Clinical Skills Assessment

Analysis of feedback statements given by examiners in the CSA (October 2007 – May 2008).

Introduction:

CSA examiners are trained to determine not only whether or not a candidate has achieved a passing standard on the case they are assessing (i.e. demonstrating he/ she is clinically competent and capable of independent practice in a Primary Care setting), but also to pick relevant feedback statements from a selection of commonly given feedback comments. The marking schedule contains a series of 16 feedback boxes, and examiners indicate up to 3-4 relevant feedback statements that relate to the candidate's performance in the case just witnessed. If the candidate passes, the examiner does not apportion feedback statements under the current assessment process.

This analysis is based on the collation and description of the number and type of feedback statements allocated by examiners over the four diets of the CSA from October 2007 to May 2008. During this time 1,811 candidates were seen (of whom 98 were re-sit candidates), and 20, 671 feedback statements allocated (but remember that not all candidates were given feedback statements, as if a candidate passed a case, he/she did not receive feedback statements for that case). The table below shows the percentage of times each feedback statement was ticked during this period.

Table 1 – Frequency with which the Feedback Statements were indicated.

Feedback Statement	Number	% times statement ticked
Data Gathering		
Disorganised and unsystematic in gathering information from history taking, examination and investigation.	1	6.8
Does not identify abnormal findings or results or fails to recognise their implications	2	5.8
Data gathering does not appear to be guided by the probabilities of disease	3	5.7
Does not undertake physical examination competently, or use instruments proficiently	4	2.2
Clinical Management		
Does not make appropriate diagnosis	5	6.8
Does not develop a management plan (including prescribing and referral that is appropriate and in line with current best practice)	6	13.3
Follow-up arrangements and safety netting are inadequate	7	4.7
Does not demonstrate an awareness of management of risk and health promotion	8	4.1
Interpersonal Skills		
Does not identify patient's agenda, health beliefs and preferences/ does not make use of verbal and non-verbal cues	9	8.7
Does not develop a shared management plan or clarify the roles of doctor and patient	10	8.7
Does not use explanations that are relevant and understandable to the patient	11	5.7
Does not show sensitivity for the patient's feelings in all aspects of the consultation including physical examination.	12	3.9
Global		
Disorganised/ unstructured consultation	13	4.8
Does not recognise the challenge	14	9.3
Shows poor time management	15	3.9
Shows inappropriate doctor centredness	16	5.7

How to interpret the Feedback Statements, as a candidate

Candidates receive a list of all of the 16 Feedback Statements, and an indication of those in which they have received more than two ticks during the examination as a whole. Feedback statements are only given to failing cases. By listing those feedback statements that apply to themselves, candidates can see areas of their clinical consulting performance that appear to be of consistently lower standard than expected. The accompanying Feedback Discussion document on the RCGP website discusses each of the 16 statements in detail with suggestions of ways in which performance could be practiced and improved. Candidates can select those statements that apply to their personal performance for special review.

How to interpret the data presented in Table 1.

These feedback statements need to be read in the following contexts:

1. Only candidates failing cases are given feedback.
2. The type of cases presented in the CSA determines the frequency with which some feedback statements are given. For example, the fact that Statement 4 was ticked in 2.2% of occasions when feedback was given does not necessarily mean that in general candidates were competent at physical examination. As only 3-4 of the 13 cases in a circuit may include a physical examination, the number of occasions when this box might be ticked is limited. Similarly, not all cases have a significant health promotion aspect and so there may not be opportunities to tick Statement 8 very often either.

Taking these caveats aside, there are still four Feedback Statements that appear to be selected more often than others and which may be worthy of special mention:

Statement 6: *Does not develop a management plan (including prescribing and/or referral) that is appropriate and in line with current best practice.*

This feedback statement could cover a number of different problems with the consultations. It may be that the candidate did not make the management plan clear enough to the patient, such that the examiner could not tell if it was clinically appropriate. Role players are trained to ask candidates for their reasons for doing things – for example, if the candidate says 'I'd like you to have some blood tests and come back to see me', the role player is likely to say 'why do I need these blood tests?', but candidates also need to be aware that their management plans remain hidden to the examiner unless they make them explicit during the consultation.

It could also be that the candidate's management plan is not sufficiently robust for the examiner to feel the candidate is practising safely, or that it does not consider the likely range of differential diagnoses for an undifferentiated presentation, or that the plan developed does not reflect

current British general practice. (Examiners are aware of regional differences in services within the UK and take these into account.)
There may be some overlap with Statement 5 – for example, if the appropriate diagnosis has not been made, then the management plan is likely to be inappropriate also.

The best way to identify the issues underlying this feedback statement, is to video record consultations and watch them with an experienced GP, checking that management plans are being made, that they are clearly stated to the patient, and that they are clinically appropriate for the presentation given.

Statement 9: *Does not identify patient's agenda, health beliefs and preferences/ does not make use of verbal/ non verbal cues.*

This statement signifies a candidate who is too doctor-centred and who does not appear to ask patients for their ideas, concerns and expectations (ICE), or to pick up on cues where the patient appears to want to add an additional detail or angle to the presentation.

Showing consultations to another GP registrar or to a Trainer (either real time or on video), should help identify the nature of this problem. To perform this aspect of the consultation well, candidates should appear to really want to know what the patient thinks, to show evidence of active listening, and not appear to ask about patient concerns in a formulaic manner, as we have seen over and over in video consultations (in the old MRCGP exam). Role players are trained to drop useful verbal and non-verbal cues during the consultation, including at stages where it appears the candidate is following the wrong track to try to help retrieve the consultation. Candidates should learn to watch their patients carefully, looking for cues and signals indicating whether the patient is uncomfortable or finding it difficult to say what is really on their mind.

Statement 10: *Does not develop a shared management plan or clarify the roles of doctor and patient.*

This statement follows on from both statement 6 and statement 9. A skilful candidate can both elicit and respond to the patient's agenda, incorporating this into the development of a shared (and agreed) management plan. Clarifying roles includes agreeing who will do what and by when, and the conditions for follow up. Again, checking the patient has understood, and has been given the chance to ask any remaining questions, comes into this statement, although it should not be done in a formulaic manner.

Statement 14: *Does not recognise the challenge (eg the patient's problem, ethical dilemma etc).*

Again, there is overlap with statements 6 and 9. In some cases the candidate has completely missed the issues being tested in the case, and despite cues from the role player does not pick them up and get back on track. In general, the CSA cases do not contain hidden agendas – if the candidate asks the 'patient' if anything is worrying him/ her, so long as this is done in context and

at the appropriate stage of the consultation, he/ she will be told if this is so. Role players do not wilfully mislead candidates!

Studying consultations either in videos or in shared surgeries can help identify if cues are being missed, or patients are being misunderstood. Clinical consulting requires very high level communication skills, understanding of nuances and cultural ways of self expression. This can be a particular problem if English is not the first language of either patient or doctor, when it becomes easy to miss the focus of the consultation, or concentrate too much on the biomedical aspects of the consultation.

If you have failed the CSA, or are helping a registrar who has failed the CSA, the tips in this document should help identify most of the reasons for failure and point to the remedies. Candidates should be prepared to video their consultations or be watched during shared surgeries and to get feedback from their peers or tutors. Seeing plenty of patients, with as many different presentations as possible, helps build experience and confidence. Working to 10 minute appointments helps candidates learn to pace themselves. Practice giving explanations on as many different clinical situations as possible – either in real consultations, or in role play. If you have done it before, it is much easier giving explanations on subsequent occasions, as you learn from experience what ‘works’.

Candidates should remind themselves that they should follow an ethical code of conduct at all times, as described in ‘Good Medical Practice’.

Finally, when looking at consultations, the following should help:

- Look carefully at the feedback statements received and think about whether they indicate the problem areas in consulting.
- Set up opportunities to watch videos of consulting with either a peer or tutor (preferably an experienced GP). In these sessions particularly check:
    - Has the doctor identified the issue(s) being tested by the case?
    - Has the doctor asked for the patient’s view of the problem?
    - Has the doctor taken a focussed history, and assimilated any other evidence (blood test results, XRs etc) to make a reasonable differential diagnosis? Is the clinical examination performed likely to identify an abnormality if one is present?
    - Has the doctor worked with the patient to make an appropriate management plan, that incorporates the patient’s view and is clinically safe and up to date with current practice?
    - Is it likely that the patient will be satisfied with that consultation?

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