

Clinical Skills Assessment (CSA)

The CSA is a clinical skills examination required for graduation from the School of Medicine. The CSA uses standardized patient (SP) encounters to assess student performance in:

- Data gathering technique (history and physical examination)
- Interpersonal communication
- Clinical management (diagnostic strategy and treatment plan)
- Professional documentation (post encounter note or PEN)

CSA is a formal examination of the School of Medicine covered by the University Honor System. Students must not discuss case content outside of approved sessions.

Scheduling

The CSA is provided on both the Kansas City and Wichita campuses on specified dates between May and July each year. Students should schedule CSA early to secure the most suitable date and location. Scheduling is arranged through

Wichita students – Karen Drake, Office Academic Student Affairs 3-2603

Kansas City students - Julie Mack, Neis Clinical Skills lab 8-2259

Rescheduling can only be arranged in an emergency and only a limited number of emergency slots are available.

Format

Each student completes 12 clinical encounters. In each encounter, the SP portrays a common clinical outpatient presentation. The specific location of the encounter (e.g. ambulatory clinic, emergency room) and other essential background information are provided for each case. The instructions for the case specify what is expected of students and the time allowed for the encounter. Typical instructions prior to a session are:

Mary Brown has come to the ambulatory clinic today because of shoulder pain. You have 15 minutes to take an appropriate history, perform a focused physical examination, communicate your assessment to the patient, and discuss an appropriate diagnostic and management plan with the patient.

The instructions for the case also include vital signs and any essential information such as laboratory or imaging test results.

Students should conduct the case as if they were the physician responsible for the patient. They must gather data from history and physical examination, communicate conclusions to the patient, and negotiate a management plan. All necessary equipment is provided to assess the case. If a sensitive physical examination (e.g. cornea, breast, rectal, vaginal) is indicated as part of the logical data-gathering for the case, students should tell the patient

they wish to conduct the examination. Appropriate information may then be provided by the patient.

Each session is strictly timed. Students may not start reading case instructions or enter a room until given permission. A warning is broadcast into the room 5 minutes before the end of the session. Students must exit the room when instructed at the end of the session.

After each encounter, the student has 10 minutes to complete a post encounter note (PEN).

Scoring

Each SP scores student performance using a checklist of key items for each case. These include essential aspects of history, physical examination, diagnostic and management plans AND aspects of communication skills. Each SP is trained to score about 25 specific key components for each case. In the example above, the scoring could include if the student asked about trauma or previous shoulder problems as well as any of the key questions for pain (location, severity, radiation, exacerbating factors etc), if range of motion was tested, and if the student discussed the need for X-rays, pain relief or physical therapy. In all cases, the SP also scores on aspects of communication skills such as introduction, use of jargon, attention to patient comfort, and use of both open and closed-ended questioning.

Faculty members score a sample of PENs for each student. The PEN scoring is based on documentation of key components for the case plus points for the organization, logic, legibility, and professionalism of the note.

Outcomes

A team of 3 faculty members reviews the performances of any student identified by a low score or other concern. The outcomes of this review are provided to the Associate Dean for Student Affairs (Kansas City students) or the Associate Dean for Academic and Student Affairs (Wichita students).

Feedback to students may take the form of:

- written feedback – with advice on specific issues of concern
- individual coaching – video review session(s) and advising by a faculty member
- clinical remediation – allocation to a clinical service and advisor to address specific serious problems in clinical skills.

The choice of strategy depends on the most effective way to meet the learning needs of the individual student.

Logistics

- The CSA takes all day and requires a complex schedule to rotate all students through the appropriate mix of cases. Lunch and other breaks are provided. Students **MUST** stay on schedule. Arriving late at the beginning or after a break may result in not

being allowed to complete the examination. If an emergency occurs, contact 3-3519 (Wichita students) or 8-3430 (Kansas City)

- Professional conduct and dress (white coat) are required
- Students must only bring stethoscope and writing materials. No pagers, cell phones, PDAs, reference materials or other resources are permitted. Everything necessary for the case is provided in the room.
- Faculty and staff monitoring CSA sessions have several roles, mainly to ensure SPs consistently portray the same scenario for every student and that the portrayal is clinically appropriate. No feedback can be provided to students in the course of the CSA.

Confidentiality

Discussion about the cases used in CSA is not only poor professional behavior and a violation of the Honor Code, it is also extremely foolish. Information from other students about cases could be inaccurate or out of date as all cases are re-edited regularly and new cases introduced every year.

More seriously, CSA tests the student's ability to gather and interpret data, work through clinical problems, and communicate with patients, NOT the ability to reach a specific diagnosis. Cases may not have a single clear-cut diagnosis or may be specifically designed to assess how students handle a specific type of patient. Information about the diagnosis ahead of time is a serious handicap and results in lower scores as students miss points for exploring the full differential and potential alternative diagnostic and management strategies.

Any suspected breach of confidentiality should be reported to the Associate Dean for Academic and Student Affairs (Wichita) or Associate Dean for Student Affairs (Kansas City)

Tips for CSA Success:

Preparation

- 1. Review your basic medical knowledge.** Revise the clinical presentation, diagnostic strategy, and management of common clinical problems, including preventive and behavioral issues. All CSA and USMLE Step 2 CS cases concern common outpatient problems.
- 2. Polish your history-taking skills.** Use information from classes, references and the textbooks for CSE¹ to ensure you have an appropriate and logical approach to common patient presentations. If you find them useful, use lists and mnemonics to make sure you remember basics during a consultation. Common examples are:

¹ Le T, Bhushan V, Shahin FA, Sheikh-Ali M, Martin LD. First Aid for the USMLE Step 2 CS McGraw-Hill New York 2004

Retegui JA Mastering the USML Step 2 CS 3rd ed. McGraw-Hill New York 2005

the 7 classical questions for pain

- Onset (*how did it start? Don't forget to ask about trauma if appropriate*)
- Location (*where is it and does it radiate anywhere?*)
- Quality (*sharp? Dull? Electrical? Burning? Etc- in patient's words*)
- Severity (*descriptive plus a 1-10 scale*)
- Alleviating factors (*anything that makes it ease or go away - position, medication, heat/cold, activity, food time of day etc*)
- Aggravating factors (*what makes it worse?*)
- Associated symptoms (*what else does patient link to pain e.g. nausea, chills, visual problems etc*)

and the “rule” of 4 for components of previous medical, social, or family history (see Guidelines for Notes – *provide link*)

- PMH: illness/hospital/surgery (+ reproductive in women): medications: allergies: preventive/prospective care items
- SH: tobacco/alcohol/illicit substances: occupation/education: living situation: health habits
- FH: parents: sibs: “anything runs in family”: specific conditions related to case/patient

and mnemonics for ADLs and IADLs

DEATH dressing, eating, ambulating, toileting, hygiene

SHAFT shopping, housekeeping, accounting, food preparation, transportation

Caution: remember to adapt the general framework to each patient situation – don't just have the same script for every case!!

- 3. Review your physical examination techniques.** Most cases require a focused exam of the body systems most pertinent to the differential diagnosis. Review the expected content of each focused exam in the USMLE-CS textbooks but use your best judgement to plan what to include in individual cases, balancing time against value of data gathered.

Note “sensitive” exams like rectal or vaginal are not expected in SP situations but if you believe it provides data you would normally gather in a case, ask the patient's permission to do one. The SP may provide you the results on a card.

The CSA and USMLE-CS **require good technical performance** of physical examination. Review the classical techniques in Mosby's textbook and ask for help before the exams if necessary.

Don't forget the absolute basics of physical examination

- **Wash your hands**
- **Tell the patient what you would like to do and why**
- **Ask patients' permission to examine them**
- **Ensure patient comfort** (e.g. asks where it hurts first, avoid causing pain)
- **Expose what you need, especially abdomen and chest, but**

- **Ensure appropriate draping and patient modesty**
 - **NEVER, EVER listen or palpate through clothes**
 - **Look confident, especially when using equipment**
- 4. Polish your communication skills.** Use textbooks and reviews of your SP encounters during clerkships to ensure you cover the basics well:
- Opening: warm/professional, eye contact, introductions (use patient's formal name until given permission to use first names)
 - Engage: open-ended questions to negotiate the agenda followed by a logical sequence of clarifying questions, avoid interrupting the patient
 - Empathy: supportive, interested in the patient (use both words and your body language)
 - Educate patient: assess and verify patient understanding of the situation, avoid using medical terminology/jargon
 - Enlist: ask the patient's views on the diagnosis, proposed work-up and management plan. Negotiate, don't dictate!
 - Close: summarize the most probable diagnosis and proposed diagnostic and management plan, arrange follow-up, and express support.

Remember the SP will be scoring you on interpersonal communication as well as technical clinical skills.

- 5. Review Documentation (PEN) Techniques.** Use the Guidelines for SOAPs/PENs and feedback on the notes you prepared during formative SP sessions to be ready to do a complete, concise, professional note in the 10 minutes allowed. You will be asked to type a subjective/history section, document your physical exam (don't forget vitals!!), list up to five differential diagnoses in order of most likely, and then list up to five diagnostic tests. If you feel a diagnostic test is not needed, simply type, "No diagnostic test needed."

6. Practice makes perfect. Practice by seeing lots of patients on your clinical rotations and ask for feedback on your performance. Keep assessing and improving your skills.

Tips for CSA Success: On the Day

- Arrive on time (or early) and well prepared
- Make sure you are rested and fed (*no hypoing during sessions*)
- Look and act professionally
- Follow staff and faculty instructions
- Don't get lost or turn up late
- READ the INSTRUCTIONS for EACH CASE, inc TIME ALLOWED
- Ditto, ditto, ditto
- Plan your initial strategy BEFORE going into the room (*most likely issues? Best way to approach it? Things to definitely rule in/out? Key data needed? Priorities for decision-making? Potential problems?*)

- Positive entry – knock, introduction, use patient’s formal name, keep focus on patient
- Let patient present the problem, keep eyes and body looking interested (avoid taking excessive notes)
- Focused, logical clarifying questions sufficient to get the story but not “machine gunning” or exhausting patient. Be selective
- Watch for patient’s verbal and non-verbal cues
- Control your own mannerisms (e.g. wriggling, clicking pens, saying “ugh”!)
- Remember pertinent FH, SH, PMH, RoS (focused on problem)
- Perform only FOCUSED physical exam (if indicated in instructions)
- Wash hands prior to physical exam
- Attend to patient comfort and modesty
- Expose what you need, NEVER listen or palpate through clothes
- If there is a piece of equipment in the room, it probably has a purpose!
- Ask patient permissions and give explanations in physical exam or sensitive questioning
- Let the patient talk, especially when negotiating diagnosis and treatment plan
- Use the time well: if you finish early, something probably got missed!
- Don’t use jargon or words/phrases that the patient might not understand
- Conduct the interview as the physician of the day: you are not reporting to an attending physician/preceptor
- Follow the instructions for notes (PENs)
- Keep the adrenaline going – if one encounter does not go well, let it go! You have plenty of opportunities to shine with 12 cases.

Treat each case like a real patient encounter

CSA: Final Thought

The CSA is a tough day but it is your opportunity to validate that you meet many of the clinical skills competencies of the School of Medicine and are ready for the next stage of your education. In addition to your clinical skills, the CSA provides valuable data on the educational programs of the School and is used in curricular planning. Finally, the design is based on USMLE Step2-CS so should help familiarize you with that format.