Medical Oncology and CBME...
Infiltration to Implementation

• Challenges at the College Level - delays
  – Limiting what can be done locally
• No Theory – be practical
  – “Tell me what to do”
• Convince them of the value
  – Make it fun - coaching
Direct Observation: What We Do
Now...
The Need for Direct Observation

• We know it’s not done
  – Time barriers
  – Lack of skill on part of the faculty
  – Inconsistency in and among faculty in evaluating

• Trainees actually want us to watch them!

• Improved quality of feedback
  – Pilot study Fall 2016
  – Audio monitoring study - ongoing
Practical Approaches

• Not everyone has to do direct observation
  – Pick champions
  – Specific faculty for specific EPAs

• Show me the money!
  – Identify those skills that actually require direct observation
Train Your Faculty!

CONSISTENCY
It’s Only a Virtue if You’re Not a Screwup.
Training Faculty for Direct Observation

• No perfect tool
• The evaluation is only as good as the person doing it
• 4-7 observations is reliable for a pass/fail for clinical skills
• Validity of faculty raters ??
  – Performance Dimension Training
  – Frame of Reference Training
Performance Dimension Training

• Designed to teach faculty what specific criteria and trainee behaviors constitute a superior performance of a specific competency
• **Knowledge**: what questions or “content” should resident ask the patient
• **Skills**: How should the resident conduct the interview, ask questions
• **Attitude**: Define behaviors that would signal to an attending that a resident was displaying a compassionate, interested professional attitude

PDT Example Counseling

• A resident is seeing a patient with a new medical condition and needs to start a new medication. What are criteria for a superior highly effective counseling and patient education session?
Frame of Reference Training

• Extension of PDT
• Main goal: consistency among different faculty in applying the criteria to distinguish *levels* of performance
• Targets Accuracy
1. Faculty given an EPA/dimension of competence (e.g. chemotherapy consent discussion) they determine the qualifications for the competency

2. Define what is a superior performance (KSA model)

3. Now define what are the minimal criteria for a satisfactory performance, then a marginal performance. All else is unsatisfactory
PDT/FORT

• 4. Raters given clinical vignettes/videotapes describing critical incidents of performance from unsatisfactory to average to outstanding.
• 5. Faculty then provide ratings on a scale
• 6. Session facilitator provides feedback on what the true ratings should be along with an explanation
• 7. Discussion about discrepancies between raters, and against true rating in order to come to a calibration
Within my Program

• Identified 6 faculty: Core Observers
• Meet every 2 weeks for 1 hour
• Defined skills requiring Direct Observation
  – In which setting
  – How the assessment should be done
    • I.e.: faculty arranges to observe resident in a clinic outside their own – does not impact clinic activity, have adequate time for assessment and immediate feedback
    • Longitudinal Clinic
    • Inpatient Service
    • Simulated Scenario
  – How often, by how many different observers
Within my Program

- Currently in the PDT/FORT
  - Each Assessment tool comes with a Framework
    - List outlining the KSA criteria
    - Assessment levels based on FORT
- Will continue to use in our individual program, and amalgamate with final EPAs/tools from the College
- Role for scholarship
TEAMWORK
Share Victory. Share Defeat.