Attending Physicians:

Your Role in Evaluating Residents

New Competencies For Internal Medicine

Clinical Competence Program
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Introduction

The purposes of this document are to define the important role you play as an attending physician in evaluating the clinical competence of internal medicine residents, and to introduce you to the newly defined general competencies of patient care, medical knowledge, practice-based learning and improvement, interpersonal skills and communication, professionalism and system-based practice. These were developed and endorsed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). The American Board of Internal Medicine (ABIM) relies on you, other members of the teaching faculty, and the program director to assess the knowledge, skills, attitudes, and values of residents in concert with the goal of certification.

In particular, the Board depends on you and other faculty to observe and evaluate those skills, attitudes and values which the written examination does not test extensively and to document your assessments of residents through formative evaluation provided to the program director. This information is critical to program directors in order to render yearly judgments to the ABIM about the competence and performance of residents.

The ABIM recognizes both the challenges and opportunities inherent in evaluating competence and appreciates the time and effort you and thousands of other attending physicians bring to this essential process in assuring physician quality.

What is Internal Medicine?

Internal medicine is a scientific discipline encompassing the study, diagnosis, and treatment of non-surgical diseases in adolescent and adult patients. Intrinsic to the discipline are the tenets of professionalism and humanistic values. Mastery of internal medicine requires a comprehensive knowledge and understanding of the pathophysiology, epidemiology, and natural history of disease processes and the acquisition of clinical skills in medical interviewing, physical examination, procedural competency, and continuous quality improvement.

What Are the General Competencies?

The following competencies were adopted by the ACGME and ABMS and defined by the internal medicine community through the collaboration of members and staff from the ABIM, ACP-ASIM, APDIM, APM, ASP and SGIM:

- **Patient Care** – This is defined as compassionate, appropriate, and effective care which encompasses the promotion of health, prevention of illness, treatment of disease and end of life. At the cornerstone of competent patient care are the abilities to: a) gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records and diagnostic/therapeutic procedures; b) make informed recommendations about preventive, diagnostic and therapeutic options and interventions that are based on clinical judgment, scientific evidence, and patient preference; c) develop, negotiate and implement effective patient management plans and integration of patient care; and d) perform competently the diagnostic and therapeutic procedures inherent to the practice of internal medicine.

- **Medical Knowledge** – This is defined as demonstrating a command of established and evolving biomedical, clinical and social sciences and the application of that knowledge to patient care and the education of others. Included in this context are: a) an open-minded and analytical approach to acquiring new knowledge; b) the ability to access and critically evaluate current medical information and scientific evidence; c) acquisition of applicable knowledge of the basic and clinical sciences that underlie the practice of internal medicine; and d) the application of this knowledge to clinical problem-solving, clinical decision-making and critical thinking.

- **Practice–Based Learning and Improvement** – This is the ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices. This effort encompasses the abilities to: a) identify areas for improvement and implement strategies to enhance knowledge, skills,

attitudes, values and processes of care; b) analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient care; c) develop and maintain a willingness to learn from errors and use errors to improve the systems or processes of care; and d) use information technology and/or other available methodologies to access and manage information, support patient care decisions and enhance both patient and physician education.

- **Interpersonal and Communication Skills** – These skills enable physicians to establish and maintain professional relationships with patients, families, and other members of health care teams. Included are the abilities to: a) provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, their families, and colleagues; b) use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families; c) interact with consultants in a respectful, appropriate manner; and d) maintain comprehensive, timely, and legible medical records.

- **Professionalism** – This is the expectation to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude towards patients, the profession, and society. Included are the abilities to: a) demonstrate respect, compassion, integrity and altruism in relationships with patients, families, and colleagues; b) demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors and disabilities of patients and professional colleagues; c) adhere to principles of confidentiality, scientific/academic integrity, and informed consent; and d) recognize and identify deficiencies in peer performance.

- **Systems–Based Practice** – This encompasses both an understanding of the contexts and systems in which health care is provided, and the application of this knowledge to improve and

optimize health care. Included are the abilities to: a) understand, access and utilize the resources, providers and systems necessary to provide optimal care; b) understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient; c) apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management; and d) collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and improve systematic processes of care.

Practical Opportunities and Settings for Evaluation

As an attending physician on inpatient or consultation services or in the ambulatory clinic, office setting or long-term care facilities, you have many opportunities to observe, evaluate, and substantiate the competence and performance of residents. Importantly, the use of multiple observations by a broad spectrum of attending physicians enhances the reliability and validity of assessing the overall clinical competence and performance of residents.

- **Inpatient Services, Ambulatory Clinic, Office Setting and Long–Term or Hospice Care Facilities:** Observation of the clinical competence and performance of residents on rounds, at the bedside, and in various outpatient settings should be conducted regularly by you. In particular, your roles are to: a) confirm and augment key historical facts and physical findings elicited by the residents, b) assess each resident's understanding and synthesis through case presentations and discussions, and c) evaluate and substantiate the resident's demonstration of appropriate interpersonal skills, clinical reasoning, decision-making, cost awareness, risk-avoidance, diagnostic abilities, technical proficiency, and quality improvement. As part of this responsibility, the Board underscores the importance of bedside teaching and direct observation and the opportunity these settings provide for you to witness the interactions between patients and

residents during training. These settings also foster unique opportunities to discuss practice-based learning and improvement and systems-based practice with residents.

- **Emergency Room, Critical Care Units, Subspecialty and Elective Rotations:** Attending staff who supervise residents on emergency room, neurology, elective (e.g., psychiatry, dermatology, gynecology), and subspecialty consultative services should evaluate and document their competence in these settings. For example, residents' consultation notes on subspecialty services should be reviewed routinely to assess patient care, medical knowledge, interpersonal skills and communication, and professionalism.

The Mini-CEX: An Efficient, Effective Strategy for Evaluation

Another opportunity to evaluate residents' competence and performance is the efficient, effective mini-clinical evaluation exercise (mini-CEX) which can be conducted as a routine part of any clinical rotation. The use of mini-CEXs combines observation and evaluation of residents' knowledge, skills, attitudes and values with timely feedback by the attending physician. The mini-CEX is designed to enhance both assessment and promote education.

- **Advantages:** The advantages of mini-CEXs link with opportunities for the resident to: a) be observed interacting with a broad range of patients in a variety of settings, b) be evaluated by a number of different faculty members, and c) have greater flexibility in both the settings and timing in which evaluation and feedback occur.

- **Time:** Mini-CEXs provide an efficient format for evaluation of patient/resident interactions, taking between 15-20 minutes for observation by the attending physician, followed by 5-10 minutes for feedback on performance.

- **Focus:** In your role as the attending physician, you are encouraged to conduct mini-CEXs on residents assigned to your service or in your clinic. Mini-CEXs are a series of faculty evaluations based on resident-patient encounters. The purposes of the mini-CEX are: a) observing residents conduct a focussed task in any setting; b) rating residents on several dimensions of competence, and c) providing residents with educational feedback. The encounters are short and should occur routinely throughout training so that each resident can be evaluated on different occasions by different faculty. These experiences can be documented on the convenient pocket-size form provided to you by the program director or the resident.

For more informaiton about mini-CEXs, visit the ABIM website <www.abim.org>

Value of Documentation

Both the Board and the Residency Review Committee for Internal Medicine request that program directors maintain files on all residents to document the evaluation of their clinical performance and progress in the training program. **Your role in documentation is essential–to complete all evaluation forms, to provide substantive comments, and to return this information promptly to the program director.** These files should comprise: a) monthly evaluation forms from you, other attendings, peers, and members of the health care team, such as nurses; b) documentation of procedures performed and verification of technical proficiency; c) brief notes substantiating critical incidents, counseling sessions, patient perspectives, and feedback on residents' skills and performance; d) reports of mini-CEXs; e) assessment of research performance, when applicable; and f) semi-annual evaluation summaries.

Feedback: Essential for Improvement

Both verbal and written feedback are fundamental to the educational process and vital to the continuing professional growth of residents. *During and at the end of inpatient, clinic, and office or other rotations, you as the attending physician should provide each resident with a*

critical appraisal of his or her clinical competence -- recognizing both the strengths and areas in which to improve performance. Residents, too, are encouraged to solicit feedback from their attendings, supervisors, chief residents, and senior houseofficers. Feedback also should be provided to residents whenever they conduct or are involved in research activities.

Introducing Competency Cards and Praise/Concern Notes: Timely feedback to the program director about a resident's performance also can be facilitated by your use of *competency cards* as well as *praise/early concern notes*, both of which fit conveniently in your pocket. The competency card helps you comprehensively assess residents at regular intervals and translate that information onto the end-of-rotation (formative) evaluation form. The double-sided praise/concern note is designed to compliment a resident's performance or constructively raise concerns and to improve the flow of information from you to the program director. The ABIM provides both types of cards (in sets of 10) to program directors for use by the teaching faculty.

Understanding Standards of Performance: Important Distinctions

Program directors and faculty must define their own standards and criteria for rating the competence and performance of residents. One strategy is to rate each component of clinical competence using the following definitions:

Superior—Far exceeds reasonable expectations

Satisfactory–Always meets and occasionally exceeds reasonable expectations

Marginal–In general, meets some expectations but occasionally falls short

Unsatisfactory–Consistently falls short of reasonable expectations.

Few residents consistently perform at a superior level, while most demonstrate satisfactory skills throughout their training experience.

In your role as the attending physician you will encounter situations when you are concerned about a resident's performance but have incomplete or inconclusive information to support a rating of marginal or unsatisfactory. In this case you should signal that certain components of the resident's clinical competence may *need attention*, a non-judgmental category often included on the evaluation form to encourage closer review of performance by the program director and future evaluators.

The Board encourages program directors and faculty to confer regularly to establish consensus over their expectations of residents' performance and to communicate their standards accordingly. In particular, the standards of performance expected at each level of training need to be defined by the program and understood by all involved in the teaching and training of residents. Likewise, it is equally important for residents to understand the performance standards set forth by the program for the teaching faculty since they have a mandated responsibility from the Accreditation Council for Graduate Medical Education (ACGME) to evaluate their attending physicians regularly.

In summary, the role of the attending physician in evaluating clinical competence is essential in providing professional accountability and the opportunity to help residents reach their potential within the profession of medicine.

Promoting Faculty Development

To assist attending physicians in improving their skills in teaching and evaluating residents, many programs have made a serious commitment to long-term faculty development. Check with the internal medicine residency program director as well as the APDIM <www.apdim.edu>, ACP-ASIM <www.acponline.org>, APM <www.im.org/apm> and SGIM <www.sgim.org> websites where current listings for faculty development conferences, programs, and seminars are provided in conjunction with their national, regional and local meetings.

ABMS/ACGME GLOSSARY OF RESIDENT EVALUATION METHODS

A series of other evaluation methods are described below as part of the ACGME Outcome Project. In your role as a member of the teaching faculty, you may also be asked to participate in these other methods. For more information about the ACGME Outcome Project and the role of the attending physician, visit the ACGME website <www.acgme.org>.

1. **Record Review:** Abstraction of information from patient records, such as medications or tests ordered and comparison of findings against accepted patient care standards.

2. **Chart Stimulated Recall:** Uses the resident's records in an oral examination to assess clinical decision-making.

3. **Checklist Evaluation of Live/Recorded Performance (single event):** A single resident interaction with a patient is evaluated using a checklist. The encounter may be videotaped for later evaluation.

4. **Checklist Evaluation of Live/Recorded Performance (multiple events):** After multiple resident interactions with patients and others (e.g., completion of clinical rotation) the resident is evaluated using a summary/global rating form.

5. **Standardized Patients (SPs):** Simulated patients are trained to respond in a manner similar to real patients. The standardized patient can be trained to rate resident performance on checklists and provide feedback for history-taking, physical examination, and communication skills. Physicians may also rate the resident's performance.

6. **Objective Structured Clinical Evaluations (OSCEs):** A series of stations with standardized tasks for the resident to perform. Standardized patients and other assessment methods are combined in an OSCE. An observer or the standardized patient may evaluate the resident.

7. **Simulations and Models:** Computer-based simulations assess use of knowledge in diagnosing or treating patients or evaluating procedural skills. Examples are virtual reality environments and computerized patient management problems. Models are simulations using mannequins or various anatomic structures to assess procedural skills and interpret clinical findings. Both are useful to assess practice performance and provide constructive feedback.

8. **360° Global Rating Evaluations:** Residents, faculty, nurses, clerks, and other clinical staff evaluate residents from different perspectives using similar rating forms. These ratings should be analyzed and summarized for feedback to residents and faculty by a neutral or outside source.

9. **Project Portfolios:** A portfolio is a set of projects that are prepared by the resident to document projects completed during each year of training. For each type of project, standards of performance are set. Project examples are summarizing the research literature for selecting a treatment option, implementing a quality improvement program, revising a clerkship elective for medical students, and creating a computer program to track patient care and outcomes.