

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](#)

[Treatment options](#)

[Guideline adherence](#)

[Logical data gathering and diagnosis](#)

[Shared and tailored plan](#)

[Patient lens -the patient perspective](#)

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[Data gathering tips](#)

[Lifestyle and self-care](#)

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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.

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.

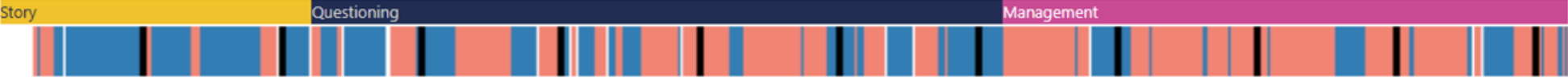
⚠ **Structure matters:** Physiotherapy and imaging advice was discussed before completing red-flag/neurological screening, then the consultation returned to those questions, which blurred the gather-plan sequence.

⚠ **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.

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Structure ▾

Story
Questioning
Management




■ Doctor ■ Patient

First 2 minutes




You spoke: 16%

Middle Third



You spoke: 60%

Final Third



You spoke: 76%

Logical data gathering and diagnosis

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- Clear communication

Logical data gathering and diagnosis

Rating: ●

Summary

- ● **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.
- i A clear routine structure (open → focused → brief summary → plan) helps keep safety screening within information gathering before moving into treatment and referrals.

Deep Dive ←

The opening allowed a patient-led account with minimal interruption, supporting an initial narrative before narrowing:

Doctor: Hi, good morning. How can I help you today?

Patient: ...lifting a few slabs and all of a sudden I got really bad pain... The main reason why I'm worried is because the pain was just really intense...

A working formulation of non-specific/mechanical low back pain was communicated and aligned with the history provided (acute onset after lifting, one week duration, no systemic features described). This is reflected in:

Doctor: ...normally if it's due to mechanical injuries, the first contact would be we have to consider offering physiotherapy.

The sequencing became less coherent because substantive management started (physio as first-line; discussion about X-ray utility) and only afterwards the consultation moved into more safety-focused data gathering, including systemic and neurological "red flag" checks:

Doctor: ...the best thing at the moment would be try some physiotherapy.

Doctor: ...there's a few questions I need to ask... any weight loss recently?

Doctor: ...Have you got any weakness in your legs...?

E1OQ-1 E2WD-1 E3STR-0

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

Red flags

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Red flags

Rating: ●

Summary

i 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.

E1REL-1 E2ALL-1

Lifestyle and self-care

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Lifestyle and self care

Rating: ●

Summary

i The doctor encouraged patient understanding, skills, and confidence with suggestions for self-care or lifestyle modification (physio-led stretching/core work, and appropriate OTC symptom control) that were directly relevant to acute mechanical low back pain.

Deep Dive ←

Lifestyle/self-care advice was present. The doctor advised moving away from prolonged rest and towards active rehabilitation via physiotherapy: "if you've been resting it, it's likely sometimes it may get stiffen up because your lack of use... so it'll be useful to start seeing the physio first", and highlighted self-management exercises: "they can also offer you good stretching advice... stretch it out, build up the core muscles".

The doctor also suggested practical over-the-counter symptom relief options: "a topical gel... like the voltro gel or the anti inflammatory gel", and "an anti inflammatory tablet... ibuprofen... make sure you take it on the full stomach because sometimes it does rot your stomach".

This advice was clinically linked to the case (acute, non-traumatic, likely mechanical low back pain without red-flag features on history), focusing on function and pain control while acknowledging the patient's work/financial context and aiming to support return to activity through "gentle exercise and stretching".

E1PRE-1 E2REL-1

Safety netting and follow up

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Safety netting and follow up

Rating: ●

Summary

💡 **Align with guidance:** Would safety-netting and follow-up have been improved by clarifying the urgent escalation route (e.g., emergency services) and timeframe for red-flag neurological symptoms?

ℹ️ A useful habit is a final 30-second "3T" close: triggers (red flags), timeframe (when to re-contact if not improving), and telephone/urgent route back.

Deep Dive ←

The consultation includes clear conditional safety-netting and a route back, including escalation for neurological red flags and deterioration, alongside an offer of re-assessment if symptoms change.

"if the pain does get worse, if the pain changes... if it travels down to the legs... you lose any movement of your legs, losing any control of your bladder and bowels, losing any sensation down below... either call us or call NHS ###."

There is also a further re-contact trigger linked to new symptoms and potential face-to-face review:

"Develop any new symptoms, by all means, let us know. Then we have to bring you in and have a look at your face to face."

In relation to NICE guidance on low back pain and sciatica in over 16s (NG59) and UK GP best practice, the safety-netting content appears to cover key serious pathology features (notably cauda equina-type symptoms). However, the escalation route is described as contacting the practice or NHS 111, without clearly signalling emergency escalation for those red-flag features, and a specific "if not improving by X time" review point is not made explicit.

E1FUP-1 E2GA-0

Treatment options

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Treatment options

Rating: ●

Summary

I A clear management menu was offered (physio/exercise plus analgesic alternatives), and the options discussed did not show a material mismatch with NICE-aligned UK practice for uncomplicated mechanical low back pain.

Deep Dive ←

A reasonable range of relevant management choices was offered for acute back pain: physiotherapy as the main non-pharmacological pathway, plus medication alternatives for symptom control.

"the first contact would be we have to consider offering physiotherapy."

"there's some other stuff we can offer you... a topical gel... Or you can use an anti inflammatory tablet which is the ibuprofen tablet."

The plan also included self-management/rehabilitation advice via first contact physio resources and stretching/core work, alongside occupational support (fit note offered) and written information.

"first contact physiotherapy... good stretching advice... build up the core muscles"

"would you like us to offer you a fit note"

Imaging was discussed in response to the patient's concern about "slip disc"; the discussion largely steered away from early X-ray, aligning with the general NICE approach for low back pain and sciatica in over 16s (NG59 is listed in the provided NICE index), and safety-netting for neurological/red-flag change was explicitly provided.

"you can't really tell it on the... X ray alone to look for a slip disc"

"if... it travels down to the legs... you lose any control of your bladder and bowels... either call us or call NHS ###."

E1RGE-1 E2ALGN-1

Shared and tailored plan

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Shared and tailored plan

Rating: ●

Summary

I The plan visibly incorporated the patient's priorities (rapid return to work, concern about "slipped disc") and was agreed through explanation, options for analgesia, and explicit checking of acceptability.

Deep Dive ←

The patient's individual circumstances and priorities were clear (self-employed builder, "finances are tight", keen to "get back to work", and concern about "slip disc"). These were directly addressed in the management discussion by focusing on steps framed as practical and time-relevant (first contact physiotherapy with self-booking), plus symptom-safety advice.

"I'm a builder... finances are tight... really need to get back to work."

"we do have resources like first contact physiotherapy, which we can give you the link and then you can contact them"

The patient's preference for imaging and stronger pain relief was explored and responded to: the clinician explained limitations of X-ray for the suspected problem and offered pain-relief choices (topical anti-inflammatory gel versus oral ibuprofen), aligning with the patient's request for "something else beyond paracetamol".

"is it possible for me to get an X ray... or maybe get some stronger painkillers?"

"those two options are either option you can use from over the counter."

Shared planning was visible through invitations to choose and explicit checking of agreement before closing: the clinician asked about trying alternatives, offered a fit note, responded to "is that the only option?", and checked acceptability, with the patient explicitly agreeing to proceed.

"would you like us to offer you a fit note...?"

"Is there anything else that you're not happy with?"

E1TAIL-1 E2SHR-1

Cues, curiosity, and impact

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Cues, curiosity and impact

Rating: ●

Summary

💡 **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.

i A routine habit is to name and explore repeated concerns (“slip disc”, “finances”) and then reflect them in the plan and safety-netting so the patient feels heard and reassured.

Deep Dive ←

There is clear interest in the patient’s circumstances beyond symptoms, particularly work and financial context. The patient volunteered pressure to return to work (“I’m a builder... finances are tight”), and this was taken up in practical ways (discussion of speed of physiotherapy access and offering a fit note), indicating awareness of functioning and real-world impact.

The patient also gave repeated cues of worry and expectation around diagnosis and management: concern about seriousness (“the main reason why I’m worried... pain was just really intense”), fear of a “slip disc”, and a request for investigations/stronger analgesia.

“My concern is that it could be a possible, like slip disc... I wanted some way to see if that’s what the problem is.”

The responses largely stayed biomedical (red flag screening, explanation of X-ray limitations, and signposting to physiotherapy). Although information-giving was detailed and safety-netting was provided, the consultation tone does not clearly show explicit acknowledgement/validation of the worry (e.g., naming anxiety about a slipped disc or the financial strain) before moving into the management pathway, and the patient had to restate the finances/work urgency before it was reflected.

E1IMP-1 E2RCU-0

Ideas, concerns, and expectations

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Ideas, concerns and expectations

Rating: ●

Summary

💡 **Explore ideas:** What did the patient think was happening to the back (beyond "slipped disc"), and what did "done my back in" mean to them?

i The patient explicitly voiced worries about a "slip disc" and asked for an X-ray and stronger painkillers; the clinician explained why X-ray was unlikely to help and offered physio, OTC analgesia options, and safety-netting.

Deep Dive ←

The patient volunteered an explanation and worry:

"My concern is that it could be a possible, like slip disc."

The patient also clearly stated a hoped-for next step:

"is it possible for me to get an X ray ... or maybe get some stronger painkillers?"

The clinician responded directly to the X-ray request and "slipped disc" idea by explaining limitations of X-ray for disc problems and suggesting physiotherapy first, alongside analgesic options (topical anti-inflammatory gel/ibuprofen) and red-flag safety-netting (e.g., leg weakness, bladder/bowel changes). The patient's broader "done my back in" belief was not further explored beyond the slipped-disc concern.

E11D-0 E2CN-1 E3EP-1 E4AD-1

Clear communication

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Clear communication

Rating: ●

Summary

💡 **Plain language:** Would it have been clearer if the explanation avoided or clarified unclear phrases (e.g., “mechanical injuries”, “first contact physio”, and “subtle shape changes”) and instead used simple terms for what to watch for and why imaging may not help?

📌 A helpful habit is to check understanding and invite questions before closing the plan (e.g., “What questions have you got for me?”), supporting partnership while agreeing clear next steps.

Deep Dive ←

The consultation largely followed a coherent sequence: the patient described the injury and impact on work, the clinician clarified timing and symptom pattern, then moved into screening questions and a plan. The transition into seriousness/risk questions was reasonably linked to the request for imaging:

“there’s a few questions I need to ask just to find out how serious the back pain’s been...”

The interaction appeared broadly shared, with the patient able to raise concerns and preferences (returning to work, finances, worry about a slipped disc, and requesting X-ray/stronger analgesia), and the clinician responding with options for symptom control alongside a proposed pathway.

“is it possible for me to get an X ray... or maybe get some stronger painkillers?”

“those two options are either option you can use from over the counter.”

Some explanations were clear and patient-facing (e.g., why an X-ray may not show a “slip disc”, and safety-netting in plain terms like bladder/bowel control and leg weakness), but parts of the language were harder to follow due to jargon or unclear phrasing, particularly around the physiotherapy pathway and a key warning symptom:

“if it’s due to mechanical injuries, the first contact would be we have to consider offering physiotherapy.”

“losing any sensation down below, what we call subtle shape changes...”

E1FLW-1 E2SHR-1 E3CLR-0

Guideline adherence

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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.

Patient lens – the patient perspective

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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