Direct Observation by Faculty

Eric S. Holmboe, MD

Chapter 9

REASONS FOR AND CHALLENGES OF DIRECT OBSERVATION

Lack of Direct Observation by Faculty
Quality of Faculty Observation

PRACTICAL APPROACHES TO TRAINING FACULTY

Behavioral Observation Training
Performance Dimension Training
Frame of Reference Training
Direct Observation of Competence Training

USEFUL TOOLS TO GUIDE OBSERVATION

The Mini-Clinical Evaluation Exercise Feedback and the Mini-CEX
Checklists Creating an Observation System

CONCLUSION

ANNOTATED BIBLIOGRAPHY
REFERENCES
APPENDIX 9-1. Sample Performance Dimension Training and Frame of Reference Exercise

Medical educators have a major responsibility to evaluate the clinical skills of trainees and to provide them with timely, useful feedback to ensure continued progress and correction of deficiencies. Despite tremendous advances in technology, the basic clinical skills of interviewing, physical examination, and counseling remain essential to the successful care of patients. The Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), and American Board of Medical Specialties (ABMS) strongly endorse the evaluation of students, residents, and fellows in these clinical skills.1–3 The Institute of Medicine has placed patient-centered care at the heart of its five core competencies for all physicians (Fig. 9-1).4

The direct observation of trainees performing a medical interview, physical examination, or counseling is mandatory for the reliable and valid assessment of these skills.5

As highlighted in Chapter 8, the use of standardized patients (SPs) to evaluate and teach clinical skills is a valuable methodology in medical education and assessment. The development of standardized patients to evaluate clinical skills is unquestionably a major advance in competency assessment as rigorous SP training and scoring methods support the security and reliability requirements of high-stakes examinations.5–10 There are limitations however, in the application of SP-based methods for teaching and evaluation along the continuum of education and practice. Standardized patients are optimally applied in clinical skills teaching and assessment as a supplement to similar activities in the real clinical setting; they cannot replace the observation of trainees by physicians on an ongoing basis with actual patients.11–16 Standardized patients may also have less validity with more advanced trainees because assessment instruments used for SP exercises, depending upon case development and standard setting approaches, may favor completeness over efficiency.17–19

Therefore, clinician-educators need to embrace their professional responsibility for evaluating these skills through direct observation of trainees in real clinical settings. George Miller’s assessment pyramid best captures the important role of faculty of evaluating what the trainee actually “does” (e.g., a trainee’s performance) with patients, despite the possibility the act of observation may change the level of performance20 (Fig. 9-2).

Stop for a moment and imagine the triangle now as a spear. At the tip of the spear is the patient, meaning that the behaviors and actions of the trainee directly affect the well-being of the patient. Unfortunately, this obvious fact has too often not resulted in effective observation and supervision of trainees in the clinical setting.21 despite the fact many trainees actually want better supervision.22 Exacerbating this situation is the sobering research demonstrating many faculty members are ill prepared to accurately observe and provide

119
effective corrective feedback about clinical skills. The good news is that observation is a skill that can be acquired by faculty, but faculty members must acknowledge that direct observation is important, is a professional obligation of a teacher, and requires training like any other skill. Being a good clinician and teacher does not equate to skill in observing others’ skills. In this chapter we will first explore problems in trainees’ clinical skills and the challenges faced by faculty performing direct observation. The purpose of this background is to give educational leaders “ammunition” to highlight the importance of clinical skills and the need to teach and observe them. We will then outline some practical methods to help you improve observation skills among your faculty. Some useful tools faculty can use when performing observations will also be highlighted.

**Reasons for and Challenges of Direct Observation**

It has long been recognized that students and residents have substantial deficiencies in the basic clinical skills of medical interviewing, physical examination, and counseling. Numerous studies have documented serious deficiencies in medical interviewing that have persisted over time and in the views of some, history-taking skills may have actually declined. Furthermore, communication skills do not appear to improve after completion of training. In a study using unannounced standardized patients, Ramsey found that a group of primary care physicians only asked 59% of essential history items. Braddock found that among 1057 counseling sessions involving primary care physicians and surgeons, only 9% of encounters met basic criteria for effective informed decision making. Other studies have shown that physicians fail to elicit over half of patient complaints and that many of the public’s complaints about physicians relate to communication problems. Effective communication has been shown to improve patient outcomes and adherence, and most patients want an active role in the decision-making processes. Errors are also common in physical examination skills. For example, deficiencies in auscultatory skills among trainees were noted over 40 years ago and poor cardiac and pulmonary physical examination skills continue to plague U.S. students and residents today.

These findings are relevant because we know that despite advances in technology, accurate data collection during the medical interview and the physical examination remains the most potent diagnostic tool available to physicians. Two important studies showed that the medical interview alone produced the correct diagnosis in nearly 80% of patients presenting to an ambulatory care clinic with a previously undiagnosed condition. Bordage recently noted that errors in data collection are one of the principal factors in diagnostic errors committed by physicians.

The preceding findings have resulted in a significant push to re-emphasize both the training and evaluation of clinical skills. Without accurate evaluation of clinical skills, which must be accomplished by direct observation, improvement in the clinical skills of our trainees is highly unlikely. First, a trainee has to know how to perform a skill before they can acquire experience through practice with actual patients. Second, physicians in general are poor at self-assessment in the absence of guidance and data. For clinical skills, the guidance and data to drive assessment is direct observation by faculty.

**Lack of Direct Observation by Faculty**

Perhaps the biggest problem in the evaluation of clinical skills is simply getting faculty to observe trainees. For decades faculty members have taken at face value the veracity of the history and physical examination presented on inpatient and outpatient rounds without ever watching the trainee actually perform any of these skills. Two of the most prominent physician-scientists and educators of the twentieth century, the late Alvan Feinstein and George Engel, strongly advocated direct observation of the history and physical examination
Finally, practicing physicians have also been shown to have significant deficiencies in clinical skills.28,29,31,34 A medical educator who possesses deficiencies in his or her clinical skills is obviously less likely to detect those deficiencies among trainees. Let’s be honest, if faculty members lack the skill or feel uncomfortable about their own proficiency, it seems pretty unlikely they would be critical of a trainee’s performance. Faculty members are very uncomfortable about admitting their own limitations, despite the powerful role modeling such an act engenders. Given the decline in clinical skills of the last 10 to 20 years, a major focus of faculty development will have to be clinical skills training for the faculty as well as the trainees.

**Practical Approaches to Training Faculty**

Given the essential role of faculty observation in the evaluation of basic clinical skills, medical schools and residency programs must train faculty for this important task. Industry and the field of psychology have grappled with the challenges of rater training in performance appraisal for decades. In 1981, Landry and Farr, pleading for a moratorium on the endless search for the “perfect” evaluation form, highlighted the need to redirect energies on training the evaluator in the most appropriate and effective use of the evaluation form.68 Yet, over the last 25 years medicine has continued to seek the “holy grail” of evaluation tools and forms. An assessment or evaluation is only as good as the individual performing it. Training approaches do exist that can improve the evaluation of performance in the clinical training setting. Early research in medical education has demonstrated that these training approaches do indeed improve observation skills. The following paragraphs summarize a set of training methods that can be used for faculty development in direct observation.

**Behavioral Observation Training**

Behavioral observation training (BOT) focuses on improving the detection, perception, and recall of actual performance.69 Three main strategies are emphasized in BOT. The first strategy is simply to get faculty to increase the number of their observations of their trainees. This helps to improve recall of performance and provides multiple opportunities for skill practice in observation by the faculty, the “practice makes perfect principle.” The second strategy is to provide some form of observational aid that raters can then use to record observations, sometimes referred to as “behavioral diaries” or “aide-de-memoir” devices. Studies show that even something as simple as a 3-inch x 5-inch index card used to record observation notes improves the quality of information provided on evaluation forms.70

Simply getting faculty to make notes on a regular basis can help them to be more specific when observing performance. In this electronic age, such notes can be quickly entered into computers or portable personal digital assistants (PDAs). It is important to encourage this activity as a habit in faculty. For example, I always carried a 3 x 5 card for teaching and clinical
interactions with my trainees. Everyday I strived to write down at least one thing the trainee did well, one thing they could improve, and my plan to help them improve. I took 5 to 10 minutes to enter these notes into a simple word document on my computer. By doing this on a regular basis, I had a rich source of observations I could simply “cut and paste,” with a little editing, onto the final evaluation form at the end of the rotation. The mini-CEX form and checklists can also serve as an immediate “behavioral diary” to record an assessment of an observation.

The third important strategy is to help faculty members learn how to prepare for an observation. To prepare, faculty members should determine the objectives or goals of the observation before entering the patient’s room with the trainee. For example, if you plan to perform an observation of a trainee’s physical examination skills, what would be the appropriate components of a physical examination for the patient’s chief complaint or medical condition? Obviously, you would need to have heard some of the patient’s history in order to determine what the critical aspects of the physical examination will be. Although rapidly becoming a lost art, bedside presentations are a valuable and efficient way to hear about the patient’s history with the added benefit that patients actually appreciate such presentations.71

Other aspects of preparation include the following: How should you position yourself in order to ensure proper technique is used by the trainee? How and when will you confirm (if you deem necessary) the physical findings obtained by the trainee? This preparation helps to maximize the effectiveness of the observation. Positioning is very important because as faculty you want to minimize interference with the trainee-patient interaction whenever possible. Don’t become a distraction to both the trainee and patient. Remember, protect the trainee-patient bond whenever possible. Figure 9-3 demonstrates the principle of triangulation that maximizes the ability of the faculty member to observe while minimizing interference. Table 9-1 lists some important yet simple rules for performing trainee observation.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct positioning</td>
<td>As the rater, try to avoid being in the line of sight of either the patient or trainee, especially when they are communicating. Use the principle of triangulation. However, during physical examinations be sure you can view the trainee’s techniques accurately.</td>
</tr>
<tr>
<td>Minimize external interruptions</td>
<td>Let your staff know you will be with the resident for 5–10 minutes, avoid taking routine calls, etc.</td>
</tr>
<tr>
<td>Avoid intrusions</td>
<td>Don’t interject or interrupt if at all possible. Once you interject yourself into the resident-patient interaction, the visit is permanently altered. However, there will be many times at some point in the visit where you need to interject yourself in order to correct misinformation, etc. from the resident.</td>
</tr>
<tr>
<td>Be prepared</td>
<td>Know before you enter the room what your goals are for the observation session. For example, if a physical examination, have the resident present the history first; then you will know what the key elements of the PE should be.</td>
</tr>
</tbody>
</table>

**Performance Dimension Training**

Performance dimension training (PDT) is designed to teach and familiarize the faculty with the appropriate performance dimensions used in their own evaluation system. Although PDT alone probably does not improve rater accuracy, it is a critical structural element for all rater training programs.72–74 PDT simply starts with a review of the definitions and criteria for each dimension of performance or competency. The goal should be to define all the criteria and trainee behaviors that constitute a superior performance from the perspective of
patient outcomes. For residency or fellowship training, the six new general competencies developed by the ACGME would be an appropriate starting point. The next step in PDT is to give faculty the opportunity to “interact” with the definitions to improve their understanding of the definitions and criteria. The overarching goal of PDT is to ensure that the faculty understands the definitions and criteria for the competency of interest as a group to reach a high level of consensus.

This consensus can then facilitate calibrating faculty to utilize these assessment criteria in a more standardized fashion, which in turn will improve the fairness, reliability, and validity of the observation. This simple faculty development technique is seldom used in training programs. Faculty members need frameworks in order to perform evaluation effectively. In Chapter 3, we covered various frameworks for the effective use of global rating scales and longitudinal evaluation forms. Performance dimension training is a validated method to help faculty both understand and then use a framework and specific criteria effectively for not only direct observation but other evaluation tools as well. The important message is that faculty training is crucial to effective observation of clinical skills.21,46,65,75

Appendix 9-1 provides a very straightforward and useful proactive PDT exercise that can be done with faculty to facilitate interaction with competency in clinical skills. As an example, one simple clinical scenario is a trainee prescribing a medication for a patient with a newly diagnosed medical condition. The clinical skill competency here is counseling and patient education. The question for the PDT exercise would simply be, What should an effective counseling session look like for a patient starting a new medication? The main task for the faculty will be to define the trainee behaviors of an effective counseling session. A focus on behaviors is crucial because trainee behaviors are what faculty will observe. I recommend performing PDT exercises in small groups and then have the small groups share their results. Inevitably, differences occur between the groups. These differences, however, lead to productive discussions on what constitute the core elements and criteria of competency in counseling, or other clinical skills. This type of PDT exercise can be done for two clinical skills over approximately 1 hour. Another approach to PDT is reactive: using actual evaluations or videotapes of clinical skills that faculty can react to when performing the PDT exercise. The accompanying DVD (Faculty Guidelines to Training) provides a number of scripted clinical encounters you can use for a PDT exercise.

### Frame of Reference Training

Frame of reference training specifically targets accuracy in rating.72,73 Table 9-2 describes the complete FORT process.

As you can see, FORT is really an extension of PDT; the main goal of FORT is achieving consistency (using the result of the consensus process in PDT) among faculty regarding application of the different performance criteria to distinguish levels of performance. For FORT, I encourage faculty to focus on defining four levels of performance: unsatisfactory, marginal, satisfactory, and superior. The PDT exercise should define the criteria and definitions for a superior performance from the perspective of optimal patient outcomes. The second step of the exercise, as shown in Appendix 9-1, is to define the minimal criteria for a satisfactory performance. These criteria for a satisfactory performance serve as an important anchoring point to define marginal and unsatisfactory performance in step 3. Once the group defines marginal criteria, by default any lesser performance is unsatisfactory. This important technique helps faculty members to distinguish levels of performance and help them provide more specific feedback to the trainee.

Evidenced-based standards for many of the clinical skills provide an excellent foundation and resource to help faculty reach consensus on performance standards for basic clinical skills. For example, use of open-ended questions at the beginning of history taking is more

<table>
<thead>
<tr>
<th>Step</th>
<th>Description of Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Performance dimension training (PDT). Faculty observers are given descriptions for each dimension of competence followed by a discussion of what they believe the qualifications are for each dimension</td>
</tr>
<tr>
<td>2</td>
<td>Faculty observers define what constitutes superior (the most effective criteria and behaviors) performance from the perspective of optimal patient outcomes.</td>
</tr>
<tr>
<td>3</td>
<td>Next, faculty members define and reach consensus on the minimal criteria for satisfactory performance. Once the satisfactory criteria are set, marginal criteria are defined. Everything else by default is unsatisfactory performance</td>
</tr>
<tr>
<td>4</td>
<td>Participants are given clinical vignettes describing critical incidents of performance from unsatisfactory to average to outstanding (frame of reference). For clinical skills, videotaped encounters are the best method.</td>
</tr>
<tr>
<td>5</td>
<td>Participants use the vignettes to provide ratings on a behaviorally anchored rating scale.</td>
</tr>
<tr>
<td>6</td>
<td>Session trainer/facilitator provides feedback on what the “true” ratings should be along with an explanation for each rating.</td>
</tr>
<tr>
<td>7</td>
<td>Training session wraps up with an important discussion on the discrepancies between the participants’ ratings and the “true” ratings.</td>
</tr>
</tbody>
</table>
likely to yield more complete and accurate information from the patient.\textsuperscript{76,77} Other examples include the Calgary-Cambridge and SEGUE models for medical interviewing and the informed decision-making model for counseling.\textsuperscript{29,78,79} Several resources now exist on the evidence for the utility of a number of clinical skills, including skills from the surgical disciplines.\textsuperscript{75,80-83} We recommend that these types of resources be available when possible as a guide for PDT and FORT exercises.

**Direct Observation of Competence Training**

Using the evidence from BOT, PDT, FORT, and SP training methods (Chapter 8) my colleagues and I developed a new approach called direct observation of competence (DOC) training. DOC training is a multifaceted approach that incorporates the key elements of these previously validated rater training methods but adds relevant, practical exercises in direct observation. DOC training can be delivered in multiple formats ranging from 1.5- to 2-hour workshops to a full-day workshop format. Each workshop typically begins with a scripted videotape (provided on the accompanying DVD) that portrays a standardized resident performing either a history, physical examination, or counseling session with a standardized patient who has a common medical problem. Three tapes were developed for each basic skill depicting different levels of performance that vary in the quality and quantity of errors committed by the resident. Typically a tape demonstrating “satisfactory” performance is shown to start the workshop and the participants are asked to rate the resident using a standard evaluation form and to write down what they saw the resident do well and any specific deficiencies they noted on the tape. Workshop participants are then given a 30-minute interactive presentation reviewing the problems with resident clinical skills and direct observation by faculty. Participants then break into small groups to work on PDT exercises for the clinical skill of interest.

The workshop leader next facilitates a group discussion to reach some preliminary consensus about what constitutes an effective clinical skill. Whenever possible, the participants should compare their PDT checklist against an evidenced-based standard. For example, after a PDT exercise focused on counseling/informed decision-making skills, we introduce the informed decision-making criteria of Braddock and colleagues.\textsuperscript{29} This helps to further standardize and calibrate the faculty on the criteria they will use in the observations. At the completion of this discussion, the participants view the same videotape encounter again but using the criteria they have developed to evaluate the performance on the tape. Finally, each participant shares the scores they gave the resident from the opening tape and how this evaluation compares with their second rating of the tape. Feedback is provided by the session trainer on the errors committed by the resident on the tape. The other two tapes, depicting different levels of performance, are shown followed by discussion and feedback to provide the “frame of reference.” A checklist is also provided to participants for use in evaluating the specific clinical skill covered in the training. This aspect of DOC training can be done as an abridged workshop, without showing the additional tapes, in 1.5 to 2 hours. If you wish to include behavioral observation techniques and the additional tapes, give yourself about 3 to 3.5 hours to complete.

The second workshop session involves actual practice with live standardized residents and patients. The first part of this live training focuses on the principles of behavioral observation training discussed earlier in the chapter. Each participant is given an opportunity to sit in the examination room observing the standardized resident and patient in a simulated clinical encounter. The resident is instructed to perform at different levels of competence for each faculty participant. At the end of the encounter the faculty member provides his/her evaluation with feedback to the standardized resident. The standardized resident is also trained to respond to the feedback in different ways.

The other faculty members observe both the clinical encounter and the evaluation/feedback session. Once the participant finishes the evaluation/feedback session, the group shares their evaluation of the resident and provides feedback to the faculty observer of their evaluation and feedback to the resident. If desired, the standardized resident and patient can also provide feedback to the faculty observer. The session trainer facilitates the feedback and points out errors made and provides suggestions for improving the observation and feedback. In total, the second session is designed to allow each faculty participant to perform two observations among the three clinical skills depicted. This is a very valuable approach if you have access to standardized patients. Chief residents and junior faculty are excellent sources for standardized residents and can be easily trained using scripts depicting varying levels of performance skill. The steps for DOC training are provided in Table 9-3. DOC training could be completed over the course of a single day, or the live standardized patient/resident session could be performed on a different day. A randomized controlled trial of DOC training demonstrated that this method of faculty development leads to meaningful changes in faculty evaluation.\textsuperscript{84}

**Useful Tools to Guide Observation**

**The Mini-Clinical Evaluation Exercise**

The mini-CEX is designed to evaluate residents in a setting reflective of day-to-day practice. Faculty observe a resident performing a focused history, physical examination, or counseling session during routine care experiences on the inpatient wards, intensive care units, outpatient clinics, and the emergency department. Unlike the traditional long case that can require several hours to complete, mini-CEX observation lasts
In the first large study of the mini-CEX, Norcini and colleagues reported on the results of 388 mini-CEX evaluations for 88 residents at five different residency programs. Over half of the encounters occurred in the inpatient setting. In this initial study, most of the participating residents were in the PGY-1 year, and each resident underwent a mean of 4.4 observations (range 2 to 10). The mean ratings for each category were significantly correlated with scores for overall competence. Higher resident ratings were noted for longer mini-CEX interactions. The authors noted that between 12 and 14 encounters would be necessary to reach a reproducibility of 0.80, sufficient for high-stakes determinations, but the standard error noted for just four mini-CEXs per resident was acceptable for pass-fail determinations. Trainees reported high satisfaction ratings for the mini-CEX format, and interestingly, there was a modest correlation between faculty satisfaction ratings and resident performance.

In a more recent study of the mini-CEX involving a more diverse set of residency programs, several new findings were noted. First, the scores on the mini-CEX suggested that interns displayed growth in clinical skills over the course of the year, with the biggest gains occurring in the dimensions of clinical judgment and organization/efficiency. Finally, the authors concluded that the mini-CEX had higher fidelity and was less expensive than the long case CEX. In a separate report, Norcini also found that ratings did not differ by the setting of the exercise, specific institution, or type of patient. Norcini concluded that it may be possible to compare ratings from different clinical settings because examiners do not appear to rate residents differently based on the setting. There is also evidence related to the validity of the mini-CEX. My colleagues and I, using scripted videotapes, found that the mini-CEX evaluation form does possess construct validity. However; we were not able to conclude if this occurs with actual observations of resident performance, and the ratings on each tape had a wide range among a group of 40 faculty members.

### Feedback and the Mini-CEX

An essential component of the mini-CEX, as with any evaluation, is feedback. A recent study investigated the feedback generated from the mini-CEX observation by audiotaping the attending/resident feedback session, with a particular focus on interactive feedback. Interactive feedback was defined as any feedback that provided a recommendation plus self-assessment, allowing the learner to react to the feedback, and development of an action plan. The study showed that 80% of the feedback sessions included at least one recommendation for improvement for the resident, and on average each feedback session contained two recommendations. The majority of recommendations, as might be expected, involved the clinical skills of medical interviewing, physical examination, and counseling. However, despite the large number of recommendations, only eight sessions concluded with a specific action plan from the faculty member on how to carry out the recommendation or improve. This is a very important aspect of feedback: including an action plan to enable the learner to act on the recommendations provided.

### Checklists

The mini-CEX is example of a global rating scale for which faculty training (described in the previous section) is crucial to the effective use of the mini-CEX form (Fig 9-4). Checklists targeting specific skills are another tool that can improve the quality of faculty observation. In one of the original studies of the long case CEX the use of a checklist doubled the detection of errors committed on a scripted videotape. As described in Chapter 7, checklists are the foundation for standardized patient assessments. However, because the purpose of faculty direct observation is to assess
performance of actual clinical practice, it is not feasible to develop highly detailed checklists for every patient encounter. Some degree of faculty interpretation of behavior and skills will be required when working in actual clinical settings. A number of checklists for assessment of interviewing skills have been developed and tested for reliability. Both the SEGUE and Calgary-Cambridge checklists are useful tools to guide the evaluation of process and general content of medical interviewing.88,89

The choice of instruments depends primarily on the objectives of the teaching or assessment exercise. Drawing upon the standardized patient literature, the use of checklists may increase the reliability of observation compared to less structured general ratings in the hands of physician observers.12 On the other hand, concerns have been raised about the validity of such a highly structured approach.14–18 However, the differences between global ratings and checklist scores in these studies were relatively small and it may be that the different approaches were measuring different constructs.88,89 At the present time, it seems reasonable to conclude that checklists may provide a reliable means of assessing whether critical data-gathering actions are completed and facilitate the provision of explicit feedback to trainees. Identification of essential examinee actions for a particular patient encounter may reduce the propensity of such instruments to over-reward thoroughness. The use of global ratings supports the valid assessment of communication and interpersonal skills and allows faculty to gauge various aspects of examinee performance against an internal or professional standard (see Chapter 8). Faculty development activities that include the abovementioned training approaches will serve to instill a common standard among raters and therefore optimize the reliability and validity of assessment.

Creating an Observation System

There are three simple steps in creating a faculty observation system. First, determine what your faculty is doing in regard to observation. If no observation is occurring, you will probably have to create a “need” for observation through culture change. You can start by highlighting with your faculty the substantial documented deficiencies in trainees to demonstrate the need to perform observation.

Second, if you have the resources and access, consider an OSCE or other standardized patient baseline assessment with your trainees. Lypson and colleagues discovered in an entry OSCE that brand-new interns lacked basic skills faculty believed they should have on day 1.19 This type of information, especially if accompanied by videotape for review by the faculty, can be a powerful motivator. My own experience with an OSCE for early fourth-year medical students was similar and productively led to a revision of the curriculum for teaching physical examination skills (once the depression among the teaching faculty had lifted).

Third, start small and get the faculty to simply perform observation of their trainees. Invariably at some point a faculty member will observe these deficiencies and experience the powerful “you will not believe what I saw today” moment. Once that happens, it becomes very difficult for your faculty to argue they no longer need to observe trainees, especially from a patient-centered perspective.

The next step is to improve faculty skill in observation, and depending on your educational climate, this can be done concurrently with creating the need for observation. We recommend you start with performance dimension and behavioral observation training. This is can be done in a series of brief workshops as described earlier in the chapter, and can then be reinforced in small aliquots of time at competency committee or other scheduled faculty meetings. Once your group feels comfortable with the definitions and criteria for the clinical skills competencies, you can then move on to frame of reference training and direct observation of competence training to further improve faculty accuracy and ability to distinguish between levels of competence.

Conclusion

The successful practice of medicine requires the effective application of medical interviewing, physical examination, and counseling skills. Studies continue to document significant deficiencies in all three of these clinical skills areas among students, residents, and practicing physicians. Despite the advances in clinical skills evaluation afforded by standardized patients and potentially computer simulation, direct observation by medical faculty remains an essential method to assess core basic clinical skills with actual patients. Furthermore, faculty observers are in the best position to assess a trainee’s acquisition and refinement of clinical skills longitudinally over time. Several practical approaches, described in this chapter, exist to help improve faculty skills in observation.

ANNOTATED BIBLIOGRAPHY

This was one of the first studies to systematically evaluate problems in faculty observation skills. Although the tool used for the study (the "tri- ditional" long-case clinical evaluation exercise [CEX]) is infrequently used today, the lesson from the study about the importance of training faculty remains valuable.


This article offers a basic review of the importance of clinical skills and the continued need for faculty to observe and evaluate trainees while caring for actual patients.

REFERENCES


Practical Guide to the Evaluation of Clinical Competence

58. Davis DA.
59. Duffy FD and Holmboe ES.
APPENDIX 9-1
Sample Performance Dimension Training and Frame of Reference Exercise

The purpose of this group exercise is to develop specific criteria for a dimension of clinical competency. The dimension we will focus on today is counseling. Counseling is a core component of the new ACGME general competency of patient care.

**Situation:** A resident is seeing a patient who has been diagnosed with a new medical condition. The resident now needs to start a new medication for this patient. What are the criteria for a superior, highly effective counseling and patient education session? In other words, what criteria will you use to judge the counseling and patient education performance of this resident? Once you have defined all the criteria, check off those criteria a resident would have to perform in order to receive a *satisfactory* rating.

**With your group:** Define the components/criteria of effective patient counseling and education, based on the knowledge, skills, attitudes (KSA) model (Box 9-1). Be sure your criteria are “behavioral;” remember that you are developing these elements in the context of faculty observation.

---

**BOX 9-1 Knowledge, Skills, Attitudes (KSA) Model**

**Knowledge**
What questions and “content” should the resident ask the patient?

**Skills**
How should the resident conduct the interview? Ask questions?

**Attitudes**
Define behaviors that would signal to an attending a resident was displaying a compassionate, interested, professional attitude.