Melbourne Medical School

Standard Case-Based Discussion

TEMPLATE

THE UNIVERSITY OF MELBOURNE

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Case Synopsis

XX, aged XX yrs. is attending/brought to his/her usual GP, Dr XX. The Patient/his/her Mother/Father/Friend is concerned….

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Topic

XXXX

Objectives of this station

Students should ascertain a history of XXX and elicit the underlying reason for this, indicate any relevant examination or investigations they would wish to undertake and formulate an appropriate management plan.

Through the SCBD format, this station should:

- Allow students to identify and manage XXX
- Allow students to determine the appropriate pace of assessment in the allocated time
- Allow examiners to understand the clinical reasoning that students are utilising

Station Writers

XXXX

Reviewed by

XXXX

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Information for students

Patient Name:

Gender:

Age:

Past Medical History:

Current Medications:

Allergies:

Immunisation History:

Smoking History:

Alcohol:

Social history:

Expectations of student performance

Level of Students/ trainees

Provide a brief description here of the level of your students/ trainees.

Particular points to look out for:

Provide further information for examiners here, e.g. advice about time management, probing versus prompting

Discussion about the medical history

Add detailed expectations of an excellent, good, satisfactory, borderline and unsatisfactory student performance here

Discussion about the physical examination

Add detailed expectations of an excellent, good, satisfactory, borderline and unsatisfactory student performance here

Discussion about investigations

Add detailed expectations of an excellent, good, satisfactory, borderline and unsatisfactory student performance here

Discussion about management

Add detailed expectations of an excellent, good, satisfactory, borderline and unsatisfactory student performance here

Additional examiner information

NOTE: Do not divulge any of this information unless the student has specifically requested it.

Further details about symptom 1

Add more information here, e.g. the cardinal features of the symptom, relevant positives and negatives. Include functional impairment.

Further information about symptom 2

Further information about symptom 3

Cardiovascular symptoms

Respiratory symptoms

Gastrointestinal symptoms

Genitourinary symptoms

Endocrine symptoms

Neurological symptoms

Other relevant systems review

Past medical history

Include details of past medical history here, including duration of different chronic conditions, and past surgeries. Include relevant positives and negatives.

Obstetric and gynaecological history (if female patient)

Include most recent screening activities e.g. cervical screening/ mammograms.

Sexual history

Family history

Outline family history in detail, including positives and negatives.

Current medications

Allergies

Exercise and diet

Social history

Include living arrangements, relationship status, smoking, alcohol and illicit drug use history, education and employment.

Physical examination findings, to be supplied on request

(Each item must be requested specifically. If the student asks for a general term like "cardiovascular examination" please ask them to be more specific, except in the case of neurological examination which as indicated below is normal.)

General appearance and vital signs

General appearance:

Gait
Oxygen saturations on room air:
Pulse rate:
Pulse is regular/ irregular (only supply if asked this specifically)
Blood pressure
Respiratory rate: /min
Temperature: degrees Celsius
Weight- kg
Height- cm
BMI
Waist circumference cm

Cardiovascular exam

peripheral signs on hands
pallor of conjunctiva or palmar creases
JVP
Carotid pulses normal volume, /min, bruits
apex beat
heart sounds
peripheral oedema
swelling or tenderness in her calves
peripheral pulses

Respiratory exam

ENT exam
cervical lymphadenopathy
stridor, no tracheal tug, no intercostal recession
chest expansion
percussion note t
breath sounds
other added sounds such as wheeze or crepitations
vocal resonance

Gastrointestinal exam

On inspection:
skin colour
peripheral signs of liver disease
distension
scars
On Palpation:
masses on palpation
hepatomegaly or splenomegaly
tenderness
evidence of hernia
flank percussion dullness or shifting dullness
Auscultation:
Rectal examination

Gynaecological exam

Speculum examination:
Bimanual examination:

Neurological examination

Mental state examination

mini-mental state examination
mood, affect, thoughts, delusions or hallucinations, suicidality

Add other relevant examinations to the case e.g. thyroid examination, skin examination, eye examination

Investigation results from GP surgery to be supplied on request

Urinalysis-
Blood glucose:
PEFR / Spirometry-
ECG:

Further investigations

List the findings of relevant investigations here, including normal reference ranges.

SCBD Marksheet

Please affix Student ID label here	Please affix your Examiner label here

Section A - Medical History					
1. After watching the interview between					
2. What other information from					
3. Taking this new information into account, what is your working diagnosis at this stage? Why?					
Please rate the student's clinical reasoning regarding the medical history					
Not Attempted	**Unsatisfactory**	**Borderline**	**Satisfactory**	**Good**	**Excellent**
Section B - Physical Examination					
1. What features would you seek on examination and how would this help to refine your diagnosis?					
2. Taking this new information into account, what is your working diagnosis at this stage? Why?					
Please rate the student's clinical reasoning regarding the physical examination					
Not Attempted	**Unsatisfactory**	**Borderline**	**Satisfactory**	**Good**	**Excellent**
Section C - Investigations					
1. Which investigations if any would you perform?					
2. Taking this new information into account, what is your working diagnosis at this stage? Why?					
Please rate the student's clinical reasoning regarding the investigations					
Not Attempted	**Unsatisfactory**	**Borderline**	**Satisfactory**	**Good**	**Excellent**
Section D - Management					
1. Please state; You determine XX has XXX					
2. Based on all the information that you have about XX at this stage, please explain what Dr XX' next steps should be and why?					
Please rate the student's clinical reasoning regarding the management					
Not Attempted	**Unsatisfactory**	**Borderline**	**Satisfactory**	**Good**	**Excellent**
Section E - Overall Standard of Performance					
Please rate the student's clinical reasoning regarding the overall performance					
Not Attempted	**Unsatisfactory**	**Borderline**	**Satisfactory**	**Good**	**Excellent**

Section Marking Guide

Please refer to the following descriptions to guide your rating of the student's performance at each phase of the case-based discussion. While these descriptions aim to describe overall performance, they should also be used to guide your judgements about the student performance at each phase of the discussion as outlined on the mark sheet.

Excellent performance

- As for Good Performance, but with greater consistency, clarity and fluency

Good performance

- Considers relevant differentials, and progressively hones in on the appropriate diagnosis as further information is provided
- Requests mostly relevant features or findings, and can provide sound reasons for doing so ie clear hypothesis-led information-seeking?
- Interprets information provided soundly and applies most or all to refining their thinking
- Explains well how each new information influences their reasoning
- Suggests an appropriate and safe initial management plan

Satisfactory performance

- Considers some relevant differentials, and show some capacity to move towards more likely diagnosis as further information is provided
- May not necessarily identify the most correct diagnosis, but much of their reasoning around the information and its interpretation is sound, and their final diagnosis is one of the acceptable differential diagnoses
- Requests several relevant features or findings, and can provide some relevant reasons for doing so
- Will occasionally request irrelevant information and/or offer unsound justifications
- Some evidence of a hypothesis-led information-seeking approach
- Is able to draw some relevant features from information provided, and shows evidence of using this to modify their reasoning in the appropriate direction
- Is able to provide a reasonable account of how the information informs their thinking
- Suggests a relevant and safe initial management plan which may be incomplete and/or incorrect in some of the details

Borderline performance

- Use this category if the student's performance varies across the descriptions for Satisfactory and Unsatisfactory, so that you are unclear which category best characterises their performance

Unsatisfactory performance

- Unclear about relevant differentials and/or pursues unlikely differentials
- Further information does little to correct or coherently influence this e.g. remains stuck on initial hypothesis despite contradictory evidence, or jumps to a new diagnosis with each piece of information
- May possibly name the appropriate diagnosis as a 'lucky guess' but can offer no reasonable account as to why this is likely, or request little or no relevant information which would support the diagnosis
- Requests for information are unsystematic or possibly random
- Cannot provide sound reasons for requesting the information; no evidence of hypothesis-led information-seeking
- Poor capacity to interprets information requested and/or apply it to clinical reasoning
- Suggests an inappropriate and/or unsafe initial management plan

Not Attempted

- Student fails to commence the relevant section.

Guide to Overall Marking

Excellent

- ✓ The final diagnosis is correct and well justified
- ✓ Clinical reasoning is coherent, focussed and sustained across the case, and substantially correct
- ✓ Student needed **minimal** probing to draw out relevant reasoning

Good

- ✓ The final diagnosis is one of the main differentials, with relevant reasons
- ✓ Clinical reasoning is generally clear and relevant across the case, with some relatively minor errors
- ✓ Student needed **some** probing to draw out relevant reasoning

Satisfactory

- ✓ The final diagnosis is a less likely differential, or one of the main differentials with limited justification
- ✓ Clinical reasoning was generally patchy, displaying some relevant reasoning but also notable gaps and/or errors
- ✓ Student needed **moderate** amount of probing to draw out relevant reasoning

Borderline

- The student's performance varies across the descriptions for Satisfactory and Unsatisfactory.

Unsatisfactory

- Manifestly unclear about relevant differentials and pursues unlikely differential diagnoses
- Further information does little to correct or coherently influence their reasoning, for example:
- Suggests a clearly unsuitable and/or unsafe initial management plan
- Likely to need **considerable** or almost **constant** probing to draw out relevant ideas or thinking

Instructions for Examiners for SCBD:

Setup

1. On the iPad, select the station and group you have been allocated to and make sure the appropriate round is also selected.
2. Attach your ID Label on the 'Tally sheet' provided.

Assessing the Student

3. Ask student for their Student ID label and attach to the 'Tally sheet' inside the clipboard.
4. Select student ID on your iPad and ask student to confirm their name.
5. Use the statements on the marking sheet to guide your discussion with the student.
6. When providing further information requested to the student, please try to give it as recorded in the examiner information sheets.
7. There will be a warning bell after **(10) TEN minutes** and a final bell at **(15) FIFTEEN minutes.**
8. Record student's interview performance in iPad as per examiner briefing. Score the student using the marking scheme provided.
9. Select your recommendation regarding the student's overall performance in the 'Performance' tab. if you have rated the student's overall performance as either **Borderline** or **Fail** then please provide some notes supporting your decision in the 'Notes' section of the 'Feedback' tab.
10. Submit the completed assessment on your iPad.
11. Record the 'final mark' calculated by the iPad along with the 'overall performance' in the spaces provided adjacent to the student's label on the 'Tally sheet' provided.
12. Do not allow the student to leave the station until the final **(15) FIFTEEN-minute** bell is rung.

BEFORE LEAVING YOUR ROOM FOR A TEA OR LUNCH BREAK, PLEASE CHECK THAT YOU COMPLETED EVERY SECTION OF EACH STUDENT'S MARK SHEET.

Scoring

Decide on the allocation of marks for your examination- for example, do you want to give more weight to one section compared to the other sections?

- History (X marks)
- Examination (X marks)
- Investigations (X marks)
- Management (X marks)

Example of scoring

Unsatisfactory (0 marks) – Borderline (1) – Satisfactory (2) – Good (3) – Excellent (4).