1 The CSA Exam

What is it, what are the examiners looking for and what can you expect on the day?

What is the CSA?

The RCGP website describes the CSA (Clinical Skills Assessment) as:

"an assessment of a doctor's ability to integrate and apply appropriate clinical, professional, communication and practical skills in general practice."

It goes on to say that the CSA is designed to (1):

"test a doctor's abilities to gather information and apply learned understanding of disease processes and person-centred care appropriately in a standardised context, making evidence-based decisions, and communicating effectively with patients and colleagues. Being able to integrate these skills effectively is a key element of this assessment."

There are three key messages to take from these statements:

1. The exam focuses on being patient centred.
2. Candidates need to make evidence-based management plans, in keeping with current UK general practice.
3. Candidates need to communicate using recognised communication techniques.

The second point acknowledges that recent knowledge of guidelines is helpful, so attempting the Applied Knowledge Test (AKT) in the same academic year as the CSA can be useful.

[Shaleen: I definitely felt more confident about being up to date with current guidelines having sat the AKT a few months before.]

Though we would not suggest relearning all the NICE guidelines, being familiar with the management of common conditions is definitely a bonus.

How to Pass the CSA Exam, First Edition. Imtiaz Ahmad, Raj Nair, Martin Block and Graham Easton.

The CSA format

You can think of the CSA as a simulated typical morning surgery, seeing 13 patients in 10-minute consultations.

[Mydhili: It is a fair exam and supposed to test normal skills. Approach it like a morning surgery.]

The RCGP describes the format in this way (1):

"The CSA is a high-fidelity skills assessment based largely on the familiar and well-proven OSCE format providing an external, objective assessment of clinical skills at a standardised, pre-determined level of challenge. The validity of the CSA resides in its realistic simulation of real-life consultations. Patients are played by trained and calibrated role-players, and cases that are written and assessed by working GPs. Each candidate is allocated a consulting room and has 13 ten minute consultations."

The CSA covers a multitude of topics within medicine; in fact, it could include just about anything. And even within this vast range of potential topics, a station could test many more skills than merely history-taking and management. The format of the assessment allows for systematic sampling from the RCGP curriculum, using a selection blueprint as in Table 1.1.

To get a flavour of the range of clinical problems that the exam could cover, and which aspect of the consultation it could focus on, imagine filling out Table 1.2 with some examples. It will help you come up with possible cases too (we have used this sort of grid to choose our

Table 1.1 Skills and attitudes that could be tested in the CSA

Blueprint area	Descriptor
Data gathering and interpretation	Gathering of data for clinical judgement, choice of examination, investigations and their interpretations
Management	Recognition and management of common medical conditions in primary care. Demonstrates flexible and structured approach to decision-making
Co-morbidity and health promotion	Demonstrating ability to deal with multiple complaints and co-morbidity and to promote positive approach to health
Person-centred approach	Use of recognised communication techniques that enhance understanding of a patient's illness and promote a shared approach to managing problems
Professional attitude	Practising ethically with respect for equality and diversity in line with accepted codes of professional conduct
Technical skills	Demonstrating proficiency in performing physical examinations and using diagnostic and therapeutic instruments

Source: RCGP: CSA blueprint derived from the RCGP curriculum (2).

Table 1.2 Clinical case topics that could be tested in the CSA

Clinical Skills Assessment Case Selection Blueprint	**Primary nature of case**					
Primary system or area of disease ↓	Acute Illness	Chronic Illness	Undifferentiated Illness	Psycho-Social	Preventive/ lifestyle	Other
Cardiovascular						
Respiratory						
Neurological/Psychiatric						
Musculoskeletal						
Endocrine/Oncological						
Eye/ENT/Skin						
Men/Women/Sexual Health						
Renal/Urological						
Gastrointestinal						
Infectious diseases						
ETC						

practice cases – see Chapters 6 and 7). Don't be daunted – there's obviously a lot to cover here, but your ST3 year should prepare you for most of the typical cases, and with a little practice and a systematic approach (which we will outline later), you should be able to tackle the less familiar problems competently.

The marking schedule

So how do you pass? What are the examiners looking for?

Each case is marked in three domains (we will use the same colour codes that the RCGP uses in its document *Generic Indicators for Targeted Assessment Domains*):

- Data gathering, technical and assessment skills
- Clinical management skills
- Interpersonal skills

Each domain contains several positive and negative indicators- specific areas that the examiners are looking out for. These are outlined in Figure 1.1.

Each domain has four grades awardable:

- Clear pass (scores 3)
- Marginal pass (scores 2)
- Marginal fail (scores 1)
- Clear fail (scores 0)

So you can see that the maximum score per station is 9 (three clear passes across all three domains). The most important thing to remember about how you are marked is that **all three domains have equal weighting**. Therefore, if you run out of time and do not spend a proportional amount of time on clinical management, you cannot score well. It is worth keeping an eye on a clock or stopwatch and when you reach around seven minutes, consider moving on to management. This will allow you time to ensure that you are sharing your management plan, summarising appropriately and safety-netting (see Chapter 2 on consultation skills).

We would recommend doing this even at the expense of not doing as well in data gathering, as **you can only score a maximum of 3 in each domain**. So imagine that you have already scored 2 in the data gathering domain. By moving on you will sacrifice the final mark in that domain; but it should then be easier to score a couple of quick marks in the management domain. This is better than spending extra time on data gathering, only to gain the one extra mark possible, but nothing at all on management. It is also well worth looking at the feedback statements that the college publishes on areas where candidates trip up (3).

How the pass mark is set

Given that the maximum mark per station is 9, and there are 13 stations, the exam is marked out of a total of 117 (13 x 9). In general over the last few years, the mark needed to pass is around the high 60s. So, as a rough guide, scoring 70 should mean that you pass the exam. As you can see, this would mean scoring an

GENERIC INDICATORS FOR TARGETED ASSESSMENT DOMAINS	
1. DATA-GATHERING, TECHNICAL & ASSESSMENT SKILLS: *Gathering & using data for clinical judgement, choice of examination, investigations & their interpretation. Demonstrating proficiency in performing physical examinations & using diagnostic and therapeutic instruments* ***(Blueprint: Problem-solving skills, Technical Skills)***	
Positive Indicators	**Negative Indicators**
• Clarifies the problem & nature of decision required • Uses an incremental approach, using time and accepting uncertainty • Gathers information from history taking, examination and investigation in a systematic and efficient manner. • Is appropriately selective in the choice of enquiries, examinations & investigations • Identifies abnormal findings or results & makes appropriate interpretations	• Makes immediate assumptions about the problem • Intervenes rather than using appropriate expectant management • Is disorganised/unsystematic in gathering information • Data gathering does not appear to be guided by the probabilities of disease. • Fails to identify abnormal data or correctly interpret them
• Uses instruments appropriately & fluently • When using instruments or conducting physical examinations, performs actions in a rational sequence	• Appears unsure of how to operate/use instruments • Appears disorganised/unsystematic in the application of the instruments or the conduct of physical examinations
2. CLINICAL MANAGEMENT SKILLS: *Recognition & management of common medical conditions in primary care. Demonstrating astructured & flexible approach to decision-making. Demonstrating the ability to deal with multiple complaints and co-morbidity. Demonstrating the ability to promote a positive approach to health* ***(Blueprint: Primary Care Management, Comprehensive approach)***	
Positive Indicators	**Negative Indicators**
• Recognises presentations of common physical, psychological & social problems. • Makes plans that reflect the natural history of common problems • Offers appropriate and feasible management options • Management approaches reflect an appropriate assessment of risk • Makes appropriate prescribing decisions • Refers appropriately & co-ordinates care with other healthcare professionals	• Fails to consider common conditions in the differential diagnosis • Does not suggest how the problem might develop or resolve • Fails to make the patient aware of relative risks of different approaches • Decisions on whether/what to prescribe are inappropriate or idiosyncratic. • Decisions on whether & where to refer are inappropriate. • Follow-up arrangements are absent or disjointed
• Manages risk effectively, safety-netting appropriately • Simultaneously manages multiple health problems, both acute & chronic • Encourages improvement, rehabilitation, and, where appropriate, recovery. • Encourages the patient to participate in appropriate health promotion and disease prevention strategies	• Fails to take account of related issues or of co-morbidity • Unable to construct a problem list and prioritise • Unable to enhance patient's health perceptions and coping strategies

Figure 1.1 Generic Indicators for Targeted Assessment Domains. Reproduced with kind permission of RCGP.

3. INTERPERSONAL SKILLS: *Demonstrating the use of recognised communication techniques to gain understanding of the patient's illness experience and develop a shared approach to managing problems. Practising ethically with respect for equality & diversity issues, in line with the accepted codes of professional conduct.* ***(Blueprint: Person-Centred Approach, Attitudinal Aspects)***	
Positive Indicators	**Negative Indicators**
• Explores patient's agenda, health beliefs & preferences. • Appears alert to verbal and non-verbal cues. • Explores the impact of the illness on the patient's life • Elicits psychological & social information to place the patient's problem in context • Works in partnership, finding common ground to develop a shared management plan • Communicates risk effectively to patients • Shows responsiveness to the patient's preferences, feelings and expectations • Enhances patient autonomy • Provides explanations that are relevant and understandable to the patient	• Does not inquire sufficiently about the patient's perspective / health understanding. • Pays insufficient attention to the patient's verbal and nonverbal communication. • Fails to explore how the patient's life is affected by the problem. • Does not appreciate the impact of the patient's psychosocial context • Instructs the patient rather than seeking common ground • Uses a rigid approach to consulting that fails to be sufficiently responsive to the patient's contribution • Fails to empower the patient or encourage self-sufficiency • Uses inappropriate (e.g. technical) language
• Responds to needs & concerns with interest & understanding • Has a positive attitude when dealing with problems, admits mistakes & shows commitment to improvement. • Backs own judgment appropriately • Demonstrates respect for others • Does not allow own views/values to inappropriately influence dialogue • Shows commitment to equality of care for all • Acts in an open, non-judgmental manner • Is cooperative & inclusive in approach	• Shows little visible interest/understanding, lacks warmth in voice/manner • Avoids taking responsibility for errors • Does not show sufficient respect for others. • Inappropriately influences patient interaction through own views/values • Treats issues as problems rather than challenges • Displays inappropriate favour or prejudice • Is quick to judge • Appears patronising or inappropriately paternalistic
• Conducts examinations with sensitivity for the patient's feelings, seeking consent where appropriate	• When conducting examinations, appears unprofessional and at risk of hurting or embarrassing the patient

Figure 1.1 (*Continued*)

average 5–6 marks per station. You can do very well in some stations and thereby compensate for stations in which you may not perform as well.

Exact details on how the pass mark is set are on the college website, but they're quite complex and it's probably not worth getting too bogged down in this (4). It's very unlikely to affect your performance on the day – you just need to score as highly as you can. But in case you are interested, we will try to explain it simply here.

Essentially, having scored the candidate, the examiner is then asked to make a separate judgement on how they felt the candidate performed overall in the station. Most of the time a 'pass' or 'fail' is fairly clear cut. However, sometimes candidates come into a 'borderline' category. Perhaps they seemed to be performing well, only to run out of time; or perhaps they came up with the correct management plan, but didn't involve the patient in the decision-making process. Being classified as borderline won't affect that individual candidate's score on that station or their overall result, but the average of all the borderline candidates' marks is used to set the pass mark for that station. The same is done across all 13 stations, which means that borderline case scores are added together to calculate an overall borderline CSA score. This will vary day to day because of small overall differences in the difficulty of the cases. A small statistical adjustment is then made to that overall borderline CSA score (increasing it slightly to err on the side of caution), which produces the pass mark for the entire exam for that day.

None of this affects your personal score – it is simply a way to set a fair pass mark based on how all the candidates perform and the difficulty of the cases on the day, as well as taking variation among examiners into account. We have heard of trainees trying to choose certain days when they predict weaker candidates may sit the exam, as the pass mark might in theory be lower on that day (theoretically weaker borderline candidates would set a lower pass mark than better-scoring borderline candidates). However, there are so many other variables, including the difficulty of the case, that we think this is a pointless exercise. In any event, it is very difficult to get the exact day or time you would like for the exam. To pass you simply need to do as well as you can in the exam, not worrying about how the pass mark is set. It is much more important to be aware of the marking scheme (as outlined above).

What you can expect on the day

You can expect to feel a bit nervous – that's normal. The key is to channel the adrenaline into useful energy that will help you perform at your best. If you have seen plenty of patients and practised some CSA cases, then you should be well prepared. It may go without saying, but do allow plenty of time to get to the examination centre,

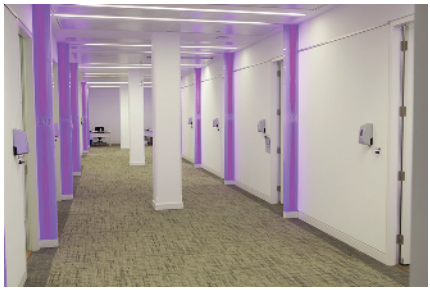

Figure 1.2 The RCGP exam centre and consultation room. Reproduced with permission from the Royal College of General Practitioners.

and make sure you've eaten something to keep you going. For guidance on what to wear, see the dress code (5).

[Shaleen: There is a 20-minute lecture-style briefing before the exam. They tell you how the day will run and how the iPads work.]

[Sam/Mydhili: Get there early. It's easy to find and don't worry, it's all fairly straightforward on the day.]

Currently the exam consists of 13 live stations. You will be handed your pack of 13 patient histories before the start. This comes in the form of an electronic booklet on an iPad and each case is summarised at the front, although you need to turn to the actual page for more details. NB: There may be some more information overleaf, so don't forget to turn the page.

Don't worry if you have never used an iPad – it is very intuitive and there are marshals around to help you if you are really stuck.

[Shaleen: If you click on another case by accident during the exam, then the iPad flashes up a banner at the top telling you that the notes you are viewing do not relate to the current patient, so you don't have to worry about losing your place.]

There is a whiteboard next to the iPad for you to make notes and we would suggest you do so in case you forget something relevant in the consultation. The stations have been piloted and used many times and key information has usually been included for a reason, so it is worth highlighting pertinent parts (for example, a previous abnormal blood result or heavy smoking status). Be careful, though, that you don't focus too much on your own agenda or keep looking at the iPad or your notes instead of the patient.

You will have around 10 minutes before the start of the exam to read through your cases. There will be a short comfort break (of around 15 minutes) after seven cases, so you can finish reading the final cases then.

[Shaleen: I only read the first seven cases on the iPad in the initial 10 minutes so I could focus on these cases before the break.]

Tea and biscuits are provided during the break, but you may wish to bring an energy drink or chocolate bar with you to consume during the exam, which can be mentally draining. You should bring a doctor's bag with you containing the instruments that are listed (along with other essential information for candidates) on the college website (6). You cannot remove any material from the exam venue and you should not discuss cases that you have come across with anyone else. There is a clock in front of you that has a countdown feature. This can be helpful to keep track of time, but be careful not to keep looking at it or put yourself under too much pressure. Your eyes should be making contact with the patient, not the iPad or the clock!

TIP: What CSA candidates can expect at the RCGP's new headquarters

Have a look at this short video from GP Online about what to expect on the day, including a glimpse behind the scenes into the preparation of examiners and role-playing patients, and a question-and-answer session that features detail about recent changes to the CSA.

http://www.gponline.com/Education/article/1184218/video-exclusive-csa-candidates-expect-rcgps-new-headquarters/

You stay in your doctor's room and the examiner and actor move along between cases. There is only one bell to start the station and one to finish. Each station lasts exactly ten minutes, with a two-minute break in between. Figure 1.3 summarises the rough structure of the exam.

Physical examinations

You will be expected to carry out some physical examinations. There are no 'real' physical signs to pick up, so practise doing focused examinations quickly (see Chapter 3 for what we recommend regarding common physical examinations) in around a minute.

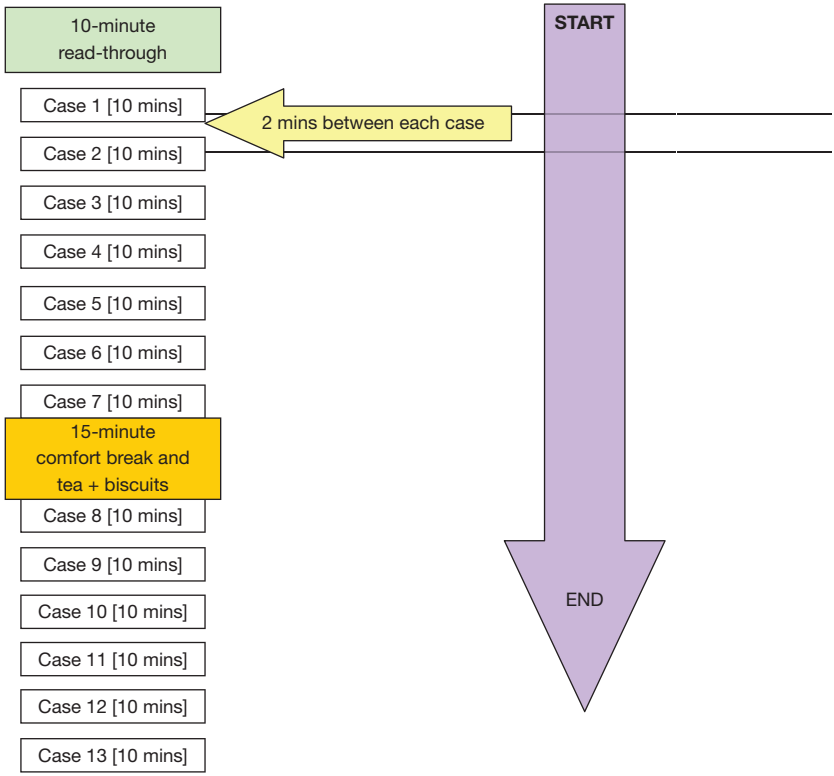

Figure 1.3 Structure of the exam.

Examples might be a focused chest exam or examining a joint.

Case A4

You should get up and attempt to examine the patient (remember to explain quickly to the patient what you would like to examine, and don't forget to ask for their permission and offer a chaperone if appropriate). Results from more intimate examinations or simulated physical signs (from, say, a 'normal' chest examination that you perform on a healthy actor) will be transferred to your iPad by the examiner. This is likely to be the only interaction you will have with the examiner, who sits out of your eyeline during the consultation.

Investigations

You may be expected to interpret simple investigations like ECGs, swab and blood results, as well as more complex

investigations like spirometry results (not graphs). So it is worth spending some time reminding yourself how to recognise common primary care-related cardiac conditions such as atrial fibrillation or left ventricular hypertrophy, and what diagnostic criteria are needed to reach a diagnosis of asthma and COPD on spirometry. For a spirometry refresher, consider arranging a session with your practice respiratory nurse. You may need to demonstrate inhaler technique and peak flow meter readings too.

Home visits and telephone consultations

These types of scenario are increasingly common in the CSA, but not everyone will have a home visit or telephone consultation to tackle. Currently you will only be given one or the other, if at all. Although they are a little different to the usual stations, they tend to be more straightforward, partly because they are new – so there's no need to panic.

For the **telephone consultation** [Case B11], you stay in your room and use the telephone provided. The examiner and actor will be in a separate room connected to the telephone, listening to the consultation on loudspeaker. The scenario usually revolves around an out-of-hours call. Important things to remember here are:

1. Introduce yourself properly.
2. Establish who you are speaking to and that you have consent to give information (if relevant).
3. Do not forget the main marking domains of the CSA (see Chapter 3 on consultation skills): enquire about the psychosocial context of the problem, as well what the patient believes may be the problem, what may help and what they require.
4. If you are the out-of-hours GP, then you need to establish any past medical and drug history as well as allergies.
5. If you are recommending a visit to the out-of-hours base or the hospital, remember to enquire about transport and bear in mind the patient's social circumstances.
6. If a patient needs to be seen, try to get them to come to the base (if safe and appropriate) rather than wasting resources on a visit. However, if the patient cannot come and clearly needs to be seen, then you should arrange a visit as you would normally. Arguments with the patient are generally frowned on, so having a lower threshold for visiting is prudent!

Case B12

For **home visits**, you will be led to a separate room where there will be a new doctor's bag. The patient will be on a couch or sofa-bed and you should perform the consultation as you would normally, paying close attention to your surroundings and environment. The first five tenets above regarding telephone consultations are as relevant for home visits, especially bearing in mind the social context of the patient, and

particularly when considering transferring the patient to hospital.

Some home visits can be quite complex (for example, a palliative care case as in Case B12). If you have not been caring for patients with these needs during your GP training, then it would be useful to spend a study session with the palliative care team. The communication skills required for these difficult end-of-life care conversations are often challenging and the more practice you have the better. Getting some feedback from your trainer or the palliative care nurses on how you discuss end-of-life care with a patient would be valuable, and a very good use of time both for the CSA and for real-life general practice. This experience doesn't only come regarding patients with advanced cancer – don't forget your house-bound heart failure and COPD patients, whom you may have seen before and whose end-of-life care needs tend to be overlooked.

[Sam: For a home visit, the marshal comes and you are taken over to a different room, perhaps with a couch or sofa. Try to pretend it's a real home visit.]

Paediatric cases

Nearly all candidates will have one paediatric case. This may or may not involve consulting with a child directly; the exam does sometimes use child role-play actors'. Of course, these children cannot be babies or small toddlers, so they are usually aged about 8, 9 or 10. However, it will often involve consulting with a parent about a child who is not actually in the room. The paediatric stations are less likely to be an acute problem and more likely to cover more chronic issues such as constipation or difficult-to-treat eczema. Remember that if the child is not present, it may be appropriate to request a review appointment to see or examine the child (if relevant). In addition, the child's psychosocial context is paramount and it is essential to enquire about home and school as well as the usual developmental and social milestones. (Also see Chapter 5 on more complex cases.)

Prescribing

The issue of safe and appropriate prescribing is becoming increasingly important in the CSA exam. Within each circuit of 13 cases, it is likely that you will have several that involve some aspect of prescribing. You may well be asked to write out a prescription – this will be made very clear in the relevant station. While writing down the patient's correct details is obviously important (for example, their name and date of birth), you are not usually expected to write, for instance, the patient's entire home address.

When you are not specifically asked to write out a prescription, we would advise you to verbalise what you intend to write. For example, for a simple lower urinary tract infection (UTI), you could say: 'I would like to prescribe you an antibiotic

called trimethoprim; you take one 200 mg tablet twice a day for three days.'

If you don't know a suitable drug or the correct dose, don't simply guess! Either check in your BNF (*British National Formulary*) or make it clear that you will need to verify the details of treatment. The examiners would much rather see a doctor who is comfortable admitting that he or she doesn't know something than one who bluffs their way in ignorance, putting the patient in danger.

[Shaleen: I put coloured tags (with no annotations) on sections in my BNF that I thought might be relevant so that I could find information easily if needed.]

When should I sit the CSA?

The answer depends on your personal circumstances and it is a good idea to discuss this with your trainer and programme director early in your ST3 year. As a general rule, you need to be comfortably seeing patients every 15 minutes in your usual surgeries. The exam consultations are timed at exactly 10 minutes, although you are not expected to do a comprehensive examination (see Chapter 3 about physical examinations) or write notes.

The CSA exam is now spread more evenly throughout the year, with sittings roughly monthly, so there is more flexibility in when you choose to take the exam. But in general, if you start your ST3 year in August, then attempting the exam the following February or March would be a reasonable plan. This would also give you a chance of sitting the exam again later on in your year, should things not go as well as hoped. However, if you or your educators are not confident with an attempt in February/March, then you are probably better off delaying your first attempt until later. There is very good evidence to suggest that your first attempt at CSA is your best attempt – if you have failed once, it may affect your confidence and overall ability to pass the exam. Don't try before you are ready.

If you are confident about passing early in the calendar year, the advantage of passing the AKT and CSA components of MRCGP is that you can concentrate on other non-examined, 'softer' aspects of the training year. We would strongly advise against sitting the CSA too early in the ST3 year, though, as consulting effectively within 15 minutes is a push for most trainees at the start of this year.

Summary

Just like any exam, the CSA is much more straightforward if you know what to expect and have prepared for it thoroughly. You can't predict which cases are likely to come up – it could be almost anything a GP might see. Nevertheless, understanding what the exam is trying to test, how it is run on the day and how the examiners use the marking scheme to assess you gives you a crucial advantage.

References

1. MRCGP Clinical Skills Assessment (CSA). RCGP website: http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/mrcgp-clinical-skills-assessment-csa.aspx
2. RCGP GP Curriculum Overview. RCGP website: http://www.rcgp.org.uk/gp-training-and-exams/gp-curriculum-overview.aspx
3. General comments about features/behaviours observed in passing and failing candidates in the CSA. RCGP website: http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/~/media/Files/GP-training-and-exams/General-comments-about-features-behaviours.ashx
4. MRCGP: The New CSA Standard-Setting System. RCGP website: http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/~/media/Files/GP-training-and-exams/Standard-Setting-the-CSA-from-September-2010-onwards.ashx
5. Dress codes for postgraduate GP recruitment training and assessment. Royal College of General Practitioners/COPMED.http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/~/media/Files/GP-training-and-exams/Dress-codes-for-postgraduate-GP-recruitment-training-and-assessment.ashx
6. MRCGP Clinical Skills Assessment: Information for candidates. RCGP website: http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/~/media/Files/GP-training-and-exams/CSA%20page/Microsoft%20Word%20-%2021%20%20CSA%20Information%20For%20Candidates%20v%2012%20MSSRKHTDJAC%20021013%20_2_.ashx