CLINITALK

Worked example

This document provides a worked example to demonstrate the feedback that Clinitalk creates from a recorded case. You are provided with the role played case and the feedback generated.

Consent information

Consent for sharing of the case recording has been obtained from the role player and resident doctor.

A suggestion for how you might wish to use this worked example

Step 1: Listen to or watch the case considering the feedback that you might wish to provide to the doctor.

Case video link

Case audio link

Step 2: View the feedback created by Clinitalk and compare it to your thoughts.

Links to feedback Clinitalk generated for this case

- Top tips and consultation structure
- Logical data gathering and diagnosis
- Red flags
- Lifestyle and self-care
- Safety netting and follow up
- Treatment options
- Shared and tailored plan
- Cues curiosity and impact
- Ideas, concerns, and expectations
- Clear communication

Guideline adherence

Patient lens -the patient perspective

Data gathering tips

The Clinitalk app feedback is shown after the recording ends and takes 1-2 minutes to return.

An hour of free recording is provided by Clinitalk on registration so that doctors can experience Clinitalk feedback first-hand with their own cases.

Clinitalk charges are necessary to cover the expenses of maintaining and operating the service, with assurance costs alone exceeding £10,000 each year. We strive to support GP training while keeping these costs as low as possible.

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Top tips and consultation structure

Top tips | Data gathering | Clinical management | Interpersonal skills | CKS

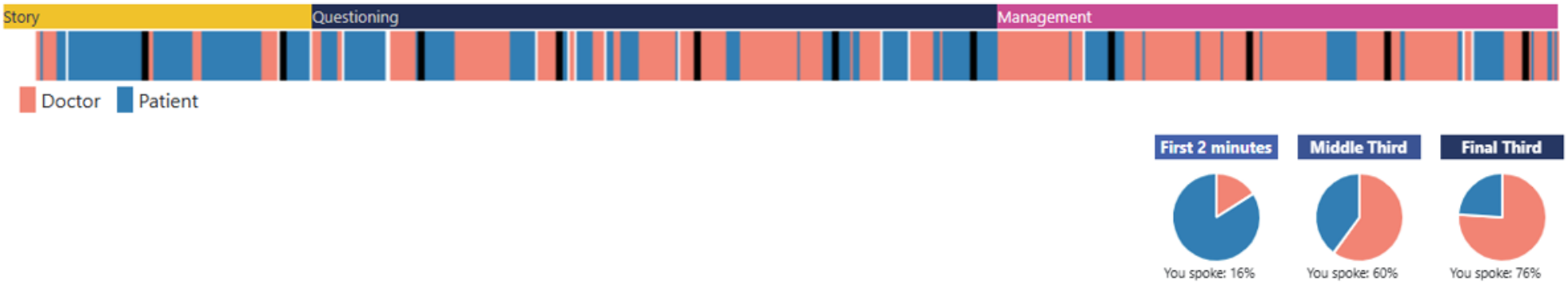
✅ **Red flags**: Comprehensive screening for systemic features, neurological deficit and cauda equina symptoms was consistent with NICE-style safety assessment for acute low back pain, alongside clear warning-sign advice.

⚠️ **Structure matters**: Physiotherapy and imaging advice was discussed before completing red-flag/neurological screening, then the consultation returned to those questions, which blurred the gather-plan sequence.

⚠️ **Follow the cue**: The patient repeatedly voiced worry about a "slip disc" and financial/work pressure; responses focused on physio access and imaging rationale without explicitly acknowledging the worry or exploring its impact.

Notes | Feedback | Reflection | Guidelines | Recording | Ask AI

Structure



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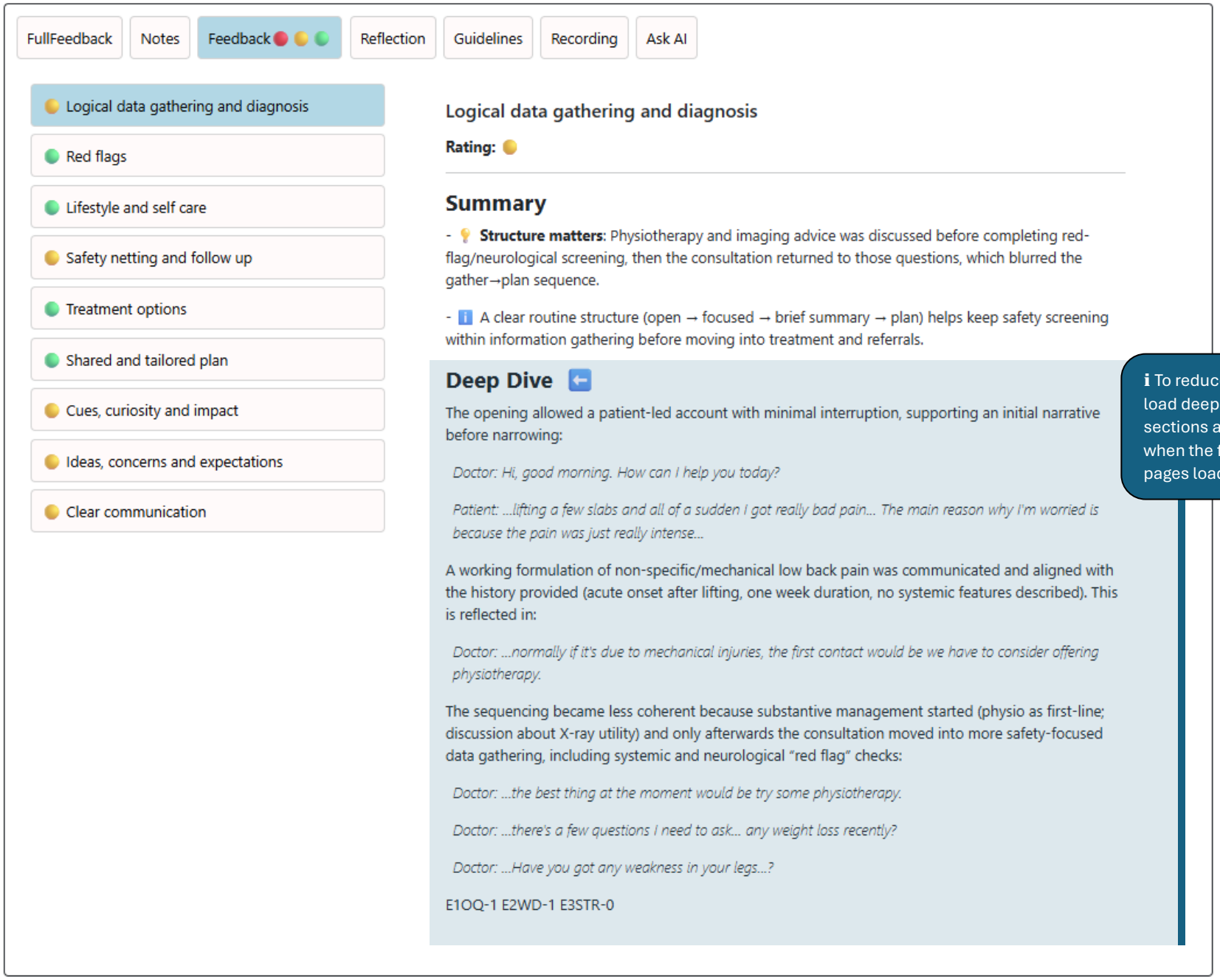
Logical data gathering and diagnosis



i To reduce cognitive load deep dive sections are collapsed when the feedback pages load.

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Red flags

FullFeedback | Notes | Feedback | Reflection | Guidelines | Recording | Ask AI

- Logical data gathering and diagnosis
- Red flags
- Lifestyle and self care
- Safety netting and follow up
- Treatment options
- Shared and tailored plan
- Cues, curiosity and impact
- Ideas, concerns and expectations
- Clear communication

Red flags

Rating:

Summary

The doctor appropriately **establishes the presence or absence of red flags** for acute worsening low back pain, including systemic features, neurological deficit and cauda equina symptoms, with additional safety-netting for deterioration.

Deep Dive

The doctor screened for **systemic serious pathology** (e.g. malignancy/infection) by asking about night pain and systemic symptoms: "**Doesn't really wake me up at night?**", "**Any temperature with it**", "**Any weight loss recently?**", and "**Any night sweat?**", with the patient denying these.

They assessed **neurological compromise** by checking lower-limb weakness: "**Have you got any weakness in your legs... moving your ankles and stuff?**" (patient: "**No, no weakness**"), and later safety-netted for new/worsening radicular or neurological symptoms: "**if it travels down to the legs big time... you lose any movement of your legs**".

They covered **cauda equina red flags** by asking about bladder/bowel disturbance: "**Any trouble with your... bowels?**" (patient: "**absolutely fine**") and reinforced urgent warning signs including "**losing any control of your bladder and bowels**" and "**losing any sensation down below**", demonstrating the consultation **establishes the presence or absence of red flags** relevant to this presentation.

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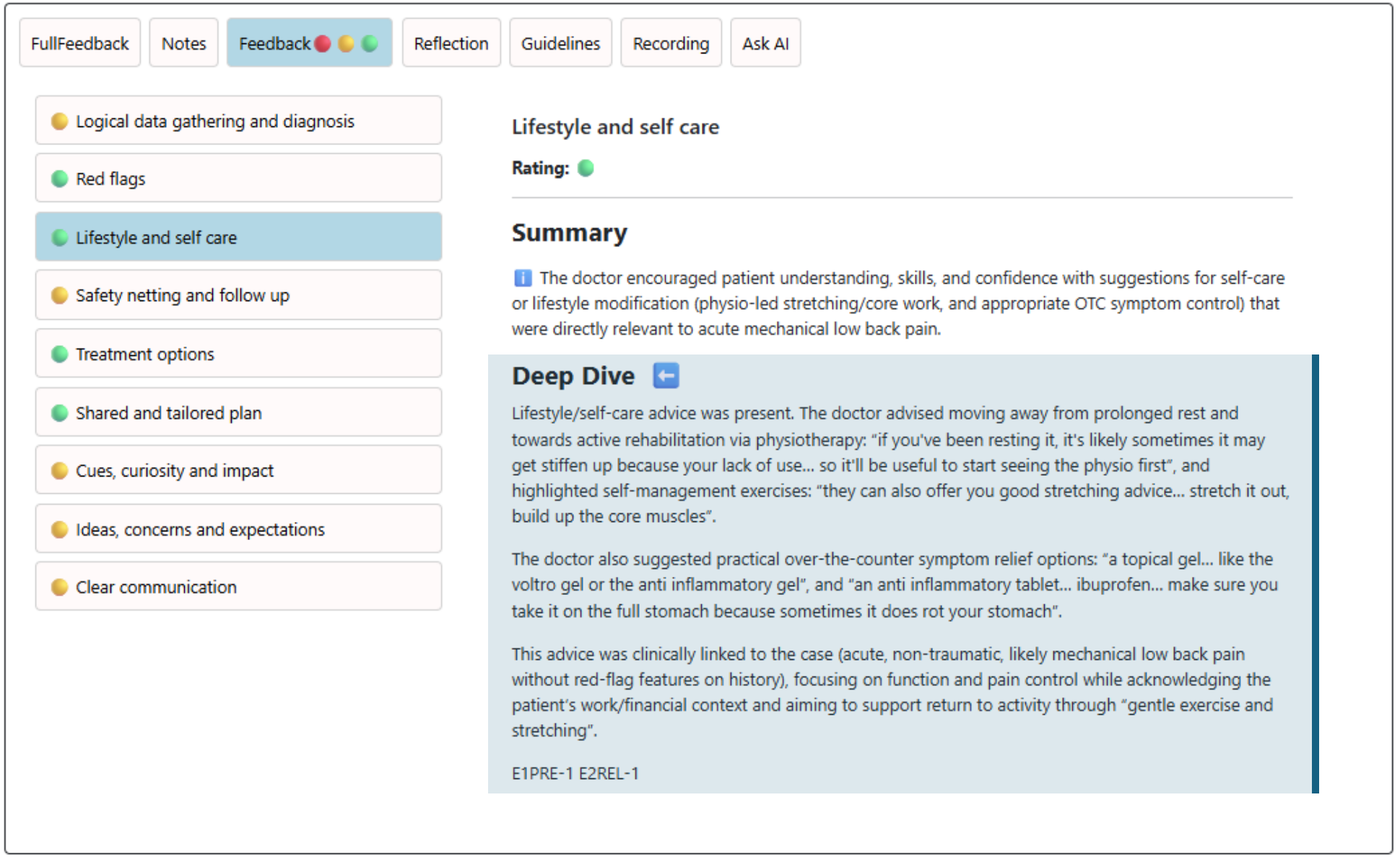
Lifestyle and self-care



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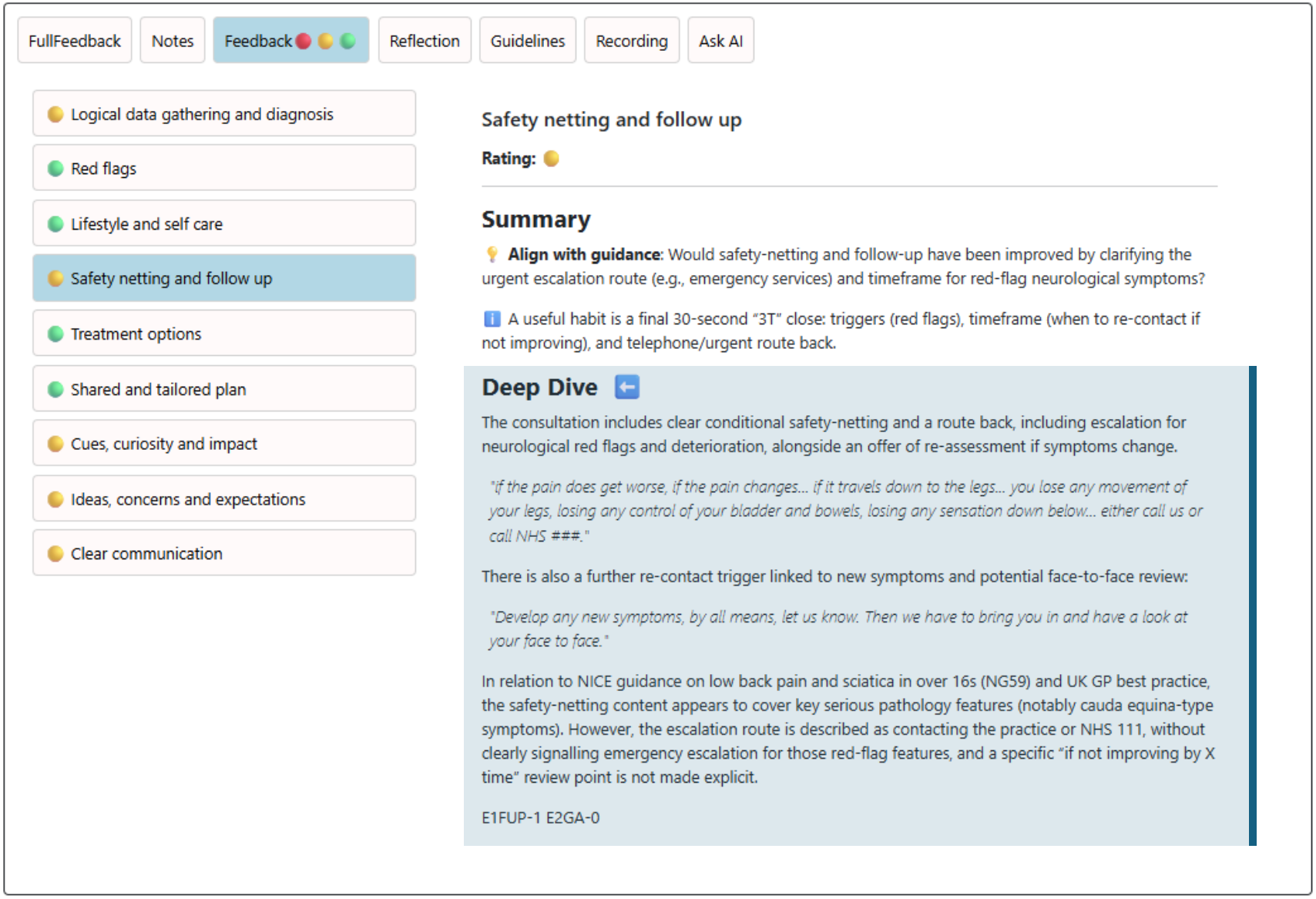
Safety netting and follow up



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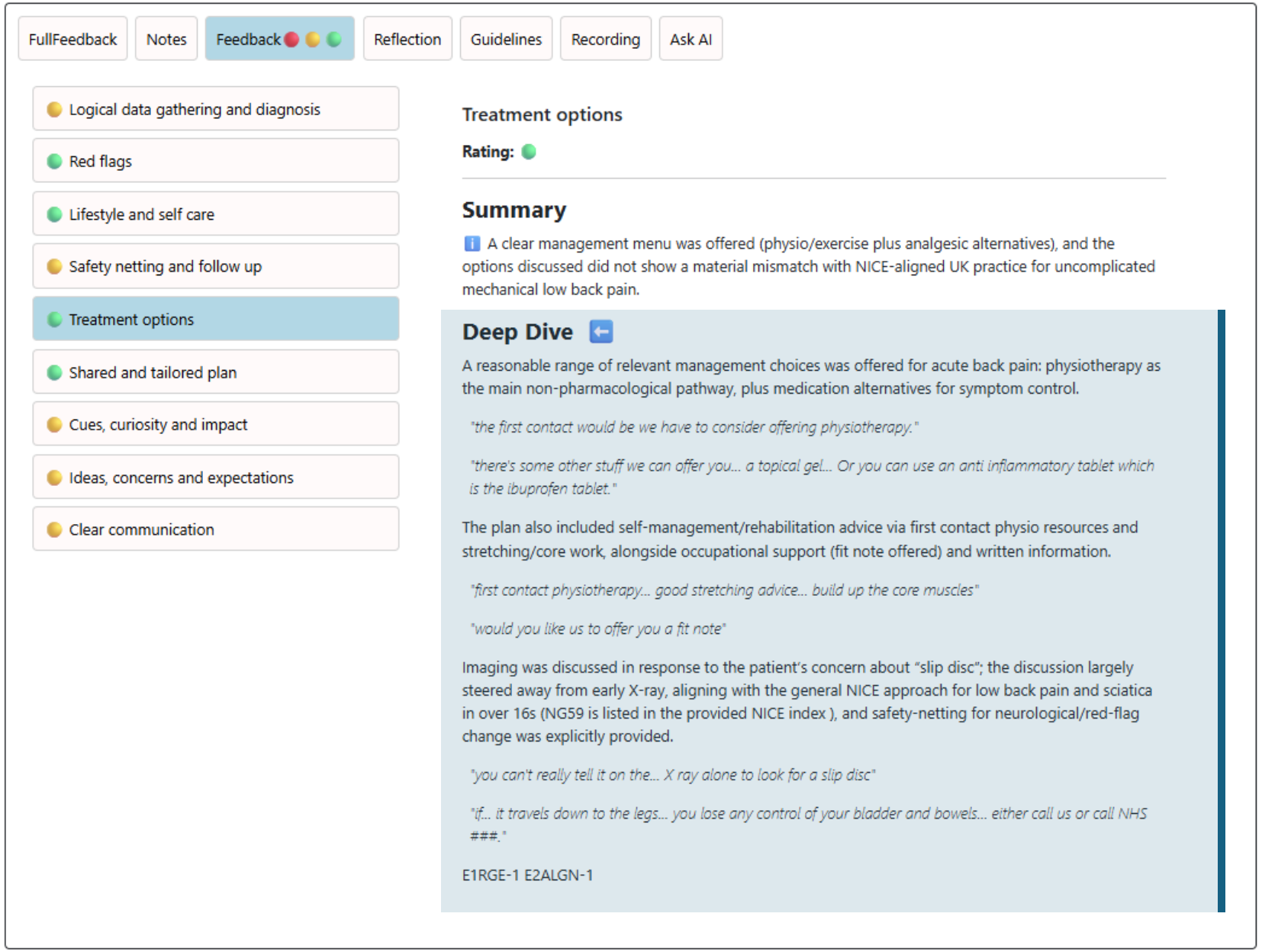
Treatment options



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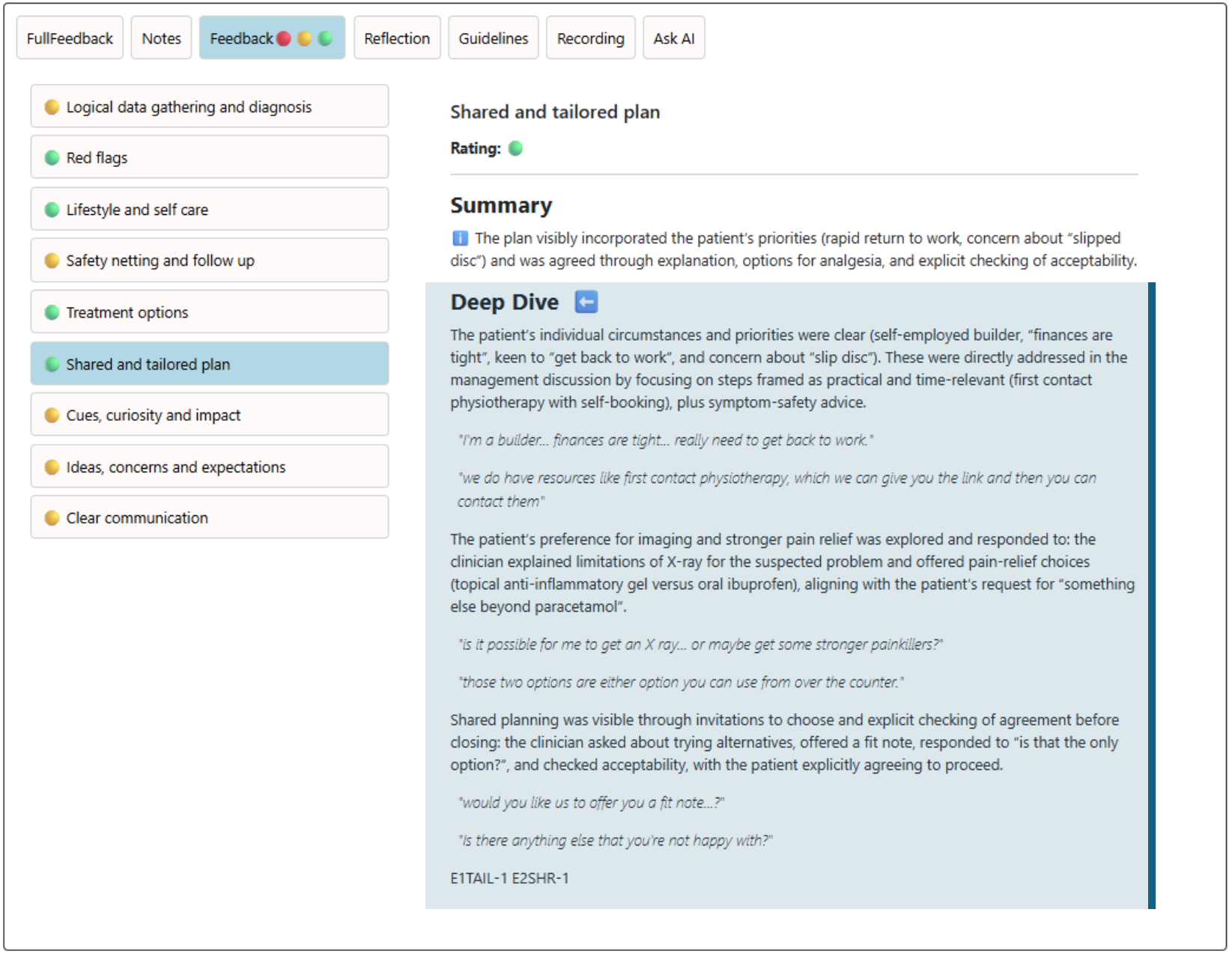
Shared and tailored plan



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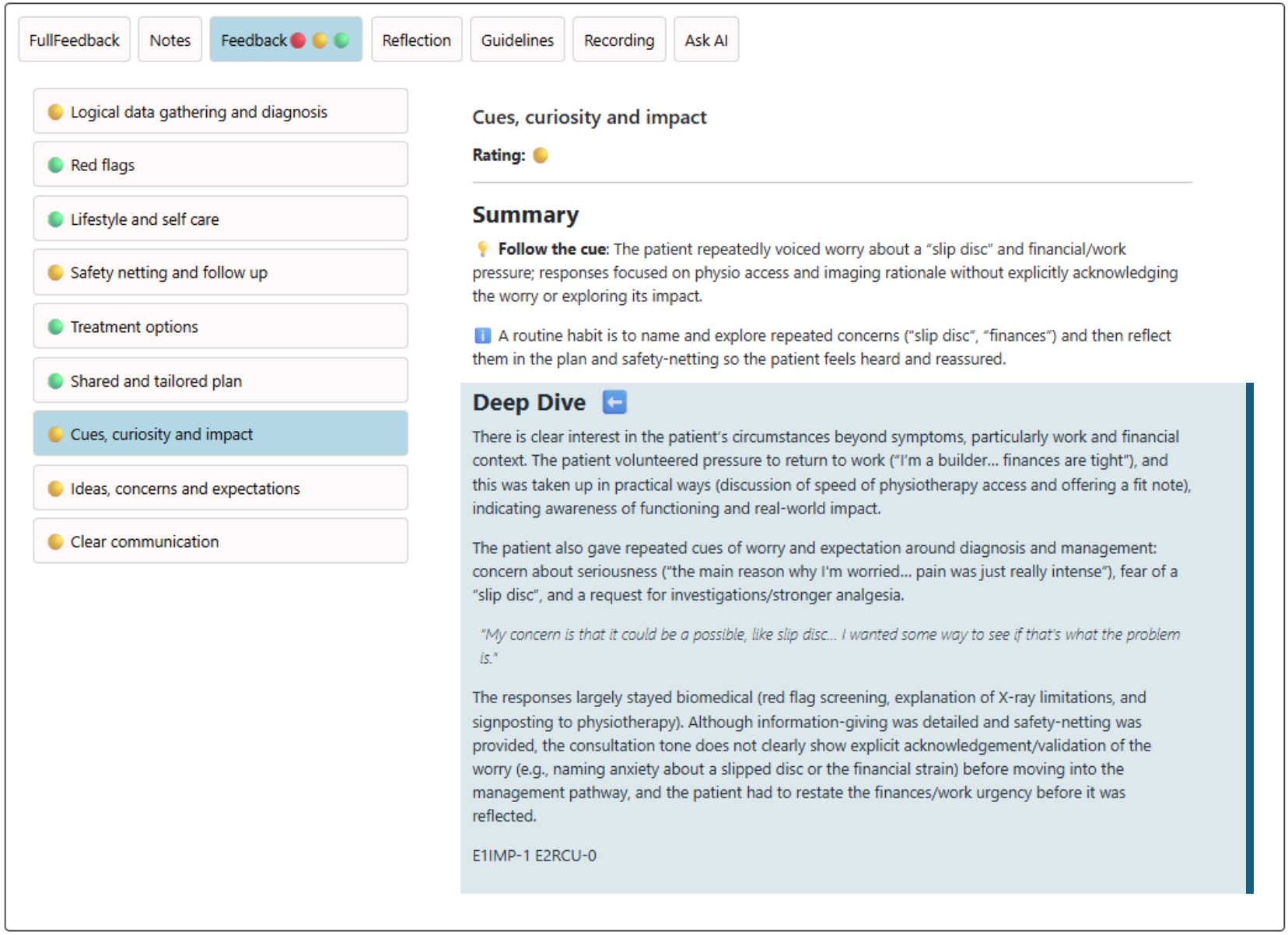
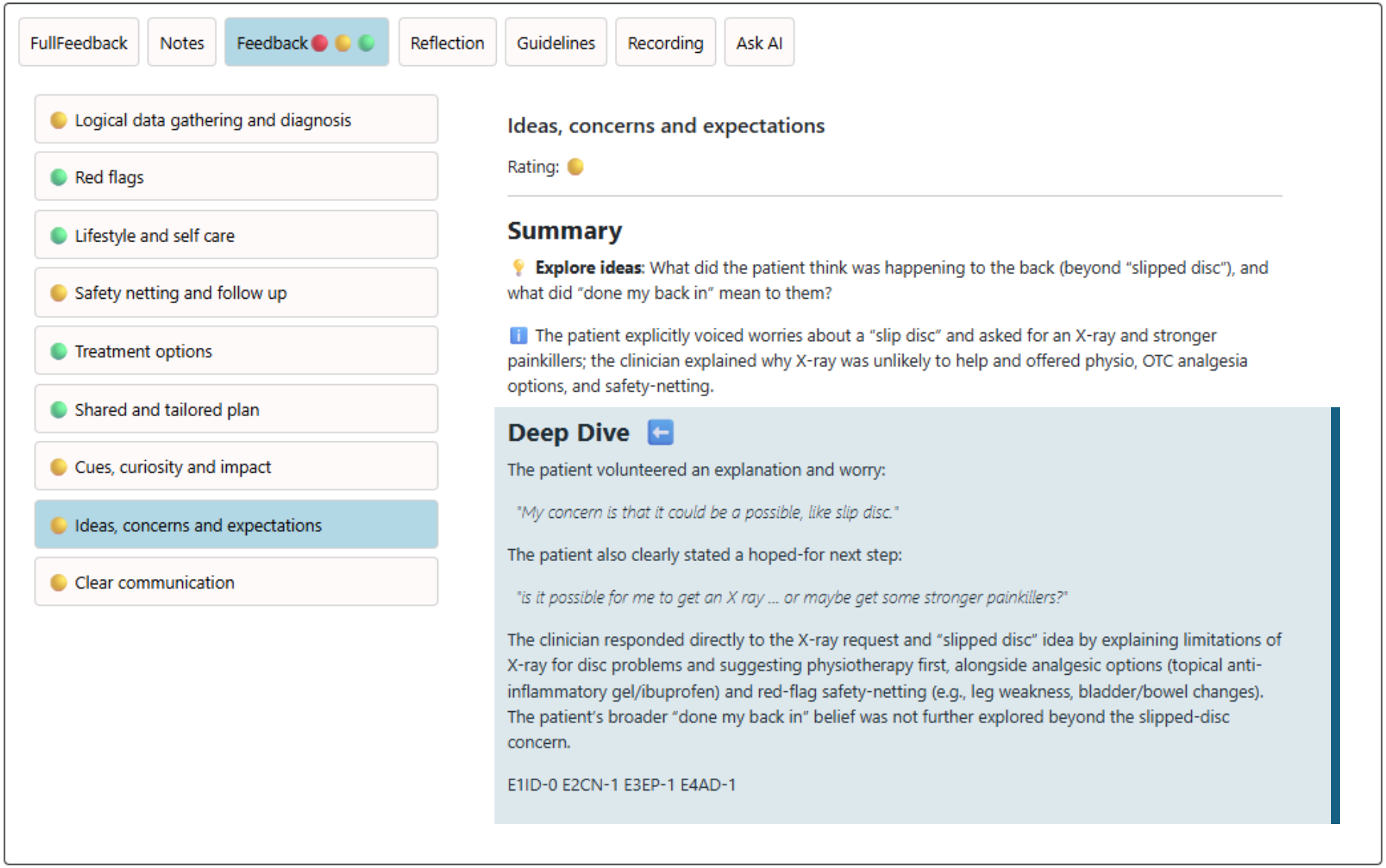
Cues, curiosity, and impact



CLINITALK

Ideas, concerns, and expectations



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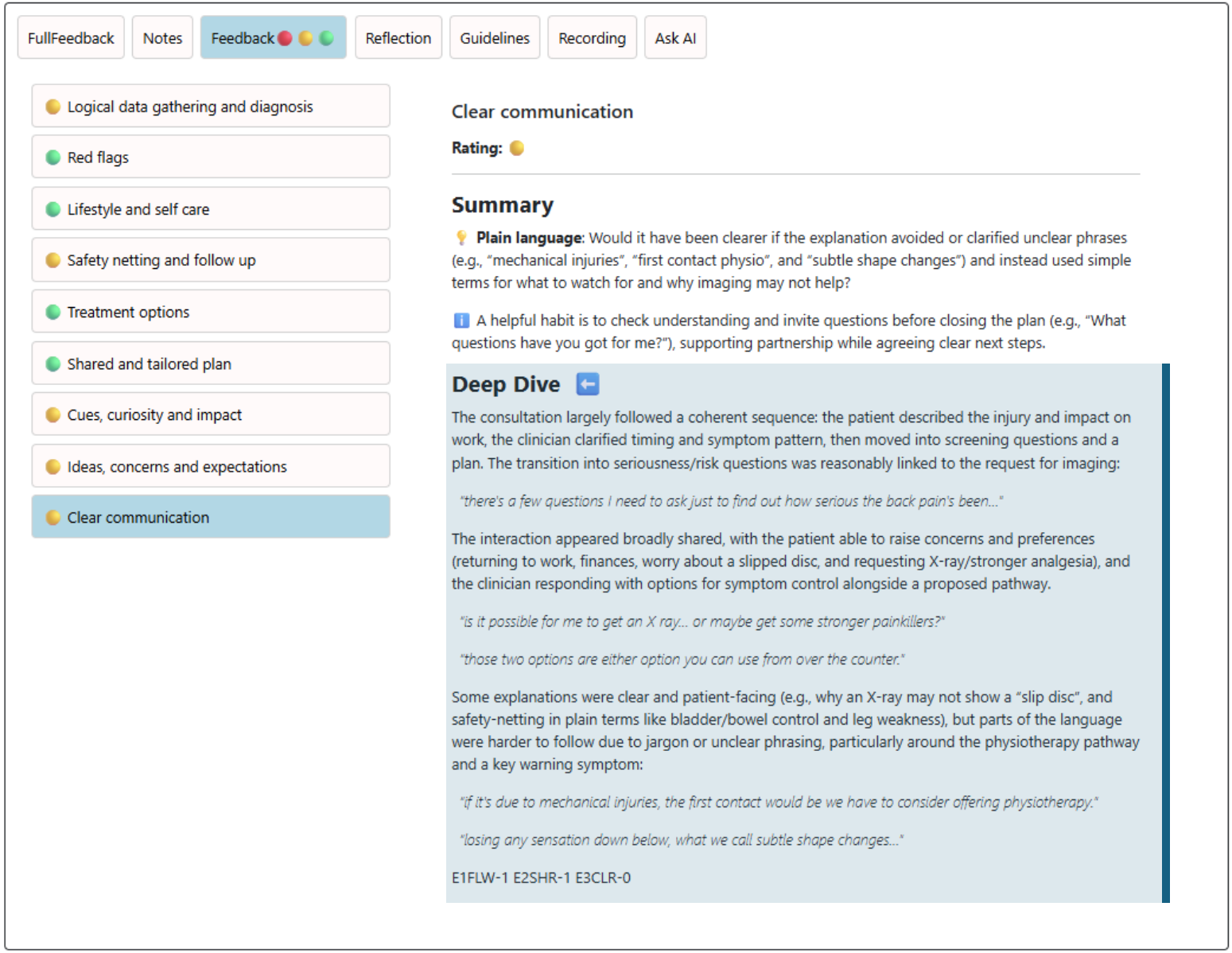
Clear communication



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Guideline adherence

Notes | Feedback | Reflection | Guidelines | Recording | Ask AI

Guideline adherence

Low back pain and sciatica in over 16s: assessment and management – NG59, last updated 11-Dec-2020.

[Read the NICE guideline here](https://www.nice.org.uk/guidance/ng59)

Observations:

- The doctor was consistent with the NICE recommendation to initially advise self-management, including use of simple analgesia (such as paracetamol) and NSAIDs, and to promote maintaining activity as tolerated. The guideline advises: "Consider encouraging people to continue with normal activities as far as possible" and to use oral NSAIDs as first-line pharmacological treatment; paracetamol alone is not recommended unless NSAIDs are contraindicated or not tolerated. The GP could suggest NSAID use more assertively if appropriate and ensure the patient is clear on expected benefits and risks.

- The GP correctly avoided routine imaging, explaining to the patient that X-rays are not usually helpful for non-specific low back pain, and that MRI is not indicated unless 'red flag' symptoms develop. This is aligned with NICE guidance: "Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica."

- The consultation explored some but not all 'red flags' for serious underlying conditions; the doctor asked about bowel/bladder symptoms, leg weakness, weight loss, night sweats, and fever. However, the assessment of neurological deficit, cauda equina syndrome, and other serious causes could be performed in a more structured and complete way (for example, explicit questioning about saddle anaesthesia was only indirect).

- The patient had been resting fully for a week, which is contrary to NICE guidance that advises people to "stay active" and avoid prolonged bedrest. The GP could emphasise more strongly that staying active improves outcomes, and should advise against bedrest.

- The GP appropriately recommended physiotherapy, especially as the patient had not improved with self-care after a week. NICE advises: "Consider a group exercise programme, taking people's specific needs, preferences and capabilities into account. Offer manual therapy (such as spinal manipulation, mobilisation, or soft tissue techniques) as part of a treatment package including exercise." The referral to first contact physiotherapist is consistent, but further encouragement about exercise and structured activity as part of the management plan could be added.

Areas for potential improvement include: further screening and clear documentation of all red-flag symptoms, more detailed advice on staying active (rather than rest), and caution with paracetamol monotherapy unless NSAIDs are contraindicated. Overall, the approach is broadly consistent with NICE NG59.

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Patient lens – the patient perspective

Notes | Feedback | Reflection | Guidelines | Recording | Ask AI

Select previous query | Help me give a clear explanation | Help me be time efficient | Patient Lens

This information is for educational purposes. The patient perspective tool is in development, drawing on real patient feedback to ensure authenticity. We thank our patient participation group contributors.

Consider the patient perspective:

As the patient, I felt that the doctor listened to my concerns about my back pain and my urgent need to return to work. I appreciated being asked about red flag symptoms and that the doctor explained why an X-ray may not be helpful. However, at times I felt that my anxiety about finances and getting back to work may not have been fully acknowledged. The explanations about treatment options, especially physiotherapy, could have been clearer and more supportive.

What I liked:

- The doctor asked important questions to rule out serious causes for my back pain, such as weight loss, night sweats, and neurological symptoms.

- I was given information about first contact physiotherapy, including how to access it.

- The doctor explained the reasons for not immediately offering imaging and provided safety-netting advice on when to seek urgent help.

- I felt involved in the decision to pursue physiotherapy and was offered a fit note if needed.

How to strengthen the consultation further:

- At several points, the conversation felt a bit rushed and lacked empathy for my concerns about finances and returning to work. For example, when I shared, "finances are tight at the moment," it would have been helpful for the doctor to acknowledge this directly and express understanding.

- The explanations about why physiotherapy was recommended over an X-ray were somewhat technical and could have been clearer, perhaps using simpler language or a leaflet.

- Some instructions were unclear or vague, e.g., "I give you the numbers in there and then, and then let them see you." Could the process of contacting physiotherapy have been explained more clearly?

- Would it have helped to summarise the plan at the end and check my understanding or concerns? This might ensure I left the consultation feeling more confident and supported.

I am a tool for educational reflection only, AI can make mistakes and my feedback must not be used for clinical purposes.

Data gathering tips

Top tips | Data gathering | Clinical management | Interpersonal skills | CKS

Yellow flags: For simple low back pain, quality of life, pain severity, function, and psychological distress are the most important factors to guide the person's management so make sure you assess these factors. Advice on how to examine Back pain in general practice.

Differentials to consider: ankylosing spondylitis *(night pain not eased by lying, morning stiffness)*, osteoporosis *(frailty, female)*, shingles *(unilateral pain and rash)* , sciatica *(+ve sciatic stretch)*

Red flags: leg weakness, sensory loss, trauma, vertebral body tenderness, night pain *(cancer)*, unexplained weight loss *(cancer)* , fever *(osteomyelitis)*, failure to resolve within 6 weeks