Reflective example that requires improvements

Scroll to page 3 for good example.
The use of a reflective model is recommended to help provide a structure and adequate analysis of a case study.

On 3rd March 2021, I reviewed a 57 year old female (Patient X) via telephone consultation, who reported lower back pain radiating into both legs, aggravated by increased walking and position changes in sleep. She described this to be a four week unresolving acute-on-chronic flare up of her L4-S1 disc prolapse, which was diagnosed in 2019 and conservatively managed with physiotherapy. Historically, her flares resolved quickly with self management in the form of pain relief, supported rest and gentle movement. She reported early morning stiffness easing within an hour and denied any red flags - except for an episode of pins-and-needles into both feet lasting 5 minutes and a 4 day history of increased urinary frequency, on average every 10 minutes, whereby her urine was offensive in odour but passed without pain or need to strain. She reported the urgency and frequency to be increasing each day but denied any incontinence. Functionally, she was managing her regular activities albeit punctuated with pain, her spinal and leg range of movement remained unchanged with the exception of reduced forward flexion more specifically in the mornings. Patient X is known to have recurrent urinary tract infections (UTIs), is menopausal and currently being treated for earache - otherwise, she reports to be systemically well.

Four differential diagnoses were considered during the consult. These included - mechanical injury (most common presentation and most likely[1]), potential progression of her disc prolapse (unlikely unless a new occurrence of trauma resulting in worsening or new herniation) and Cauda Equina Syndrome (CES; the least likely as statistics show this to be rare condition, more so in patients who have not undergone spinal surgery). As the assessment commenced, I reasoned from Patient X's ongoing aggravating factors of increased walking and initiating movement after being in a prolonged static position (turning in bed[2]) - therefore increasing load to her spine - supported by her history of frequent flare ups of similar symptoms that my first and main differential diagnosis of mechanical back pain was accurate. I began to discount the progression of her disc prolapse and any development of CES from the list of differential diagnoses as they did not fit her reported symptoms and mostly unchanged functional ability.

That said, naturally, to ensure a thorough assessment I ensured to take the patient through the list of Cauda Equina Syndrome (CES) red flags. It was during this line of questioning that she disclosed a new onset of increased urinary frequency and urgency that brought CES back onto the forefront of the list of differential diagnoses[3]. However, as she continued to describe her symptoms to include offensive urine odour, intact urinary continence and denied any other

[1] Text in brackets not usually recommended in Level 7 academic writing
[2] The use of a reflective model is recommended to help provide a structure and adequate analysis of a case study, sentence structure and make more succinct
[3] Not Level 7 writing, also remains descriptive instead of analytical

presence of CES red flags, I recalled her history of frequent UTIs which brought me to my fourth differential - was Patient X suffering from a UTI?

As I was intending to contact my colleague to discuss my conclusion and potential line of treatment, Patient X added that she felt the urinary symptoms were **worsening at a daily rate and did not feel the same as her previous UTIs, she also sounded very distressed whilst disclosing these symptoms**[4]. At this point, mental alarm bells sounded causing hesitancy on my conclusion of UTI as a diagnosis. On one hand, despite the prolonged duration of this flare up, Patient X's symptoms were stable and unchanged compared to her normal flare ups with no other red flags. On the other, she clearly and strongly expressed her urinary symptoms were **new and worsening**. I looked to discuss this with my colleague however he was in a meeting which I did not feel I could interrupt; I did not think to IM another clinician as I had not met many of them prior to this situation[5].

During that time, I recalled another patient I had previously treated following urgent CES surgery whose symptoms mirrored Patient X's - lower back pain radiating into both legs with minor urinary symptoms. I calmly reassured the patient and highlighted my concerns and reasons for advising her to attend urgent care to rule out CES. My reasoning were as follows:

- Unresolving lower back pain radiating into both her legs
- Episode of bilateral pins and needles
- New onset of increased urinary frequency and urgency, described to be worsening at a daily rate and different to all previous UTIs

In addition to that, I made sure to reiterate she could contact the surgery for a follow-up review following being cleared by urgent care if still appropriate. Patient X was understanding and accepting of my concerns and agreed to attend urgent care.

During the debrief discussion on the case with a colleague, he highlighted another potential differential diagnosis for Patient X's increased urinary urgency e.g. stress incontinence or diabetes[6]. I could have possibly further dwelved in her history prior formulating my treatment plan. Whilst it was clear she was not diabetic, best practice would have been to check her recent blood results - specifically Hb1Ac - to confirm this. Furthermore, when reviewing this patient's clinical record she had UTIs - these mimicked [7]her current presentation, despite what she disclosed during the assessment. Through contemplating the assessment, I realised despite thinking I was merely hesitant and cautious, I had slightly panicked and allowed it to fuel my concerns and ultimately my decision. Whilst it wasn't a detrimental one, it escalated when it could have been managed in primary care with minimal drama[8]. In my panic, I had also made a communication error.

After the discussion, I concluded that I would have changed the outcome of the assessment, Patient X could have been safety netted for red flags and provided with more pain relief and exercise; as she only ticked some of the urinary symptoms off the CKS UTI resource[9], those symptoms could have been monitored for progression and treated then. If really concerned

[4] Writing in bold is not appropriate a Level 7
[5] What made you feel the need to seek review / discuss with a supervisor? What were your concerns? How did you it make you feel and act when you couldn't and why? What were your concerns? How did this influence your decision making?
[6] What will you do differently next time? Why are these conditions relevant?
[7] What is the learning?
[8] Implications of this for the patient? Cost / resources implications? Implications on future presentations?
[9] Was there anything else you could have done to enhance your assessment such as asking refever heart rate?

regarding the presence of a UTI, she could have been referred to another senior clinician for review, still avoiding urgent care all together.

On reflection, there are several takeaways from this situation. Firstly[10], resist the urge to worry at any [11]potential sign of a red flag. Wise words were said, “The most complex and worrisome situations have the simplest outcomes. Worrying does nothing to help.” If in doubt, **go back to basics** and properly consider each piece of information. On top of that, **I always have a team behind to support** me in any uncertainty. Regardless if they are otherwise engaged, I should not hesitate to send them IMs with questions. It is also acceptable to place the patient on hold, or call them back in order to ensure thorough investigation and consideration, provided they are stable and safe.

From a clinical perspective, whilst the outcome could have been very different, I felt I did the best I could to manage Patient X at that point in time and ensured her concerns and worries were heard during the consultation[12]. My history taking from the patient was structured, clear and pre-planned by checking prescriptions, letters and medical overview, it could still be improved by taking in **more detail** in her previous consultations, particularly when a differential diagnosis is one that frequently occurs in the patient. Despite them meaning well, patients are not always the best historians nor do they always tell the truth - cross check all information given. A **good history** encompasses also previous test results to rule out/in other potential working diagnoses. In addition, there are **gaps in my clinical and medical knowledge** that will aid in formulating accurate differential diagnoses to ensure nothing is missed. Further reading and experience with managing more cases will help with closing these gaps.

Moving forward, I will be considering and working on these points to ensure thorough and safe patient care.

Reflective learning example

In the process of developing my clinical capabilities I have been exposed to a multitude of situations that have influenced me, my perceptions of delivery musculoskeletal (MSK) care and my general clinical practice. Reflecting on these situations has been crucial to my learning. One of the events that have been significant for my learning was the management of a patient case with back pain. In order to efficiently analyse this experience the Borton’s (1970) reflective framework has been utilised. This is because as a learner I have found it the most comfortable in exploring reflective events.

What happened?

A 57 year old female (Patient X) was booked in my remote clinic for a telephone consultation. She reported lower back pain radiating into both legs, aggravated by increased walking and position changes in sleep. She described this to be a four week unresolving acute-on-chronic flare up of her L4-S1 disc prolapse, which was diagnosed in 2019 and was conservatively managed with physiotherapy. Historically, her flares resolved quickly with self management in the form of over the counter analgesia; paracetamol and ibuprofen as required, supported rest

[10] MSc Level and FCP capability – managing uncertainty – both from patient and practitioner – could reference – make of academic value
[11] Not quite academic style
[12] How did you ensure her concerns and worries were heard?

and gentle movement, but in this occasion there was limited effect. She reported early morning stiffness easing within an hour and described an episode of pins-and-needles into both feet lasting five minutes. She also reported a four day history of increased urinary frequency, on average every ten minutes, whereby her urine was offensive in odour, changed in colour and passed without pain or need to strain. Furthermore, the urgency and frequency of urination was increasing each day but she denied any incontinence. Patient X is known to have had recurrent and multiple urinary tract infections (UTIs). She denied any saddle paresthesia or any further red flags. Functionally, she was managing her regular activities albeit punctuated with pain. On video examination her spinal and leg range of movement remained unchanged with the exception of reduced forward flexion in the mornings. Otherwise, she reported to be systemically well. Based on the clinical findings I decided to refer Patient X to urgent care.

So what?

During the consultation, based on the patient history, potential causes were considered. These initially included a mechanical injury, UTI and Cauda Equina Syndrome (CES). Due to the nature and presentation of this patient's symptoms it was difficult to differentiate between a MSK, non-MSK cause or combination of both. For me, the most important aspect of the assessment was to recognise whether Patient X's symptoms were related to CES or an urinary tract infection. At the time, I realised that both conditions have a degree of time dependence. In respect of CES, according to the United Kingdom Spine Societies Board, the patient met some of the criteria for escalation i.e. presence of new bladder dysfunction, however did not demonstrate any other risk factors towards this. Equally, I noted that the symptoms were present for over four weeks and have not been rapidly deteriorating and there were no acute neurological changes on the video examination. Due to the limitations of virtual neurological assessment however the conclusion was somewhat unclear. Virtual examination can provide valuable information in the assessment of range of movement and overall strength in cases such as shoulder pain, however it has limitations especially in examining reflexes and sensation. Virtual assessments can also be limited in establishing a clear level of communication due to a multitude of factors such as; connectivity, camera quality, and patient digital literacy. When investigating the possibility of the symptoms being related to a UTI I felt that this may be a possible explanation to the symptoms of dysuria, change in colour. What I failed to explore was whether there was nocturia. I thought that the presence of a UTI may explain the increased urinary frequency, however the patient did report that these symptoms felt different to her usual UTIs with regards to the intensity of symptoms in her back. This factor further challenged my formulation of a clinical plan. This may be also due to my concern of a possible pyelonephritis that may have explained both the back pain and urinary symptoms. Pyelonephritis also requires prompt management to avoid progression to sepsis or acute kidney injury. This was not considered to be the primary clinical diagnosis as the presence of back pain in pyelonephritis usually antecedes urinary symptoms. In Patient X's presentation it did not reflect the assessment findings. Additionally, there were no symptoms of fever or abdominal pain and Patient X was systemically well. Because of the remote nature of the examination the possibility of urinary dipstick or temperature measurement was not available to confirm the suspicion of a UTI diagnosis. Unfortunately there was no clinical capacity for a face to face examination in my clinic. This prohibited aspects to clinical examination that would have influenced the decision making for both CES and UTI and therefore the management plan.

Additional learning arose when I discussed this case with one of my colleagues at the clinical debrief session. Even though I had checked previous consultations, I did not consider checking previous haematological and urological investigations to identify risk factors towards the recurrent presence of UTIs and the associated presenting symptoms. Subsequently, it was discussed that I could have possibly instigated a course of antibiotics while closely monitoring

the patient over two to three days, albeit with clear escalation and safety netting advice as well as a further face to face examination. This may have helped to demonstrate a change in the urinary symptoms and offer the capacity of a neurological assessment. I believe that I had not considered this management, due to my increased focus on the time sensitivity of CES and perhaps due to my lack of exposure in the assessment and management of UTIs. On the other hand, I was able to acknowledge that the patient's main concern was the back pain and not the urinary symptoms and that her symptoms related to a significant progression of her previous back injury. Recognising patients' ideas, concerns and expectations (ICE) exemplifies a personalised care approach in care. I felt that though exploring Patient X's ICE and explaining the risks and alternative management plans, we mutually agreed to a shared decision of a visit to A&E that better met her expectations. Yet, I now appreciate that my advice on the possible management plans would have been better tailored if I had a better comprehension of the UTI management options. Equally, I could also have discussed my concerns with another member of the multidisciplinary team to provide a more lateral insight in the management options.

Now what?

Having analysed this experience I now know that I need to further develop my understanding of the presentation, assessment and management of UTIs and better grasp their clinical presentation. I will utilise resources such as CKS and NICE guidance, and ensure the learning is reflected as part of my personal development plan. Additionally, I have learned that I should be more aware of the value of gathering a range of information from the patient clinical record from a multitude of sources. I have significantly developed my understanding of the recognition of CES and I feel more confident in my structured history taking skills. Furthermore, I have successfully applied the ICE model and was able to recognise my patient's expectations. I was also able to recognise the limitations of remote consulting versus face to face clinical examination and appropriately managed the associated risk. This knowledge is essential to me as a practitioner for the delivery of safe and effective patient care while providing a good service experience. Because I have not fully developed my understanding of UTIs I will now need to further explore my professional development and ensure to revisit clinical guidelines. As a next step, I will arrange to discuss this case with our clinical team in our next protected learning time event.