Feedback on performance at the September 2010 CSA exams (MRCGP)

Overall performance outcomes

Three hundred and fifteen candidates sat the September CSA exams, of whom 56% were sitting it for the first time. This is therefore an unrepresentative sample of candidates, due to the timing of the sitting (in 2009, 81% of all candidates were first time sitters, and the peak time to sit the CSA for the first time was in the period January - April).

The pass rate for this cohort overall was 45.7%, with 62.1% of first time sitters passing.

Why do candidates fail?

One of the ways we can identify reasons for failure is from the type and frequency of feedback statements given to candidates - for the first time, feedback was given to ALL candidates where two or more examiners had identified a deficient area of performance, regardless of whether they passed or failed the case, or whether they failed overall. However, it is reasonable to assume that more feedback statements were given to failing than to passing candidates, as the feedback statements are all couched in ‘areas for improvement’ terms.

The three commonest statements (in order of frequency) given by examiners were:

1. Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient.
2. Does not recognise the issues or priorities in the consultation (for example, the patient’s problem, ethical dilemma, etc).
3. Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice.

The CSA website gives further definitions of the individual feedback statements and tips on what candidates can do to improve their performance if they receive targeted feedback such as this.

These three feedback statements are also within the top 5 feedback statements that were given out in the CSA in the twelve months from Jan 09-Jan 10, so the reasons why this cohort of candidates did not do well is very similar to the larger year group.

What can candidates do to improve on their performance?

Taking the three feedback statements in chronological order in a consultation:

   The ability to understand the implications of the patient’s presentation in the context of his/her lifestyle, family, work situation is of clear importance in demonstrating the following competencies (to be found as domains in the RCGP Curriculum).

   - Holistic care - demonstrates understanding of the patient in relation to their socio-economic and cultural background, recognises the impact of the problem on the patient’s family/carers, utilises appropriate support agencies targeted to the needs of the patient
   - Attitudinal aspects – an ethical approach and showing respect for diversity and the patient’s viewpoint
   - Community orientation- identifies important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features. The candidate can apply this understanding appropriately

These are all part of the RCGP curriculum and competence framework, and also covered in WBA assessments. They are part of the integrative consulting approach to individual patient presentations, that does not just take presentations at face value, but searches for reasons for the problems presented,
and their effects on the patient’s current life and future health. Demonstrating these competencies shows that the practitioner is capable of consulting at a deeper level that is more likely to get to the nub of the problem and be of greater help to the patient. He/she is also ‘seeing the problem with the patient’s eyes’.

- A combination of CBDs and watching video consultations with an experienced practitioner who understands the local community set-up of the registrar will help develop expertise in these competencies.
- Looking at consultations specifically with these competencies in mind, can help registrars see issues and priorities they may not have previously recognised.
- Small group work targeted at considering these competencies, based on cases they have individually seen, can also help.

The remaining two feedback statements are linked, in that if a recognisable, defensible management plan is not developed, then it is unlikely that a candidate will be able to demonstrate sharing that management plan.

Developing a management plan that reflects knowledge of current best practice. This demonstrates the following competencies:

- Primary Care Management
- Specific problem solving skills

It may be that the registrar has made assumptions in the consultation and has failed to make the management plan explicit to the patient, even though the underlying management plan is sound.

- Watching videos of consultations and doing joint surgeries with the registrar should help to identify if this is the case.
- Practising explaining management plans as part of a role play can help the registrar develop this skill.

If it turns out that the registrar is not developing management plans that reflect current best practice, then intensive supervision and frequent hot reviews are needed to ensure that performance is improved and that the registrar is competent and safe to practice.

The commonest feedback statement given is that the candidate has not shown an ability to develop a shared management plan, in partnership with the patient. The competency being tested here is:

- Person-centred care

Some registrars take a formulaic approach to person-centred care, asking questions suggested in the text books, such as ‘what are your worries?’, ‘is that OK?’ and ‘what are you going to tell your husband/wife when you get home today?’. These are not ways of getting to understand people in everyday ‘normal’ consulting discourse. The patient does not feel that the doctor is really being empathetic and the consultation feels ‘wooden’.

In other cases, registrars can sustain the patient-centredness for the data gathering part of the consultation, but then switch to doctor-centred mode in ‘telling’ the patient what he/she should do or take. The best shared management plans take account of the patient’s ideas, concerns and expectations that are gathered in the first half of the consultation, and deal with them as well as with guiding the patient through the management options for that presentation.

- Watching videos and allowing registrars to sit in with experienced good consulters, should help them gain insight into the effect of their consulting style on patients.
- Asking a few patients to give feedback to registrars about this effect can also be very illuminating.
- Getting registrars to role play, or practise, explaining diagnoses and management plans to patients can also help them develop their patient-centredness, rather than relying on stock phrases that do not suit their individual style of consulting.

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