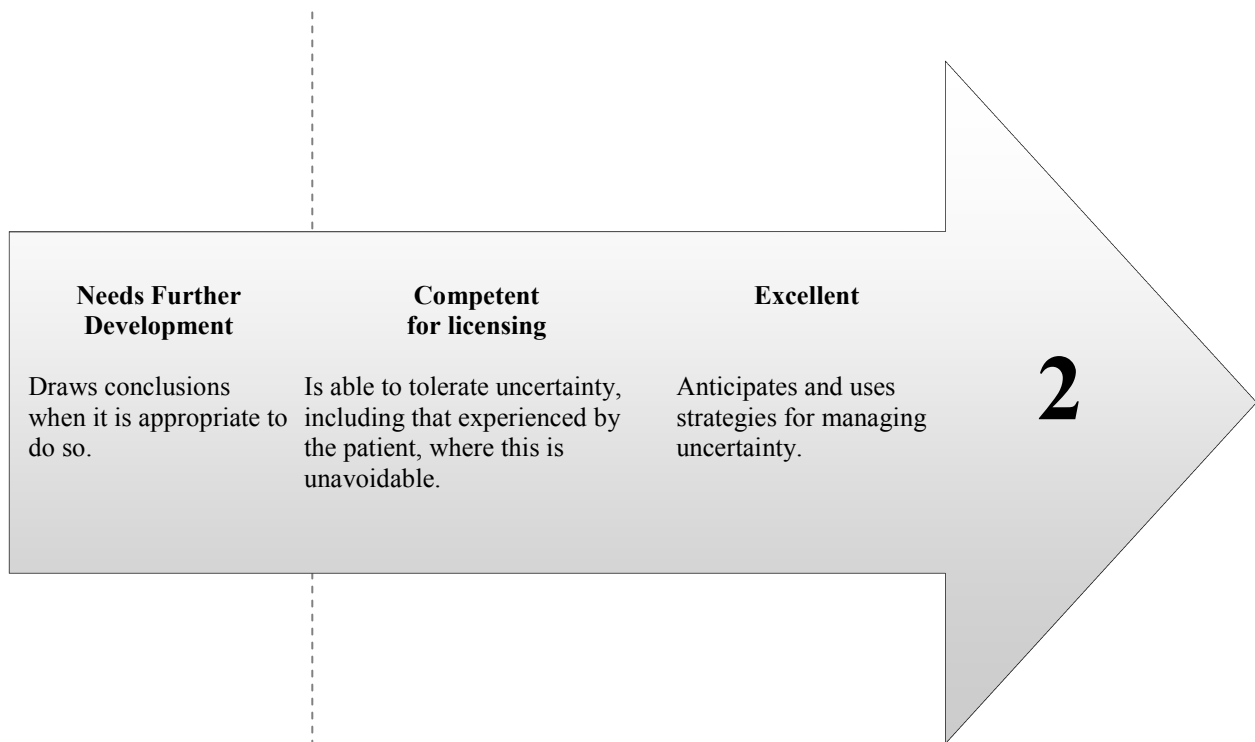
The examples given here have been to do with *physical* illness, but the same principles apply when *mental* health is involved. Most mental health problems are made temporarily worse by intercurrent physical illness and this can be anticipated and managed accordingly. For example, a patient with postnatal depression who was stable on medication before contracting flu, may need to be reviewed sooner than planned to check for deterioration in her mental state.

Accepts responsibility for co-ordinating the management of the patient's acute and chronic problems over time.

This competency falls within the 'excellent' category because 'accepting responsibility' may extend beyond the individual patient and include reviewing/improving the *systems* in the practice that support acute and chronic problem management. This might include the establishment of clinics for chronic diseases and possibly (with Nurse practitioners) for acute conditions. It might also include a review of the communication links so that:

- An adequate summary of the patient's conditions is available at all times including on visits
- An adequate shared patient record is kept and
- Key personnel such as the patient's usual doctor are routinely informed of significant developments.

This competency overlaps with providing continuity of care in that we accept longer-term responsibility, for example by making arrangements to follow through the patient's problem or manage significant problems that may be long-term. The latter requires us to demonstrate our *organisational skills* such as keeping colleagues informed and updating the practice administration systems so that the line of responsibility is clear.



The second progression concerns how we manage the uncertainty that is an inevitable part of decision-making in primary care. In this, we move from:

Not jumping to conclusions when trying to identify the major problem(s), priorities or possible actions, but exploring the likelihoods until there is sufficient information to give advice or make decisions.



Being able to accept the fact that despite striving to obtain sufficient information, we may still be left with areas of uncertainty and will have to make a judgement on the 'blanks' and act on the basis of what is *probable* rather than what is definite.



Being able to predict when definite answers or clear guidance are unlikely to be forthcoming and take steps to reduce the adverse effects that this might have on the management plan, the patient and ourselves.

Looking at each of the word pictures in turn:

Draws conclusions when it is appropriate to do so.

In primary care, problem-solving is challenging because patients present with unselected problems that have usually not had the benefit of a doctor's opinion or investigations and may still be in the process of evolving. This is very different from secondary care. It is often not possible, therefore, to exclude a serious condition at the initial consultation and this creates anxiety for both patient and doctor.

Patients and colleagues understand this, which should reduce the anxiety because the emphasis is less on being certain and more on evaluating the probability of what the diagnosis might be, trying to exclude the most dangerous possibilities and developing reasonable management plans with adequate safety nets.

Doctors who act in this way are much less likely to cause avoidable harm. Interestingly, they are also less likely to generate complaints because rather than pull a correct diagnosis like a rabbit from a hat, they talk about the probabilities with their patients as a result of which, they are perceived as being thorough and careful.

How long should we wait before drawing conclusions? In the process of problem solving, we first need to identify the problem(s) and then establish the priorities for action. To identify a problem, we need to allow time for a recognizable pattern to emerge. How long this takes depends upon our:

- Skill in collecting information from history taking, examination and investigation and on our
- Mental library of patterns against which the emerging information can be mapped.

There are obvious dangers with jumping to conclusions. For example, a patient may be wrongly diagnosed with hypertension after one or two moderately-raised blood pressure readings and this could result in the adverse consequences of labelling, treatment and surveillance. However, the converse is also true and it may be risky to wait before taking action even though the information available is scanty. An example of this is when we act on the basis of red flag symptoms or signs, whereby a single symptom such as an isolated postmenopausal vaginal bleed may be enough to trigger referral.

Is able to tolerate uncertainty, including that experienced by the patient, where this is unavoidable.

This competency is thought by educators to be particularly significant in this domain.

Building from the previous competency, in which we demonstrated our ability to judge when to wait and when to act, this competency looks at our ability to cope with the pressure that uncertainty puts upon us. Doctors may be ‘coping with uncertainty’ simply by being blasé about it. This is why the competency refers to uncertainty that is ‘unavoidable’, because blasé doctors might inappropriately tolerate uncertainty in situations where the uncertainty is *avoidable* and should be acted upon.

There are a number of ways in which to show that we are coping appropriately. In addition to the ones shown in the box, we should show that our follow-up arrangements and safety-nets are sound and are understood by those involved, in particular the patient.

Anticipates and uses strategies for managing uncertainty.

There are two facets of this competency that mark it out as being more evolved than the previous one. Firstly, whereas the ‘competent’ descriptor spoke of being able to ‘tolerate’ uncertainty, at the higher level we have to do more than tolerate or live with it. We now *anticipate* when uncertainty might occur and take action to prevent, reduce or cope with it. Additionally, we need to have a number of ways of dealing with the uncertainty.

When might uncertainty be anticipated? The context of uncertainty is the consultation and we might begin by establishing the patient’s health beliefs and in particular, their concerns. In addition to the patient’s concerns, we will have concerns of our own and these collective concerns will define the areas in which uncertainty will be particularly



Question: when trying to recognize a pattern, why can’t we always depend upon the evidence?

The *threshold* for making a diagnosis is often not clear-cut. For example, when does a painful toe with a normal serum uric acid become probable gout?

The *patients* used in research are often not representative of patients in the community. For example, many studies on depression excluded patients who were taking other drugs, had other chronic health problems or drank alcohol. How many depressives do you deal with who fall into this category? It is therefore difficult to extrapolate research findings from an unrepresentative population to our own practice communities.

The *treatments* used in research are often binary because this suits trial designs like RCTs, whereas treatment strategies in primary care are usually multifactorial. For example, children treated for otitis media may receive a combination of parental advice, antipyretic and antibiotic. However, much of the research only considers the antibiotic element.



Question: How might you respond to uncertainty?

Uncertainties should be tolerated in proportion to the evaluation of risk. Our judgment may not be sound if we are overconfident. Keep a check on whether you are overconfident by reflecting on feedback from colleagues and through your portfolio of assessments.

Assessing risk means knowing the red flags (specific symptoms & signs that indicate further action is required) for example in back pain, dyspepsia and headache.

A reflective diary recording consultations where you feel a high degree of uncertainty will help you see where your DENs (doctors educational needs) lie.

We also have to live with the *patient's* uncertainty. For example, the patient may want an x-ray for reassurance, but if it is not clinically indicated we have to resist the temptation to reduce anxiety by investigating more than the situation warrants. Clearly, communication skills are vital if the patient is also to be helped to live with the uncertainty caused by not having (unnecessary) tests.

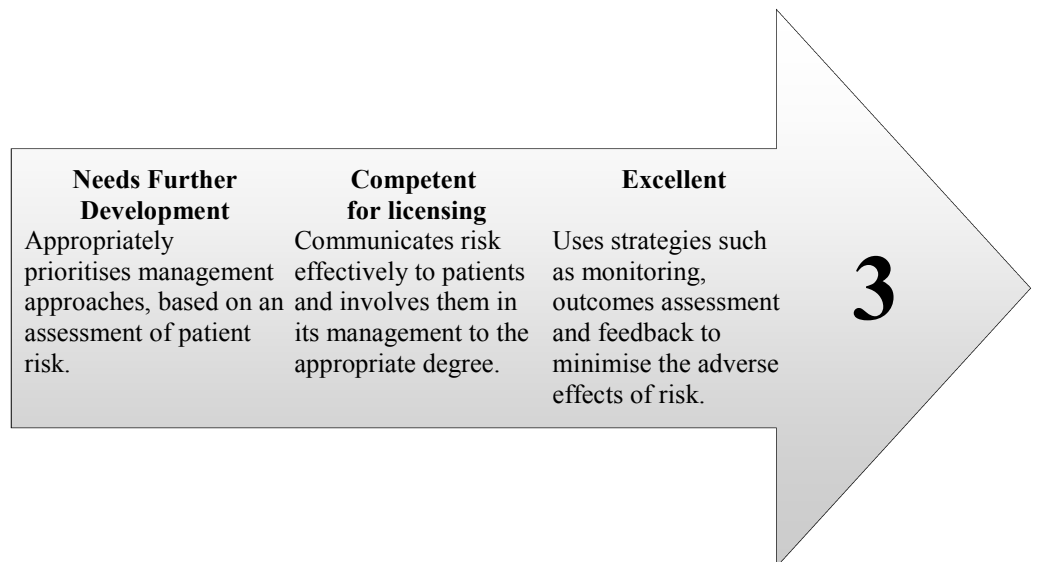
difficult to tolerate for one or other party. Having an early discussion about how likely it is that peace of mind will be achieved, which itself might depend upon the diagnostic ability of the tests, will help to prevent expectations becoming inappropriate. For example, a patient presenting with hesitancy of micturition may be worried about prostatic cancer. Discussing what can be achieved from GP tests including PSA would help the doctor and patient decide whether to go for these tests alone or whether referral is likely to be needed irrespective of the tests.

We are in a good position to influence patient expectation, because of our knowledge of probabilities. Therefore, we might anticipate and prevent problems by talking through the natural history of the condition or the way in which it might evolve. This also educates patients about *deviations* from the expected path that should be brought to our attention.

Reducing uncertainty is not done at a single point in time, but is a continuous process that involves data-gathering from tests, guidelines and *discussions* with patients and colleagues in primary and secondary care. Conversing is also a highly effective way of keeping the anxiety caused by uncertainty under control in both patients and doctors.

In the longer term, uncertainty diminishes through experience as we internalise more scripts of how problems evolve and how the significant deviations from what appears 'benign' come to light (e.g. how does dizziness start to look like an acoustic neuroma?; how does anxiety start to look like OCD?)

This might make us think strategically, so that we share these experiences with our colleagues and use the educational process to learn to appropriately manage uncertainty.



The third progression deals with patient safety, specifically with how well we gauge risk and how effectively this is shared with the patient. Note that evaluating risk is part of dealing with uncertainty. We move from:

Making an evaluation of risk and on the basis of this, deciding upon appropriate priorities



Explaining the risk in terms that the patient can understand and to a degree that they feel manageable, so that the patient can make informed choices where appropriate.



Making plans and using mechanisms to keep patient harm to a minimum.

Looking at each of the word pictures in turn:

Appropriately prioritises management approaches, based on an assessment of patient risk.

We mentioned earlier in this chapter (page 102) how doctors can decide with the patient which problems to prioritise. The next stage of dialogue is to formulate management approaches that seem reasonable from a medical point of view. Patients can't help with this aspect of risk analysis because either they do not have medical expertise, or if they do, they can't be objective about themselves. However, they can help by being open about their symptoms so that risk can be adequately gauged, rather than playing the symptoms down, e.g. to avoid admission to hospital.

The management approaches that are then discussed with the patient should, first and foremost, be the safest available given the known facts.

Assessing patient risk isn't simply a matter of establishing the medical diagnosis. Patients may also be at risk for social reasons e.g. if they are depressed and can't self-manage or be adequately supervised. Therefore, whereas an elderly patient with bronchopneumonia who was living with her daughter could be treated at home, a widower with only elderly neighbours for support might require domiciliary nursing or hospital admission.

Risk assessment also comes into play when deciding on the pros and cons of treatment. For instance, a decision on the drug management of depression (nowadays, a contentious issue) might be influenced by an objective depression score. Formal risk assessment is becoming a more prominent feature of chronic disease management as a method of gauging the overall impact of many factors on disease progression. Chronic heart and chronic kidney disease are conditions where multifactorial analysis converts risk to a percentage and a category respectively. These analyses can then guide how intensively the patient's condition needs to be managed and therefore how much of a medical priority the problem becomes.

Communicates risk effectively to patients and involves them in its management to the appropriate degree.

As we progress, the challenge is to explain the risk factors, put them in proportion with each other and importantly, prevent misunderstanding. For example we may need to



Tip :example of risk assessment from the curriculum on sexual health

- Use the sexual history (including partner history and information on sexual practices including condom use) and other relevant information to assess risk of sexually transmitted infection, unwanted pregnancy and cervical cancer.
- Use risk assessment to tailor advice and care accordingly, including advice on safer sexual practices and Hepatitis B immunisation.
- Be aware of factors which may indicate that a woman is at high risk of cervical cancer and the value of an opportunistic approach to screening in this group.

explain to patients with CKD3 that they are not suffering from kidney failure and in need of dialysis or a renal transplant! Checking what the patient has understood may seem unnecessary, particularly when they have been smiling and nodding during the explanation, but as this example shows, it is vital when risk is being explained.

Once we have explained the data on risk, we next need to discuss the *implications* such as the pros and cons of different legitimate approaches and do so in a way that allows patients to take part in the management decision to the *appropriate degree*. This last phrase is important because in some situations (for example, emergency admission for chest pain) our aim may be simply to inform the patient of what needs to be done and why, rather than get them to make a choice where, actually, no legitimate choice exists.

Good communication skills are important, because risk causes *fear*. Language is important, so for example we might talk about ‘the *chances* of’ rather than ‘the *risk* of’. Again, establishing the patient’s concerns will help us to guide the explanation appropriately so that these concerns can be addressed and wherever possible, minimized.

Often, the explanation of risk will cover what might happen (particularly, what might go wrong) in different situations including what might happen if *nothing* was done. We might also discuss the possible timescale. Sometimes, the explanation may require a diagram or picture and occasionally the use of numbers and percentages. If we remember to ask, patients can usually guide us about which approach they prefer. Studies have shown that numbers are often better understood when presented in pictorial form, such as two sad faces and 98 smiley faces, representing a 2% risk of a particular outcome. People also understand medical risk better when it is compared to something they have an intuitive feeling about, such as ‘the chances of being struck by lightning’. If needed, the discussion can be supported by patient information materials such as leaflets and websites.

Not infrequently when a genuine choice is being offered, patients will ask for our opinion as to what they should do. If we’re sure that they are not asking this because they haven’t understood our explanation, then one way forward is to say what we would choose for *ourselves*, making it clear that this is not a recommendation of what the patient should do.

Uses strategies such as monitoring, outcomes assessment and feedback to minimise the adverse effects of risk.

In practice, much of risk reduction depends upon the quality of our follow-up arrangements and safety-netting. As ever, good communication and record keeping are important so that both patient and clinicians are aware of the degree of risk, the timescale for improvement and the circumstances under which the patient should be reviewed.

When the risk is more complicated or potentially more serious, the management approach may need to be explained to the patient more detail, with supporting information and possibly with another family member or carer sitting in attendance. For example, think about how you would explain risk to an asthmatic with cardiac failure who is being initiated on a beta-blocker.

‘Outcomes assessment’ means learning from the outcome of a particular management approach by weighing up the positive and negative outcomes. In general practice, the outcomes may not be simply the physical or psychological benefits or the adverse effects. Because we are interested in the *impact* of illness, the outcomes may include the holistic elements of the effects on everyday life, work, schooling and social relationships.



Assessor’s corner: does the doctor try to learn from the outcomes of risk management?

The outcomes may be gauged *indirectly* from audit, case review and feedback from those involved in the patient’s care and *directly* from the patient and patient’s family.

If the doctor claims to have learned from the management of risk, which methods has s/he used? Which were the most helpful and why? Does the doctor try to pass these valuable lessons on to others? How?