NHS
Health Education England

Clinical Skills Assessment (CSA)

Guidance on the exam

Introduction

This short guidance is written to hopefully dispel some of the myths about the Clinical Skills assessment (CSA). The CSA is your opportunity to demonstrate your expertise of consulting with patients in what is often called a patient-centred way. The style represents the usual way in which GPs consult and has been the subject of much research. It has been shown to:

- Help patients share their worries and concerns;
- improve their understanding of their problems;
- promote better self care;
- improve compliance with treatment;
- reduce the number of complaints a Doctor receives.

The CSA should be thought of as a meeting between two experts, with you as the expert in diagnosis and management of illness and the patient as an expert in terms of the unique story they want to tell you.

It certainly shouldnt be viewed as a scary, artificial, impossible exam where you will be expected to behave differently from your everyday practice. If you enjoy General Practice consulting, which hopefully you do then this needs to come across in the exam. It will put you at ease and just as importantly make the patient feel more comfortable.

The guidance has been broken down into four sections; History, Examination, Diagnosis and Management, which although not the marking criteria for the CSA - if done correctly will ensure you are successful in each case.

Hopefully you will have already come across some consultation models which you are already practising, but as a start, look at the podcasts on consulting, read Bill Bevingtons consultation booklet both on the KSS website and review 'The Doctor's Communication Handbook' by Peter Tate. Looking at specific text books on the CSA will give you some guidance on the types of questions and this is also useful, but remember the answers are the Gold Standard so do not feel too demoralised if you dont remember every point.

History

The history is a dialogue between two people, a full history needs to be taken for you to be able to reach a diagnosis.You will be much more effective at getting the right history if you work with the patient, be naturally inquisitive and try not to make assumptions. But your questions do need to be in context to the problem and asking an exhaustive list of questions half of which arent relevant will be viewed negatively as well as using valuable time. Remember you only have 10 minutes for the whole case, this is definately long enough to complete the case but only if you stay focused. The hospital clerking method has to be long forgotten.

Try and be as open as you can with your questioning, sometimes it is very easy to close a conversation down with lots of yes/no type answers from the patient and although you do need to ensure that red flag symptoms have been covered this can still be done in an open way.

There are some questions which are always quite useful to ask, the timing of these need to thought about as it very easy to follow your own agenda and then not appear to be listening to the patient, but knowing about the patients thoughts as to the diagnosis of the problem aswell as how the problem is affecting them are really helpful and can be used in your subsequent management plans.

Hopefully around five minutes into each case you can stop taking a history, you will have got a good idea as to a possible diagnosis or what is going on and an idea of how best you are going to manage it.

Examination

Examinations are an area which cause a lot of anxiety amongst trainees as to how you will know whether or not you need to examine someone. It will usually be obvious and shouldnt give you any concern. Go through the motions of starting to examine a patient and the examiner will either send you the findings via the ipad or he won't. The findings are then clearly visible as a resource on the ipad. At no point will you have to ask the examiner if an examination is expected. The patients will also know that an examination is expected and chances are they will be asking you where you want them and whether or not they need to undress.

You do need to be able to examine slickly and certainly practicisng examination techniques with your colleagues and supervisors is extremely useful and this time wont be wasted. It is very easy to spend a lot of time examining when again a short focussed examination is all that is required.

Equally make sure you know how equipment works, for example how to use a tuning fork to test for a hearing deficit or using a monofilament to diagnose neuropathy will quickly identify someone who has performed the examination before against someone who doesnt appear to even know what the equipment is for.

Diagnosis

It is surprising how many trainees forget to give patients a diagnosis in the CSA and launch straight from history taking to management plans. This seems to occur for a number of reasons which range from just simply forgetting to not wanting to give a diagnosis due to the seriousness of the condition, for example cancer. Always try to give a diagnosis – or a suspected/provisional diagnosis and sound confident with your diagnosis, the chances are this will be part of the marking and it quite hard to ensure a patient follows their management plans if they dont know what is wrong with them.

It is really important to practice giving an explanation of the diagnosis. These need to be kept simple – patients do not understand medical words and they dont want to know about the pathophysiology. Practice giving short, one sentence, understandable explanations, ie what is a headache, IBS, depression, hypothyoroidism, asthma, diabetes etc. Reading patient information leaflets can help with this.

It is also a good idea to get into the habit of checking patients have understood your diagnosis and that they agree with you, especially if they were worried it was something else. Patients are likely to be much nore compliant with their treatment if they agree with their diagnosis!

If your diagnosis needs to come from hospital reports, x-ray results, blood tests, ECGs, spirometry reports, make sure you have already practiced doing this. (Dont forget to recap on the patients history before giving out results, or you will forfeit your data gathering mark).

Management

Management plans are one of the key areas where it is really easy to let yourself down. On the whole trainees have taken a history which should reach the right diagnosis, you have had a two way interactive dialogue and then for some reason trainees can become Doctor-centred as they dictate to the patient just what their management plan needs to be. There has to a demonstration of shared management, which is more than you giving the patient a list of options, asking them to pick one and then asking them if they are happy with the plan. As with history taking there should be a shared two way conversation where the different options are explored and the patient needs to feel empowered.

It is very easy in the stress of the exam to talk far too much, talk far too quickly as you can see the clock ticking up to 10 minutes and because you feel you have such a lot to say then the patient can become fairly mute. Shared management is one of the skills the examiner is looking for and this needs to be practiced.

However there will be some cases when you may have to be more direct because the condition is life threatening – don't then offer lots of options but the decision of referral still needs to be discussed in an open way and as much as possible all management plans need to link in with the patients ideas

If the patient disagrees with your advice and there will be some cases where this might happen, if the patient is competent and this has been established, then this is fine, providing you have fully informed them of all of the risks. Even if the patient still doesnt agree, maintain your Doctor-patient relationship and give them options. Don't get cross or irritated with the patient or try to trick them into your way of thinking.

As much as possible always try and offer follow up if it is relevant.

General

Practice by videoing lots of your surgeries and either in a study group or with your supervisor get someone to look at them. Get used to receiving constructive feedback even if sometimes you feel this might be a bit harsh. It is much better for someone to identify something you arent doing now rather than for it to be identified in the exam feedback.

Joint surgeries are another useful way for both direct feedback and also to watch how your supervisor consults as you can often pick up useful ways of saying things or learn different ways of tackling a problem. It also helps you get used to having someone else sitting in the room, so when that person is an examiner hopefully you can ignore them.

The more real life exposure to consultations that you have, and the more conditions you have seen in the surgery the better you will be.

Good Luck!

Important to note

With the introduction of the Recorded Consulatation Assessment (RCA) due to limitations imposed by Covid-19, the skills required remain the same, albeit with the competencies being assessed remotely and using patient consultations.

The latest information can be found via the Royal College of General Practitioners website.