

A Simplified Observation Tool for Residents in the Outpatient Clinic

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Abstract

Background The Accreditation Council for Graduate Medical Education promotes direct observation of residents as a key assessment tool for competency in patient care, professionalism, and communication skills. Although tools exist, validity and reliability have not been demonstrated for most, and many tools may have limited feasibility because of time constraints and other reasons. We conducted a study to measure feasibility of a simplified observation tool to evaluate these competencies and provide timely feedback.

Methods In the pediatric resident continuity clinic of a large children's hospital, we used a direct observation form with a 3-point scale for 16 items in the domains of patient care, professionalism, and communication skills. The form was divided by portion of visit, with specific items mapped to 1 or more of the competencies, and was used to provide direct oral feedback to the resident. Faculty and residents completed surveys rating the

process (ease of use, satisfaction, and self-assessed usefulness) on a 5-point Likert scale.

Results The study encompassed 89 surveys completed by attending physicians; 98% (87 of 89) of the time the form was easy to use, 99% (88) of the time its use did not interfere with patient flow, and 93% (83) of the observations provided useful information for resident feedback. Residents completed 70 surveys, with the majority (69%, 48) reporting they were comfortable about being observed by an attending physician; 87% (61) thought that direct observation did not significantly affect their efficiency. Ninety-seven percent of the time (68) residents reported that direct observation provided useful feedback.

Conclusion The data suggest the form was well-received by both faculty and residents, and enabled attending physicians to provide useful feedback.

Background

Observation and documentation of resident clinical skills is required by the Accreditation Council for Graduate Medical Education (ACGME) as part of its outcome-based accreditation initiative.¹ The ACGME has mandated that residency programs require resident competencies in 6 areas: (1) patient care, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism, and (6) systems-based practice. Residency programs need to develop methods to assess each of these competencies.

The ACGME promotes direct observation of residents as a key assessment modality for 3 of these 6 competencies: patient care, professionalism, and interpersonal skills and

communication. Direct observation provides data for ongoing formative evaluation and feedback, which is critical to reinforce appropriate learning of clinical skills and to correct deficiencies.² Despite recognition of the importance of direct observation,^{3–6} clinical faculty rarely have applied it as a basis for clinical assessment.^{7,8} Several observation tools exist,^{5,9–11} yet most of them do not have established validity and reliability, and the applicability of many of these tools is limited by time constraints and by the discomfort levels of observers (faculty) as well as those being observed (residents). We conducted this study to measure the feasibility of a simplified observation tool within a pediatric resident continuity clinic to evaluate these 3 specific competencies and to provide timely feedback.

Methods

The direct observation study was instituted within our pediatric resident continuity clinic. There are 59 residents and 6 faculty attending preceptors in this clinic. Each resident spends a half-day per week seeing his/her own panel of patients, paired with a consistent preceptor. All residents received an introduction to this project. The skills and competencies being assessed were reviewed with them. Residents were instructed to tell their preceptor when they were going to see a patient, and in which room they would be. Residents were instructed to inform the patient and

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family that an attending faculty member might enter the room and observe them. Residents were told to expect specific feedback that would help them improve their clinical skills, and were instructed to speak to the preceptor before leaving the clinic.

We developed an observed encounter form to assess 3 competencies: patient care, interpersonal and communication skills, and professionalism. The form consists of 16 items, each rated on a 3-point scale (“yes,” “no,” or “partially”). The form is divided by portion of visit (history, examination, assessment, and plan). Each specific item also ties into 1 or more of the 3 measured core competencies. Items 1 through 7, 13, and 14 target patient care; items 8 through 12 and 15 target interpersonal and communication skills; and items 1, 3, and 16 target professionalism. Faculty received initial training on this tool prior to the study. Faculty were instructed to provide immediate feedback at the end of each clinic session in order for the observation to be of learning value to the resident. This encounter form was designed to be simple and easy to use. It was intended to be used for only a specific section of a visit (ie, history taking), not the whole visit, thus decreasing the faculty time requirement. All of the residents in the residency program were selected for observation. The resident surveys were blinded so we were unable to determine how many surveys were completed by each resident.

The goal was multiple short observations of various aspects of a visit during the course of an academic year. These multiple observations followed by immediate feedback should give residents the opportunity to incorporate what they have been taught into future encounters, thus improving their clinical skills. This process follows the guidelines of adult learning theory in that it shows respect for the learner, builds on previous experiences, has immediacy of application, and allows for opportunity to practice.¹² The 6 continuity clinic attending physicians were responsible for performing these short observations. After each observed encounter, faculty and residents completed a survey rating the process (ease of use, satisfaction, and perceived usefulness) on a 5-point Likert scale, ranging from 1 (strongly agree) to 5 (strongly disagree). Faculty were asked to record the time it took to perform observations, complete the forms, and provide feedback. Narrative comments were collected from both residents and faculty. The Vanderbilt University Institutional Review Board approved this study in 2007 (IRB No. 070773).

Results

This study was conducted during the 2008–2009 academic year in the Vanderbilt General Pediatrics Continuity Clinic. The results on the Likert scale were collapsed so they reflect responses marked as either “strongly agree” or “agree” (1 or 2 on the scale). Eighty-nine surveys were completed by

attending physicians. The form was considered easy to use in 98% (87) of the observations. Use of the form did not interfere with patient flow 99% of the time (88 of 89). In 93% (83) of the observations, attending physicians thought the form provided useful information for resident feedback. Faculty reported spending 5 minutes per observation. Residents completed 70 surveys (postgraduate year-1 [PGY-1], 28; PGY-2, 22; PGY-3, 20; response rate, 79%). Most residents (69%, 48) felt comfortable being directly observed by an attending physician and 87% (61) thought direct observation did not significantly affect their efficiency. Nearly all of the time, 97% of the residents (68) felt they were provided useful feedback based on the observation.

Discussion

Observed encounters are a critical part of resident education. The ACGME Residency Review Committee for Pediatrics requires direct observation of pediatric residents in the clinical setting. A recent study suggests brief structured clinical observations of medical students are feasible and effective.¹⁰ Observed encounters were highly rated by both the faculty and the medical students as an important educational tool. However, the quantitative effects on performance were not measured. Most of the research on observed clinical encounters has been done in internal medicine and are not practical in a busy clinical setting because of time constraints. The Observed Structured Clinical Examination has been used for medical students, and the Clinical Evaluation Exercise (CEX) is an equivalent tool that has been used since the early 1990s for internal medicine residents. Although praised for its evaluation of real patient interaction and immediacy of feedback, results from CEX evaluation have not been generalizable. Moreover, the process consumes at least 2 hours of time for each examination.^{13–16}

Ideally, a tool for observed encounters would be brief, flexible, user-friendly, and simple. A variation on the CEX, the Mini-CEX, shows promise. It has been shown to have instrument reliability as well as a shorter time requirement (typically 15–20 minutes).^{11,17,18} The Mini-CEX has 7 items that are ranked on a 9-point scale. These items are general categories that allow for broad-based feedback over time. Even though this is a definite improvement, we developed and tested a brief tool requiring roughly 5 minutes of faculty time. Our goal was to document feasibility and usefulness of this observation tool. If effective, this tool could provide not only documentation of the 3 ACGME competencies for the individual resident but it could also provide documentation of direct observation for the Residency Review Committee. In addition, it would guide faculty feedback to residents, which should result in improvement and growth in resident performance that could be documented longitudinally.

We were surprised as to how well this tool has been accepted. We did not encounter any resistance or barriers from faculty or residents. Faculty reported ease of use of the

observed encounter forms and residents did not report any problems with direct observation. Given the competing demands on faculty, the short amount of time necessary for an observation is important for both the success and sustainability of the tool. Residents reported being comfortable being directly observed and thought they were provided useful feedback. They also thought that being observed did not significantly affect their efficiency in seeing patients.

Our study has several limitations. First, it was performed in a single pediatrics residency program so the results may not be generalizable to other residency programs and institutions. Second, although residents believed they were provided useful feedback, we were not able to demonstrate improved clinical skills or improved quality of care. We did not assess the quality of the feedback or follow up with residents to see whether they implemented any of the suggestions for improvement. Each faculty member observed the same group of residents in continuity clinic so we were unable to determine interrater reliability. Although the tool was well received by both attending physicians and residents, the validity and reliability of the tool has not been assessed.

Conclusions

Observed encounters are a critical part of resident education. Development of a simple tool is essential to overcome many of the barriers to this process. This study sought to document usefulness of a new observation tool. The data we have collected suggest that this form was well received by both faculty and residents and it enabled attending physicians to provide immediate feedback to residents. Our next step will be to test the reliability and validity of this tool. If this tool is found to be valid and reliable it can be modified and used in other specialty areas and could be adopted by other residency programs.

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