

Working in a Study Group for the CSA – Top Tips

‘Mutual assistance makes for mutual success’ – Traditional Chinese Proverb

Although not every ST will have the opportunity or inclination to join a study group, I would strongly recommend your VTS considers forming a group(s) early on in the ST3 year.

Forming a study group is not just a necessity in helping to formulate your approach and revision when preparing for the CSA, but it will help you refine your skills in giving feedback and working with others within teams to attain a common goal. You will find that as your group evolves, you will develop a greater degree of self awareness when observing others, and when being observed in how you communicate, consult and commit.

Over the years, I have helped to facilitate scores of study groups across many different VTS schemes and in doing so have observed and helped trainees to work through interesting and challenging group dynamics which can either make or break the way in which a study group functions.

From a CSA perspective, I believe there needs to be specific ‘CSA ground rules’ when considering a functional and effective study group. The following rules are used by my trainees on the St Marys VTS scheme which has to date a 100% 1st time CSA pass rate and has always incorporated regular study group sessions in the lead up to the exam.

1. Start Early!

The CSA cannot be crammed for. I always advocate coming on a course ideally 2 months before sitting the CSA, but really the earlier the better. The same applies to study groups. Role play under scrutiny is not easy, so the earlier you get used to this, the easier it becomes to get into role.

2. Study groups should be no larger than 3-4 in number

The rationale for this is that the CSA is all about practice – there is little point in sitting around in a large group to discuss a case without actually playing it out as a role play in real time. A group of 4 allows the following roles to be allocated – ‘patient’ / ‘GP’ / ‘1st examiner’ / ‘2nd examiner and timekeeper’

Several study groups can be formed to accommodate all of those who are undertaking the CSA. The groups can also swap members to allow for variety in role play, consultation style and feedback.

3. Role-play and feedback

Active observation and feedback of consultation behaviours mapped to the 3 CSA marking domains is what your study group needs to aim for. There are now many books on the market which include role player briefs with discussion of the case after it has been played out. However, try also to use challenging cases that you have seen in practice and map these to a role play with you playing the patient.

The only information that is generally required for the others in the group is the name and age of the patient you are playing.

For effective CSA study group feedback, the examiner(s) need to critique both the GP and the patient. If the patient 'gives' too much information away about the presenting complaint in response to a generic open question and without being specifically asked in context, the case will lose its validity with regards to the challenge of what actually happens and is being assessed for in the CSA.

Examiner feedback needs to be based upon the 16 formative CSA statements, which are mapped to the 3 CSA marking domains. These statements have been covered in detail in my other CSA articles linked to this series, but in summary always look to identify and consolidate areas of improvement according to the following:

GLOBAL

Reasons for failing:

1. **Disorganised and unstructured consultation**
2. **Does not recognise the issues or priorities in the consultation e.g. the patient's problem, the ethical dilemma**
3. **Shows poor time management**

DATA GATHERING

Reasons for failing:

4. **Does not identify abnormal findings or results or fails to recognise their implications**
5. **Does not undertake physical examination competently, or use instruments proficiently**

CLINICAL MANAGEMENT SKILLS

Reasons for failing :

6. **Does not make appropriate working diagnosis or identify range of differential possibilities.**
7. **Does not develop a management plan (prescribing +/- referral) that is appropriate and in line with current best practice.**
8. **Follow-up arrangements and safety netting are inadequate.**
9. **Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options.**
10. **Does not attempt to promote good health at opportune times in the consultation.**

INTERPERSONAL SKILLS

Reasons for failing:

11. **Does not appear to develop rapport or show sensitivity for the patient's feelings.**
12. **Does not identify patient's agenda, health beliefs & preferences.**

13. Does not make adequate use of verbal and non-verbal cues. Poor active listening skills.
14. Does not identify or use appropriate psychological or social information to place the problem in context.
15. Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient.
16. Does not use language and/or explanations that are relevant and understandable to the patient.

The marking templates which I use on my course and which I would encourage you to use when working in a study group can be downloaded from the website www.passmrcgp.com

4. Be systematic, specific and objective. Use your time effectively.

This applies not just to feedback, but also what you hope to cover with each session. Within each session, aim to cover 3 cases each of which should have a different focus on one of the following areas:

Diagnostic uncertainty / Ethical Dilemma / Negotiation / Health promotion / Breaking Bad News / Communication of a diagnosis

Get into role play quickly, make sure that the examiner keeps an eye on the clock and during the initial stages of the study group, ask the examiner to give you an indication of the timing of your consultation. Remember that each consultation lasts 10 minutes and no longer, and all cases will have 2 halves. On my course and at St Marys we advocate a 6 minute, 4 minute rule which applies to the 1st half (data gathering, examination) and 2nd half (clinical management, follow up and safety netting) of the consultation respectively. With repeated practice, you will not need to look at the clock as you will have mental stop watch as to where you are.

After the role play, it should be the examiner who leads the feedback and facilitates the discussion. The examiner should look to identify 'nervous' or 'rigid' habits – a typical behaviour I have observed on numerous occasions, is the way in nervous doctors superficially acknowledge patient's health beliefs by repetitively saying 'ok' or 'fine' in response to a patient's concern. Well is not 'ok' or 'fine' if a patient has just told you something serious which requires sincerity and empathy on the doctor's part. Identifying such habits will help you address the behavioural indicators which are assessed in the exam. Use your books (if you have them) to help but ultimately just as with the CSA, any feedback which is given must be justified by the corresponding behavioural indicator which was observed. Make sure that everyone is clear as to which statements are being highlighted as areas for improvement. Ultimately as a group you must calibrate and decide upon what defines a Clear Pass, Marginal Pass, Marginal Fail and Clear Fail. With repeated practice at both consulting and giving feedback this process becomes much easier. Covering 3 cases with feedback should take just over 1 hour.

5. Be pro-active and supportive – no room for complacency

Everyone needs to participate. After each case, you must rotate to take up a different role. Support each other and try out different approaches to the consultation which you will have observed from watching others. Don't rely on simply reading and regurgitating the books – the CSA is not a test of knowledge per se, but applying knowledge in a problem solving manner which is fluent, justified, relevant and centred on the individual patient opposite you. Use video-recording of role plays or real life consultations (with consent) to demonstrate behavioural indicators whether these be positive or negative.

6. Avoid CSA Burnout – Have fun! Relax!

As the exam closes upon you, nervous anxiety can take hold. If you tire of repeated role play, then switch your attention to practicing examinations. Become fluent in peripheral systems, especially ENT, EYES, MSK ensuring that you are all consistent and systematic in your approach.

Practice explaining and communicating diagnoses to each other in no more than 2-3 sentences, trying to avoid unnecessary medical terminology and keeping it simple.

Most importantly try to enjoy your time together – ultimately the CSA is just an exam. There is much to life before and after! All too soon it will be over and you will actually miss the peer support of your group in this respect. I think one of the big reasons I decided to become a Programme Director is so that I could back to the VTS – it is great fun!

On the course, I make a point of treating everyone to a drink – alcoholic or otherwise – at the end of the day. Call it housekeeping but learning to unwind is an equally important part of your preparation.

7. Don't ever give up!

We will end this series with a final Chinese proverb:

“Failure lies not in falling down, but in not getting up.”

I do hope you have found this series of articles helpful. I would like to thank Pulse for the opportunity to work with them once again.

Special thanks to my trainees and fellow Programme Directors at St Marys for keeping me sane and youthful, my trainer Dr Jane Doherty who I have not seen for many years, but will always remember as the ‘one’ who taught me self awareness in the consultation and last but not least, my wife – Dr Hilda Ho, who is also a GP and continues to inspire me in the way she consults, communicates and strives to take the best away from every experience, whether it be positive or negative. What a lucky man I am!

About the author:

Dr Nigel Giam

MBBS MRCGP MRCP Bsc DRCOG DCH DFSRH PGCertMedEd

Dr Nigel Giam is the course director for Mentor MRCPG preparation courses–
www.passmrcgp.com for more details.

He is a GP Programme Director for the St Marys VTS and works as a GP and a lecturer in medical education. He is a Senior OSCE Examiner and Tutor of General Practice at Kings College School of Medicine and Imperial College School of Medicine. He has worked as a RCGP and PACES course organizer.