

## How to use the feedback

Alongside your results, you may receive formative feedback designed to help you reflect and improve. The CSA is essentially a summative assessment, designed for licensing rather than training, so the scope for formative feedback is necessarily limited. We use pre-formed “feedback statements” as outlined below.

This is a separate process from the marking itself, so please note that feedback is not an indication of your mark per se, and may be offered to passing candidates. Only areas considered deficient by more than one examiner will trigger feedback statements appearing with your results grid.

Many of the statements overlap slightly, and it may seem that some of the statements are at odds with one another. For example you may find that exploring the patient’s concerns takes time which in turn might lead to your not being able to complete the consultation in the ten minutes. It is important to remember that the CSA is a test of your ability to integrate and apply your clinical skills to the specific scenario so that in order to do well you need to be able to manage the tensions between different aspects of good consulting.

Examiners choose the most applicable feedback statements to that consultation focussing on where they think you need to develop. This does not mean there were no problems in other areas.

## **How might these results be interpreted?**

- We recommend that your trainer is involved in interpreting the feedback, and that you consider it in the context of your WPBA and any areas of weakness of which you are already aware. For each of the statements, there is a corresponding note below, intended to help you assess your learning needs and build on what you can already do. Please remember, when the statement reads, “does not...” this should be taken to mean “does not sufficiently...” or “does not always...”
- Firstly, feedback is generated in an entirely different and separate way from the grades for the cases. The examiner will, in giving feedback, pick the most relevant items from a list of 16 feedback statements (see below). If, during the course of the CSA examination, the candidate fails more than two cases, and if he/she accumulates more than one of a numbered feedback statement (for example, been given feedback statement number 3 on two or more occasions), then that feedback statement is given to you, together with the marks. Therefore, if you receive a feedback statement this means that you have been allocated this statement by at least two different examiners.
- Feedback is intended to be developmental, so all candidates, including those who pass, may be able to learn from it.
- Where you have had feedback that identifies areas for improvement, try to put this in context by asking yourself ‘How does this compare to what I know of my performance, for example from workplace based assessment?’
- Then read the text below and, where improvement is needed, look closely at the suggestions that are offered.

## Feedback statements

### **1. Disorganised / unstructured consultation.**

Examiners did not feel that the consultation followed a logical structure. For example, your history taking may have appeared disjointed, with your line of questioning erratic and not following a clearly reasoned way of thinking. The consultation may have appeared disorganised, with some elements (for example, health promotion) thrown in apparently at random.

This gives the impression of a doctor whose line of diagnostic thinking and clinical management may miss important clinical issues because he/she is not systematic.

### Suggestions:

Practising with one of the published consultation models (such as Neighbour, Pendleton or Cambridge-Calgary) and analysing some of your video consultations might help you develop a more fluent approach. Ask a colleague or your trainer to critique your consulting. When taking a history you should initially listen to the patient and ask open questions to explore the presenting features before focussing on the specific detail with closed questions if appropriate. It is sometimes helpful to signal to the patient that you are about to do this by saying something like "Would it be Ok if I ask you some specific questions now?"

Explain to the patient what you are doing and why. This is good for patient care and will also demonstrate to examiners that you have a clear and systematic approach. Explaining to the patient exactly what further tests (e.g. blood tests, if appropriate to the case) are going to be necessary for further patient management, helps the examiners know what you are planning to do and why.

Summarising aspects of the information you have collected also demonstrates to examiners that you are collating and processing the information, and is useful in checking with the patient that you have understood him/ her.

## **2. Does not recognise the issues or priorities in the consultation (for example, the patient's problem, ethical dilemma etc).**

Examiners felt that you did not demonstrate that you were able to identify the patient's problem/agenda or the possible challenges in the consultation and appropriate priorities from the doctor's perspective. There were aspects to the case that needed to be covered, in addition to the superficial clinical presentation. For example, if a patient presents with an infection that could be sexually transmitted, the consultation should include sensitive enquiry about the likelihood of this (addressing the patient's worries) AND a section on contact tracing, and whether the regular partner needs to know about the STI (addressing the wider ethical dilemma).

### Suggestions:

Patients don't always tell you straight away what is worrying them, and sometimes have to be asked. Sometimes the way they look, or what they say gives you clues to an underlying worry. They may bring a situation that has an ethical dimension to it that the patient may not have considered, but as a professional, you should be aware of this, and should discuss it with the patient (another example is an issue of confidentiality).

Being alert to verbal and non-verbal cues and analysing your consultations either on video or in shared surgeries might help you with this. Look closely at your ability to encourage the patient to share his/her thoughts and expectations. Ask an experienced colleague what they thought the issues and priorities in the consultation were and discuss how these compare with your opinion. Think about the implications of the presentations you see in your own surgeries, and how they might present in the CSA.

## **3. Shows poor time management.**

Examiners felt that you showed poor time management during the cases, perhaps taking too long over certain tasks or failing to cover what was thought to be essential.

### Suggestions:

Seeing patients in ten minute appointments in your own surgeries, and trying to ensure that you remain focussed on the problem presented might help. Try to observe doctors who consult effectively and efficiently and learn how to modify your own approach.

A common reason for running out of time in CSA cases is due to candidates taking too long to take a history, and then having to rush the second half of the consultation, clinical management, explaining and follow up arrangements. Pace yourself, and work out how long you should be taking for the different parts of the consultation.

Gathering information requires you to be appropriately selective in the questions you ask, the tests you request and the examinations you choose to undertake. You may feel that it would be better to be 'on the safe side' by ordering a battery of tests and whilst understandable, this can make you appear indiscriminate. Likewise, history taking and examination is not expected to be all-inclusive and should be tailored to the circumstances and include psychosocial factors where relevant.

This will help you greatly in clinical practice as well as in the assessment.

#### **4. Does not identify abnormal findings or results or fails to recognise their implications.**

Examiners felt that you did not demonstrate an ability to identify or recognise significant findings in the history, examination or data interpretation from results provided. Sometimes findings have been identified but then not acted upon appropriately, so that examiners conclude the candidate did not recognise their significance. Issues identified may need to be prioritised clearly.

##### Suggestions:

This is a clinical rather than interpersonal skill and requires you to make sure that you can correctly interpret the significance of test results or the findings of physical and mental state examinations. The abnormal findings will nearly always relate to common or important conditions, and you should bear in mind that common conditions are more likely than uncommon ones in real life, as well as in the CSA. This should be reflected in the differential diagnosis you make, and how you explain your differential diagnosis to the patient.

When you prepare for the CSA, pay close attention to your ability to assess and manage risk by picking up on abnormal findings and dealing with them safely. Discuss your management with colleagues, asking them to comment particularly on your risk management and safety-netting. Also, take an active part in significant event reviews, look back on these, especially if relating to clinical errors and see what you can learn.

#### **5. Does not undertake physical examination competently, or use instruments proficiently.**

Examiners felt that you could improve your physical examination skills. You should be able to demonstrate the appropriate and fluent use of instruments, in a way that does not distress patients, with their full understanding of what you are doing and their consent.

##### Suggestions:

Improving these skills is a matter of practice and it pays to spend time developing a systematic method that you can repeat over and over again. Before doing so, take advice and make sure that your technique is correct; otherwise you will simply be reinforcing bad habits. Once correct techniques are practised and become fluent, your approach will appear competent and confident to the examiner.

You should always explain what you are proposing to do in an examination to the patient, and why you are doing it. In the case of intimate examinations (and they do occur in the CSA), you should make absolutely sure you have gained informed consent and offered a chaperone.

#### **6. Does not make the correct working diagnosis or identify an appropriate range of differential possibilities.**

Examiners felt that you failed to make the appropriate diagnosis. You should consider common conditions in the differential diagnosis.

##### Suggestions:

This statement is linked with statement (4), where candidates fail to recognise abnormal information, either in the history, the examination, or data provided to them in the case notes.

Making a diagnosis means committing yourself on the basis of the information you have available to you. Make sure that your knowledge-base is adequate, and think carefully about all the information that is presented to you in the case. Then ensure that when you have made a diagnosis in consultation, you state this clearly and explain it to the patient using language that is understandable to them ( see 16) If your summary is too vague, the examiner may not be sure that you have made a diagnosis at all. If you have a differential diagnosis list, explain this to the patient too, remembering that common things occur commonly, and are (usually) more likely! It is not always necessary to make a single diagnosis; you can still do well provided you explain what you are thinking and why. To say you are unsure is OK as long as you explain to the patient how you plan to reach a definite diagnosis or to find out the answer to a question they might have asked and your plan can be understood by the examiner and judged to be safe.

## **7. Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice.**

Examiners felt that your management plan for the case was inadequate. You may not have developed an obvious management plan at all, or it may not have been complete enough to satisfy the examiner that you were a safe practitioner. You would be expected to show that your clinical management skills are in line with current UK best practice.

### Suggestions:

Your management plan and follow up arrangements should reflect the natural history of the condition, and be appropriate to the level of risk. They should be coherent and feasible. You should be aware of up to date national guidelines such as those published by NICE (National Institute of Clinical Excellence) and SIGN (Scottish Intercollegiate Guidelines Network) and demonstrate you have an evidence-based approach.

Possible risks and benefits of different approaches including prescribing need to be clearly identified and discussed. Your knowledge base is also important in this area. Use the concept of PUNS (Patients' unmet needs) and DENs (Doctors' educational needs) to improve this selectively, and discussing the management of cases you have seen with an experienced doctor will help you in these areas.

Your understanding of decisions for referral should also mirror current guidelines and UK best practice.

## **8. Does not show appropriate use of resources, including aspects of budgetary governance.**

Some cases may include an aspect that requires you to demonstrate your role as a 'gate-keeper' of NHS resources. This includes aspects of requests for 'fit notes', surgical procedures, newly developed medications, use of appropriate referral pathways and referrals for second opinions. All of which are the 'bread and butter' of British general practice.

### Suggestions:

Discuss this issue with an experienced general practitioner, such as your trainer or one of the partners in the practice. Think about the different types of NHS resource that GPs are 'gate-keepers' for, and how reference to them could come up in routine consultations. Look through your video consultations to identify times when appropriate use of resources has come up - you will find it comes up in nearly every consultation in one way or another. This does not mean that you refuse access to services, new medications or 'fit notes', but that you show your awareness of the issues and responsible use of resources.

## **9. Does not make adequate arrangements for follow-up and safety netting**

Examiners felt that your follow up arrangements were not adequate and that you did not ensure that there was an appropriate safety net.

### Suggestions:

It is easy for consultations to be seen as isolated incidents, rather than a continuum in the course of an illness. Making arrangements for follow up demonstrate your commitment to the continuity of care of patients and your concern for their welfare and safety. It shows that you are prepared to take responsibility for managing the ongoing presentation of the condition until the problem has been resolved in some way.

Safety-netting is a term that describes the explanations you should be giving to each patient about what to expect, including a time scale if appropriate, and about what to do if symptoms get worse or develop in some way that is unexpected. If there is uncertainty about the diagnosis this should be communicated to the patient so they are empowered to reconsult if necessary. You should include a description of where and how to get help, at any time of day or night, (if this seems appropriate for the case being presented), as well as arrangements for follow up.

## **10. Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options**

Examiners did not feel that you managed risk appropriately. This could mean either that you failed to identify the potential risks or that having done so you did not integrate that into the consultation in a useful way.

### Suggestions:

In order to manage risk appropriately, you should make the patient aware of the relative risks of different approaches. Managing risk and living with uncertainty are key skills in general practice. Your knowledge base is important here, as is your ability to integrate that knowledge with the specific information you have gained about the patient.

Listening to how more experienced practitioners explain common risks might be helpful (for example, the risks of taking Hormone Replacement Therapy) and then practising doing the same in your own words might help to develop this skill. You don't want to be doing this for the first time in the CSA – an unpractised candidate is very obvious to examiners! Role play with teachers and colleagues would give you a start.

## **11. Does not attempt to promote good health at opportune times in the consultation**

Examiners did not feel that you used appropriate opportunities to promote good health.

### Suggestions:

Health promotion requires doctors to demonstrate an awareness of health (rather than just illness) and to be proactive in maintaining the patient's health. Try to be aware of health promotion issues and apply these appropriately. The key to doing this successfully is to identify the patient's health beliefs and work with them towards a plan for maintaining good health. The use of computer-generated prompts can sometimes be helpful in order to keep this issue on your agenda during a consultation, but you won't have this benefit in the CSA. You will need to keep health promotion in mind as part of the tasks of the consultation.

The doctor's agenda, for example gathering data for health promotion, is important, but the challenge is to achieve an appropriate balance with the patient's agenda. It is also important that attempts at health promotion are done in an opportune way so that they complement the patient's agenda rather than trying to supersede it.

One of the keys to doing this successfully is in the feedback statement "... at opportune times in the consultation". Just firing off a list of health promotion questions out of context is unlikely to be welcome to the patient and so is also unlikely to be effective.

## **12. Does not appear to develop rapport or show awareness of patient's agenda, health beliefs and preferences.**

Examiners felt that they did not see any evidence of you developing a rapport, or professional relationship with the patient or demonstrating an awareness of the patient's feelings either during an examination or by insensitive data gathering. You may not have shown that you could identify the patient's agenda, health beliefs or preferences, or if you did do this, you did not then use that information to guide the rest of the consultation. Asking questions, about a patient's concerns, for example, but then not utilising the information or incorporating it into the consultation does not demonstrate patient centred care.

### Suggestions:

Demonstrating interest in, and warmth toward, the patient and seeking consent for any clinical examination is important. How you develop a rapport depends on factors relating not only to the patient and their situation, but also to your personal style preferences. Smiling and welcoming patients into the consultation helps put patients at ease.

Identifying when you achieve rapport with a patient and working out how would be helpful, then you can build on your strengths rather than copy how others do it. It is often just a matter of showing a true interest in the patient and their problems by non-verbal as well as verbal communication.

By 'health beliefs' we mean the reasons underlying the patient's thinking about his/ her presentation in the case. It does not need to be investigated exhaustively, but the patient's perspective should be sought.

This skill lies at the heart of patient-centred consulting and a number of educational resources will help you to understand the concept. (e.g. the Consultation Models listed with statement 1). Being curious about the patient and trying to understand their perspective will help you to identify their views, much as in statement 11. This is most effective if integrated into the consultation and you are more likely to find out about the patient's concerns if you tailor your questions and their timing to each individual rather than asking questions such as "Is there anything you are worried about?" out of context. You could prepare by allowing doctors who are skilled in this approach to assess your performance by, for example, rating you on the COT (consultation observation tool) and providing formative feedback.

## **13. Poor active listening skills and use of cues. Consulting may appear formulaic (slavishly following a model and/or unresponsive to the patient), and lacks fluency.**

Examiners observed verbal or non-verbal cues in the consultation that you did not use to increase your understanding of the patient's situation. They may also have felt your listening skills were poor, for example asking questions but not listening to or acting upon the answers.

### Suggestions:

Active listening includes asking questions at the appropriate time, in a logical sequence to the patient's last contribution. It is demonstrated by good use of verbal and non-verbal cues (see below). Good active listening includes allowing the patient to say what they want to tell you, and sometimes helping them by clarifying and summarising what they have already said (which shows you were listening and have understood them).

Recognising cues, both verbal and non-verbal is a key component of patient-centred clinical method. Cues can include gestures, pauses in speech, facial expressions as well as clues in the patient's account that indicate he/she has additional issues to tell you. The information gained from acting on patient cues is likely to increase patient satisfaction.

By 'formulaic' consulting, we mean that the doctor appears to be rigidly applying a set consulting 'model' to the consultation, that does not take into account the patient's agenda or response. The doctor may repeat questions (see active listening above), ask questions at inappropriate times in the consultation and use pre-prepared phrases. Some of these phrases seem to come from CSA courses or CSA guides, as suggestions for how to show empathy or to elicit and manage patients' concerns. For example, we often hear candidates ask the patient: "How does that make you feel?" To the examiner, especially if it is asked

repeatedly during the consultation and then little or no notice is taken of the answer, it appears that the question is being asked as part of a 'formula' that candidates have learnt to pass the CSA. In order to get the right meaning across, you need to find your own way of asking about this, in your own words, and to make sure that you ask this at an appropriate time in the consultation and take due notice of the reply.

This is an area that is sometimes difficult to develop without the help of more experienced doctors. Watching yourself on video and asking your trainer to review videos with you is a useful way of seeing yourself as others might observe you. It might also be helpful to gather information about what your patients feel about this aspect of your work before and after you have tried to improve these skills.

#### **14. Does not identify or use appropriate psychological or social information to place the problem in context**

Examiners felt that you did not obtain/use existing information about the patient's background in such a way as to increase your understanding of how the problem might affect the patient's everyday life rather than just their health. The common elements of this 'background' are the patient's psychological state and the influences of their social network, occupation and culture.

##### Suggestions:

Understanding and appreciating the social and psychological aspects of a patient's problem are key to practising patient-centred medicine. Using a consultation model and reviewing your consultations either alone or with your trainer, paying special attention to this aspect will help it to become second nature. Similarly, asking yourself a few questions after each consultation will soon enable you to identify whether this is something that you do routinely.

Such questions might be: How is the problem affecting the patient? What changes have they had to make to their life because of this problem? Who else is affected by the problem? etc. In addition, ask yourself whether you have any blind spots. For instance, do you ask what the patient's job involves rather than just what their job title is? Are there issues of diversity in the case? People differ in their life experiences, factors such as social class, ethnicity, age, gender and sexuality, and all may play an important part and understanding how that might relate to the patient.

#### **15. Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient**

Examiners felt that you did not demonstrate the development of a shared management plan. Listing options without explaining their relative pros and cons or without taking account of the patient's views does not aid the development of shared understanding.

##### Suggestions:

This may be improved by responding appropriately to the patient's agenda and by attempting to involve patients in making decisions regarding their problem. Clarifying the respective roles may involve reaching agreement with the patient as to what will happen next, who does what and when and the conditions (i.e. the timescale and circumstances) for follow-up. There should be a shared understanding before the patient leaves and this can be confirmed by asking the patient to summarise what they have understood.

How you do this is a matter of finding out what works best for you and taking a lead from the patient. Using standard questions such as "What will you tell your wife when you get home?" rarely works well, as it is not a 'common' way to talk and sounds synthetic (see above). On the other hand, it might be just the right question to ask when you have identified that the patient's wife has a particular concern about their health.

Patient-centred doctors are responsive to patient preferences, including when they don't want to share decision making, and work to develop common ground and a shared understanding. There are many educational resources (books, DVDs of consulting skills etc.) that will help you to achieve this.

## **16. Does not use language and/or explanations that are relevant and understandable to the patient**

Examiners felt that your explanations were not sufficiently relevant or understandable to the patient.

### Suggestions:

In developing this skill, it is important to avoid the use of jargon, to establish the patient's level of understanding of medical and health matters and tailor your explanation to these. Whether or not your explanation has been understood can be checked through non-verbal communication but also (and more explicitly) by asking the patient to summarise. Explanations are often most effective when you affirm a patient's health beliefs e.g. "Like you, I think this pain might be due to a trapped nerve..." Similarly using the same language as the patient aids understanding and helps to make the patient aware that you have listened to what they have been saying.

1. [PUNs and DENs: Discovering Learning Needs in General Practice](#)  
Richard Eve (Radcliffe Medical Press)
2. Diagnostic safety netting - Almond, Mant and Thompson, BJGP 2009