Introduction

The MRCGP examination can seem a daunting prospect for candidates, consisting of Workplace Based Assessment, an Applied Knowledge Test (AKT) and a Clinical Skills Assessment (CSA). Success in the MRCGP is essential for a candidate to obtain a certificate of completion of training (CCT).

Because of the nature of General Practice the depth and level of revision required to pass the MRCGP examination is enormous. You will also be tested on far more than just factual recall. To become a GP requires not only a solid foundation of medical knowledge but also many other attributes, including a commitment to caring for others, the ability to remain calm under pressure and the capacity to make important decisions with limited time available.

The Royal College of General Practitioners attempts to test all of these intangible qualities in the MRCGP examination to ensure that the GPs that they produce will be fully able to deal with the constant challenges and stresses of General Practice.

We hope that this revision guide will be a useful tool and help candidates prepare for this difficult examination.
Good luck with your exam preparation!
Background and history

The MRCGP exam was first held in 1965, when five candidates attempted the first sitting. Prior to this membership was awarded following assessment by the Board of Censors. The number of candidates has increased steadily since, and now stands at over 2000 each year.

Historically the MRCGP examination was not a pre-requisite to become a GP but instead a benchmark of excellence for GPs to aspire to. In 1996 a system of summative assessment of training for GPs was introduced that ensured that doctors that wanted to become eligible to become GP principles satisfied the Joint Committee on Postgraduate Training for General Practice (JCPTGP) that they had adequate knowledge, consulting skills and clinical competence. This assessment took the form of a multiple choice question paper, a videotaped assessment of consulting skills, a piece of written work, such as an audit and a written report of practical work in the General Practice setting.

The MRCGP examination was a separate entity that took the form of a multiple choice question paper, a written paper with clinical and critical appraisal type questions, a videotaped assessment of consulting skills and a viva.

In 2007 the assessment and examination procedure changed. The process of assessment by the JCPTGP and the MRCGP examination merged into a single assessment that is now a pre-requisite to become a GP. Candidates completed a three-year speciality-training programme and were awarded the ‘nMRCGP’ upon successfully
passing their exams. The ‘n’ representing ‘new’ was later dropped and the exam process reverted to being the MRCGP once again. The MRCGP is also recognised in Australia, New Zealand and most countries in the Middle East.

The MRCGP exam currently consists of three components:

1. Workplace Based Assessment (WBA)
2. The Applied Knowledge Test (AKT) and;
3. The Clinical Skills Assessment (CSA).

Information on the dates and fees and how to apply for the AKT and the CSA can be found on the RCGP website here:

Workplace Based Assessment

This assessment looks at a doctor’s progress at regular intervals throughout the training period. It is useful for identifying areas of weakness and providing positive feedback on clinical practice. The tools used for the WBA include the following:

- Case-based discussions
- Multi-source feedback
- Patient satisfaction questionnaires
- Consultation observation tools
- Personal development plan
- Learning log
- Clinical supervisor’s report
- Direct observation of procedural skills
- Clinical examination and procedural skills
- Clinical evaluation exercises

Further information about the WBA can be found on the RCGP website:

The Applied Knowledge Test (AKT)

This is a computer-based exam that lasts three hours and ten minutes, with a total of 200 questions. It requires the candidate to have a good understanding of general practice within the UK and assesses whether they would be safe to practice at a high level independently. There are 3 sittings each year, taking place at 150 Pearson VUE centres across the UK. A candidate can attempt the test a maximum of 4 times, at any stage during or after ST2 level. It is also possible to do as part of GP induction and refresher schemes. The cost of sitting the AKT is £530 at each attempt.

The breakdown of the test is as follows:

- Clinical medicine 80%
- Administration and health information 10%
- Evidence-based and critical appraisal 10%

The current overall pass rate is about 75%. The exam is not negatively marked, so it is a good idea to attempt all questions.

To get a good grip of the topics covered takes a great deal of time and candidates should start preparing at least 3-4 months before the examination.

Common reference materials include:

- GMC Good Medical Practice guidelines
Candidates often underestimate the length of time required to prepare for the MRCGP AKT and it is a good idea to start preparing at least 3 or 4 months before the examination.
Once you have started to get to grip with basics of each topic it is a good idea to start to supplement your learning with regular online practice using resources such as our website www.mrcgpexamprep.co.uk.

Try to isolate areas of weakness and concentrate on these areas and spend less time on your areas of strength.

*It is a good idea to supplement your learning with regular online practice.*

**Attending a course**

Besides reading, many candidates find it useful to attend an AKT preparation study day or course. There are numerous different revision courses available and these are often run by experienced GP trainers or doctors that have recently sat and passed the exam themselves.
You can learn many tips and hints about hot topics that keep coming up and exactly what examiners are looking for in the marking schemes. These sorts of insights are invaluable and can make the difference between passing and failing.

Many candidates find it useful to attend an AKT preparation study day or course.

**Types of questions**

The question format of the AKT comprises the following:

- Extended Matching Questions (EMQ)
- Single Best Answer (SBA)
- Free text
- Rank Ordering
- Picture format
Multiple Best Answer (MBA)
Drag and Drop

The commonest question types that appear in the AKT at present are SBAs and EMQs.

**Single Best Answer Questions**

Single best answer (SBA) questions require convergent thinking and the ability to come up with a single answer to a set problem. It is relatively easy for an examiner to test higher order thinking, such as application and evaluation of knowledge in this type of question.

Standard format SBA questions usually have three parts:

1. A statement or a clinical scenario that the question will be asked about
2. The question itself
3. The answer options, which will include one single correct answer

The answer options in an SBA will contain one single correct answer and several other distracting options. The question commonly asks for the ‘single most likely diagnosis’ or the ‘most appropriate next management step’. In many SBA questions several of the answer options are correct, but only one will be the ‘best’ answer.

Within the statement or clinical scenario there will be many useful clues to point you towards the correct answer. It is worthwhile highlighting or underlining these clues whilst reading the scenario. Most clinical scenarios will include vital signs, history points, examination findings and/or results of investigations.
Here is an example of a the sort of SBA question that you might expect to encounter in the AKT, with a model answer included:

**Screening tests:**

Which **ONE** of the following statements regarding the Wilson-Jungner criteria for appraising the validity of a screening programme is true?

A. The test can be used to understand the natural history of the condition
B. Treatment should be effective regardless of the disease stage
C. Intervals for repeating the test should be determined
D. There should be no extra clinical workload created as a consequence of the screening
E. Psychological risks need not be factored

**Answer: C. Intervals for repeating the test should be determined**

The Wilson-Jungner criteria for appraising the validity of a screening programme are as follows:

- The condition being screened for should be an important health problem
- The natural history of the condition should be well understood
- There should be a detectable early stage
- Treatment at an early stage should be of more benefit than at a later stage
- A suitable test should be devised for the early stage
- The test should be acceptable
- Intervals for repeating the test should be determined
- Adequate health service provision should be made for the extra clinical workload resulting from screening
• The risks, both physical and psychological, should be less than the benefits
• The costs should be balanced against the benefits

Extended Matching Questions:

Extended matching questions (EMQs) first appeared in medical examinations 1993 after work by Case and Swanson. They have become an increasingly popular way of testing medical students and doctors over the past few years. MCQs and SBAs have received some criticism as it has been suggested that candidates can often guess the answer via a combination of what they partially know and utilization of clues in the question. It has been suggested that EMQs address some of these key flaws and are a better means of assessing higher knowledge as opposed to simple factual recall.

A standard EMQ generally has four parts:

1. A theme that sets the stage for the questions
2. A list of options from which the questions that follow can be answered
3. A lead-in that gives the candidate instructions on how to answer the questions
4. The questions, usually in the form of clinical scenarios but can also be statements of facts or data that requires interpretation

EMQs generally require a greater knowledge base to answer all five parts than an MCQ or SBA would require. Distracters are often included to attempt to increase the complexity of the question and to help discriminate the better candidates. The difficulty is further
increased by the fact that the same answer can be used more than once, increasing the number of potential answers for each part and removing the ability of the candidate to exclude options by a process of elimination.

It is a good idea to read all five questions and attempt to formulate an answer for each without the options as guidance. If you then can see your proposed answer in the list of options you can answer with a greater degree of confidence. EMQs generally require a good understanding of the topics the question is assessing and are probably the most discriminatory method of testing the candidate in a multiple choice or multiple option type question style.

Here is an example of a the sort of EMQ that you might expect to encounter in the AKT, with a model answer included:

**Causes of a red eye:**

**Options:**

A. Corneal ulcer  
B. Acute angle closure glaucoma  
C. Scleritis  
D. Orbital cellulitis  
E. Acute iritis  
F. Corneal abrasion  
G. Subconjunctival haemorrhage  
H. Episcleritis  
I. Blepharitis

**For each of the following clinical scenarios select the SINGLE MOST appropriate diagnosis from the above options. Each option may be used once, more than once or not at all.**
Q1. A 68-year-old gentleman comes to see you with a painful red left eye. He feels nauseous. When you examine his eye, you can see that the cornea appears hazy and that his pupil is fixed and partially dilated.

**Answer: B. Acute angle closure glaucoma**

Acute angle closure glaucoma presents with severe pain that may be associated with nausea and even vomiting. Visual acuity is markedly reduced and the patient often describes haloes appearing around lights. It is an ophthalmological emergency.

Examination shows a red eye with a pupil that is fixed and partially dilated. Mild digital pressure to both eyes will reveal the affected eye to be harder than the other and tender to palpate.

If untreated, all types of glaucoma result in optic nerve damage, leading to ultimate blindness. Treatment includes reducing the intra-ocular pressure with acetazolamide and using agents to cause papillary constriction, such as pilocarpine.

Q2. A 65-year-old woman comes to ask about her left eye. She suffers with hypertension and when she looked in the mirror this morning, she noticed a bright red patch of blood in her left eye. Her visual acuity is normal, and the eye is not painful. When you examine her eye, you see a well-defined area of redness just under the conjunctiva.

**Answer: G. Subconjunctival haemorrhage**

Subconjunctival haemorrhages can occur spontaneously or following head trauma. They can occur after coughing, sneezing or straining. No
treatment is necessary and the blood is slowly absorbed over a period of 10-14 days.

A patient should be referred if they present with a subconjunctival haemorrhage following a head injury, as it can correlate with a base of skull fracture.

Q3. A 27-year-old man has been to see you about his lower back pain. He finds that the pain and stiffness is particularly worse in the mornings. You are arranging for further investigations as he has not responded to physio, but today he is concerned about his left eye. The eye is red and very sensitive to light. When you examine his eye, you note that the pupil appears irregular in shape and responds slowly to light.

**Answer: E. Acute iritis**

Iritis is inflammation of the anterior uvea. When iritis occurs with inflammation of the iris and ciliary body, it is known as anterior uveitis. Around half of patients presenting with iritis will be positive for HLA-B27. You should always suspect this condition if a patient presents with photophobia.

Clinical features include:

- A unilateral red eye
- Pain
- Photophobia
- Irregular and sluggish pupil
- There may be a history of ankylosing spondylitis
Treatment usually involves the use of topical mydriatics and corticosteroids.

The presence of loss of vision indicates the need for an urgent referral.

Q4. A 54-year-old man presents with an acutely painful right eye. The pain woke him from sleep and he describes it as ‘deep and boring’ in nature. He has a history of rheumatoid arthritis.

**Answer: C. Scleritis**

When the eye is painful on movement, there is inflammation within the extraocular muscles. The pain of scleritis can wake a patient from sleep and is often described as a ‘deep, boring pain’.

Scleritis may be idiopathic or associated with connective tissue diseases such as rheumatoid arthritis.

Q5. A 28-year-old woman comes to see you complaining of a ‘gritty’ sensation in both of her eyes. Her eyes appear slightly inflamed around the eyelid margins, but otherwise examination is unremarkable.

**Answer: I. Blepharitis**

Blepharitis is a common condition that is either due to staphylococcal hypersensitivity or to dysfunction of the meibomian gland. This results in inflammation of the eyelid margin. The patient usually presents with a bilateral sensation of burning and ‘grittiness’. There may be
some crusting of the eyelashes in the morning, but this is usually mild compared to that of conjunctivitis. Treatment includes good lid hygiene and the use of topical lubricants.

**Free text questions:**

Free text questions require the ability to formulate an answer based on the information given in the question without the advantage of having options to choose from. They usually take the form of a clinical scenario and sometimes contain data that requires interpretation such as a list of blood results, X-rays, ECGs or rhythm strips. The answer to free text questions in the MRCGP AKT is usually brief and can often be answered concisely with a single word or a short sentence.

Here is an example of a the sort of free text question that you might expect to encounter in the AKT, with a model answer included:

**Antibiotic prescribing:**

A 25-year-old woman returns from a camping trip in the American Rockies with a flu-like illness. She can recall being bitten by insects on several occasions and has a spreading red rash with an area of central clearing at the site of one of these bites. She has joint pains in her knees and ankles and prominent cervical and inguinal lymphadenopathy is present on examination.

**Which antibiotic would be most appropriate to prescribe in this case?**

**Answer: Doxycycline**
Explanation:

This patient has a history of a flu-like history and a skin rash consistent with erythema chronicum migrans following a camping trip in an area where Lyme disease is known to occur.

Lyme disease is a vector born illness caused by the spirochete *Borrelia burgdorferi*. It is transmitted by the bite of an infected deer tick (*Ixodes scapularis*). Lyme disease is a multisystem disorder that has cutaneous, joint, neurological and cardiac manifestations.

Following the initial tick bite the patient can experience the following clinical features:

- Fever
- Headache
- Arthralgia and myalgia
- Lymphadenopathy
- Hepatomegaly

In addition to this roughly 75% of affected patients develop the classic skin rash erythema chronicum migrans, an annular red lesion with an area of central clearing.

5-10% of patients go on to develop cardiac involvement, including myopericarditis and conduction defects. 10-15% of patients experience neurological manifestations including meningoradiculoneuritis (Bannwarth’s syndrome), meningitis and cranial neuritis.

Treatment is generally with oral doxycycline 100 mg BD for 14 days.
Essential revision topic checklist for the AKT

This is not designed to be an exhaustive list but rather a list of high-yield topics that have appeared in previous exams and should form an essential part of your revision:

**Clinical Medicine:**

**Emergencies for General Practice:**

- Basic life support (Paediatric and Adult)
- Management of anaphylaxis
- Myocardial infarction
- Meningitis
- Status epilepticus
- Pulmonary embolus
- Subarachnoid haemorrhage
- Management of the suicidal patient
- Recognising and managing an acutely unwell child
- Life-threatening asthma
- Acute limb ischaemia
- Pneumothorax
- Acute psychosis
- Diabetic ketoacidosis
- Acute hypoglycaemia

**Cardiovascular system:**

- Acute coronary syndromes
- Hypertension
- Cardiomyopathies
- Arrhythmias
- Stroke and TIA
Heart failure  
Differential diagnoses of chest pain  
Cardiac causes of syncope, dizziness and collapse  
Peripheral vascular disease  
Risk factors and risk assessment tools for coronary heart disease  
Congenital heart disease  
Valvular disorders  
Management of raised cholesterol/hypelipidaemia  
Pulmonary hypertension  
Pacemaker care

**Respiratory system:**

Management of asthma  
COPD  
Cystic fibrosis  
Respiratory causes of chest pain  
Lung cancer  
Respiratory infections  
Bronchiectasis  
Smoking cessation  
Interpretation of spirometry, peak expiratory flow rates  
Indications for oxygen use  
Occupational lung diseases

**Gastrointestinal system:**

Causes of an acute abdomen – presentation, diagnosis and management  
Crohn’s disease/ulcerative colitis  
Constipation/diarrhoea  
IBS
Reflux oesophagitis/ dyspepsia
Pancreatitis
Bowel cancer including screening programme
Upper GI cancers
Obesity
Jaundice
Coeliac disease
Hernias
Rectal pathology

**Neurological system:**

- Headache
- Multiple sclerosis
- Parkinson’s disease
- Meningitis
- Epilepsy
- Brain tumours
- Motor neurone disease
- Subarachnoid haemorrhage
- Cerebellar disorders
- Different types of dementia
- Movement disorders
- Stroke/ TIA

**Dermatology:**

- Eczema
- Psoriasis
- Skin manifestations of systemic disease
- Acne
- Skin cancer
- Benign skin lesions
- Leg ulceration
- Skin infections
- Iatrogenic skin disease
- Lichen planus
- Hair disorders
- Nail disorders

**Musculoskeletal system:**

- Rheumatoid arthritis
- Osteoarthritis
- Osteoporosis
- Polymyalgia rheumatica
- Gout
- Frozen shoulder
- Back pain
- Septic arthritis/ osteomyelitis
- Ankylosing spondylitis
- Autoantibody testing

**Mental Health:**

- Addictions including smoking, alcohol, drugs
- Eating disorders
- Depression
- Schizophrenia
- Deliberate self harm
- Anorexia/ bulimia nervosa
- The Mental Health Act
- Anxiety and panic attacks
- Personality disorders
- Post-traumatic stress disorder
- Psychological interventions
ENT:

- Sinusitis
- Epistaxis
- Rhinitis
- Snoring
- Otitis externa and media
- Hearing loss
- Tonsillitis
- Bell’s palsy
- Causes of neck lumps
- Head and neck cancer
- Tinnitus
- Labyrinthine disorders

Endocrine system:

- Diabetes
- Impaired fasting glucose
- Thyroid disease
- Cushing’s syndrome
- Addison’s disease
- Conn’s syndrome
- Prolactinoma
- Calcium / Vitamin D metabolism
- Disorders of sex hormones
- Inherited metabolic diseases

Ophthalmology:

- Differential diagnosis of the red eye
- Differential diagnosis of the sticky eye
- Differential diagnosis of the painful eye
Cataracts
Chalazion/ styes
Retinal detachment
Sudden loss of vision
Orbital infections
Glaucoma
Iritis/ uveitis
Scleritis/ episcleritis
Measuring visual acuity
Fundoscopic changes in diabetic and hypertensive eye disease

Renal disease:

Acute kidney injury
UTIs (adults and children)
Chronic kidney disease
End-stage renal failure
Management of proteinuria and haematuria
Glomerulonephritis
Renal artery stenosis
Prescribing in renal disease
Renal tumours
Calcium metabolism and deficiencies in chronic kidney disease

Genetics:

Modes of inheritance
Current screening methods for genetic disorders
Understanding family trees
Probability of offspring being affected
Familial cancer syndromes
Paediatrics:

- Neonatal complications
- Normal developmental milestones and when to refer
- Immunisation schedules
- Child abuse
- ADHD/ autistic spectrum disorders
- Childhood respiratory diseases
- Cerebral palsy
- Down syndrome
- Childhood malignancies

Haematology:

- Haematological malignancies
- Anaemia
- Clotting disorders
- Lymphadenopathy
- Splenectomy

Immunology:

- Needlestick injury
- Types of allergic reactions
- Immune deficiency states

Women’s Health:

- Dysmenorrhoea, amenorrhoea, menorrhagia
- Contraception
- Pre-natal counselling
- Management of infertility
- Pregnancy – routine care, complications
Identifying/ managing miscarriage
Antenatal care
Postnatal care, including post-natal depression
Cervical screening
Breast screening
Breast cancer
Symptoms and managing the menopause
Urinary frequency and hesitancy
Sexually transmitted infections
Vaginal bleeding

Men’s Health:

- Erectile dysfunction
- Testicular conditions
- Prostate disease
- Male sterilisation
- Disorders of the penis
- Sexually transmitted infections

Elderly care:

- Management of falls
- Elder abuse
- Conditions presenting with dizziness/ syncope
- Dementia – causes, diagnosis and management
- Prescribing in the elderly
- Advanced directives/ living wills/ power of attorney
- End of life care

Evidence based medicine and statistics (10% of the examination):

- Types of study – case control, cohort, randomised etc
Specificity and sensitivity
Prevalence and incidence
Calculating risk
Type 1 and type 2 errors
Averages – mode, mean, median
Graphs, scatter plots, Forrest plots etc
Critical appraisal

Organisational/ Ethical/ Legal (10% of the examination):

- GMC ‘Good Medical Practice’ guidelines
- Organisation of the NHS
- Risk management
- Clinical Governance – audit, appraisal and revalidation
- What to do if a doctor is performing poorly
- Local and National systems of Clinical Governance
- Practice management
- DVLA regulations
- Fitness to fly
- Acts relevant to General Practice such as Access to Medical records, Mental Capacity, Mental Health Act etc
- Certification e.g. benefits and allowances, Fitness to Work certificates, notification of infectious diseases, death certificates etc.
- Ethical principles of care
The Clinical Skills Assessment (CSA)

The Clinical Skills Assessment (CSA) is an examination that assesses the ability of a doctor to use their clinical, practical and communication skills in a professional manner. It is based on an OSCE-type format and is made up of 13 ten-minute consultations. This part of the examination first took place in 2007 in Croydon, and is now held at the Royal College of General Practitioners in Euston Square. Since November 2013 there have been Paediatric cases included.

You are eligible to sit the CSA during or after the ST3 year. There are now 8 separate CSA sessions each year, and candidates have a maximum of four attempts. The cost of sitting the CSA is £1780 at each attempt.

The pass rate differs at each setting. The RCGP has some very helpful guidance and we would strongly recommend to take the time to look through their website.

All 13 stations contribute equally to the final score. Each case is graded on three domains:

- Data gathering skills
- Clinical management skills
- Interpersonal skills
Cases are not assessed on a pass or fail basis, instead each case is marked in the 3 domains to produce a score for that case. At the end of the whole CSA the scores of all of their cases are added, and it is this score that then determines whether you have passed or failed.

Below is a link to some detailed guidance about the marking scheme:

http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/__media/F0E9EF64C6224E279090C5E769213B14.ashx

Each examiner will invigilate and mark the same case throughout each day of the examination. They are not there to interact with the candidates, but instead operate in a more observational capacity. It is important therefore to focus entirely on the patient. The patients are professional actors that have undergone specific training for the CSA examination. The actors and examiners spend 90 minutes at the start of the day calibrating the case they are with for that day to ensure even deliverance to all candidates.

Each case is only 10 minutes, and marks will be lost for failure to complete a consultation within that time. Try and hone your time management skills so that you are used to completing cases under this degree of time pressure.

If a case does not go as well as you had hoped, take a few deep breaths and try and focus on the next case. The CSA is designed to be challenging and candidates are often be surprised at how well they have performed on a seemingly difficult case. You should aim to perform well in all 13 stations.
Preparing for the CSA

All candidates should watch this video from the RCGP to get an understanding of the format of the day:


The CSA is a unique examination and preparation should be approached in a manner that is fitting for its specific structure and format. There are many ways to optimize your preparation for the CSA and here is some guidance and tips from our team on the best way to prepare:

1. See your own patients

The best possible preparation is to see as many patients as possible in the primary care setting. The scenarios used in the CSA are based on commonly seen cases and scenarios. Focus on developing your communication skills as much as possible and discuss difficult cases and experiences with your trainer after your surgeries. It is useful for time management to get used to consulting in ten minutes.

2. Video your consultations

Most GP trainers strongly advocate the use of videos when preparing for the CSA. This may make you feel uncomfortable initially, but it is an invaluable way to critique your consultation with an experienced GP. It can also be very useful to use the marking sheets used in the CSA and mark your own consultations before discussing them with your trainer.
Most GP trainers strongly advocate the use of videos when preparing for the CSA.

3. Do joint surgeries

Joint surgeries are an excellent way of letting your trainer see how you consult. Again, they can be a little daunting at first, but they will help you become accustomed to having an ‘observer’ present whilst you consult.

Your trainer will have lots of helpful tips such as picking up on cues, time management, and using open questions. They will be able to help you to ‘fine tune’ your consultation style for the CSA.

4. Prepare in groups

Practice in small groups with your friends and colleagues, and take it in turns to role-play the candidate, patient and observer. It is very helpful to get used to being the observer as you can gain a useful insight into the sorts of mistakes that can easily be avoided and see where easy marks can be picked up by monitoring and marking the performance of your friends. As you get closer to the date of the
assessment, you can introduce a timer and increasing the pressure a little. This will help to improve your presentation skills and your confidence.

Small group practice is an excellent way to prepare for the MRCGP CSA.

5. Attend a course

Revision courses are an excellent adjunct for CSA preparation. Actors are usually used in a very similar way to the examination itself and they provide an excellent opportunity to see how the actual day works. You will usually receive guidance on how to approach different types of cases, the importance of dress and how to behave on the day of the exam. Try to look for a well-established course that has received good feedback from course attendees. Ask your friends and colleagues which courses they attended before their exams and which they would recommend. Don’t book onto a course without thoroughly researching it first.
Topics for the CSA

It is impossible to cover and specifically prepare for all the possible scenarios that can occur within the CSA. There are over 600 cases in the RCGP CSA case bank, and it is sensible to focus on your consultation techniques in a way that will prepare you for any potential cases you may encounter. The following are essential good ‘practice’ areas to focus on:

1. Telephone triage cases

These are usually held in a different room, which will be set up for the specific scenario. You will be taken to this room in between the other cases. Here it is good to reflect on the out-of-hours cases that you (or your colleagues) have encountered, and how you dealt with them. You should think about where you might refer the patient, or how you might handle a relative who is asking questions about one of their family.

2. Home visits

Again, these are often held in a room that is set up differently from your own consultation room. Think about situations that you have encountered - have you had difficult relatives to speak to? How do you manage language barriers in the community? Perhaps you’ve seen a patient that refuses to go to hospital even though you feel it is in their best interests – how would you manage this type of situation?

3. Paediatric cases

Paediatric cases have been included since November 2013. The youngest child you are likely to see is around the age of 8 years. Try to think about how you would interact with a child and their parent or
guardian in a consultation. Think about the things that could go wrong and how you would manage them.

4. Clinical examination

There are usually around three stations in the CSA that involve clinical examination. These can assess the candidate’s ability to perform a specific examination and also their ability to interpret any clinical signs elicited. Take a moment to reflect on the examination, there may be a manikin present for situations such as a rectal or gynaecological examination. If you feel that examination is important, offer to go ahead, and the examiner can always intervene if it is not needed. Make sure that you are well practiced with equipment commonly used in the general practice setting, such as otoscopes, ophthalmoscopes and sphygmomanometers, so that your examination looks polished and confident. There is also likely to be a consultation that involves the care of an elderly person. Again, review any challenges that this may bring up and how you would focus on coping with these.

Make sure that you are well practiced with equipment commonly used in the general practice setting, such as otoscopes, ophthalmoscopes and sphygmomanometers, so that your examination looks polished and confident.
5. Ethical issues

There are a wide variety of possible ethical issues that can arise in the CSA. These may be simple cases such as a request for a fit note, or a fitness to fly note, or more complex ones such as a patient complaining about one of your colleagues, or asking for controlled drugs. Again, working in groups can be very useful for these types of cases. Work together with your group to run through cases that you have each personally encountered, and then brainstorm ideas about other scenarios and cases that could come up. For each scenario, go over the ethical dilemma involved, and how each of you would manage it. There may not be an actual correct outcome for some of these situations and marking with revolve around your approach to the patient, communication skills and empathy.

6. Acutely unwell patients

You may encounter a patient who is acutely unwell in the CSA and this can sometimes take candidates out of their comfort zone. In these situations it pays dividends to know the correct doses of emergency drugs and how you would proceed with basic life support. Review the emergencies section of the AKT revision and remind yourself of the initial procedures or treatments for each scenario. It is a good idea to try and attend an Advanced Life Support (ALS) course at some point during your GP training, as many practices now have emergency drug kits and automated defibrillators on site. If this is not possible Basic Life Support (BLS) training should be the absolute minimum level of knowledge to have obtained.
7. Patients with chronic disease

Patients with chronic disease can also be very challenging to manage, especially in short time periods. Here the patient’s understanding of their condition is important, as is any psychological impact that their disease has on their everyday life. It is vital to display a compassionate attitude towards the patient and involve them in decisions about their own care.

8. Working effectively as part of a team

Team working is a fundamental part of a GP’s everyday life. These cases could be anything from an encounter with a member of the admin team, to a clinical problem that one of the nurses is experiencing. There may be an ethical slant too, perhaps one of your colleagues would like a prescription for their partner etc. Again, brainstorm with your study group to come up with as many of these scenarios as possible.

Example CSA station:

Here is an example of a the sort of station that you might expect to encounter in the CSA, with specific guidance included:

**Information for the candidate:**

**Patient records**

You are a salaried doctor in a busy suburban practice. It is a Friday afternoon and you have a couple of patients left to see. Your next patient has a history of depression, and is well known to one of the partners in the practice, but you have never seen her before.
Name: Sophie Caswell

Age: 31

Address: 24 Rosebury Gardens

PMH: Depression, for which she takes sertraline 50mg od

Information for the role player:

Curriculum statement: 3.10 Care of People with Mental Health Problems.

Depression with suicidal intent.

Patient history:

You are Sophie Caswell, a 31 year-old paediatric nurse. You’ve had a fairly long-standing history of depression for which you take sertraline 50 mg once a day. The last few years have been especially challenging as you’ve experienced a marriage break-up and two miscarriages. You usually enjoy your job, but there has been a change in management that has been causing some friction. You are not keen to make eye contact during the interview and can become tearful.

Opening statement: I feel so exhausted; I don’t think I can carry on much longer like this.

Openly revealed: You are a paediatric nurse in the local hospital. You usually enjoy your job, but the change in management has increased pressures at work and split up the usual working team. Your depression was previously well controlled with the sertraline, but you
feel it is getting worse. You don’t feel like seeing your friends anymore and feel that there is little to look forward to.

**Only revealed on questioning:** There was no real trigger for your initial episode of depression several years ago. Over the past few years your marriage ended and you had 2 miscarriages. You find it difficult as all your friends seem to be happily married and having children. Consequently, your social circle seems to have become smaller and you don’t feel like seeing any of your friends anyway. You have started to enjoy your job less due to the recent management changes and nearly gave a child the wrong medicine the other day as you felt so tired and worn out. There was some spare paracetamol at work in the drug cupboard, so you took some home and have thought about taking it with some alcohol. Last night you even wrote a ‘goodbye’ letter to your estranged husband and lined up the paracetamol tablets. You have a history of a previous overdose attempt.

**ICE:** You don’t really like psychiatrists as you had a bad experience when you previously overdosed. You are asking for help though, as you feel a little desperate, and don’t know where else to turn. You can be persuaded to see a professional, but will need a bit of encouragement to understand the seriousness of the situation.

**PMH:** Depression, hayfever

**DH:** Sertraline 50mg od

**SH:** Non-smoker. Alcohol 22 units per week (this has increased lately). You live alone.

**FH:** Your mother had a history of depression too.

**Examination:** Not necessary for this case.
**Information for the examiner:**

Curriculum statement: 3.10 Care of People with Mental Health Problems.

Depression with suicidal intent.

**Data gathering:**

- Asks the relevant questions to obtain a full history from the patient.
- Asks about the somatic effects of depression
- Thinks about a scoring tool such as PHQ9 or HADS to help assess the severity of the situation.
- Assesses risk, covering aspects such as intent, planning, social history, past medical history, suicide notes etc.
- Conducts a thorough mental state examination.

**Clinical management:**

- Uses scoring tools such as PHQ9/HADS to help clarify the severity of this situation
- Recognises that this is a patient with suicidal intent.
- Although dealing with a fellow healthcare professional, ensure the candidate uses simple, professional language to explain the seriousness of the situation and to make sure the patient understands this.
- Recognises that the patient needs to be referred urgently to the psychiatry team.
- Ensures that the patient does not leave the surgery until they are referred to the psychiatry team on call.
Interpersonal skills:

- Uses a professional and courteous manner throughout the consultation.
- Uses language that the patient understands (taking into account her profession)
- Is empathetic and understanding, but yet maintains the need for psychiatric involvement.
- Adequately explains the risk to the patient, and gently impresses the need for the psychiatric referral whilst acknowledging that the patient did not have a positive previous experience.
- Gives the patient the opportunity to ask questions.

Essential revision topic checklist for the CSA

Again this is not designed to be an exhaustive list but rather a list of high-yield topics that have appeared in previous exams and should form an essential part of your revision:

Clinical problems (please note that almost any clinical scenario could come up):

- [ ] Headache
- [ ] Blurred/ double vision
- [ ] Hearing loss
- [ ] Hair loss
- [ ] Recurrent tonsillitis
- [ ] Difficulty swallowing
- [ ] Painful ear in a child
Flare up of eczema
Concerns about a skin lesion
Dyspepsia
Explaining the results of a smear test
Notifiable diseases
Returning traveler with a fever
Newly diagnosed diabetic patient
Joint pains
Depression/ post-natal depression
Asthmatic patient
TIA/ stroke
Poorly controlled hypertension
Back pain (red flags)
Breast lump
Dyspnoea
Chest pain
DVT
Urinary incontinence
Basic life support

Giving advice:

Smoking cessation
Fitness to fly
Communicating with a patient that speaks a different language
Antenatal counseling
DVLA guidelines
Infertility management
Advice following a miscarriage
Contraceptive advice (including emergency contraception)
Telephone triage
Ethical issues:

- Aggressive patients
- Confidentiality issues (sexual health/ relative requesting access to a patient’s notes etc)
- Driving guidelines – e.g. patient with Alzheimer’s refusing to drop driving
- Breaking bad news
- Issues surrounding screening tests such as PSA test
- Dealing with teenagers
- Assessing capacity
- Patient insisting on antibiotics for a viral illness
- Patient requesting a sick note
- Patient requesting a large amount of sleeping tablets
- Dealing with a complaint
- A patient that refuses a smear test
- Dealing with a colleague that is drinking alcohol at lunch
- Non-compliant patients
- New patient asking you to sign their passport form