

## CSA Guidance – the way to succeed

### **A. Purpose:**

This paper is designed to help trainers and trainees who have failed the CSA plan the extension to training.

### **B. Learning directed to CSA:**

After failing the CSA the trainee requires an educational prescription using the feedback from; the exam, courses undertaken and trainers' comments as well as using their own insight into their difficulties. The most important process is the **diagnosis** of the individual trainee's difficulties.

The **feedback form** given to trainees after the CSA failure, is very helpful to direct the learning. It is not the marking schedule for the CSA exam (such would not be released after any public national exams!), and trainees requesting detailed marking of each case are being unrealistic. The feedback form clearly guides the trainer and trainee to work on parts of the consultation and is ignored at the trainees peril!

Trainees need to work on various aspects of their consultations having broken down their learning needs into workable objectives. Often more work is needed on basic history taking, diagnosis and management skills.

A fundamental change is required in the trainee so that new consulting and management skills are acquired for consultation. Then, when under stress whether due to exam nerves or a stressful busy time in the practice, the trainee will not regress to their old way of consulting (which after all has been their method for years), but will use their new consolidated skills. An inner change is necessary; so that the trainee develops those higher skills for consultation which then becomes their way of working

The best preparation for the CSA is working in the practice and seeing patients.

### **C. International Medical Graduates (IMGs):**

*54% of overseas graduates fail their first attempt in CSA. (RCGP)*

Some of the issues for IMGs with UK consultations are:

- Concept of sharing in doctor patient relationship.
- The structure of UK consultations is culturally determined. In the UK we have a spiral method of developing our consultations which is very different from those in many other countries who follow linear methods of history taking etc.
- IMGs frequently don't pick up on patient's frustration or anxiety, as this comes across through the intonation and subtle linguistic cues in our language.

IMG trainees have to learn the concept of the different roles of patient and doctor in the UK. They then have to put this into practice. If they have not acquired appropriate complex language and have unstructured consultations this gives the appearance of confusion and lack of clarity. They come across as disorganized.. Some will need language and cultural help, others will need consultation work, and some will need to go back to basic level history taking, diagnosis and management skills.

#### **D. Trainers**

We need our most able and experienced trainers to work with remedial trainees. However, it becomes an issue of where there is space and which trainers have capacity or willingness to take on these trainees. They often stay in the same practices due to these problems.

Either by changing trainer and practice, or by using other local trainers or CSA examiners, it is helpful to have other views on the trainee's communication and consulting skills.

#### **E. Timetable**

It is recommended that any trainee after 2 x CSA failures does their extension on a part time basis so that there is more time for change in between attempts at the CSA. The minimum recommended so that there is enough clinical exposure is 60%.

#### **F. Repeat Exams**

Trainees often sit the CSA within 3 months of failing however this does not give time for the changes in their skills to have been recognized, developed and consolidated.

#### **G. Portfolio requirements**

All aspects of WPBA and Portfolio have to be continued during this placement:

- Trainee log mapped to curriculum
- All entries open to CS to map to competencies
- OOH x 6
- CBDs x 6
- COTs x 6
- PSQ
- MSF
- Recommended ESR at 3 months and 6 months.

#### **H. Resources and Teaching/Learning methods**

Many Trainers and remedial ST3s, "work to the CSA exam" rather than concentrating on the trainee becoming a rounded GP. This leads to fewer teaching methods being used.

Below are some suggested resources and teaching/learning methods.

### **1. Reading:**

- books to read and understand more about the consultation
  - Roger Neighbour: Inner Consultation
  - Peter Tate: the Drs Communication Skills Handbook
- back to a basic consultation model that gives emphasis to the basic stages of the consultation
- books on patient's journeys eg A Long Walk Home Rachel Clark
- Guidelines for management eg NICE

### **2. Study leave and Courses:**

All courses for consultation skills and CSA need to be done early after a CSA failure, so that the messages can be consolidated into the normal practice of the trainee.

- Deanery Consultation Course ( should have been done as a GPR)
- The London Deanery Language, Culture and Communication Skills Course for trainees who have failed the CSA and are on an extension of training. Lynne Rustecki, Language & Communication Skills Consultant has been working with the LD since 2002 Modules:
  - Complex Language skills
  - Cultural Adaptation of the consultation
  - Small groups Communication Skills training with role player, Lynne Rustecki and Trainer present
- Other consultation courses as agreed with Trainer:
  - There is a private CSA course that advocates rote behaviour. This promotes superficial learning and is not recommended by the Deanery
  - The RCGP and London Faculties CSA course is recommended
- No other study leave is agreed as the best way to learn for CSA is to do the job.

### **3. Feedback from CSA taken:**

- use feedback already given in CSA examiners feedback report
- CSA DVD

### **4. COTs:**

- Trainer sitting in, maybe 3 patients at a time. Work on particular aspects of the consultation not a "global overview". Give verbal and written feedback from the trainer and above average protected time for the trainer to sit in on the trainee's surgeries. Give time for change!
- Video: trainee to gain insight and not be told by trainer all the time. GPRs to show Trainer videos where a problem has been identified rather than "good ones" to pass the COTs for WPBA

## **5. Reflection:**

- reflecting by trainee on patients
- work on specific parts of consultation so that any changes made become ingrained and habit
- Lots of CBD discussion about patients. To help CSA CBDs are very important to discuss and to see the patient's perspective hence to be a patient centred doctor.

## FORMAT FOR CBD DISCUSSION

Each week write up 4 x CBD.

Summary of case

What went well

What could have gone better

What are you learning needs for this case.

- Trainer expects Trainee to write up cases in Trainee log every week

## **J. A trainee's perspective:**

### **WE DON'T KNOW WHAT WE DON'T KNOW**

Being amongst the best students at school and the university, I believed in my medical abilities so much that I never even dreamed of failing in any exam.

CSA failure made me think. Still not believing that I was doing anything wrong, I tried to accuse the system for my failure. I didn't realise that I needed someone to help me but thankfully other people did. And here my journey with my next trainer – whom I owe greatly – began.

Isn't medicine all about treating illnesses? Don't we doctors know all about the diseases, and patients come to get advice in order to get better? Shouldn't a patient just listen to what his/her doctor says? To be honest, spending years as a hospital doctor, the possibility of any other existing attitude rarely crossed my mind.

I came across the word "Patient-centeredness" for the first time in my registrar year. Was I supposed to do all those cumbersome and often time consuming steps in order to make sure the patient is happy? For almost a year, still believing that I could manage well without being patient-centred, I struggled forcing myself to do these things without quite believing in them.

I had so much to take in during the registrar year. On one hand, there were day to day medical issues in general practice. The simplest problems such as treating a wart or prescribing a contraceptive pill was such a big issue that I would rather be in casualty seeing a patient with acute MI! On the other hand, as an immigrant doctor, there was plenty to be learnt including community care, the social aspects of patient care and understanding the way that general practice worked.

I encountered as an international medical graduate a few specific issues such as understanding colloquial language, cultural differences, significant diversity of cases depending on the areas, dealing with specific cases of alcohol & drug abuse and ethical issues.

Although CSA tests the clinical management, it also focuses on our consultation style and the way we deal with the patient as a whole person. Obviously, each registrar has certain learning needs and every individual is different so I only comment on my own experience. Yet, I believe we often face common challenges and you might find these points on different educational methods helpful:

1. Problem finding: observing consultations very carefully by the trainer to find out **specifically** where the problem is. Unless you know about things that need to be changed you can not change them!
2. Reading books on consultations, taking notes on what you need to change and applying them in your consultations. Recommended books: *Inner Consultation* by Roger Neighbour and *The Doctors Communication Handbook* by Peter Tate.
3. Attending consultation courses are equally important.
4. Reflecting on your own consultation. I found writing summaries of the challenging cases and clarifying what went well, what could have gone better and my learning needs for each case very powerful tools to analyse and reflect on my own consultations. While initially it looked like a difficult task, upon my trainer's insistence, I made a habit of writing several (at least two each week) which helped me greatly. My trainer and I then used these summaries for case based discussions.
5. Watching others' consultations and trying to find out what they do differently and how you can use their methods in your own consultations.
6. Role playing with other registrars can be helpful as well.

I think sometimes we need an overhaul in our attitude towards patients, working in collaboration with them and considering their agenda in the process of decision making. I believe patients are the main decision makers during the consultations and the whole point of a good consultation is to make sure that we reach a point that doctor and the patient understand each other and are able together to reach to a shared decision. This is the proof of the change in my attitudes and beliefs about consultation during my time as a registrar.

In his book "*Other side of Medicine*" Peter Tate says: "The first and fundamental step is the change in attitude. If we think about our attitudes, then our intelligence might be useful. Get the attitude right by thinking, then let instinct, experience and evolution take over and the results are almost magical".

Of course none of this can be possible without dedicating time and effort, using every consultation to improve your skills. And last but not the least: **Never lose your faith, be patient and it will happen.**

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