

Residents:

**Evaluating
Your
Clinical
Competence**

**New
Competencies
For
Internal
Medicine**



**Clinical Competence Program
September 2001 – June 2002**

Information Request

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Introduction

The purposes of this document are twofold: first, to define the important role that faculty play in evaluating your clinical competence, and second, 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 competencies were recently identified 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 the members of the teaching faculty and the program director to assess your knowledge, skills, attitudes, and values in concert with the goal of certification.

In particular, the Board depends on your attendings to observe and evaluate those skills, attitudes and values which the written examination does not test extensively and to encourage both your self-assessment and the formative evaluation provided by the teaching faculty to the program director. This information is critical to the program director in order to render yearly judgments to the ABIM about your competence and performance.

The ABIM recognizes both the challenges and opportunities inherent in evaluating competence and appreciates the time and effort that you contribute to self-assessment and 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 American Board of Internal Medicine, American College of Physicians-American Society of Internal Medicine, Association of Program Directors in Internal Medicine, Association of Professors of Medicine, Association of Subspecialty Professors, and Society of General Internal Medicine:

- **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 a resident on inpatient or consultation services or in the ambulatory clinic, office setting or long-term care facilities, you have many opportunities to have your clinical competence and performance observed, evaluated, and substantiated. Importantly, multiple observations by a broad spectrum of attending physicians enhances the reliability and validity of assessing your overall clinical competence and performance.

- **Inpatient Services, Ambulatory Clinic, Office Setting and Long-Term or Hospice Care Facilities:** Observation of your performance on rounds, at the bedside, and in various outpatient settings should be conducted regularly by the attending physician. In particular, the attending physician should: a) confirm and augment key historical facts and physical findings you elicit from patients, b) assess your understanding and synthesis through case presentations and discussions, and c) evaluate and substantiate your 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 attending physicians to witness your interactions with patients. These settings also foster unique opportunities for you to discuss practice-based learning and improvement and systems-based practice with your attendings.

■ **Emergency Room, Critical Care Units, Subspecialty and Elective Rotations:**

Attending staff who supervise you on emergency room, neurology, elective (e.g., psychiatry, dermatology, gynecology), and subspecialty consultative services should evaluate and document your competence in these settings. For example, your 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 your competence and performance is the use of the efficient, effective mini-clinical evaluation exercise (mini-CEX) which can be conducted as a routine part of any clinical rotation. Mini-CEXs combine observation and evaluation of your knowledge, skills, attitudes and values with timely feedback to you from 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 you 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 your performance.

■ **Focus:** During residency training, you are encouraged to experience mini-CEXs on inpatient and clinic rotations. Mini-CEXs are a series of faculty evaluations based on resident-patient encounters. The purposes of the mini-CEX are: a) observing you conduct a focussed task in any setting; b) rating you on several dimensions of competence, and c) providing you with educational feedback. The encounters are short and should occur routinely throughout training (at least four in PGY-1, and preferably four each year) so that you can be evaluated on different occasions by different faculty. These experiences can be documented on the convenient pocket-size form provided by the ABIM to the program director for distribution to attendings and residents.

For more information 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 which document their evaluation of clinical performance and progress in the training program. These files should comprise: a) monthly evaluation forms from your attendings, peers, and other members of the health care team, such as nurses; b) documentation of procedures you performed and verification of technical proficiency; c) brief notes substantiating critical incidents, counseling sessions, patient perspectives, and feedback on your skills and performance; d) reports of mini-CEXs; e) assessment of your 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 your continuing professional growth. *During and at the end of inpatient, clinic, and office or other rotations, you should receive a critical appraisal of your clinical performance from the attending physician which recognizes both your strengths and areas in which to improve your performance.* As a resident, you are encouraged to solicit feedback from your attendings,

supervisors, chief residents, and senior houseofficers. Feedback also should be provided to you whenever you conduct or are involved in research activities.

Introducing Competency Cards: Self-assessment of your performance can be facilitated by easy-to-use *competency cards* that fit conveniently in your pocket. The competency cards (available from the ABIM in sets of 10) can help you reflect on your performance, and identify your strengths as well as areas needing improvement. They should be maintained only by you and used as tools to set learning objectives, target practice improvement and measure change throughout your training. You can obtain these cards from your program director.

Understanding Standards of Performance: Important Distinctions

Program directors, faculty and residents all have a common definition of the standards and criteria for rating clinical competence. 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.

Throughout your residency training, your program director will seek your evaluations of each of your clinical rotations and respective attending physicians, as well as your annual review of the program as a whole. In these cases, you may need to signal that certain faculty performance *needs attention*, a non-judgmental category to encourage closer review by the program director.

The Board encourages program directors, faculty and residents to confer regularly to establish consensus over their expectations of 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 roles of residents in self-assessing their clinical competence and evaluating their attending physicians and programs are essential in providing professional accountability, striving for continuous quality improvement, and seeking the opportunity to help each other reach their potential within the profession of medicine.

ABMS/ACGME GLOSSARY OF RESIDENT EVALUATION METHODS

A series of other evaluation methods are described below as part of the ACGME Outcome Project. During your residency training, you may have the opportunity to experience these other evaluation methods. For more information about the ACGME Outcome Project, 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 medical interviewing, 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.