Aspiring to be a consultant: understanding how consultants think.

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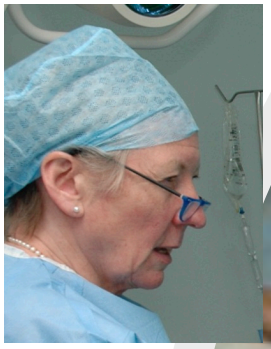
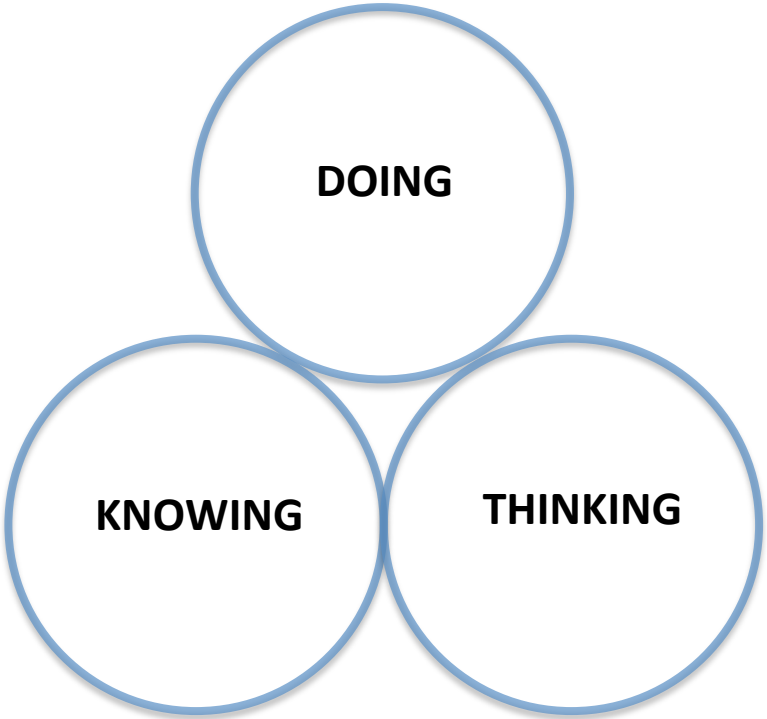
The aims of this session are:

- to deepen your understanding about how consultants think because you are responsible for bringing them to practice
- to offer a model and a language to understand, explore and develop the quality of the professional judgements and the clinical thinking that underpins being a wise practitioner
- to share with you a way of exploring it and teaching it to doctors and dentists.

My Intentions for this session

- To explore the Why? What? How?
- To offer the underpinning theory and ideas that we have published and researched
- To offer, for critique, a way of doing it.

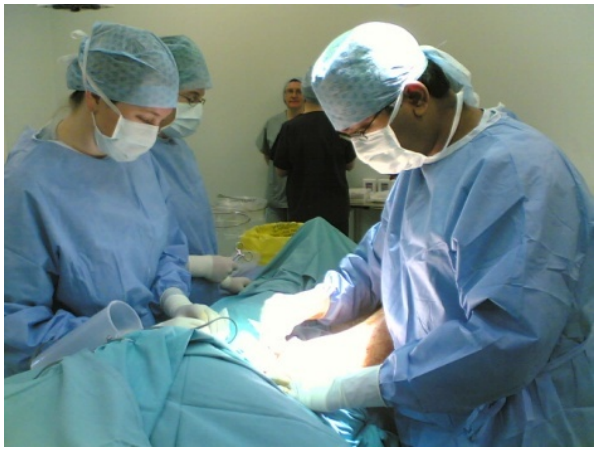



DOING
KNOWING
THINKING

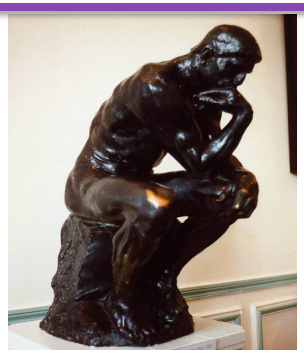
Understanding how we think

Observable Action

Triggered by a Professional Judgement



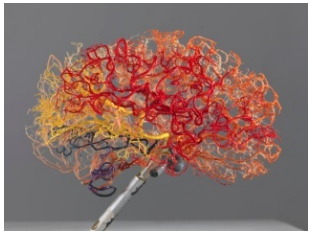
Underpinned by Clinical Thinking



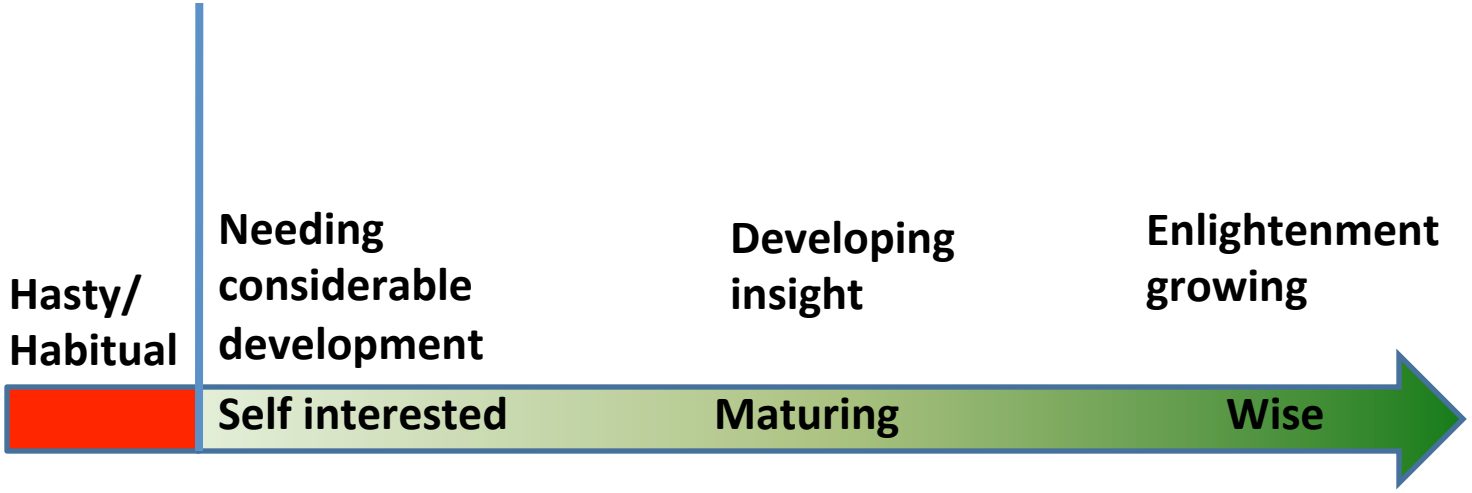
'The workings out'

Usually Implicit

Sometimes TACIT



Quality of the judgement for each particular patient



The Invisibles

(de Cossart and Fish, 2005, 2007, 2012, 2013, 2020)

influences on professional judgements

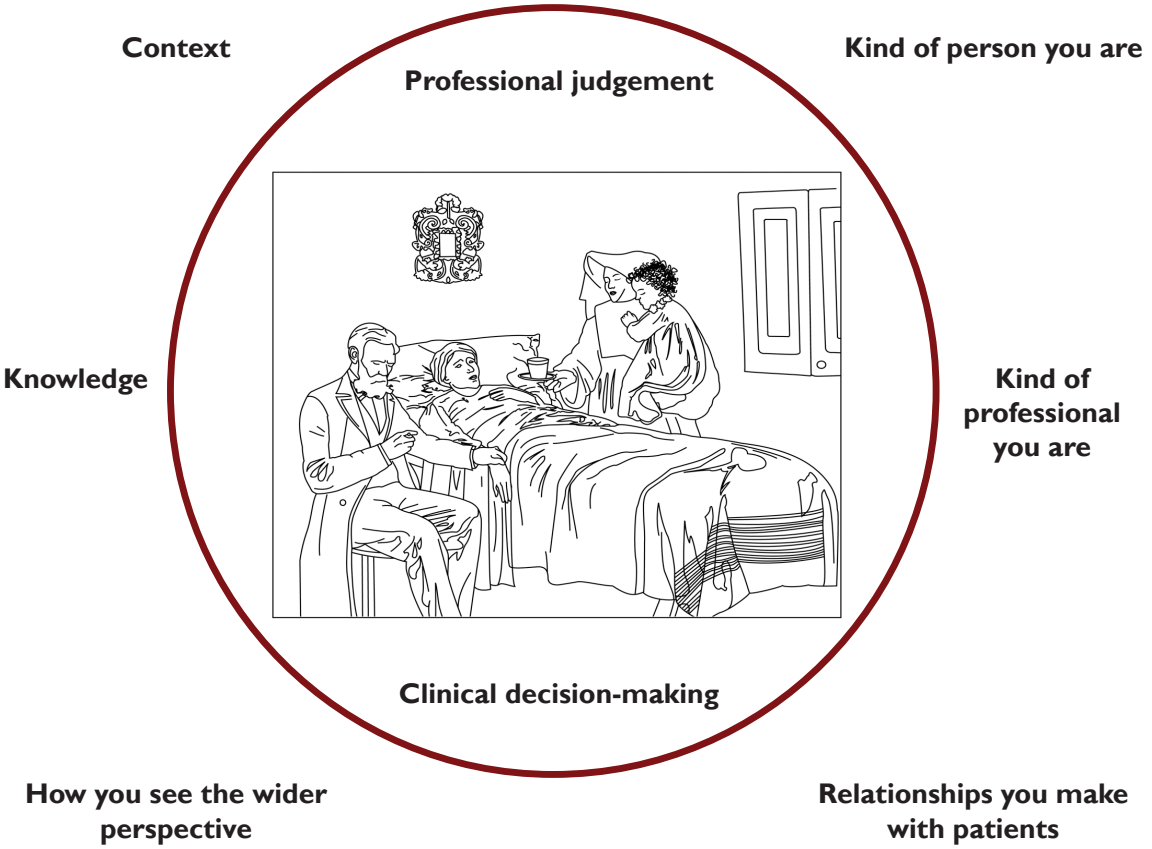
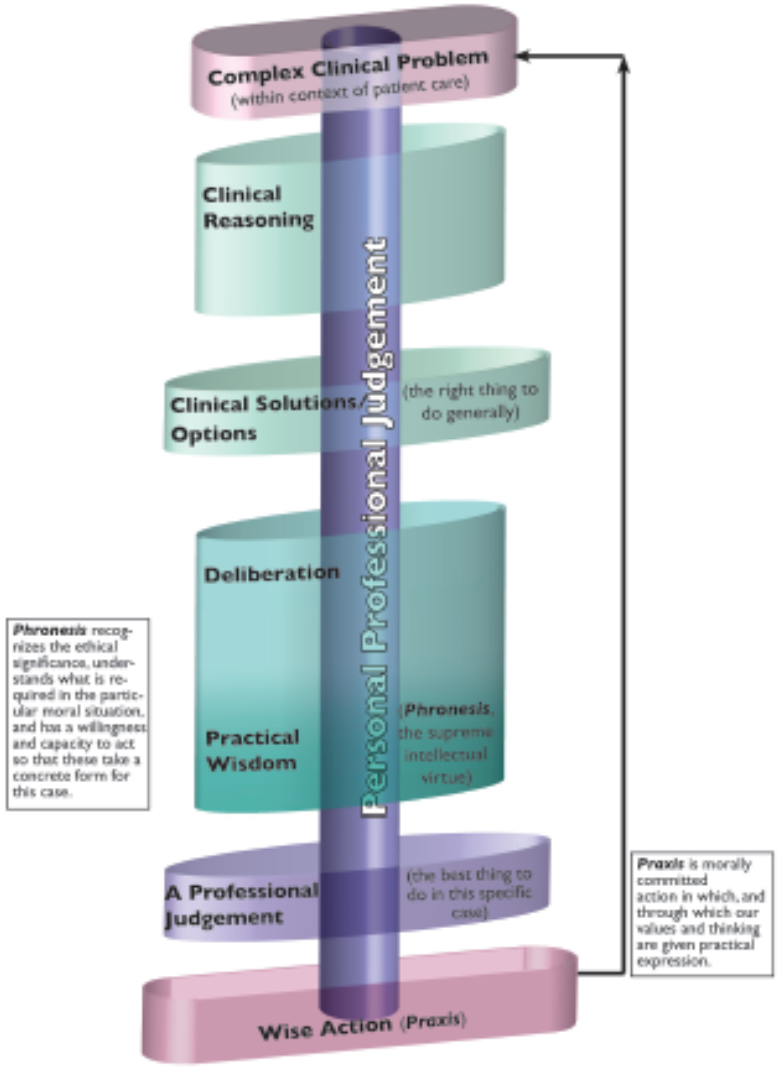


Table 1.1 An Aristotelian classification of *Forms of Reasoning* See Fish, 2012, p. 41 *(Adapted from Carr, W. 2009: 60)*

Form of reasoning	**Theoretical Reasoning**	**Technical Reasoning**	**Practical Reasoning**
Disposition	***Episteme*** The disposition to seek knowledge for its own sake	***Techné*** The disposition to act in a rule-governed way to make a pre-planned artifact	***Phronesis*** The disposition to act wisely or prudently in a specific situation
Aim (***telos***)	**To seek truth for its own sake...** Seeking to achieve eternal and pure truth	**To produce some object or artifact (like a chair or a house or some thing a craftsperson has made *to a pre-conceived design*).** This would produce craft, but not art	**To do what is ethically right and proper in a *particular*, practical situation.** The basis of art which includes craft
Form of action	***Theoria:* contemplative action**	***Poesis:* Instrumental action that requires mastery of the knowledge, methods and skills that together constitute technical expertise**	***Praxis:* morally committed action in which, and through which, our values are given practical expression**
Form of knowing	**Philosophy or abstract reasoning**	**Applied knowing or technical reasoning (Greek craftsmen and artisans applied their knowledge — the principles, procedures and operational methods — to achieve their pre-determined aims)**	**Knowledge-in-use or practical reasoning eg: clinical reasoning/ professional judgement/ going beyond protocols — in relation to a specific case**

The clinical thinking pathway



The top end of the CTP

Exploratory

Formulaic

Protocol driven

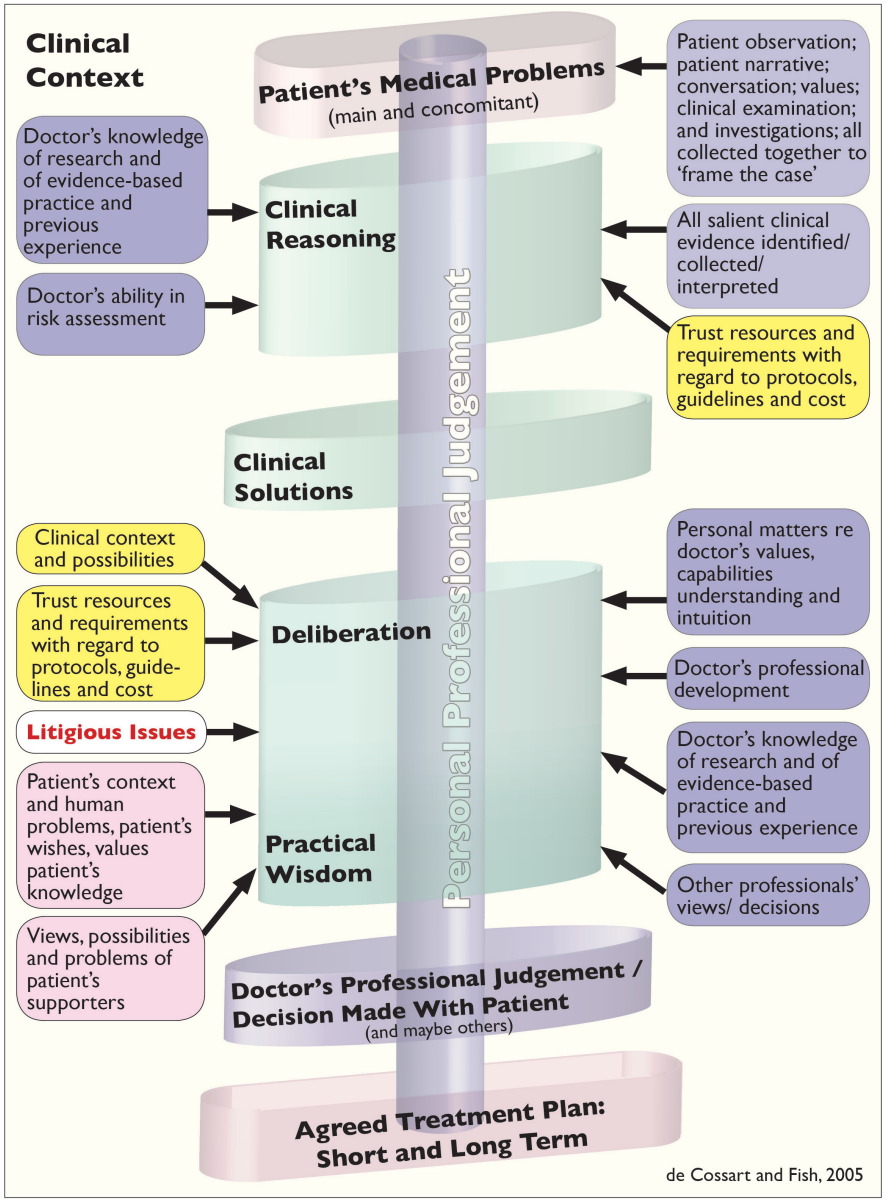
Clinical Reasoning

The bottom end of the CTP

Complex Exploratory

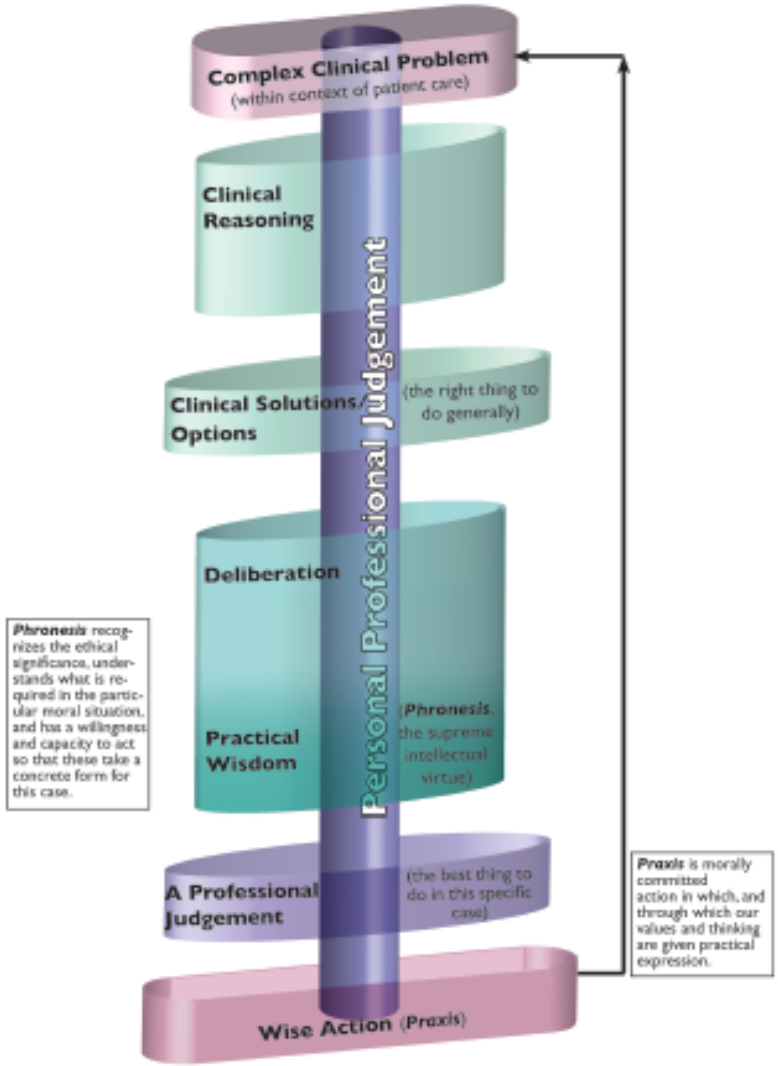
Weighing up of equally possible options

Deliberation


Clinical Context
Patient's Medical Problems
(main and concomitant)
Patient observation; patient narrative; conversation; values; clinical examination; and investigations; all collected together to 'frame the case'
Doctor's knowledge of research and of evidence-based practice and previous experience
Clinical Reasoning
All salient clinical evidence identified/ collected/ interpreted
Doctor's ability in risk assessment
Trust resources and requirements with regard to protocols, guidelines and cost
Clinical Solutions
Personal Professional Judgement
Clinical context and possibilities
Personal matters re doctor's values, capabilities understanding and intuition
Trust resources and requirements with regard to protocols, guide-lines and cost
Deliberation
Doctor's professional development
Litigious Issues
Doctor's knowledge of research and of evidence-based practice and previous experience
Patient's context and human problems, patient's wishes, values patient's knowledge
Practical Wisdom
Other professionals' views/ decisions
Views, possibilities and problems of patient's supporters
Doctor's Professional Judgement / Decision Made With Patient
(and maybe others)
Agreed Treatment Plan: Short and Long Term
de Cossart and Fish, 2005


S/R
12A

The clinical thinking pathway

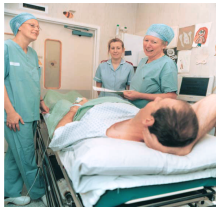


Clinical Reasoning

Deliberation

The Invisibles Process: learning to do it

Selecting the case and creating the Bullet Points



The patient case starts the process

Professional conversation to ensure appropriateness of the case and agree facts of the patient's journey

Title

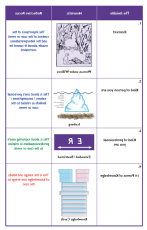
- Xccccccccccccc
- Vxxxxxxxxxxxxx
- Fccccc
- Bxxxxxxxxxx
- Mnnnnnnn
- Ghhhhhhhhhhhh
- WSsssssssssss

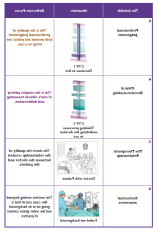
The Bullet Points

Creating the Written Narrative using Rainbow Writing and *The Invisibles*

Title

- Xccccccccccccc
- Vxxxxxxxxxxxxx
- Fccccc
- Bxxxxxxxxxx
- Mnnnnnnn
- Ghhhhhhhhhhhh
- WSsssssssssss





Bullet 1

- Xccccccccccccc
- BBBBBBBBBB
- ccccccccccc
- ddddddddd
- eeeeeeeeee
- Fffffffffffff
- Ggggggggg

Bullet 2

- Fccccccccc
- ccccccccccc
- dddddddddd
- eeeeeeeeee
- Fffffffffffff
- Ggggggggg

Bullet 3

- Vxxxxxxxxxx
- BBBBBBBBBB
- cccccccccc
- ddddddddd
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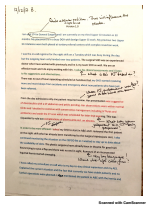
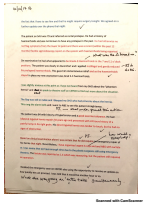
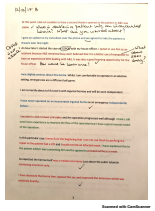
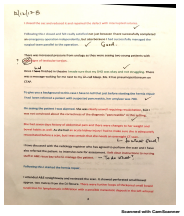
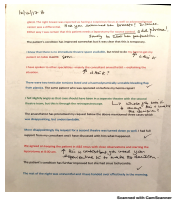
Interrogating the case for the quality of Professional Judgment and Clinical Thinking











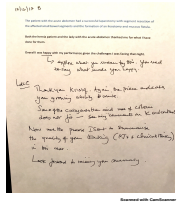
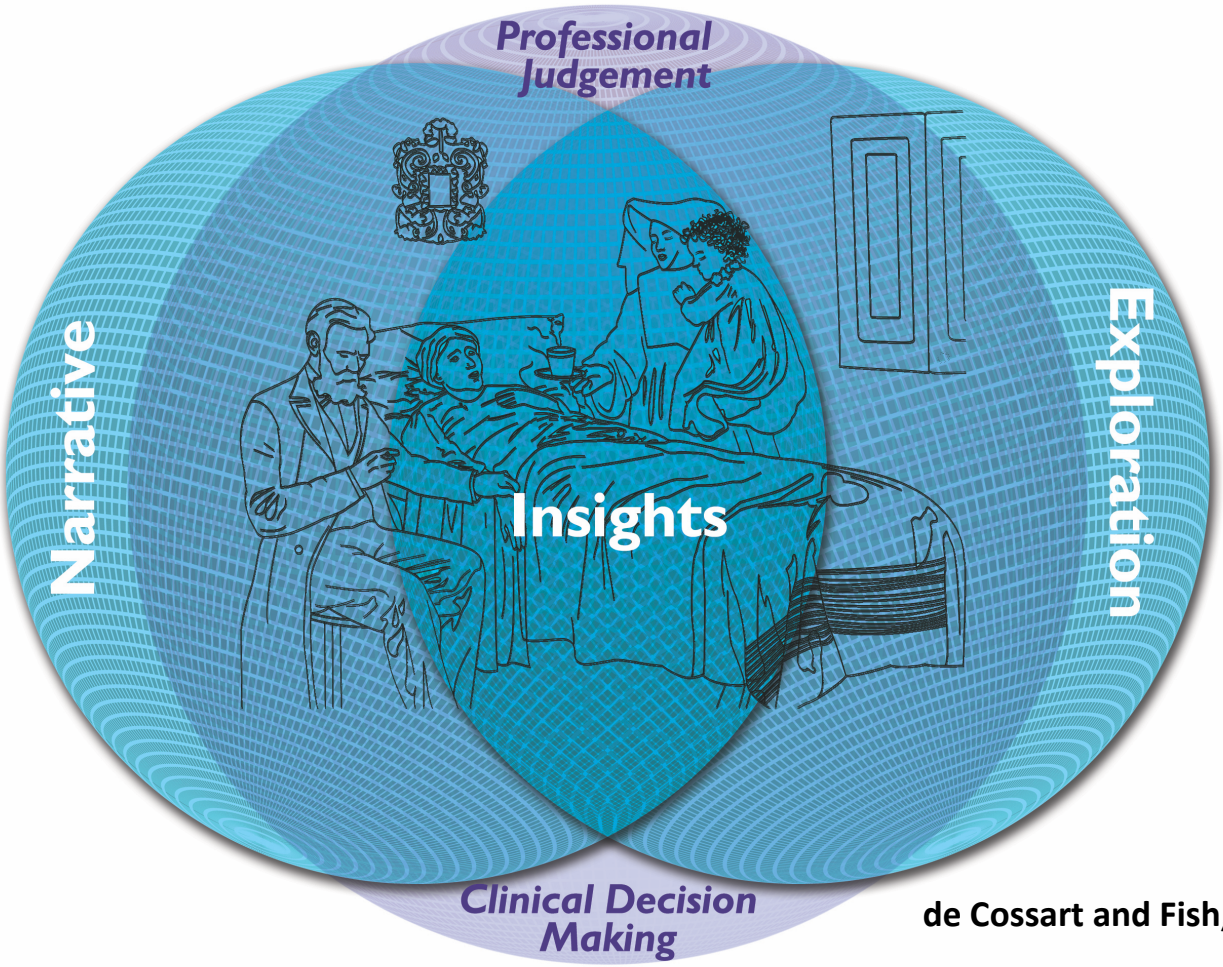


Figure 1.4.1 Transformative Reflection for Doctors: How the components inter-relate

The elements and their inter-relationships



de Cossart and Fish, 2020

Figure 1.4.2 Transformative Reflection: The Process

An overview of the detail of the *process* as offered in Part Two

Step One **Chapter 5**

Selecting the case, developing the bullet points

Outline of a recent case to stimulating thinking and writing
An essential starting point
Moving the focus from the patient to the doctor

Step Two **Chapter 6**

Creating the narrative

Using the bullet points to create the Doctor-centred narrative
Using *The Invisibles* as prompts and Rainbow Writing
Noting surprising things

Step Three **Chapter 7**

Interrogating the case

Exploring and assessing the quality of your Professional Judgements and Clinical Thinking
Noting surprising things

Step Four **Chapter 8**

Summarising the results of your efforts

Summarising your new learning
Recording your new understandings and evidence of your development

Definition: Reflective Practice

Reflective Practice is a special kind of practice, which involves systematic critical enquiry into one's professional work and one's relationship to it. Where reflection is focused on the detail of one piece of practice or event, it will explore clinical expertise; where it is focused on wider perspectives, it will serve to help us recognize, explore and develop our Professional Identity (the nature of our practice more generally and how we conduct ourselves within it).

Aneumi Time

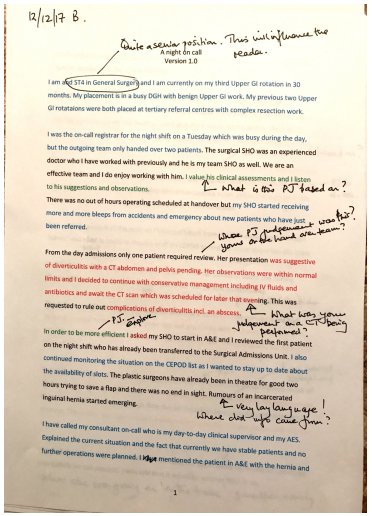
The 45 minute Educational Transformation of a CBD

through a planned worthwhile teaching session in the moral mode of educational practice

The narrative is the evidence for exploring Professional Judgement & Clinical Decision making

The experienced doctor quickly assimilates the knowledge of the writer. Learning opportunities Evolve from this activity.

The evidence accrued Provides for self assessment and supervisor assessment



12/12/17 B.

Quite a senior position. This will influence the reader.

A night on call
Version 1.0

I am an ST4 in General Surgery and I am currently on my third Upper GI rotation in 30 months. My placement is in a busy DGH with benign Upper GI work. My previous two Upper GI rotations were both placed at tertiary referral centres with complex resection work.

I was the on-call registrar for the night shift on a Tuesday which was busy during the day, but the outgoing team only handed over two patients. The surgical SHO was an experienced doctor who I have worked with previously and he is my team SHO as well. We are an effective team and I do enjoy working with him. I value his clinical assessments and I listen to his suggestions and observations.

What is this PJ based on?

There was no out of hours operating scheduled at handover but my SHO started receiving more and more bleeps from accidents and emergency about new patients who have just been referred.

Where PJ judgement was his? Your's or the band one team?

From the day admissions only one patient required review. Her presentation was suggestive of diverticulitis with a CT abdomen and pelvis pending. Her observations were within normal limits and I decided to continue with conservative management including IV fluids and antibiotics and await the CT scan which was scheduled for later that evening. This was requested to rule out complications of diverticulitis incl. an abscess.

PJ. — What was your judgement on the CT being performed?

PJ. Simple

In order to be more efficient I asked my SHO to start in A&E and I reviewed the first patient on the night shift who has already been transferred to the Surgical Admissions Unit. I also continued monitoring the situation on the CEPOD list as I wanted to stay up to date about the availability of slots. The plastic surgeons have already been in theatre for good two hours trying to save a flap and there was no end in sight. Rumours of an incarcerated inguinal hernia started emerging.

Very low bar to age! Where does help come from?

I have called my consultant on-call who is my day-to-day clinical supervisor and my AES. Explained the current situation and the fact that currently we have stable patients and no further operations were planned. I also mentioned the patient in A&E with the hernia and

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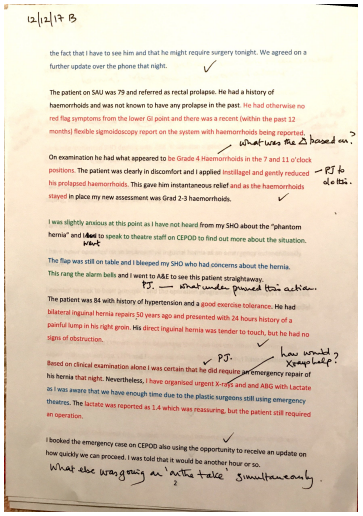


12/12/17 B

the fact that I have to see him and that he might require surgery tonight. We agreed on a further update over the phone that night.

The patient on SAU was 79 and referred as rectal prolapse. He had a history of haemorrhoids and was not known to have any prolapse in the past. He had otherwise no red flag symptoms from the lower GI point and there was a recent (within the past 12 months) flexible sigmoidoscopy report on the system with haemorrhoids being reported.

What was the D based on?

On examination he had what appeared to be Grade 4 Haemorrhoids in the 7 and 11 o'clock positions. The patient was clearly in discomfort and I applied Instillagel and gently reduced his prolapsed haemorrhoids. This gave him instantaneous relief and as the haemorrhoids stayed in place my new assessment was Grad 2-3 haemorrhoids.

PJ to do it.

I was slightly anxious at this point as I have not heard from my SHO about the "phantom hernia" and I need to speak to theatre staff on CEPOD to find out more about the situation.

What

The flap was still on table and I bleeped my SHO who had concerns about the hernia. This rang the alarm bells and I went to A&E to see this patient straightaway.

PJ. — What made you ground this action.

The patient was 84 with history of hypertension and a good exercise tolerance. He had bilateral inguinal hernia repairs 50 years ago and presented with 24 hours history of a painful lump in his right groin. His direct inguinal hernia was tender to touch, but he had no signs of obstruction.

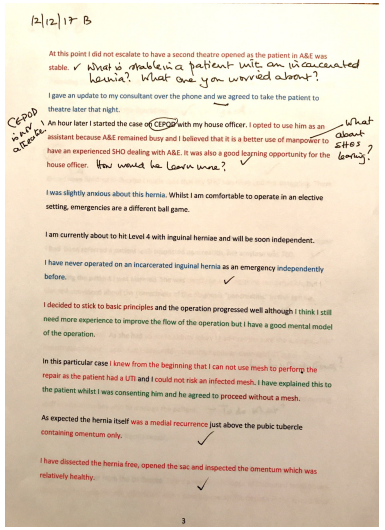
How would you triage him?

PJ.

Based on clinical examination alone I was certain that he did require an emergency repair of his hernia that night. Nevertheless, I have organised urgent X-rays and and ABG with Lactate as I was aware that we have enough time due to the plastic surgeons still using emergency theatres. The lactate was reported as 1.4 which was reassuring, but the patient still required an operation.

I booked the emergency case on CEPOD also using the opportunity to receive an update on how quickly we can proceed. I was told that it would be another hour or so.

What else was going on? Maybe take simultaneously.



12/12/17 B

At this point I did not escalate to have a second theatre opened as the patient in A&E was stable. ✓ What is stable in a patient with an incarcerated hernia? What are you worried about?

I gave an update to my consultant over the phone and we agreed to take the patient to theatre later that night.

CEPOD in my absence.

An hour later I started the case on CEPOD with my house officer. I opted to use him as an assistant because A&E remained busy and I believed that it is a better use of manpower to have an experienced SHO dealing with A&E. It was also a good learning opportunity for the house officer.

What about SHO learning?

How would he learn mine?

I was slightly anxious about this hernia. Whilst I am comfortable to operate in an elective setting, emergencies are a different ball game.

I am currently about to hit Level 4 with inguinal herniae and will be soon independent.

I have never operated on an incarcerated inguinal hernia as an emergency independently before.

I decided to stick to basic principles and the operation progressed well although I think I still need more experience to improve the flow of the operation but I have a good mental model of the operation.

In this particular case I knew from the beginning that I can not use mesh to perform the repair as the patient had a UTI and I could not risk an infected mesh. I have explained this to the patient whilst I was consenting him and he agreed to proceed without a mesh.

As expected the hernia itself was a medial recurrence just above the pubic tubercle containing omentum only.

I have dissected the hernia free, opened the sac and inspected the omentum which was relatively healthy.

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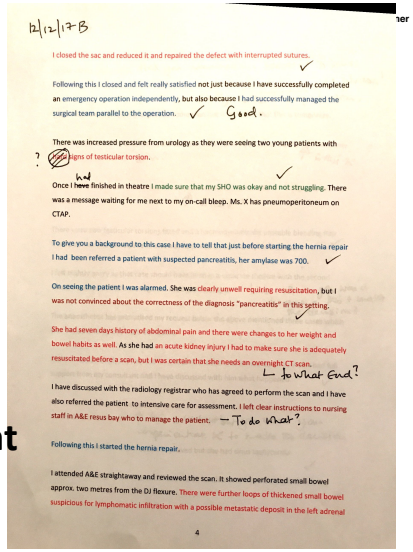

12/12/17 B

I closed the sac and reduced it and repaired the defect with interrupted sutures.

Following this I closed and felt really satisfied not just because I have successfully completed an emergency operation independently, but also because I had successfully managed the surgical team parallel to the operation. ✓ Good.

There was increased pressure from urology as they were seeing two young patients with signs of testicular torsion.

had

Once I ~~have~~ finished in theatre I made sure that my SHO was okay and not struggling. There was a message waiting for me next to my on-call bleep. Ms. X has pneumoperitoneum on CTAP.

To give you a background to this case I have to tell that just before starting the hernia repair I had been referred a patient with suspected pancreatitis, her amylase was 700.

On seeing the patient I was alarmed. She was clearly unwell requiring resuscitation, but I was not convinced about the correctness of the diagnosis "pancreatitis" in this setting.

She had seven days history of abdominal pain and there were changes to her weight and bowel habits as well. As she had an acute kidney injury I had to make sure she is adequately resuscitated before a scan, but I was certain that she needs an overnight CT scan.

to what end?

I have discussed with the radiology registrar who has agreed to perform the scan and I have also referred the patient to intensive care for assessment. I left clear instructions to nursing staff in A&E resus bay who to manage the patient. — To do what?

Following this I started the hernia repair.

I attended A&E straightaway and reviewed the scan. It showed perforated small bowel approx. two metres from the DJ flexure. There were further loops of thickened small bowel suspicious for lymphomatic infiltration with a possible metastatic deposit in the left adrenal

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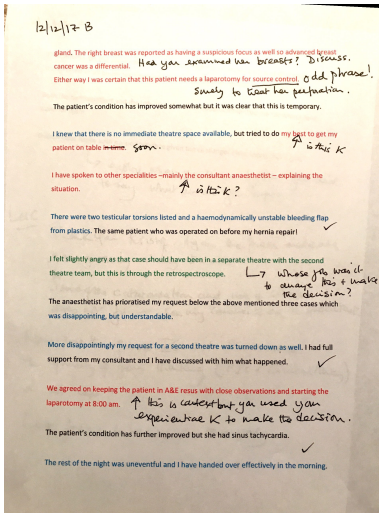
Scanned with CamScanner



12/12/17 B

gland. The right breast was reported as having a suspicious focus as well so advanced breast cancer was a differential. Has you examined her breasts? Discuss.

Either way I was certain that this patient needs a laparotomy for source control. Odd phrase! Surely to treat her perforation.

The patient's condition has improved somewhat but it was clear that this is temporary.

I knew that there is no immediate theatre space available, but tried to do my best to get my patient on table ~~asap~~ soon.

What is it?

I have spoken to other specialities –mainly the consultant anaesthetist – explaining the situation.

What is it?

There were two testicular torsions listed and a haemodynamically unstable bleeding flap from plastics. The same patient who was operated on before my hernia repair!

I felt slightly angry as that case should have been in a separate theatre with the second theatre team, but this is through the retrospectroscope.

Whose job was it to arrange this & make the decision?

The anaesthetist has priorotised my request below the above mentioned three cases which was disappointing, but understandable.

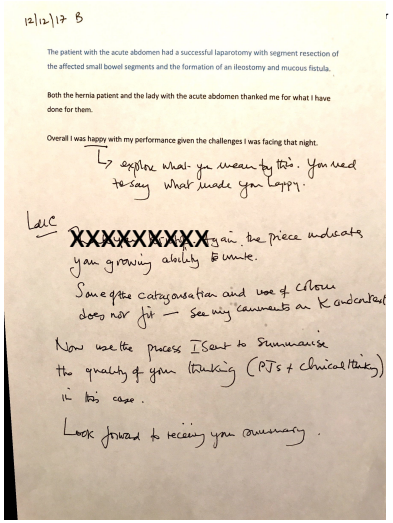
More disappointingly my request for a second theatre was turned down as well. I had full support from my consultant and I have discussed with him what happened.

We agreed on keeping the patient in A&E resus with close observations and starting the laparotomy at 8:00 am.

It is understandable you used your experience to make the decision.

The patient's condition has further improved but she had sinus tachycardia.

The rest of the night was uneventful and I have handed over effectively in the morning.



12/12/17 B

The patient with the acute abdomen had a successful laparotomy with segment resection of the affected small bowel segments and the formation of an ileostomy and mucous fistula.

Both the hernia patient and the lady with the acute abdomen thanked me for what I have done for them.

Overall I was happy with my performance given the challenges I was facing that night.

explore what you mean by this. You need to say what made you happy.

LdlC

XXXXXXXXX again the piece indicates your growing ability to unite.

Some gaps categorisation and use of colour does not jar — See my comments on K understanding

Now use the process ISBAR to summarise the quality of your thinking (PJs + clinical thinking) in this case.

Look forward to receiving your summary.

Scanned with CamScanner

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