



Case based Discussion (CbD) Assessment Form

Please complete the question using a cross (x). Please use black ink and CAPITAL LETTERS

Trainee's surname			
Trainee's forename(s)			
GMC number		GMC NUMBER MUST BE COMPLETED	

Code number			
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Observed by			
GMC number		GMC NUMBER MUST BE COMPLETED	
Date			
Signature of supervising doctor			

Clinical setting:

Theatre ICU A&E Delivery Suite Pain Clinic Other

Case category:

Elective Scheduled Urgent Emergency ASA Class: 1 2 3 4 5

Assessment:

λ	Practice was satisfactory	
λ	Practice was unsatisfactory	

If the performance was judged to be unsatisfactory, you must tick the boxes on the reverse of this form to indicate which areas of performance you judged to be unsatisfactory.

Example of good practice were:

Areas of practice requiring improvement were:

Further learning and experience should focus on:

Special focus of discussion:

	Please grade the following areas: (Please see domain descriptors)	Below your expectation for their grade and experience	Appropriate for grade and experience	Above your expectation for their grade and experience	Not observed or not applicable
1.	Record keeping:				
2.	Assessment and review of Investigations:				
3.	Identification of potential problems and difficulties:				
4.	Understanding of clinical alternatives:				
5.	Justification of clinical decisions shows understanding of risks and benefits				
6.	Understanding of the issues surrounding the clinical focus chosen by the assessor				
7.	Planning for future care:				
8.	Quality of written instructions for future care:				
9.	Overall clinical care:				

Case-based Discussion (CbD) – Anaesthesia

Case-based discussion is designed to evaluate trainee clinical practice, decision-making and the interpretation and application of evidence, by reviewing their record of anaesthetic practice. Its primary purpose is to enable a conversation between trainee and assessor about the presentation and anaesthetic management of a patient. It is not intended as a test of knowledge, nor as an oral or clinical examination. It is intended to assess the clinical decision-making process and the way in which the trainee used medical knowledge when managing a single case.

The trainee should bring to their assessment a copy of the anaesthetic record of three patients they have dealt with independently. The assessor will select one case. The trainee should be asked how they proceeded with each stage of the anaesthetic. In particular questions should be directed towards asking them to explain and justify the decisions they made. It is important to ask questions that bear directly upon the thought processes of the trainee during the anaesthetic case being discussed and not to digress into a long exploration of their knowledge of theory.

The assessor should also identify one particular issue that should have influenced the anaesthetist's decision making in this case. They should explore the trainees thinking in relation to the impact of this issue. This exercise is to explore in greater depth the way that the trainee reacts to events. If this specific focus is relevant to the case then the trainee should have taken its impact into account in their planning and decision-making. If they believed their knowledge of the issue to be inadequate they should have sought advice before proceeding. Therefore the trainee does not need to have prior notice of the focus the assessor will discuss. If their knowledge and understanding of the clinical problem is inadequate this will be reflected by the marking.

Such discussions will also incorporate an assessment of the adequacy of a trainee's record keeping, although this is not the primary purpose of CbD.

In practical terms, the trainee will arrange a CbD with an assessor (Consultant or Senior trainee) and bring along a selection of three anaesthetic records from cases in which he/she has recently been solely involved. The assessor selects one and then engages the trainee in a discussion around the pre-operative assessment of the patient, the choices and reasons for selection of techniques and the management decisions with respect to pre-, intra- and post-operative management. The assessor then scores the trainee in each of the seven domains described below, using the standard form. It may be appropriate only to score three or four domains at a single event, and it should be emphasised that the purpose of the tool is to understand the decision making processes and thinking of the trainee. CbD is the trainee's chance to have somebody pay close attention to an aspect of their clinical thinking and to provide feedback. Feedback and discussion is mandatory.

Domain Descriptor

1. Record keeping:	The records should be legible, signed, dated and timed. All necessary records should be completed in full.
2. Assessment and review of Investigations:	The trainee should have conducted a proper pre-operative evaluation of the patient and should be aware of all important aspects of their pre-operative state. They should have ordered additional investigation and prescribed pre-operative treatments where this was indicated.
3. Identification of potential problems and difficulties:	Did the trainee identify potential problems?
4. Understanding of clinical alternatives:	Can the trainee explain the clinical alternatives they considered?
5. Justification of clinical decisions shows understanding of risks and benefits	Did the trainee show understanding of the different risks of their possible courses of action?
6. Understanding of the issues surrounding the clinical focus chosen by the assessor	The trainee should show knowledge of the issues that is appropriate to their decision to proceed with the case. Their decision making should reflect an understanding of the issues appropriate to their experience
7. Planning for future care:	Planning should show an understanding of possible complications, their likelihood and their severity.
8. Quality of written instructions for future care:	All instructions to other staff should be timely, legible and understandable. Important issues relating to risks, possible complications and the need for special attention should be clearly indicated.
9. Overall clinical care:	The case records and the trainees discussion should demonstrate that this episode of clinical care was conducted in accordance with good practice and to a good overall standard.