ePAEDCbD

Purpose

CbD is designed to assess clinical reasoning and decision-making and the application or use of medical knowledge in relation to patient care for which the trainee has been directly responsible. It also enables the discussion of the ethical and legal framework of practice, and in all instances, it allows trainees to discuss why they acted as they did.

Completing a CbD

Ideally half the cases should be selected by the trainee and half by the assessor. It is expected that the trainee should offer the assessor a selection of case notes from which the case for discussion will be selected. The cases selected should cover a range of clinical problem areas and should be cases that reflect their stage of training. For example, while a straight forward gastroenteritis which they clerked because the trainee was overloaded would not be suitable whereas a gastroenteritis seen by the trainee and reviewed by them because of concerns about underlying failure to thrive and possible neglect would be.

The focus of discussion should be around an actual entry that they have made in the notes and exploring the thought processes that underpinned the entry. It should not be seen as an opportunity to conduct a viva but should be seen as an opportunity to explore their clinical reasoning and decision making. All ratings are on a 1 – 6 scale with an 'unable to comment option' as it is recognized that assessors may not be able to make a judgment about all the ePAEDCbD areas for every case they observe.

A few possible questions are set out below to provide an example of the sort of style of questioning that is effective:

- What was going through your mind when you wrote that management plan, just talk me through your thought process?
- I see that you have written down a number of different investigations – how did you think the results would help you work out what was going on and what you needed to do?
- You have referred to the ward guidelines in your notes – tell me a bit about how you used the guidelines to help plan management and whether there were any aspects that didn't fit in this case?
- I see that you have decided to treat child with xx – talk me through how you decided to prescribe that regime and what the alternatives you considered were?
- You have written down that you were going to ask Dr X for their advice – what specifically did you want to discuss with them, why was it important in this case, how did their advice help and what did you learn from it?

The discussion must start from and be centered on the trainee's own record in the notes.

Ideally the ePAEDCbD should cover the following:

Common Clinical Conditions, eg	**A Range of Settings, eg**
- Breathing difficulty	- General Paediatrics
- Febrile illness	- Neonates
- Diarrhoea	- Community Paediatrics
- Abdominal pain	- Ward setting
- Seizure	- Clinic setting
- Rash	- Safeguarding
- Safeguarding awareness	

Feedback

Following discussion of the case the assessment record should then be filled out on line. Immediate feedback focusing on aspects of the discussion of the case where you felt the trainee did especially well (anything especially good), suggestions for development and any agreed action should be provided and documented. In order to maximize the educational impact of using ePAEDCbD trainees and trainers will need to identify agreed strengths, areas for development and an action plan for each case.