INTRODUCTION

General practice covers all aspects of modern medicine; health maintenance, disease prevention, diagnostics and the holistic, compassionate care of those with illness. This necessitates integrating both of the principle types of human knowledge;

Firstly, the rational, scientific knowledge that answers questions with probabilities and mechanisms that provides the necessary certainty that can inform prevention strategies, diagnostic criteria and management guidelines.

Secondly, the more relative, subjective knowledge that often suggests several explanations for phenomena. Caring and helping our patients through suffering, discrimination, inequality, loss and deprivation are critical factors in disease outcomes. To do this, we need to appreciate that knowledge about these issues is less certain, more varied but builds gradually through experience and reflection into something powerful.

General practice clinical method must therefore be capable of incorporating these different but complementary types of knowledge and adapt them for use in consultations where the following factors may be at play:

1. Multiple problems (an average of 2.5 per consultation)
2. Problems spanning disease and non-disease matters
3. If diseases are encountered they may be several different conditions in different pre-diagnostic, diagnostic or post-diagnostic phases
4. Rare and common conditions.

Generalist clinical method therefore also needs to be sufficiently adaptable to cover this diversity. Finally, general practice is focussed on efficiency, meaning that any clinical method needs to integrate both knowledges, be highly adaptable and time efficient.

The commonly used clerking method was developed in Parisian hospitals in the nineteenth century that dealt with primarily acute infectious diseases. It is therefore very useful where students meet a patient once, practice making a diagnosis where a single acute illness is present, and time-efficiency is not so important. It can therefore be useful for junior students in General Practice who are not routinely consulting.
The clerking method:
• PC - Presenting complaint
• HOPC - History of presenting complaint
• PMH - Past medical history
• DH - Drug history (current medications etc)
• SH - Social history
• FH - Family history
• Full clinical examination
• Formulation, differential diagnosis and treatment.

Other communication models are taught in medical schools such as the Calgary-Cambridge model (1), however, the method that is almost universally taught by clinicians is the clerking method (2). The substantial differences between the clerking and Calgary-Cambridge methods can lead to confusion in clinical settings - particularly general practice, as neither methods are often applicable to the wide range of presentations outlined.

In addition, diseases have changed dramatically over the past century - with chronic multiple conditions now accounting for much of clinical general practice. In addition, advances in genetics, immunology, psychology and the effects of environment have led to a more balanced view of illness - not always as acute invasions by foreign pathogens but as an interaction between pathological processes and the internal characteristics of an individual.

**Interaction between external pathological processes and internal host factors in illness:**

Most conditions presenting to general practice can therefore be understood in terms of a process - rather than an acute event. The stages of this process are summarised:
The illness cycle:

<table>
<thead>
<tr>
<th>Pre-diagnosis: ‘symptoms’</th>
<th>Post diagnosis: management</th>
</tr>
</thead>
<tbody>
<tr>
<td>immune 'stressor'</td>
<td>resolution / ongoing management</td>
</tr>
<tr>
<td>exposure to pathological agent</td>
<td>diagnosis</td>
</tr>
<tr>
<td>interaction</td>
<td>treatment</td>
</tr>
</tbody>
</table>

NEED TO KNOW

CLINICAL METHOD FOR GENERAL PRACTICE

Any clinical method in general practice needs to address a wide range of presentations in a time-efficient way and make use of appropriate technology now routinely used. Several adaptations are therefore necessary to the conventional clerking model:

1. The use of ‘problems’ instead of ‘presenting complaints’. Many patients have several issues that may not all be clinical as implied by ‘presenting complaint’. This approach is based on a model\(^1\) already used in routine general practice (3), which has been simplified for student use:
   a. Problems agreed and discussed
   b. Solutions (if applicable) discussed.

2. Patients Ideas, Concerns and Expectations (ICE) are explored (if relevant) for each problem.

3. Extensive use is made of IT - making routine collection of some information (PMH, DH, FH, SH) at every encounter unnecessary.

4. A focussed approach to clinical examination is adopted.

These modifications are incorporated into an adapted clerking method for general practice outlined below.

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\(^1\) There are many consultation models for general practice consulting but they are predominantly the sphere of post-graduate study. They are usefully summarised in the book *The New Consultation* by Pendleton, Schofield, Tate and Havelock. Oxford University Press, 2003
The focussed clerking method:
- Presenting problem(s)
- Patient ideas concerns and expectations (ICE) relating to problems
- PMH - Past medical history
- DH - Drug history (current medications etc)
- SH – Social history
- FH – Family history
- Focussed clinical examination (if necessary)
- Formulation of problem(s) / differential diagnosis / management and follow up.

The model can be adapted for use in the differing stages of the illness cycle encountered in GP as outlined below:

1) PRE-DIAGNOSTIC REASONING AND COMMUNICATION

Most consultations with GPs do not result in referral or a diagnosis. Here, clinical method is primarily aimed at understanding why a patient has come; what the patient's ideas, concerns and expectations are regarding the issue.

An approach to structuring a consultation is based on the first part of the focussed clerking method and is outlined below:

- Agreement on an appropriate problem list
- Exploration and definition of each problem using the ideas, concerns and expectations model.

Knowledge about the relative importance of symptoms (especially new ones), is important in helping to decide what may merit further consideration. There are now some very useful resources about the relative importance of symptoms - especially concerning the earlier diagnosis of cancer:

- *Symptom Sorter* by Keith Hopcroft and Vincent Forte; Radcliffe Books 2014
- https://www.bjfm.co.uk/media/7668/bjfm_march_14_p17-21_early_diagnosis_-_cancer_and_the_gp.pdf
2) DIAGNOSTIC COMMUNICATION AND REASONING

DIAGNOSTIC COMMUNICATION

Certain symptoms carry particular significance and may indicate potential disease. Here the full use of the focussed clerking model is relevant:

- Agreement on problem list
- For potentially significant symptoms or problems:
  - PC and HOPC (including ICE)
  - Relevant PMH, FH, SH gleaned from electronic record
  - Focussed exam
  - Clinical formulation and communication with patients, including management plan.

This provides a structure to feedback to GPs. Summarising statements, encapsulating in 3-4 sentences the essence of the case are very helpful to start presentations with. This helps practice the day-to-day communication patterns used by clinicians when communicating with each other.

DIAGNOSTIC REASONING

There are two main methods used in making a diagnosis:

1) THE ROLE OF PATTERN RECOGNITION IN DIAGNOSIS

After years in practice, seeing thousands of cases, patterns emerge associated with diagnoses. Pattern recognition is the preferred diagnostic method in ‘expert’ clinicians (who are often clinical teachers), who use knowledge in a different way to ‘novices’, such as students. For experts, knowledge, skills and attitudes have become rolled into one type of knowledge - tacit or intuitive knowledge (4, 5). Disentangling the knowledge pieces of this cognitive jigsaw such as relevant basic anatomy and physiology can be difficult for senior clinicians. This can be problematic for medical students wanting to learn clinical essentials!

2) THE ROLE OF LOGICAL THOUGHT PROCESSES IN FORMULATING A DIAGNOSIS

The importance of a more formal method of diagnosis - often used by clinicians in earlier stages of professional development (the novice / competent stage) involves the following stages (6).

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2 It is useful to look at three main stages of knowledge maturation in most professions; novice, competent and expert. For more on this try reading Michael Eraut; Developing Professional Knowledge and Competence or Donald Schon; The Reflective Practitioner.
1. Recognition of ‘cues’ (symptoms of particular significance)
2. Using clinical knowledge to reason and reach a working hypothesis
3. Searching for evidence to confirm or refute a working hypothesis and modification of the hypothesis as a result. Here, the use of evidence and guidelines in formulating diagnoses can be helpful and further information about this important topic can be found. See the sections on evidence and uncertainty in clinical decision-making for more about this.

### 3) POST-DIAGNOSTIC COMMUNICATION AND REASONING

Many patients present to general practice with established diagnoses and again the clerking method is not relevant here. The focussed clerking model can therefore be applied to following up patients:

- Agreement on appropriate problem list
- Exploration of each chronic problem using ICE
- Solutions offered where appropriate:
  - Whilst solutions for all patient problems may not be appropriate for junior medical students, there is much that medical student can contribute to helping patients make sense of their symptoms and in giving health promotion advice. Here the use of motivational techniques can be useful. This is further explored in chronic conditions
- Exploration of any new / significant symptoms using the focussed clerking approach.

### ACTIVE LEARNING

- Try experimenting with the two different types of clinical method outlined:
  - The clerking method
  - The focussed clerking method.

- Observe your placement provider doing consultations, which model is used more often?

- Observe how clinical communication differs with patients that your provider knows and does not know.

- How is a diagnosis made in General Practice? Where diagnoses are made, ask the diagnostician to try and explain what went through their minds when making a diagnosis.

The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact **Prof. Joe Rosenthal** or **Prof. Alex Harding**, Co-Chairs of SAPC’s Heads of GP Teaching Group.