GEEKY MEDICS

Clinical Reasoning Activities | Clerking

Step 1. Before seeing the patient, review a brief summary of the patient's presentation. Treat this like your case vignette if you were in an exam. You could get this information from a doctor on the hospital ward, from a triage nurse in ED, from receptionists taking calls in general practice, or from the patient.

Step 2. Write a list of potential underlying diagnoses. Try to rank your diagnoses from most likely to least likely. Remember to consider what is common, what is important, and what is less likely (but not impossible) to be. This list will likely be large initially, as you don't have much information.

Step 3. Write down questions that may increase or decrease the likelihood of each diagnosis depending on their answers. Use these questions to structure your approach to history taking.

Step 4. Once you have collected your information through history taking, review your list of potential diagnoses. Strike out any diagnoses you feel have been ruled out by the history. Re-order your ranking if the information you collected has altered the likelihood of your diagnoses.

Step 5. Write down examination findings that would increase or decrease the likelihood of each diagnosis. Use these points to structure your focused clinical examination. As you examine the patient, actively look for important positive and negative findings to narrow down your differentials.

Step 6. Once you have examined the patient, review your list of potential diagnoses again. Strike out any diagnoses you feel have been ruled out by the examination findings. Re-order the ranking if the information you collected has altered the likelihood of your diagnoses

Step 7. Write down investigation findings that could distinguish one diagnosis from another. Which investigations would make a diagnosis highly likely? Consider the sensitivity and specificity of each investigation.

Step 8. Write down your suggestions for managing this patient below. Try to consider the biopsychosocial model when you do this. Once you have a suggested management plan, you should discuss the case with a supervisor, teaching fellow, or appropriate healthcare professional based on the information you have written on this sheet.

Final steps: Review investigation results (with your supervisor if required). You should be left with a few remaining diagnoses. At the top is your **most likely diagnosis** based on the information from your history, examination, and review of investigations (note - there may still be diagnostic uncertainty, this is useful to discuss with your supervisor).