Portfolio for Internal Medicine Residency Programs

Evaluating Your Residents: New Competencies, New Forms

This collaborative work-in-progress presents suggested definitions, guidelines, competency-based vignettes and example forms for use by program directors and faculty in the evaluation of residents.
Also included are example forms for residents to use for self-assessment, and to evaluate attending physicians and the residency program

July 2001 - June 2002

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PORTFOLIO OVERVIEW

Purpose: This work-in-progress portfolio is designed to help internal medicine program directors, faculty and residents understand and use the definitions of the new six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice) conceptualized and adopted by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) for implementation in July 2001. Practical evaluation strategies are also described.

Content: Through collaborative efforts within the community of internal medicine, a series of working definitions have been developed for the new competencies, along with a revised evaluation form (global ratings) and related descriptors. Guidelines for faculty development, illustrative competency-based vignettes, and suggested performance standards are also included along with examples of other evaluation forms and strategies that reflect the new competencies.

Work-in-Progress: As the ACGME Outcome Project moves forward and the Residency Review Committee for Internal Medicine develops the next set of program requirements, this resource portfolio serves as a starting point for program directors, effective July 2001. Building on the feedback solicited during the coming year from program directors, faculty, residents and medical educators, we anticipate continuous quality improvement in the content, design and scope of the portfolio and in the evaluation strategies it describes.

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Organizations Committed to Improving Graduate Medical Education In Internal Medicine

American Board of Internal Medicine <www.abim.org>
American College of Physicians-American Society of Internal Medicine <www.acponline.org>
Association of Program Directors in Internal Medicine <www.apdim.edu>
Association of Professors of Medicine <www.im.org/apm>
Association of Subspecialty Professors <www.im.org/asp>
Society of General Internal Medicine <www.sgim.org>

Evaluation of Residents: Program Requirements for Internal Medicine

Draft Guidelines Under Consideration by the Residency Review Committee for Internal Medicine, Summer 2001

A. Formative Evaluation

1. The program must evaluate the performance of residents on a regular basis. This evaluation must include the six competencies. Each resident must be closely observed performing specific tasks of patient management such as medical interviews and physical examination, choice of diagnostic studies, formulation of differential diagnosis or problem lists, development of plans for short-term and long-term medical management, communication of treatment plans, invasive procedures, and (when on inpatient services) discharge planning.

2 Structured clinical evaluations (for example, a minimum of four mini-clinical evaluation exercises during PGY-1) should be conducted as described in publications by the American Board of Internal Medicine.

3. Standardized chart review by faculty with the purpose of documenting and evaluating the format and quality of data entry, diagnostic reasoning, clinical judgment, and quality of patient outcome should be performed on a representative sample of resident inpatient and outpatient records (including inpatient discharge summaries) during each rotation. Accordingly feedback should also be provided to the residents. Results of these chart reviews are to be incorporated into the resident's evaluation file, and utilized for formative and summative evaluation. It is desirable that this information be used in program CQI activities.

   a. Records must be maintained by documentation logbook or equivalency to demonstrate that residents have achieved competence in the performance of invasive procedures. These records must state the indications and complications and include the names of the supervising physicians. Such records must be of sufficient detail to permit use in future credentialing.

   b. Residents must be evaluated in writing and their performance reviewed with them verbally on completion of each rotation period.

   c. Formal evaluations of knowledge, skills, and professional growth of residents and required counseling by the program director or designee must occur at least semiannually.

   d. Permanent records of both of these evaluation and counseling sessions (and any others which occur) for each resident must be maintained in the resident's file and must be accessible to the resident and other authorized personnel.

B. Summative Evaluation

1. The program director must prepare an annual evaluation of the clinical competence of each resident and at the conclusion of the resident's period of training in the program.

2. The summative evaluation must stipulate the degree to which the resident has achieved the level of performance expected in each competency (i.e., patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice).

3. Upon successful completion of the educational program, the program director must verify that the resident has demonstrated sufficient professional ability to practice competently and independently.

4. A record of the summative evaluations must be maintained in the program files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in other bodies' actions. Written documentation of formal summative evaluation must be in addition to the above noted formative evaluations.

5. In the event of an adverse annual evaluation, a resident must be offered an opportunity to address a judgment of academic deficiencies or misconduct before a constituted clinical competence committee.

6. There must be a written policy that ensures that academic due process provides fundamental fairness to the resident and protects the institution by ensuring accurate, proper, and definitive resolution of disputed evaluations.

ABMS/ACGME GENERAL COMPETENCIES
Working Definitions for Internal Medicine
July 2001 - June 2002

These definitions have been developed collaboratively by the internal medicine community, presented at the APDIM Spring 2001 Meeting, and posted on the APDIM web site for comments during April through June 2001. They are a work-in-progress.

Patient Care: *Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.*

- Gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records and diagnostic/therapeutic procedures
- Make informed recommendations about preventive, diagnostic and therapeutic options and interventions that are based on clinical judgement, scientific evidence, and patient preference
- Develop, negotiate and implement effective patient management plans and integration of patient care
- Perform competently the diagnostic and therapeutic procedures considered essential to the practice of internal medicine

Medical Knowledge: *Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.*

- Apply an open-minded, analytical approach to acquiring new knowledge
- Access and critically evaluate current medical information and scientific evidence
- Develop clinically applicable knowledge of the basic and clinical sciences that underlie the practice of internal medicine
- Apply this knowledge to clinical problem-solving, clinical decision-making, and critical thinking

Practice-Based Learning and Improvement: *Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.*

- Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes and processes of care
- Analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient practice
- Develop and maintain a willingness to learn from errors and use errors to improve the system or processes of care
- Use information technology or other available methodologies to access and manage information, support patient care decisions and enhance both patient and physician education

Interpersonal and Communication Skills: *Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.*

- 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.
- Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families
- Interact with consultants in a respectful, appropriate manner
- Maintain comprehensive, timely, and legible medical records

Professionalism: *Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.*

- Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families, and colleagues
- Demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors and disabilities of patients and professional colleagues
- Adhere to principles of confidentiality, scientific/academic integrity, and informed consent
- Recognize and identify deficiencies in peer performance

Systems-Based Practice: *Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.*

- Understand, access and utilize the resources, providers and systems necessary to provide optimal care
- Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient
- Apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management
- Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care

GUIDELINES-IN-BRIEF FOR ATTENDING PHYSICIANS TO USE NEW GLOBAL RATINGS EVALUATION FORM

Overview

The new global evaluation form is designed to help program directors and faculty assess specific knowledge, skills, and attitudes of all internal medicine residents in the context of the six newly defined ACGME/ABMS general competencies: *patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice*. This form will serve as the template for the revised ABIM tracking form effective 2003.

Using the Evaluation Form

The form can be used for common inpatient rotations or easily adapted for any clinical experience or setting. However, program directors should discuss with their faculty the specific knowledge, skills, and attitudes required for each particular setting. For example, the medical knowledge required in an intensive care unit will differ markedly from that needed in an ambulatory setting.

Standards for Ratings

When evaluating residents, program directors and faculty should use the following definition as their standard — the level of knowledge, skills, and attitudes that is expected from a clearly satisfactory resident at this stage of training. Using a nine-point scale, a clearly satisfactory resident should receive a rating of “5”. A rating of “4” should be considered “marginal.”

Why Does the Board Use A Nine Point Scale? The principal advantage of the nine-point scale over shorter scales are the additional levels of discrimination it provides. Thus, scales that include more rating steps tend to produce more reliable ratings.

A feature of all scales with an odd number of rating steps, such as the nine-point scale, is that an “average rating” can be given. Allowing program directors to describe residents as average seems appropriate for the judgments they are asked to make about knowledge, skills and attitudes such as patient care and professionalism, along with the other defined competencies.

Why Are Observation and Documentation Important? Any evaluation should be based on as much direct observation as possible. Written comments, particularly those that provide support for ratings in the unsatisfactory or superior categories, are encouraged along with specific examples of performance and recommendations for professional growth and improvement.

Feedback to Residents

Attending physicians should take the opportunity to use the evaluation form to provide specific feedback to residents about their performance during and at the end of each rotation and to enhance their understanding of the six general competencies.

INTERNAL MEDICINE RESIDENT EVALUATION FORM: AN EXAMPLE

This form can be used to evaluate residents on clinical rotations or as a template to be easily adapted for any clinical experience or setting.

INTERNAL MEDICINE RESIDENT EVALUATION FORM

Resident's Name Rotation Name

Attending's Name Rotation Period Evaluation Date

In evaluating the resident's performance, use as your standard the level of knowledge, skills and attitudes expected from the clearly satisfactory resident at this stage of training. **For any component that needs attention or is rated a 4 or less, please provide specific comments and recommendations on the back of the form.** Be as specific as possible, including reports of critical incidents and/or outstanding performance. Global adjectives or remarks, such as "good resident," do not provide meaningful feedback to the resident.

	Unsatisfactory			Satisfactory			Superior			
1.Patient Care Incomplete, inaccurate medical interviews, physical examinations, and review of other data; incompetent performance of essential procedures; fails to analyze clinical data and consider patient preferences when making medical decisions ❑ Insufficient contact to judge	1	2	3	4	5	6	7	8	9	Superb, accurate, comprehensive medical interviews, physical examinations, review of other data, and procedural skills; always makes diagnostic and therapeutic decisions based on available evidence, sound judgment, and patient preferences
	❑ Performance needs attention									
2.Medical Knowledge Limited knowledge of basic and clinical sciences; minimal interest in learning; does not understand complex relations, mechanisms of disease ❑ Insufficient contact to judge	1	2	3	4	5	6	7	8	9	Exceptional knowledge of basic and clinical sciences; highly resourceful development of knowledge; comprehensive understanding of complex relationships, mechanisms of disease
	❑ Performance needs attention									
3.Practice-Based Learning Improvement Fails to perform self-evaluation; lacks insight, initiative; resists or ignores feedback; fails to use information technology to enhance patient care or pursue self-improvement ❑ Insufficient contact to judge	1	2	3	4	5	6	7	8	9	Constantly evaluates own performance, incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self-improvement
	❑ Performance needs attention									
4.Interpersonal and Communication Skills Does not establish even minimally effective therapeutic relationships with patients and families; does not demonstrate ability to build relationships through listening, narrative or nonverbal skills; does not provide education or counseling to patients, families, or colleagues ❑ Insufficient contact to judge	1	2	3	4	5	6	7	8	9	Establishes a highly effective therapeutic relationship with patients and families; demonstrates excellent relationship building through listening, narrative and nonverbal skills; excellent education and counseling of patients, families, and colleagues; always "interpersonally" engaged
	❑ Performance needs attention									

	Unsatisfactory			Satisfactory			Superior			
5.Professionalism Lacks respect, compassion, integrity, honesty; disregards need for self-assessment; fails to acknowledge errors; does not consider needs of patients, families, colleagues; does not display responsible behavior ❑ Insufficient contact to judge	1	2	3	4	5	6	7	8	9	Always demonstrates respect, compassion, integrity, honesty; teaches/role models responsible behavior; total commitment to self-assessment; willingly acknowledges errors; always considers needs of patients, families, colleagues
				❑ Performance needs attention						
6.System-Based Learning Unable to access/mobilize outside resources; actively resists efforts to improve systems of care; does not use systematic approaches to reduce error and improve patient care ❑ Insufficient contact to judge	1	2	3	4	5	6	7	8	9	Effectively accesses/utilizes outside resources; effectively uses systematic approaches to reduce errors and improve patient care; enthusiastically assists in developing systems' improvement
				❑ Performance needs attention						
Resident's Overall Clinical Competence in Internal Medicine on Rotation	1	2	3	4	5	6	7	8	9	
				❑ Performance needs attention						

Attending's Comments

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Signatures: Resident's ______________________________ **Attending's** ______________________________

PRACTICAL SUGGESTIONS FOR FACULTY DEVELOPMENT IN USING THE NEW COMPETENCIES AND NEW FORMS

Background

The American Board of Internal Medicine is revising its tracking form to reflect the six new general competencies developed by the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS). Faculty evaluation of residents will remain a vital component of each residency program's overall approach to evaluating residents' clinical competence and performance. The implementation of the six new general competencies provides an opportunity to educate the teaching faculty about important principles of evaluation. Provided below are some practical suggestions about how to familiarize the faculty with the new competencies and their definitions, how to educate faculty about performance standards, and how to effectively use the new evaluation forms.

Strategies

- **Pre/Post Rotation Meetings**: Meeting with faculty prior to and after a specific rotation allows for "real-time" faculty development. In the pre-rotation meetings, program directors can explain the new competencies, provide examples (clinical vignettes, competency cards) and set performance standards. The post-rotation meeting allows the program director to learn specifics about performance, as well as to help "calibrate" ratings and evaluations by the faculty.

- **Competency Cards**: These convenient cards (e.g. a folding 3" X 5" card) can be used to provide a reference to the new competencies and to record observations made about residents over the course of a rotation (see example, page 10). Simple programs can also be used for personal digital assistants such as the Palm Pilot.

- **Clinical Vignettes**: Program directors can help educate faculty by providing examples of performance specific to each of the new competencies. A series of competency-based vignettes are included as examples. As noted below under performance dimension training, the best use of vignettes is in a structured educational session to facilitate feedback.

- **Performance Dimension Training**: Performance dimension training is a technique that comes from industry but is directly applicable to evaluation in residency programs. This type of training is designed to teach and familiarize faculty with the appropriate performance dimensions used on the new evaluation form. The first step requires the faculty to review the definitions for each new competency. Faculty should then "interact" with the definitions to improve their understanding of the new competencies. Reviews of actual resident performance, clinical vignettes, or videotaped encounters are all potentially useful methods to help faculty grapple with the new competencies. Performing actual practice ratings based on clinical vignettes or videotapes is very valuable, and also allows the program director to "calibrate" the ratings of faculty and set rating standards. Faculty education can be done as a short workshop, or incorporated succinctly into the pre and post rotation meetings, depending on faculty availability.

- **Evaluation Workshops**: Depending on availability and local resources, program directors may want to plan a more formal workshop or two hour interactive discussion to introduce the faculty to the new competencies and evaluation form. Workshops facilitate group interaction with multiple concepts, and provide a "safe" environment for skill practice (e.g. use of the evaluation form), and feedback.

- **Training Manual**: Developing a concise "training manual" that provides background and information about the new competencies and evaluation may be useful provided that it is succinct and easy to read. Experienced evaluators indicate that simply handing out written materials without discussion or some form of education and follow up is usually ineffective.

EXAMPLE: COMPETENCY CARD

A useful card that can provide attending physicians with a quick reference to the essential competencies residents are expected to demonstrate.

Resident: ____

Rotation: ____

PERFORMANCE NOTES	COMPETENCIES - AT A GLANCE
	Patient Care: Resident provides compassionate care that is effective for the promotion of health, prevention, treatment, and care at the end of life. **Medical Knowledge**: Resident demonstrates knowledge of biomedical, clinical and social science, and applies that knowledge effectively to patient care. **Practice-Based Learning and Improvement**: Resident uses evidence and methods to investigate, evaluate, and improve patient care practices. **Communication and Interpersonal Skills**: Resident demonstrates these skills to establish and maintain professional and therapeutic relationships with patients and healthcare team. **Professionalism**: Resident demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity, and responsible attitudes. **Systems-Based Practice**: Resident demonstrates an understanding of both contexts and systems in which health care is provided and applies this knowledge to improve and optimize health care.

The Competency Card can be used by attending physicians to document specific performance related to the six general competencies observed during this rotation. Packets of printed cards can be obtained by contacting the ABIM <1-215-446-3530> or <hlespoir@abim.org>

COMPETENCY-BASED CLINICAL VIGNETTES

The next several pages include competency based vignettes that reflect marginal performance by residents and suggest remediation plans and timelines from which to judge improvement or consider adverse action. These vignettes, contributed by Drs. Glenn Braunstein, Thomas Cooney, Ron Loge, Mark Noah, Maxine Papadakis and Kelly Skeff, are designed to raise awareness, provide definitive examples, and stimulate program directors to think about these issues within the context of evaluation.

Patient Care	Remediation Plan: Steps and Responsibilities	Time Line
A 68-year-old woman is seen by the resident to evaluate a 15-pound weight loss over the previous six months. She describes fatigue, non-specific weakness, difficulty climbing stairs and feeling nervous. The resident finds nothing remarkable on physical exam and concludes that malignancy is the most likely diagnosis. He fails to ask the patient about prior thyroid disorder disease and misses an abnormal, diffusely enlarged thyroid gland. *Competency Issue: Data-gathering and synthesis*	1. Attending physician or chief resident to review the H & P with the resident at the bedside 2. Resident to review literature on signs and symptoms of thyroid disease in elderly patients 3. Attending physician or chief resident to provide close supervision of subsequent care and decide if this error was specific to situation or reflective of more global deficiencies	1. Immediately 2. Immediately 3. As long as needed 4. Continue spot checks for completeness
A PGY-2 resident is noted to frequently miss key elements in the history. For example, he seldom took a careful dietary or medical compliance history in patients presenting with decompensated CHF. He often missed key physical exam findings and was unable to recognize certain findings or use maneuvers designed to elicit them. At other times, he incorrectly interpreted and reported findings. *Competency Issue: Data gathering and accuracy of information*	1. Program director to review performance with resident 2. Expectations are made clear to the resident 3. Goals for remediation and timetable agreed upon, including: a. Review of demonstration videotapes (or readings) on history and physical exam techniques b. Demonstration, then supervised practice followed by feedback and reflection c. Assessment (OSCEs or mini-CEXs) d. Program director to review performance with resident	1. Immediately 2. Immediately 3. Immediately a. Two weeks b. Three weeks c. Three months d. Three months
The resident does well in the ICU setting, but in the ambulatory clinic does not adequately judge the acuity of patient problems or adjust her work ups to the chronicity and longitudinal nature of patient care. *Competency Issue: Synthesis/clinical judgment, patient management*	1. Clinic attending to monitor resident's performance. 2. Clinic attending to directly evaluate all patients for three month period; resident to present her plans for each patient 3. All patient records to be reviewed in detail by the clinic attending	Three months
A PGY-1 resident's written communications (history and physical examinations, progress notes, and discharge summaries) are inadequate. He demonstrates adequate knowledge and understanding of clinical medicine during attending rounds and morning report but his written documents are so cursory as to be meaningless. *Competency Issue: Effective communication*	1. Program director to review performance with resident 2. Expectations are made clear to resident 3. Goals for remediation and timetable agreed upon, including: a. Chief resident to provide and review examples of documents that meet program's standard b. Have resident's write ups reviewed with resident by current faculty or chief resident, and send critique to program director c. Program director to review performance with resident	1. Immediately 2. Immediately 3. Immediately a. One week b. Ongoing c. Quarterly
A PGY-2 resident's armamentarium of drugs reflects exposure to pharmaceutical representatives. He almost always initiates treatment with the newest drug, and while this approach is effective, it is unnecessary and expensive. *Competency Issue: Make informed decisions about diagnostic and therapeutic interventions based upon patient information and preferences, up-to-date scientific evidence, and clinical judgment; use information technology to support patient care decisions and patient education*	1. Program director to review performance with resident 2. Expectations are made clear to the resident 3. Goals for remediation and timetable agreed upon, including: a. Resident reviews with program director his drug utilization profile and cost of care for common problems as compared to his peers (if available) b, Resident reviews with assigned faculty where to find evidence-based information on drug therapeutics c. Resident reviews with assigned faculty evidenced-based clinical care guidelines for common medical problems d. Resident assigned to make a series of presentations (along with peers) on cost-effective treatment of common medical problems e. Resident participants on panel presentation of ethics of pharmaceutical interactions with housestaff f. Program director reviews performance with resident	1. Immediately 2. Immediately 3. Immediately a. One month b. One month c. Over next year d. Over next year e. Within next six months f. Every six months

Medical Knowledge	Remediation Plan: Steps and Responsibilities	Time Line
A 26-year-old male with a long history of depression has been evaluated for recurrent episodes of confusion, diaphoresis, ataxia, and on two occasions loss of consciousness with seizure activity. During the last episode, he was found to have a blood sugar of 20 mg/dl, a markedly elevated insulin level (>1000 uU/ml) and an undetectable C-peptide level. The resident states that the patient has an insulinoma and should go to surgery. When asked to explain the discrepancy between the insulin and C-peptide levels, he says, "what is a C-peptide?" After the attending answers the question, the resident says "ok" but still insists that the patient has an insulinoma that requires surgery. *Competency Issue: Application of knowledge, awareness of own limitations, interests in learning*	1. Resident to review literature and demonstrate mastery by presenting to team, without notes 2. Program director to review prior evaluations, conference attendance, ITE results, to identify patterns of knowledge gaps, if present. Use MKSAP and Board review courses 3. Program director and/or advisor to meet with resident to discuss attitudes and apparent inability to learn feedback 4. Program director and/or chief resident to monitor performance carefully, to ensure that over confidence does not lead to poor patient care	1. One week 2. One week 3. One week 4. Begin immediately, continue as long as indicated
A PGY-1 resident uses the advice of his senior resident and clinic attending to manage patients with Type 2 diabetes and learns the appropriate doses of the various oral agents. His empiric approach results in reasonable glucose control, and he is enthusiastic about learning to treat patients with diabetes. He, however, has no understanding of the pathophysiology of insulin resistance in Type 2 diabetes and how this applies to management. Only with repeated encouragement does he make the effort to read about these issues. *Competency Issue: Access and use of information/minimal level of knowledge of drugs to prescribe them safely*	1. Resident is to review and report on medically-related literature 2. Resident to provide update at morning report 3. Learn to access drug references 4. Have resident discuss the mechanism of action of drugs he prescribes at each attending sign-out clinic 5. Chart stimulated recall with specific questions about diabetic therapies	End of PGY-1
A patient presents with anemia, the PGY-2 resident does not initially present a systematic approach to the patient's problem. When asked about the differential diagnosis of a macrocytic anemia, he states that it could be B-12 deficiency but cannot come up with a reason why this patient would be B-12 deficient. *Competency Issue: Develop understanding of science-based medicine and applicability to patient care*	1. Responsible teaching attending to monitor this event-based episode 2. Resident is required to prepare and present this patient to the "team", including a discussion of the causes and mechanisms of B-12 deficiency anemia 3. Program director should review the resident's performance on the ITE, and if indicated, develop a longitudinal plan of self-assessment and self-teaching	One week for this event; longer if the diagnosis reveals a more extensive problem with medical knowledge
PGY-2 resident's fund of knowledge has gaps in it. He leaps around in his thought processes, without carefully organizing his knowledge base when investigating a clinical problem. For example, he was asked about the differential diagnosis of a patient with altered mental status. He talked about stroke, head trauma and "metabolic abnormalities", but the attending physician was not convinced that the resident had a good handle on how he should approach this patient's problem. *Competency Issue: Apply analytical approach to acquisition/application of knowledge to patient care*	1. The resident's advisor/mentor will monitor 2. The ITE would be an excellent tool for diagnosing the extent and specific areas of knowledge deficiency. In addition, the resident should be informed by his mentor about self-assessment and self-teaching 3. The resident should present a weekly log of self-questioning and evidence-based answers to each question, after a period of 6-8 weeks, the log may be presented on a monthly or quarterly basis	6-8 weeks

Interpersonal Skills and Communication	Remediation Plan: Steps and Responsibilities	Time Line
A 40-year-old woman with long-standing inflammatory bowel disease is seen by a PGY-2 resident. During the interview she tells him that she is taking her Azulfidine, but is also using acupuncture and a variety of herbs, and she firmly believes that the latter have helped her. The resident rolls his eyes and tells the patient that these are ridiculous therapies, are of no benefit, and she is "foolish" to use them. *Competency Issue: Therapeutic and professional relationships with patients; and respect for diversity*	1. Program director or advisor to review the case with the resident and determine why the resident reacted as he did 2. If specific issue can be identified, and resident demonstrates insight, assign mentor/preceptor to counsel resident in future encounters that may be problematic 3. If pattern of difficulty is identified and/or persists, encourage/require counseling and implement plan for careful monitoring	1. Immediately 2. As long as needed 3. Begin with one week; continue as needed
The resident has a patient with newly diagnosed breast cancer. She and her family members have lots of questions about prognosis and the various potential therapeutic alternatives. The resident answers the questions in a superficial fashion and does not set time aside to meet with the patient and her family. He does not refer the patient to available educational resources so she can find out more about her disease. *Competency Issue: Effective listening*	1. Use mini-CEXs specifically focused on counseling and patient education 2. Use OSCEs/SPs to work on communication skills 3. Use patient and peer evaluations to track progress	6-12 months depending on attitude; if attitude is poor, time line should be shorter
A PGY-2 resident often ignores psychosocial complaints. For example, he sees an elderly patient for worsening seizures and appropriately manages the problem. At the end of the clinic visit the patient becomes tearful and wonders if her problem is related to fatigue and sleeping poorly. She volunteers several symptoms strongly suggestive of depression. The resident ignores these symptoms and reminds her to take her pills and get a blood test before the next visit. *Competency Issue: Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning and writing skills. Create and sustain a therapeutic and ethically sound relationship with patients*	1. Program director to review performance with resident 2. Program director determines if performance is due to lack of knowledge (about depression) or lack of skill (communication), or both 3. Expectations are made clear to the resident 4. Goals for remediation and timetable agreed upon, including: a. Skills training in patient centered interviewing (medical school resources, videotape demonstrations, role-playing or role-modeling) b. Reflection on encounters with experienced mentor c. Assigned readings d. Real-time or videotaped supervision of patient encounters e. Program director reviews performance with resident	1. Immediately 2. Immediately 3. Immediately 4. Immediately a. Four months b. Ongoing c. Ongoing d. Ongoing e. Six and 12 months
A PGY-3 resident demonstrates a disrespectful attitude toward her peers. For example, while she has an excellent knowledge base and strong clinical skills she is considered by her peers and allied health staff to be disrespectful of their opinions. She also has a reputation for dodging or dumping work. *Competency Issue: Work effectively with others as a member or leader of a health care team*	1. Program director to review performance with resident 2. Program director determines if resident has any insight into the problem 3. Program director sets expectations 4. Program director helps resident determine how expectations can be met in practical, concrete ways 5. Program director might consider use of residency-wide peer/nursing/patient evaluation system 6. Program director reviews performance with resident	1. Immediately 2. Immediately 3. Immediately 4. Immediately 5. Ongoing 6. Quarterly
The resident is courteous to those "above" him in the medical hierarchy, such as the chief residents and the attending physicians. However, he has been sarcastic and condescending to the discharge planning nurses and to the nurses in his medical clinic who have called him about his patients. *Competency Issue: Effective listening and working in teams*	1. Program Director, with CMR, monitors resident 2. Explore resident's potential gender bias with a professional counselor 3. Assign the resident to work for 1-2 weeks with the discharge planners	One month

Practice-Based Learning and Improvement	Remediation Plan: Steps and Responsibilities	Time Line
A 60-year-old woman who has been on estrogen since menopause is seen for physical examination. She does not see any other physicians, and her last visit to the medical clinic was 2 years ago. The resident fails to perform a pelvic exam or order a mammogram. The clinic attending mentions this oversight to the resident's preceptor, the resident has made the same mistake with two other patients in the last month. On both occasions the attending discussed the error with the resident. *Competency Issue: Ability to learn from prior mistakes and do what is needed to improve practice*	1. If a PGY-1 resident, program director to meet with a resident to probe for cause/analyze problem. If senior resident, consider disciplinary action (probation, etc.) 2. Resident to keep a log of potential errors, lessons learned, practice improvements, and review with program director or advisory every month 3. Program director or chief resident to review randomly selected cases treated by resident and determine whether or not problems persist	1. One week 2. Begin with 1 month, continue as needed 3. Begin within two months; if problem persist, implement next phase of remediation plan
A PGY-2 resident demonstrates little or no initiative in self-directed learning. For example, a patient with Parkinson's disease is seen in clinic having developed "on-off" phenomenon. Rather than use this as an opportunity to learn about management approaches for this problem, the resident simply arranges for a neurology clinic appointment. *Competency Issue: Ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve practices.*	1. Program director to review performance with resident 2. Expectations for self-directed learning are made clear to the resident 3. Goals for remediation and timetable agreed upon, including: a. Resident will identify learning needs to clinic and ward attending physicians. Faculty are aware of this requirement b. Resident articulates to attending faculty how he will obtain information to remedy his learning needs c. Resident demonstrates results of his learning during rounds or at subsequent ambulatory clinics d. Program director reviews performance with resident	1. Immediately 2. Immediately 3. Immediately a. Ongoing b. Ongoing c. Ongoing d. Six and 12 months
The resident has several patients with congestive heart failure in her medical clinic. She has not consistently used the therapeutic modalities that are evidence-based and have been shown to prolong life, such as ACE inhibitors or beta-blockers. *Competency Issue: Identify areas for improvement and implement effective strategies, use technology to access and manage information*	1. Probe resident for cause/analyze problem 2. If found, consistent knowledge deficit, may: a. Assign to review practice guidelines b. Collaborative learning with attending physician to review guidelines c. Ask resident to teach others 3. Review resident's practice patterns to follow up impact of above interventions — medical record audit with specific feedback 4. Have resident review her own charts using practice guidelines	Three months, or long enough to see more patients with same problem
The PGY-2 resident has five patients in his clinic practice that have either episodic, or chronic atrial fibrillation. The patients' ages range from 45-85 years old. Several of the patients are on anticoagulation with coumadin, while others are not. When asked about his reason for this variation in use of anticoagulation, he has no particular explanation other than these were the medications the patients were taking when he took over their care last year. *Competency Issue: Analyze and evaluate practice experiences and implement strategies for improvement*	1. Resident to review the literature on evidence that anticoagulation may prevent strokes in patients with atrial fibrillation and effect of age on stroke 2. Present findings and discuss with clinic supervisor	1. Two weeks 2. Two weeks

Professionalism	Remediation Plan: Steps and Responsibilities	Time Line
A 36-year-old woman with terminal metastatic ovarian carcinoma is admitted to the hospital with obtundation. She has an advance directive that states that she does not want to have her life prolonged with heroic measures. The patient previously was treated with multiple courses of chemotherapy with minimal response. Prior to admission, when she was alert at home, she told her family that she wanted to die at home. When the patient became lethargic and less responsive, her daughter panicked and called the fire rescue for transport to the hospital. After examining the patient and explaining to the family that the patient's condition is terminal, the attending physician confirms that the advance directive is on the chart. The family agrees that the most appropriate course of action is to admit the patient and let her die. When the resident reviews the admission labs and notes that the calcium is 18mg/dl, he orders aggressive IV hydration, furosemide and pamidronate. *Competency Issue: Respect and sensitivity; care at the end of life*	1. Program director or chief resident to discuss with the resident the medical, ethical and legal issues of the case 2. Attending physician or chief resident to review all orders on his patients to ensure that their wishes are respected 3. Resident to complete self-study project regarding end of life care, and present his newly-acquired knowledge to other members of the team including a written personal narrative 4. Resident to identify and implement strategy for performance improvement, with program director or chief resident to follow-up	1. Immediately 2. Begin immediately, continue throughout hospitalization 3. One week 4. Begin immediately, continue as needed
The resident is scheduled to be in her Continuity Clinic from 1:00 PM - 4:30 PM. She arrives at 1:30 PM and learns that three of her patients have not kept their appointments. She sees her other patients and finishes her work at 3:00 PM. Another resident in the clinic asks her for help; he has three "walk-in" patients in addition to all of his scheduled patients, and at least one of his patients will require admission. He asks her to see one or two of the "walk in" patients but she refuses, stating that she wants to leave the hospital early. *Competency Issue: Respect and responsibility/accountability*	1. Clinic attending to meet with both residents to clarify/confirm sequence of events and identify any "hidden agendas" 2. Program director or chief resident to determine if the resident's refusal to help in this instance is an isolated incident or part of the pattern. In either case, program director or chief resident to clarify expectations and responsibilities 3. Resident to design and implement program for self-improvement, with monitoring by program director or chief resident	1. One or two days 2. One week 3. Begin within one week; continue for at least six months
A PGY-2 resident fails to demonstrate cultural sensitivity to patients. For example, she treats a non-English speaking patient for a skin infection. A translator is not used and therefore important information regarding social history, health beliefs, and understanding are not elicited. When challenged by her clinic attending, she replies that her practice plans do not include immigrants. *Competency Issue: Demonstrates sensitivity and responsiveness to patients' culture, age, gender and disabilities*	1. Program director to review performance with resident 2. Expectations are made clear to the resident 3. Goals for remediation and timetable agreed upon, including: a. Reading or attending conferences on cultural competence b. Close review of resident's interactions with cultural diverse patients by clinic attending c. Program director to review resident's performance	1. Immediately 2. Immediately 3. Immediately a. 3-6 months b. Ongoing c. 6 and 12 months
A resident who generally performs well in most areas of clinical medicine has shown a pattern in both inpatient and clinic settings of not treating homosexual male patients infected with HIV because of his strong religious beliefs. He is known to try to impose his religious thinking upon these patients. *Competency Issue: Respect and compassion*	1. Resident must understand that this type of behavior is unacceptable and intolerable. 2. Discuss strategies to address resident's bias and prejudice — consider counseling 3. Program director to provide close observation and monitoring of resident	1. Immediate, prejudice cannot be tolerated regardless of personal beliefs 2. Immediate, violates established ethical standards of the profession 3. Six month monitoring
A patient with a history of intravenous drug use is admitted to the hospital with a leg abscess at the site of an injection. The resident does not order adequate analgesia as a way in which to teach the "patient a lesson." *Competency Issue: Respect/compassion*	1. Close observation by program director 2. Longitudinal monitoring by attending 3. Open discussion about reasons for beliefs, and background of resident 4. Allow resident to self evaluate and reflect on his own prejudices and their source. 5. Establish absolute standard of performance expected of resident	1. Immediate — violates basic standards of the profession 2. Six months 3. Immediate 4. Immediate 5. One week

Systems-Based Practice	Remediation Plan: Steps and Responsibilities	Time Line
A 60-year-old post-menopausal woman is found to have spinal osteoporosis. She has a past history of breast cancer and gastrointestinal reflux disease. The resident orders Raloxifene, but the patient's health plan refuses to authorize payment for it. The health plan reviewer states that Alendronate is the appropriate therapy. The resident changes the prescription, ignoring the potential toxicity of Alendronate and potential benefit of Raloxifene in this patient. *Competency Issue: Negotiating the system to ensure optimal patient care; patient advocacy*	1. Resident required to do a literature search on treatment of osteoporosis and the pros, cons and side effects of various therapies 2. Chief resident to discuss with the resident how to appeal an appropriate denial of service or recommendation from a patient's health plan 3. Chief resident or clinic attending to meet with the resident every two months to see if similar issues have arisen and evaluate how well the resident has handled them. Resident to keep a log of interactions with insurers 4. Program director to schedule an educational session for all residents, since it is likely that other residents will encounter similar challenges. Resident to present the case an example	1. Two weeks 2. Immediately 3. Begin in one month, continue for 6-12 months, or longer if needed 4 Within two months
A PGY-2 resident is unaware of systems of practice that can help manage chronic medical conditions. For example, she evaluates a patient with a diabetic foot ulcer, rules out osteomyelitis and arranges for a three-month follow up visit. However, she is unaware of diabetic care guidelines, and does not utilize the diabetic educator, podiatrist, and wound care specialist available in the health system. *Competency Issue: Awareness of and responsiveness to the contexts and systems of health care and the ability to effectively elicit system resources to provide care of optimal value*	1. Program director to review performance with resident 2. Program director determines if this is primarily a resident problem or a system problem (residents not aware of services) 3. Program director arranges for meeting with residents to discuss system-wide problem and uses opportunity to improve quality of care system-wide 4. Program director arranges for a series of conferences/team meetings to inform resident(s) and faculty about available services 5. Service use is monitored using plan established by residents 6. Program director reviews performance with residents, quality improvement team, and allied health care teams	1. Immediately 2. Immediately 3. One month 4. Three months 5. Semi-annually 6. Semi-annually
The second-year resident is supervising a medical ward team. He has appropriately diagnosed and treated an 83-year-old women who was admitted for a community acquired pneumonia. The patient lives alone and has no family locally. When the patient is no longer febrile and has no sign of respiratory compromise, the resident determines the patient should be discharged. Prior to discharging the patient, the resident does not work with the social worker or home nursing services to assure that the patient gets appropriate home nursing follow up, including meals, and has the means to pay for the very expensive oral antibiotic prescribed. *Competency Issue: Interdependence between patient care within system and by society; apply knowledge of systems to improve patient care; collaboration/coordination of patient care*	1. Resident to use chart stimulated recall focusing on discharge planning 2. Nursing/social worker evaluations of the resident 3. Mini-CEXs: focus on discharge planning with the patient 4. Assign to social work rounds to learn about important systems	One month
The resident has an elderly patient with recurrent falls in his medical clinic. He has not investigated the support systems available to that patient through the patient's health care delivery system. For example, the patient has not had a home safety check. *Competency Issue: Apply knowledge of systems to improve patient care*	1. Chart stimulated recall focusing on outpatient systems needed for effective care 2. Clinic nursing/social worker evaluations of the resident 3. Mini-CEXs: focus on outpatient assessment and needs at the end of the patient visit 4. Spend afternoon working with clinic social work to learn about important systems	1-3 months
The resident discovers a 2.2 cm right thyroid nodule in a 50 year old patient sent to his clinic for primary care. He orders thyroid function tests, a serum calcitonin level, a radioactive iodine thyroid uptake and scan, and a thyroid ultrasound. After the results show normal thyroid function, and a solid, cold nodule, the patient is referred to the Endocrine Clinic where a fine needle aspiration is carried out. The endocrinologist reminds the resident that the most cost-effective direct way of evaluating a nodule is to perform a fine needle aspiration initially. *Competency Issue: Apply systematic and cost-effective strategies to prevention, diagnosis and treatment in a way that does not compromise quality of care*	1. Program director to have resident review literature on thyroid nodules and current approach to diagnosis 2. Chief resident to have resident present his findings at a journal club or other forum to demonstrate medical knowledge and clinical judgment 3. Program director to review with resident the need to read or ask for help when uncertain about the best approach to the problem	1. One week 2. One month 3. One week

PERFORMANCE EXPECTATIONS AND STANDARDS

In the context of introducing the new competencies and definitions, questions that program directors and faculty should consider in establishing guidelines and performance standards for the residency program include:

- How do you know when a resident is ready for more challenging ward rotations?
- How do you identify and define the "hurdles" between each year of training?
- What do you expect of your residents at the end of each year?
- Is there any reason you should not advance this resident to the next level at the conclusion of this year of training?
- Can you use the same evaluation form (with or without different definitions/expectations) for each year?
- Does this resident have the skills necessary for "team leading" that incorporate some or all of the general competencies?
- Can this resident recognize when a patient is acutely ill and in need of urgent medical attention, make an appropriate assessment, and institute a reasonable plan of management?

Program directors and faculty may find the following outcome measures for each level of training useful in the global assessment of an individual resident:

- **PGY-1:** At the conclusion of this year, the resident has demonstrated sufficient progress in the components of clinical competence that he/she is capable of functioning as a team leader. Specifically, the resident has the necessary skills in data gathering, medical knowledge, clinical insight, and critical thinking to assume a team leadership role.

  Core descriptors of performance milestones that may be useful to consider at the end of each rotation and include on the evaluation form are:

  Lacking in skills to function as a team leader . . . moving towards team leader role. . . capable of being a team leader

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- **PGY-2:** At the beginning of this year, the resident is capable of making independent decisions based on previous clinical experiences. As the resident progresses through PGY-2, he/she develops the ability to recognize and manage "new" clinical problems, those clinical scenarios not previously encountered.

  Core descriptors of performance milestones that may be useful to consider at the end of each rotation and include on the evaluation form are:

  Lacks insight and judgment in clinical situations. . .recognizes most new clinical situations and seeks appropriate consultation. . . recognizes and manages new clinical situations skillfully

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- **PGY-3:** At the conclusion of this year, the resident should demonstrate mastery of a large set of special skills and is prepared to practice independently. The resident now has the sufficient knowledge base, problem-solving skills, and clinical judgment that enable him/her to teach other residents and to evaluate the performance of junior residents.

  Core descriptors of performance milestones that may be useful to consider at the end of each rotation and include on the evaluation form are:

  Not yet capable of practicing as an independent physician. . .moving towards independent practice. . . practices as independent physician

SOME TIPS ON ASSESSING PRACTICE-BASED LEARNING AND SYSTEM-BASED PRACTICE: SETTINGS AND QUESTIONS TO CONSIDER

ASSESSING PRACTICE-BASED LEARNING AND SYSTEM-BASED PRACTICE: SETTINGS AND QUESTIONS TO CONSIDER

Recognizing that the competencies of practice-based learning and improvement and systems-based practice are new concepts to most faculty responsible for evaluating residents, a short list of definitive questions is provided as a template from which faculty can observe a resident's proficiency in these areas.

While the questions listed below are framed to be answered either yes or no, resident performance usually spans a broad spectrum that ranges from "always to never." Residency programs should determine if the questions listed below are appropriate for their use and applicable to the 9-point scale on
the sample evaluation form.

A better understanding of these competencies can be facilitated by dialogue among colleagues. Such discussion can focus on individual residents who do or do not demonstrate these important aspects of competence. These examples provide a common construct upon which ratings can be determined and assessment strategies can be considered.

Practice-Based Learning and Improvement

Inpatient Rotation

1. Does the resident use information about self-errors to improve practice and change behavior?
2. Does the resident voluntarily (without prompting or assignment) discuss and research relevant literature to support decision-making processes?
3. Does the resident's ability to teach junior colleagues or peers demonstrate the level of research and preparation expected by the program?
4. Does the resident's patient care reflect learning from previous experiences?
5. Does the resident demonstrate understanding and use of an evidence-based approach in providing patient care?
6. Does the resident effectively and efficiently use consulting services to improve both patient care and self-knowledge?

Ambulatory Rotation

1. Does the resident assess patient compliance to ambulatory regimens and accordingly modify prescribing practices?
2. Do the resident's educational discussions indicate a thorough, systematic review of the topic?
3. Does the resident freely admit to and seek help in remedying errors?
4. Does the resident readily seek formative feedback on performance?
5. Does the resident use self-assessments of knowledge, skills and attitudes to develop plans for addressing areas for improvement?
6. When presented with practice data, does the resident participate actively to improve practice?

Critical Care Rotation

1. Does the resident appropriately differentiate care delivered in the unit from other venues?
2. Does the resident quickly access appropriate reference material for current patients?
3. Does the resident use interactions with nursing staff and other professionals as two-way educational opportunities?
4. Does the resident participate actively in quality improvement practices pertaining to patient care (e.g., morbidity and mortality conferences)?
5. Does the resident's response to critical problems reflect more than rote learning and protocol management? Does the resident suggest data-driven modification of protocols?
6. Does the resident review autopsy findings to understand illness and the care of critically ill patients?
7. Does the resident voluntarily plan instructional experiences in procedures not yet mastered?

Consultation Service

1. Are the “non-internal medicine” patient care issues researched and learned by the team?
2. Does the resident identify the questions and wishes of the physician who requested the consultationand evaluate the issues with these in mind?
3. Does the resident spontaneously keep a log of unique cases? If such a log is required by the program, does the resident use it to self-assess performance patterns?
4. Does the resident acquire appropriate evidence-based information for the consultation? Is the resident facile in using this information during consultations?

Systems-Based Practice

Inpatient Rotation

1. Does the resident effectively utilize hospital resources to achieve appropriate patient care?
2. Does the resident recognize and surmount obstacles to appropriate patient care?
3. Does the resident provide appropriate patient care followup?
4. Does the resident use practice guidelines when appropriate?
5. Does the resident provide attention to discharge planning beginning at admission?

Ambulatory Rotation

1. Does the resident utilize community and clinic resources for successful patient care?
2. Does the resident access clinical information systems to enhance patient care?
3. Does the resident collaborate with payers to ensure that patients receive required care?
4. Does the resident use practice guidelines when appropriate?

Critical Care Rotation

1. Does the resident work effectively with nursing staff and ancillary health care personnel?
2. Is the resident aware of resource utilization in critically ill patients?
3. Does the resident use alternate care venues (stepdown units, etc.) appropriately

Consultation Service

1. Does the resident appropriately delineate relationships between the consulting service and the primary service?
2. Does the resident understand coordination of current inpatient and subsequent outpatient care?

EVALUATION RESOURCES:
HELPFUL INFORMATION FOR THE PROGRAM DIRECTOR

What Evaluation Strategies and Outcomes Are Required by the RRC-IM and the ABIM?

1. RRC-IM (Revisions to evaluation section of Program Requirements are expected when the new PRs are distributed later this year for review and comment)
    a. *Competency-based*
    b. *Annual summative evaluation*
    c. *Semi-annual meetings with each resident to review performance*
    d. *Formative evaluations for every rotation*
    e. *Evaluation of faculty and program every year*
    f. *Use of results to provide feedback and document progressive improvement in competence and performance*

2. ABIM
    a. *Annual tracking form, required each year throughout training*
    b. *Strongly recommend systems approach to evaluation and the use of multiple evaluators and direct observations of residents throughout residency*
    c. *Strongly recommend the use of mini-clinical evaluation exercises (mini-CEXs) a minimum of four in PGY-1, and preferably four throughout each year of training (visit <www.abim.org> and click on the mini-CEX page for more information)*

3. Other
    a. Requirements set by individual program
    b. Requirements set by Institution/GMEC

What Evaluations Are Suggested?

1. Consider developing a standardized form to communicate feedback to residents during semi-annual meetings with program directors
2. Ideally, evaluation of each educational experience would include review of institutional GME Committee/Division learning objectives and documentation of their achievement

3. Provide opportunity to implement different forms for different rotations (encourage web-based development)
    a. *Generic forms for*
        – *Critical care rotations*
        – *Inpatient ward rotations*
        – *Consult rotations*
        – *Outpatient rotations*
        – *Community-based rotations*
    b. *Consider development of a web-based menu from which programs could construct their own forms to suit their needs, e.g., with specific examples encompassing the six competencies*

4. Provide monthly evaluation form that parallels ABIM tracking form
    a. *Reflects each new competency*
    b. *Uses nine-point rating scale and descriptors (programs may use any rating scale, however, summative evaluations of residents by the program need to translate to the nine-point scale on the ABIM Tracking Form)*

5. Use separate evaluation of procedures
    a. *Log book or computer log*
    b. *Not evaluated well on monthly attending form*

6. Ideally, monthly forms should prompt specific evaluative information, e.g., examples of good or unsatisfactory behavior, and definitive areas for improvement

7. Need to ensure better documentation that end-of-rotation review of performance takes place (date and signature)

8. Define rating descriptors for 9-point scale so that 5 conveys “Expected level of performance” rather than “Satisfactory”
   - *“1-2”—Unsatisfactory*
   - *“3” —Needs attention*
   - *“4” —Marginal approaching expectations*
   - *“5” —Expected level of performance*
   - *“6” —Exceeds expectation*
   - *“7-9”—Outstanding*

EXAMPLE: SELF ASSESSMENT COMPETENCY CARD FOR RESIDENTS

Resident:____________________

Rotation:____________________

COMPETENCIES - AT A GLANCE: SELF-ASSESSMENT

Patient Care: Resident provides compassionate care that is effective for the promotion of health, prevention, treatment, and care at the end of life

Self Rating 1 2 3 4 5 6 7 8 9

Medical Knowledge: Resident demonstrates knowledge of biomedical, clinical and social science, applies that knowledge effectively to patient care

Self Rating 1 2 3 4 5 6 7 8 9

Practice-Based Learning and Improvement: Resident uses evidence and methods to investigate, evaluate, and improve patient care practices

Self Rating 1 2 3 4 5 6 7 8 9

Interpersonal and Communication Skills: Resident demonstrates these skills to establish and maintain professional and therapeutic relationships with patients and healthcare team

Self Rating 1 2 3 4 5 6 7 8 9

Professionalism: Resident demonstrates behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity, and responsible attitudes

Self Rating 1 2 3 4 5 6 7 8 9

Systems-Based Practice: Resident demonstrates both an understanding of contexts and systems in which health care is provided and applies this knowledge to improve and optimize health care

Self Rating 1 2 3 4 5 6 7 8 9

The Competency Card can be used by residents to self-assess and document their competencies throughout training and to measure progress and improvement for each rotation.
Packets of printed cards can be obtained by contacting the ABIM <1-215-446-3530> or email <hlespoir@abim.org>

EVALUATION OF ATTENDING PHYSICIAN

Attending Physician:______________________ Service/Rotation:______________________

Evaluator:______________________ Month/Year: ______________________

For each of the following criteria, please rate (√) the attending physician whose rotation you have just completed.

Availability:	Not Observed	Marginal	Satisfactory	Very Good	Excellent
● Was prompt	❑	❑	❑	❑	❑
● Adhered to rounds and consult schedules	❑	❑	❑	❑	❑
● Kept interruptions to a minimum	❑	❑	❑	❑	❑
● Spent enough time on rounds; was unhurried	❑	❑	❑	❑	❑
● Encouraged active housestaff participation	❑	❑	❑	❑	❑

Comments:____

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Teaching:	Not Observed	Marginal	Satisfactory	Very Good	Excellent
● Stated goals clearly and concisely	❑	❑	❑	❑	❑
● Kept discussions focused on case or topic	❑	❑	❑	❑	❑
● Asked questions in non-threatening way	❑	❑	❑	❑	❑
● Used bedside teaching to demonstrate history-taking and physical skills	❑	❑	❑	❑	❑
● Emphasized problem-solving, (thought processes leading to decisions)	❑	❑	❑	❑	❑
● Integrated social/ethical aspects of medicine	❑	❑	❑	❑	❑
● Stimulated team members to read, research, and review pertinent topics	❑	❑	❑	❑	❑
● Accommodated teaching to actively incorporate all members of team	❑	❑	❑	❑	❑
● Provided special help as needed to team members	❑	❑	❑	❑	❑

Comments:____

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Patient Care and Professionalism:	Not Observed	Marginal	Satisfactory	Very Good	Excellent
● Placed the patient's interests first	❑	❑	❑	❑	❑
● Displayed sensitive, caring, respectful attitude toward patients	❑	❑	❑	❑	❑
● Established rapport with team members	❑	❑	❑	❑	❑
● Showed respect for residents	❑	❑	❑	❑	❑
● Served as a role model	❑	❑	❑	❑	❑
● Was enthusiastic and stimulating	❑	❑	❑	❑	❑
● Demonstrated gender sensitivity	❑	❑	❑	❑	❑
● Recognized own limitations; was appropriately self-critical	❑	❑	❑	❑	❑
● Encouraged housestaff to bring up problems	❑	❑	❑	❑	❑

Comments:____

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Medical Knowledge:	**Not Observed**	**Marginal**	**Satisfactory**	**Very Good**	**Excellent**
● Demonstrated broad knowledge of medicine	❑	❑	❑	❑	❑
● Was up-to-date	❑	❑	❑	❑	❑
● Identified important elements in case analysis	❑	❑	❑	❑	❑
● Used relevant medical/scientific literature in supporting clinical advice	❑	❑	❑	❑	❑
● Discussed pertinent aspects of population and evidence-based medicine	❑	❑	❑	❑	❑

Comments: ____

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Practice-Based Learning and Improvement:	**Not Observed**	**Marginal**	**Satisfactory**	**Very Good**	**Excellent**
● Explicitly encouraged further learning	❑	❑	❑	❑	❑
● Motivated residents to self-learn	❑	❑	❑	❑	❑
● Evaluated residents ability to analyze or synthesize knowledge	❑	❑	❑	❑	❑

Comments: ____

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System-Based Practice:	**Not Observed**	**Marginal**	**Satisfactory**	**Very Good**	**Excellent**
● Reviewed expectations of each team member at beginning of rotation	❑	❑	❑	❑	❑
● Provided useful feedback including constructive criticism to team members	❑	❑	❑	❑	❑
● Balanced service responsibilities and teaching functions	❑	❑	❑	❑	❑

Comments: ____

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Recommendations:	Yes	No
● Would you recommend that this faculty member continue to serve as an attending physician for the training program?	❑	❑
● To further enhance professional development, would you recommend that this faculty member receive formal training in teaching and faculty education?	❑	❑

Overall Comments: ____

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RESIDENT'S ANNUAL EVALUATION OF INTERNAL MEDICINE TRAINING PROGRAM

Please evaluate your training program, based on your experiences during this past year.
Your feedback is very important to the continuous quality improvement of the residency program

Rating Scale:	N/A	Poor	Fair	Good	Very Good	Excellent
	Not applicable	(1)	(2)	(3)	(4)	(5)

I. TRAINING ENVIRONMENT:

1. Quality and diversity of pathology seen N/A 1 2 3 4 5

2 .Learning value of attending rounds N/A 1 2 3 4 5

3. Adequacy of attending supervision N/A 1 2 3 4 5

4. Quality of attending supervision N/A 1 2 3 4 5

5. Quality and timeliness of feedback from attending N/A 1 2 3 4 5

6. Opportunity to perform required procedures N/A 1 2 3 4 5

7. Opportunity to perform research N/A 1 2 3 4 5

8. Quality of research environment N/A 1 2 3 4 5

9. Interdisciplinary support

   a. nursing N/A 1 2 3 4 5
   b. social work N/A 1 2 3 4 5
   c. dietary N/A 1 2 3 4 5
   d. pharmacy N/A 1 2 3 4 5

10. Availability of consultations

   a. internal medicine N/A 1 2 3 4 5
   b. other surgical specialties N/A 1 2 3 4 5
   c. psychiatry/psychology N/A 1 2 3 4 5
   d. neurology N/A 1 2 3 4 5
   e. general surgery N/A 1 2 3 4 5
   f. physical medicine and rehabilitation N/A 1 2 3 4 5

Rating Scale:	N/A	Poor	Fair	Good	Very Good	Excellent
	Not applicable	(1)	(2)	(3)	(4)	(5)

11. Ancillary services

   a. laboratory data retrieval N/A 1 2 3 4 5
   b. radiology data film retrieva N/A 1 2 3 4 51
   c. procedure report retrieval N/A 1 2 3 4 5
   d. intravenous and phlebotomy services N/A 1 2 3 4 5
   e. messenger/transport services N/A 1 2 3 4 5
   f. secretarial/clerical services N/A 1 2 3 4 5

12. Appropriateness of workload N/A 1 2 3 4 5

13. Overall quality of rotations N/A 1 2 3 4 5

14. Provides comprehensive evaluation of resident's competence in

   a. patient care N/A 1 2 3 4 5
   b medical knowledge N/A 1 2 3 4 5
   c. practiced-based learning N/A 1 2 3 4 5
   d. interpersonal and communication skill N/A 1 2 3 4 5
   e. professionalism N/A 1 2 3 4 5
   f. system-based practice N/A 1 2 3 4 5

15. Identify the core strengths and weaknesses of the program:

Core strengths:____

____

____

Areas needing improvement:____

____

____

Rating Scale:	N/A	Poor	Fair	Good	Very Good	Excellent
	Not applicable	(1)	(2)	(3)	(4)	(5)

II. TEACHING CONFERENCES:

Please rate the quality of the teaching conferences listed below

1. Professor's Rounds N/A 1 2 3 4 5
2. Chief of Service Rounds N/A 1 2 3 4 5
3. Grand Rounds N/A 1 2 3 4 5
4. Core Curriculum Lectures N/A 1 2 3 4 5
5. Morning Report N/A 1 2 3 4 5
6. Clinical Pathology Conference N/A 1 2 3 4 5
7. Morbidity and Mortality Conference N/A 1 2 3 4 5
8. Journal Club N/A 1 2 3 4 5
9. Subspecialty/ Other Conferences N/A 1 2 3 4 5
10. Research Seminars N/A 1 2 3 4 5
11. Radiology N/A 1 2 3 4 5
12. Ethics Seminars N/A 1 2 3 4 5

III. TEACHING FACULTY:

1. Availability N/A 1 2 3 4 5
2. Commitment to teaching N/A 1 2 3 4 5
3. Quality N/A 1 2 3 4 5
4. Promote scientific/discovery literacy N/A 1 2 3 4 5

IV. ON-CALL FACILITIES:

1. Room Availability N/A 1 2 3 4 5
2. Privacy N/A 1 2 3 4 5
3. Safet N/A 1 2 3 4 5y
4. Adequate housekeeping N/A 1 2 3 4 5

V.OVERALL QUALITY OF TRAINING:

Please rate the overall quality of your training program in each of the following domains:

1. General Internal Medicine N/A 1 2 3 4 5
2. Cardiovascular Disease N/A 1 2 3 4 5
3. Critical Care Medicine N/A 1 2 3 4 5
4. Critical Care Medicine/Pulmonary Disease N/A 1 2 3 4 5
5 .Endocrinology, Diabetes & Metabolism N/A 1 2 3 4 5

Rating Scale:	N/A	Poor	Fair	Good	Very Good	Excellent
	Not applicable	(1)	(2)	(3)	(4)	(5)

6. Gastroenterology N/A 1 2 3 4 5
7. Geriatrics N/A 1 2 3 4 5
8. Hematology N/A 1 2 3 4 5
9. Hematology/Medical Oncology N/A 1 2 3 4 5
10. Infectious Disease N/A 1 2 3 4 5
11. Nephrology N/A 1 2 3 4 5
12. Medical Oncology N/A 1 2 3 4 5
13. Pulmonary Disease N/A 1 2 3 4 5
14. Rheumatology N/A 1 2 3 4 5
15. Adolescent Medicine N/A 1 2 3 4 5

GENERAL COMMENTS

1. My colleagues behave in an appropriate manner. N/A 1 2 3 4 5.
2. My colleagues are reliable. N/A 1 2 3 4 5.
3. My attending physicians behave in an appropriate manner. N/A 1 2 3 4 5
4. My attending physicians are reliable. N/A 1 2 3 4 5
5. The training program promotes self-assessment. N/A 1 2 3 4 5
6. The training program promotes life-long learning. N/A 1 2 3 4 5
7. The training program recognizes excellence in continuous quality improvement. N/A 1 2 3 4 5

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Resident's Name: ______________________________

RESIDENT'S AWARENESS OF PAIN

These questions can be used as a brief survey for the attending physician or as a self-assessment tool for the resident. They can serve as a helpful prompt for measuring practice-based learning and improvement.

1.Did the resident specifically question patients about the presence of pain?

1) never

2) infrequently

3) frequently

4) always

9) unknown

2.Did the resident specifically question patients at the end of life about symptoms such as dyspnea and fatigue which are likely to be disabling?

1) never

2) infrequently

3) frequently

4) always

8) not applicable

9) unknown

3.When the resident saw patients in pain, was a specific therapeutic intervention prescribed?

1) never

2) infrequently

3) frequently

4) always

9) unknown

4.When the resident prescribed a therapeutic intervention for pain, was the pain regimen modified to provide as effective palliative care as possible?

1) never

2) infrequently

3) frequently

4) always

8) no pain regimen needed

9) unknown

PROGRAM REQUIREMENTS FOR INTERNAL MEDICINE

Draft Guidelines Under Consideration by the Residency Review Committee for Internal Medicine, Summer 2001

Resident Evaluation of the Faculty Members and Program

A. The residents must evaluate the educational effectiveness of the program at least annually. Specifically, the quality of the curriculum and the extent to which the educational goals and objectives of the program have been achieved must be assessed.

B. Written evaluations by residents must be utilized in developing programmatic changes.

C. Provision should be made for residents to confidentially provide written evaluations of each faculty member at the end of a rotation, and for the evaluations to be reviewed with faculty annually. The results of the evaluations should be used for faculty-member counseling and for selecting faculty members for specific teaching assignments.

D. Each program must maintain a system of evaluation by its graduates. The residency should obtain the graduates' perceptions of the relevancy of training to practice or other career pathways, suggestions for improving the training, and ideas for new areas of curriculum.

Faculty Evaluation of Program

A. The faculty must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them.

B. At least one resident representative should participate in these reviews of the training program.

C. The faculty should at least annually evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of faculty members, and the quality of supervision of residents.

D. The residency should maintain demographic data and practice profiles, licensure and board certification, on its graduates.

ABMS/ACGME GLOSSARY OF RESIDENT EVALUATION METHODS

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:** 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 Evaluation (OSCE):** 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 evaluate 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.

Notes