RACGP

Template for Case Studies

The key headings in this template are provided to guide you in writing a case study. Extensive answers are not be needed for every point – simple dot points of relevant information are adequate.

For guidance about how to use case studies in exam preparation, see the document 'Advice about how to use the in-practice activities in preparing for the exam' which you will find in the Additional references tab for this unit.

History

- What was the patient's presenting complaint?
- What were the key features of the history?
- Were there any risk factors to consider in this case?
- What was the patient's family, social and cultural background?
- What was the patient's and/or parent's or carer's agenda? (i.e. what do you think were their main concerns and wants?)

What were your initial hypotheses and why?

- What were your differential diagnoses? What features support or do not support each diagnosis?
- Of these, what was the most likely diagnosis? Why?
- What were the important diagnoses (i.e. conditions not to be missed)? Why?

Examination

What were the key features you looked for on examination and why? Include relevant positives and negatives

As a result of history and examination, what was your resultant principal diagnosis?

- What red flags were important in this consultation?
- What is the impact of this diagnosis on the patient?

Develop a problem list for this patient

- Include the presenting complaint and any other issues that were important to consider for this patient (for example, there may be issues related to medication, social issues or preventative activities to consider).

Management

- What investigations did you organise and why?
- What was the management plan? – include details about counselling and education provided, safety netting, follow-up and referral (if applicable).

- Describe the basis for the management decisions:
    - How did the patient's social and cultural background influence your management plan?
    - Did you use any clinical guidelines? Or any other sources of assistance/ guidance?
    - How does your management compare with the best practice guidelines for management of these symptoms and condition?
- Is the patient and/or parent or carer likely to comply with the management plan? If not, why not and what could you do to improve?
- Are there any preventative activities to consider for this patient?

Reviews

Have you reviewed the patient since the initial consultation?

- If yes, what were the outcomes?
- If no, what was the reason?

Final reflection:

- Were there any challenges you experienced in provision of care to this patient? Include a consideration (where relevant) of:
    - Ethical issues
    - Communication issues - How did you ensure you communicated effectively with the patient and how did you know if communication was effective?
    - Ensuring that shared decision making occurred
    - Any medico-legal issues such as informed consent, confidentiality, mandatory reporting etc
- *If you work in a rural or isolated area:* How did working in a rural or isolated area impact this case and your management?
- *If you do not work in a rural or isolated area:* How would working in a rural or isolated area impact this case and the management?
- How might this case influence your practice in the future?