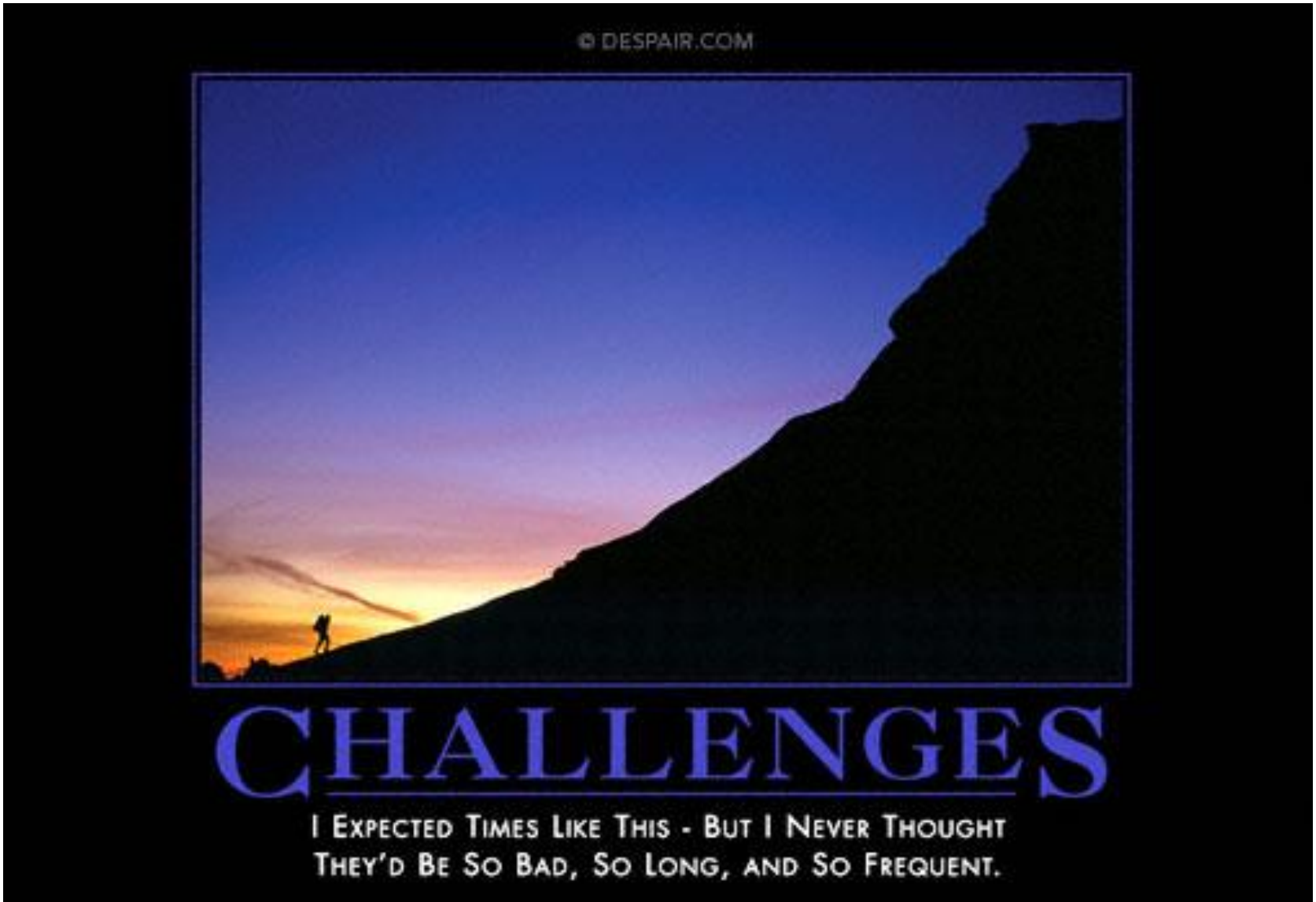
Medical Oncology and CBME…



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…

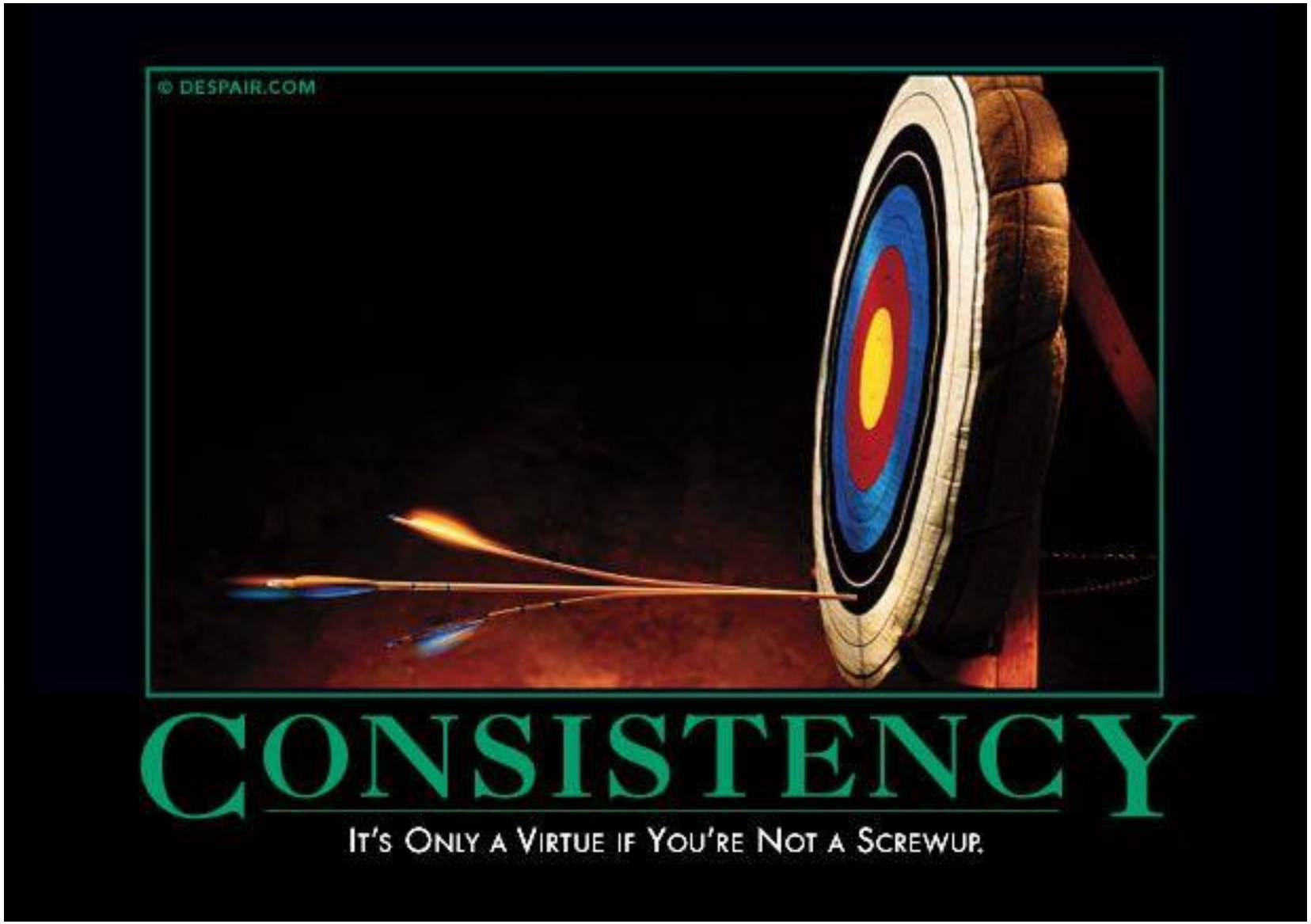
The Need for Direct Observation

- 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!



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

Holombe E, Hawkins R; Practical Guide To The Evaluation of Clinical Competence, Mosby Elsevier, 2008

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

PDT/FORT

- 1. Faculty given an EPA/dimension of competence (eg. 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
    - Ie: 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.