

# A Revision Guide to the CSA

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CSA consultations are a reflection of what the ideal GP consultation should be. It is a patient centred consultation. This means that the doctor is required to acknowledge that the patient has a set of beliefs and values, which can influence the diagnosis and management from a doctor. Consequently to achieve this type of consultation it would be important to illicit the 'ICE' ideas, concerns and expectations, knowing their social background and negotiating a management plan (as oppose to telling them what you as the doctor think is best). According to a number of patient surveys this is what they want from a UK GP. The advantage of a patient centred consultation in primary care is that it promotes a strong positive relationship between the patient and the doctor. This relationship ensures continuity care, medication compliance, successful health promotion and reduces complaints.

## About the resource

The resources used to help develop this guide was from:

Personal experience.  
Correspondence with Dr Mark Coombe, Senior CSA Examiner.  
Roger Neighbour's CSA course (Birmingham)  
Mark Coombe's CSA course (Southampton)  
Pennine website  
Southampton Programme directors  
My Educational Supervisor- Professor Mark Rickenbach

If you have any questions about this guide please feel free to contact the Wessex AiT Subcommittee – wessexAiT@gmail.com

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# Structure

To run a successful CSA consultation it's very important to always maintain a structure.

The foundation of the structure should ideally be (in this order):

- Patient agenda
- Doctors agenda
- Shared management

## Patient agenda

Patients will normally want to explain about their medical problems from their own perspective. It's important to surface this information at the beginning as it makes the patient feel that the doctor has fully listened to them. This will consequently have a positive influence in the shared management plan (as discussed later).

The components of the patient agenda include:

Golden minute: Allowing the patient to talk for approx. a minute without interruption.

ICE: Ideas, concern and expectation

Psychosocial: How is it affected their work, home life, mood, driving

## Doctors Agenda

This would be asking the typical questions in a medical history. Hopefully by this stage the information from patient agenda would have given an overview of the problem. Therefore it is only clarifying the information with closed questions and ruling out red flags to focus towards a diagnosis.

## Shared Management

Discussing the diagnosis but relating it to the patient's ICE. By doing so you would have addressed the patient's agenda. For example 'I know you're interested in a MRI scan to rule out a brain tumour but having assessed you I haven't found any evidence of a brain tumour. This is because.....'

Try to be flexible. Part of the shared management is negotiating to a stage where both the doctor and patient are in agreement and satisfied. For example a patient demanding a referral may be persuaded for a trial of treatment if it is suggested that they can be referred if the treatment fails. Present a realistic range of options for treatment and help the patient decide if they are uncertain would be good practice. Presenting an unrealistic, long list of options, for the sake of it should be discouraged.

## The typical CSA structure

You should formulate your own consultation model based on the principles above.

One proposed model used by candidates and taught by the Wessex Faculty course is:

1. Open question/golden minute
2. ICE
3. Psychosocial (work, home life, mood)
4. Confirm drug hx and PMH based on patient information given
5. Closed questions, Red flags
6. Examination
7. Relate to ICE
8. Discuss diagnosis
9. Options for treatment
10. Follow up +- safety net

1-5: should last 4-5mins

6 should last 1-2mins

7-10 should last 4 minutes

### Open questions

The opening gambit from CSA patients will be one sentence (which may not be a reflection of real life practice). It's important not to proceed to closed questions, which can be a pitfall for a lot of candidates. The golden minute needs to be facilitated by asking open questions. 'Can you tell me more' or 'how did it all start'. If the response is still not adequate then another open question may be required.

If this fails then this may be a cue for a hidden agenda, which may need to be addressed before you can progress (see reading cues for more information)

### ICE

ICE is one of the important components to achieving a patient-centred consultation. Candidates often only elicit part of the ICE due to the stress of timekeeping or lack of practice.

ICE can reach to the nub of the case but needs to be done correctly or else it can annoy the patient. It would be worth having a list of different ways of asking the questions and practicing them regularly so that it appears natural. You can find this from the Pennine website (see resource list).

Eliciting ICE may cause the patient to respond by 'that's why I came to see you' or 'well you're the doctor'. It may work better after the psychosocial history. However if there is a strong underlying emotion from the patient (anxiety, sadness) or if the symptoms are vague, eliciting ICE early would be appropriate.

Be aware not all patients have ideas, concerns or expectations. In the CSA, the actors will not deliberately withhold their ICE when asked (unfortunately this may not be true to real life). Therefore it's important not to pursue this

line of questioning if the patient has said no, as this is time wasting and irritating for the patient.

### **Psychosocial**

This is another patient centred component. This helps to appreciate the patient as a whole and how the illness affects them, which enables the GP to manage the problem holistically. Some candidates do not normally take an adequate psychosocial history as this is not commonly done in secondary care. The key is to develop a strong curiosity of their background and how that may have influenced the patient's views about their symptoms.

The questions to consider are occupation and the home situation. Then this needs to be expanded by asking how the illness affects them particularly their mood, sleep and driving if relevant. If the consultation is focused on health promotion then it would be important to enquire about exercise and diet.

### **Closed questions and red flags**

By this stage of the consultation, the doctor's agenda will finalise the data gathering. Certain conditions have set questions that need asking. This should be asked as a list of questions to save time. But you should prepare the patient (by signposting) by saying for example: 'I am now going to ask you a series of questions'.

If you feel some of the questions that will be asked will stimulate anxiety (for example weight loss or blood in the stool) then you could signpost like this: 'To ensure I don't miss anything important I'm just going to ask you these set of questions'.

You should learn to develop your own set of questions for common problems like headache, energy loss, chest pains, back pain, cough and etc. Here are a few examples:

#### *Cough*

productive? Coughing blood? breathless? Chest pains? Weight loss? Smoker? Hoarseness?

#### *Back Pain:*

Trauma? Weight loss? Night pain? Perianal numbness? Incontinence? Weakness or loss of sensation in the lower limbs? Shooting pains to legs?

It is not essential to ask every closed question relating to the illness but it is important to rule out all red flags.

### **Examination**

As you approach to examine you should signpost and briefly explain the examination. –in jargon free language and what you plan to do. This is especially important when performing intimate exams.

In some cases the examiner will stop you and either give you a card with the examination findings or vocalise them. The role player may ask what you would examine before the examiner releases the information. Avoid saying a whole list of examinations as this would not be realistic and would likely affect the marks.

If you are required to examine, it should be focused and last approximately 1-2 minute.

### **Relate to ICE and explaining the diagnosis**

Being able to relate the ICE to the management and diagnosis will help persuade the patient in accepting your medical opinion as it shows you have listened to them. Therefore if there has been a failure to elicit the ICE in the consultation it will surface in the management plan leading to a long back and forth discussion. Consequently the patient will be less likely to be persuaded by your recommendation and significant time would have been wasted.

### **Options:**

Sometimes there may be too many options of treatment to discuss, for example contraception. One method is to break them down into categories to simplify the choice: for example hormonal or non-hormonal.

Other times there is only one clear management- for e.g. chest pain requiring admission. This can be presented as a recommendation and then seeking the patient's opinion. 'I think you need to be admitted but what are your feelings about this?' Or you could say that 'I think we have two choices: admit or manage in the community but I am concerned that if we don't admit.....'

*To follow guidelines or not?*

There are clear guidelines for managing certain conditions like blood pressure and diabetes. However it's important not to present the first line treatment as the only option, as the patient may have strong reservations. This could be because they are not keen to start long-term medication or have had bad experience with the treatment from friends or relatives. As a result, you should use guidelines as a framework for your management but also remain flexible to respect the patient's autonomy. For example 'I would recommend starting you on medication but another option is to attempt lifestyle changes first and closely follow you up. What would you prefer?'

### **Follow-up+ Safety netting**

Rarely will there be a consultation in the CSA that shouldn't end with advising follow-up as it helps enhance rapport and builds the foundation of a long-term relationship with the patient.

Safety netting is best done as part of follow up. "Come and see me in 2 weeks if your back pain is no better or sooner if it gets worse".

In acute cases safety netting becomes even more important and you would have to be more specific. "If despite the new inhalers your cough gets worse or you start to get more short of breath come back straight away.

Unsurprisingly this is a skill that is essential in out of hours.

# Essential Skills

## **Summarising**

Failing to summarise will not result in any penalisation in marks. Therefore choosing not to summarise can add additional time to the consultation. But if you do choose to summarise it can be advantageous in helping to clarify your thoughts.

## **Reading Cues**

Cues are signals given by patients to the doctor to prompt further exploration. It is essential to pick up the cues as they unlock the consultation. Failing to do so can lead to barriers in the history taking which can result in missed information and loss of rapport.

Cues can be verbal or non-verbal.

### Verbal

The patient may mention:

- 'I came in because my wife pressured me to come in'
- 'I m worried because my mother had cancer '
- 'Its been tough what with work.'
- 'I would like to have a well man check'

Another verbal cue could be a patient frequently mentioning or asking about the same topic.

These should prompt you to ask the 'why, what and how' questions. 'Why did your wife pressure you?', 'what happened to your mother', 'how has it been tough at work' and 'why the sudden interest in a check up'.

Prior to asking these questions, the verbal cues can also be opportunities to demonstrate empathy and reflective listening to the patient. 'It must have been really tough for you and your mother' 'I m sorry to hear that work has been tough for you'

### Non verbal

The patient may

- purposely avoid eye contact
- give only brief answers
- talk very slowly
- appears irritated

By recognising both these cues, it should be a prompt to explore the ICE or psychosocial component of the consultation. If this fails to reveal anything it would not be unreasonable to say to the patient 'I feel like I m missing something here' or 'I feel that there is more to this'. This is essentially highlighting the elephant in the room. Typical scenarios of where a patient is

not forthcoming of information but demonstrates plenty of non-verbal cues are depression and domestic abuse cases.

### **Chunk and check**

Towards the end of the consultations most candidates feel the stress of the time pressure which inevitably affects the clinical management. This usually leads to a long lecture to the patient about their diagnosis and management without involving them in a discussion. The consultation becomes doctor centred and interpersonal marks will be lost.

One method to avoid this is to chunk and check. After explaining the diagnosis or treatment option pause and check their understanding or their thoughts. 'Do you think this diagnosis is plausible?' or 'how does this sound, before I go on'.

### **Failing to keep to structure**

In some scenarios the patient will present with a problem that doesn't fit with the typical CSA consultation structure as discussed above. Consequently candidates will fall in to the trap of doing clinical management before data gathering. These scenarios tend to be when the patient's opening gambit is to discuss results or making a request.

It's important to maintain the consultation structure whenever possible.

Given the added exam and time stress, failing to keep to structure will inevitably lead to missed components of the consultation and backtracking.

This will lead to a disjointed consultation that will affect the consultation flow and interpersonal marks.

#### Opening gambit: Discussing results

When a patient request for a recent test result, a common phrase that can be used is 'given we haven't met each other, would it be ok if I asked some questions about how you have been?'

#### Opening Gambit: Requests

Patients may start by asking the doctor can I have a referral, test, sick note or a letter. It's important to explore the reasons that will eventually lead to the data-gathering element of the consultation.

Even if the request is unreasonable its important not to refuse it too early, as this will antagonise the patient and the consultation may fail to progress smoothly. The key is to acknowledge the request but not necessarily agree to it: 'that's something we can definitely talk about but can I find out a bit more about what has been going on?'

#### Doctor' opinion during data gathering.

Occasionally the patient may ask for the doctor's opinion while your eliciting the history. For e.g. 'I have been using glucosamine tablets for my knee pain. Do you think that's a good idea?' Its important not to add an opinion that may stimulate a debate at this stage as this will undermine the data gathering flow. One method is to 'park' the question to the end. 'I do have an answer for you but would it be ok if I shared it with you towards the end?'

#### The exception:

If the patient is repeatedly asking the same question despite attempts to delay the answer this can invariably affect the rapport. This tends to occur in



patients who are in high emotional states: depressed/worried, short tempered or expecting bad news.

It's important to recognise these moments as cues to break from structure to acknowledge their concerns.

Once the concern has been dealt with it's vital to return back to the data gathering when possible. For e.g. 'I know that what I have told you has been upsetting but there are available treatments. Before we discuss this would it be ok if I asked some more questions about how you have been?'

### **Thinking out loud**

Thinking out loud is narrating your thoughts as you're approaching to a conclusion for a diagnosis or management plan. 'Given that your joint became rapidly swollen and it's only affected the big toe, I think you may have gout.

Because I'm not 100% certain I would like to arrange for a blood test'.

By demonstrating your logic the patient will be more likely to be persuaded in accepting your clinical decision and management.

### **Remaining positive**

Balint describes how doctors can be a drug for the patient in his consultation model where patients can immediately feel better after seeing the doctor.

Appreciating this concept can be very helpful in dealing with heart sinks or highly anxious patients.

As well as listening to the patient, (particularly their ICE) and offering support, it's also important to remain positive for the patient (despite your personal feelings of the disease). This would involve being optimistic on treatment options, prognosis or the nature of the disease. For example 'I know that fibromyalgia is not curable but it's important that you know that many people do get better with time.' 'Although the IBS symptoms have been difficult, the good news is that there is nothing structurally wrong with your bowels. Therefore IBS will never severely affect your general health.'

### **Asking uncomfortable questions**

This can occur when having to explore suicide, recreational drug usage, sexual history and STDs. This could be softened by saying 'to ensure I'm not missing anything important I have to ask....'

An alternative is the 'my friend John' method. 'Some patients I know who have been through similar difficulties had thoughts about harming themselves. Has this been the case for you too?'

# Difficult Clinical Cases

## **Uncertainty**

There may be a situation where you may not be certain what the diagnosis or the treatment should be. Good medical practice is to share your uncertainty with the patient as this is likely to occur in real life. Therefore you can still score highly on the station if you can explain how you would find the answer and follow up but also offer a safe management plan in the meantime. Even without a specific diagnosis you will most likely be able to address their concerns. For e.g. if they were worried about cancer but there were clearly no red flags found.

## **Ethical situations**

There will usually be an ethical situation in the CSA. This may include DVLA related issues, prescribing control drugs, euthanasia, fitness to work, confidentiality and etc.

If the answer to the ethical problem is clear and unfavourable to the patient or you have decided an unfavourable management plan for the patient, the key is not to reveal it immediately as this will damage the rapport of the consultation. 'Thinking out loud' can be helpful as you can explain the pros and cons when considering the situation. You can then mention the consequences it may have on the patient and relatives.

It would not be unreasonable to share how you feel of the situation. 'I have to admit it makes me feel uncomfortable knowing that you are still driving when your seizures are not under control'.

As a last measure, you can talk about hypothetical situations involving relatives and friends. 'How would you feel if your loved one was killed by a driver who was having a seizure at the time.'

## **Managing a List of problems**

The typical CSA station will not have the patient presenting a list of problems unless the theme of the station is about managing the list. Its important to surface the list early as oppose to reactively dealing with the problem one by one as you will most likely not finish. Once you know the list, you need to triage the problems based on what's important to the patient and to the doctor. You can say to the patient ' given our limited time together I don't believe I can deal with each problem with the justice it deserves. Perhaps we can decide together which problems needs attention now and the others can be dealt with in another appointment.'

## **Talking to a Third party**

There will usually be at least one case where a third party (friend or relative) will want to discuss about a patient. If the patient is an adult it is vital that you respect confidentiality. This will need to be highlighted to the third party. Any information discussed has to be based on what is revealed by the third party.

If any plan is made, the patient will need to be involved unless it's an exceptional circumstance- mental illness, history of violence, safety of the third party.

If there is a strong emotional element, it is likely that the third party is under a lot of strain. It's important not to forget to show empathy to them by asking how they feel and if they need any support.

## Important tips

### **Leaflets**

Giving a leaflet can be helpful to finalise the consultation. However, you won't get any marks for giving a leaflet unless you explain its contents briefly. 'The leaflet will explain what cholesterol is and why it's important to lower it'.

As you will not have a leaflet to hand, don't pretend to hand one as this will appear odd in the CSA. You can mention (for e.g.) that it can be collected from reception.

### **Formulaic**

There are certain phrases that are commonly used in the CSA which have been proven to be effective. However due to their frequent usage they can occasionally sound unnatural, mechanical and formulaic which can affect how the examiner marks and how the actor reacts. It would help to have some of your own unique phrases- particularly for eliciting ICE.

Would some examples to avoid be useful???

# How to prepare

How much time is needed for preparation is variable depending on the individual. The average amount of time to prepare is 3 months. But to know if this is appropriate, you will need to discuss with your educational supervisor.

## **Consultations in your surgery:**

You ideally should be at 10 minute consultations for at least 4 weeks. There is the argument that 12 minutes would be acceptable to account for 2 minutes of paper work. However if you are able to run 10 minute consultations you will be more acutely aware of your timekeeping and much less likely to over run in the CSA.

You should aim to run several appointments in your surgery in a CSA style. Practising with patients can be very different from having doctors acting as patients. One other method is to just practice one aspect of the CSA- for e.g. just eliciting the ICE or presenting options.

## **Practice as many cases as possible:**

The more cases you practice the less uncertainty you face in the CSA. If you have exhausted all the cases or there is a specific learning need, then you should aim to write cases with your peers for each other

## **Group work:**

The ideal is 3-4 in a group, to allow for at least one observer in the group to critique the doctor. Any more than 4 will drastically reduce the opportunities in role-playing the doctor per group session.

It would also help to change into different groups on occasions to gain different learning experiences.

## **Video consultations**

Sometimes the best critic is yourself. Filming your consultations in your surgery will give you insight to your unconscious bad habits. The video can also be shared with your supervisor and peers to gain further feedback. Video consultations are particularly useful if you are unable to participate sufficient group sessions.

## **Educational supervisor**

Your educational supervisor should be trained and experienced to guide and assess your ability to hold a successful consultation. Therefore their feedback can be invaluable. This is likely to come from COTS and focusing your seminars towards the CSA.

Remember the COT was written by CSA examiners.

## Some Popular resources

### **Pennine website:**

Offers an extensive bank of CSA scenarios that will take weeks to months to complete. The cases are a good reflection of what happens in the actual CSA. Their marking sheets are generally good although some could be better. They offer several youtube videos of the 'good and bad' CSA consultations done by doctors. As well as the CSA, the website offers a good resource of information for any related GP topics.

### **The Bradford VTS website:**

Uses the same CSA case bank as the Pennine website. But they also provide a CSA revision guide similar to this one.

### **CSAcases.com (website):**

This is a paid website. It offers approximately 50 cases laid out as sets of 13 cases to reflect the actual CSA. Each set has a balance of topics and the candidate information is presented in the same format as the CSA. Therefore you can use the set as a mock if choose to. Wessex AiT Subcommittee (with funding from Wessex Deanery and Wessex RCGP Faculty) are sometimes able to provide free subscriptions for Wessex ST3s. Look out for information via the ePortfolio messaging service if this applies to you.

### **CASEcards (flash cards):**

These are flashcards that offer concise and simplified explanations for most diseases and management that you will encounter in the CSA. These can be particularly helpful in cutting down explanation time and help explain difficult diseases in layman terms for e.g. autism, heart failure.

### **CSA Scenarios for the MRCGP by Thomas M. Das(Book):**

This book provides a list of questions to elicit for common conditions. They can be helpful when developing your own set of closed/red flag questions when dealing with certain problems.

### **A guide to the CSA (DVD)**

This is a DVD from the Wessex faculty RCGP. A new series is released almost every year; and at the time of this writing there are now 4 series. They are videos of actual GPs doing CSA cases and being critiqued by CSA examiners. You may be surprised what is considered good and bad by the examiners, which can offer a lot insight to how the exam is marked.