



Children's Hospital and Health System  
 MEDICAL COLLEGE OF WISCONSIN  
 Children's Specialty Group

## Teaching and Evaluating Professionalism Competencies within Fellowships and Milestones: Conflict Resolution as Exemplar

SAAA Fall 2014

**Susan Staudt, MD, MSED**  
 Medical College of Wisconsin  
 Children's Hospital of Wisconsin

## Objectives

- Describe non traditional teaching methods & rationale (*conflict as example curriculum*)
- Delineate Milestones evaluation expectations common to our fellowships
- Present evaluation techniques useful for qualitative competencies
- Discuss what is "reasonable and appropriate" program evaluation (vs. aspirational ACGME)

## Disclosures

None







## Preliminaries-5 minutes


- Rearrange into 2's (3's-no solo)-find a "stranger"

1. Intro-Why are you here?
2. What do you do currently for "soft competency" training?
3. **LEFT-Methods You Use to Teach**
4. **RIGHT- Methods You Use To Assess**

## World View Shift-circa 1998 (ACGME Outcomes Project)

<p><b><u>Traditional approach:</u></b></p> <ul style="list-style-type: none"> <li>• Self taught, only assessed if problems-no time</li> <li>• MD comes with these attributes ; implicit education</li> <li>• Stable over time and situations</li> </ul>	<p><b><u>Competencies/Milestones:</u></b></p> <ul style="list-style-type: none"> <li>• Need to be taught and evaluated; key to resilient successful career</li> <li>• MD comes with basics; expand with explicit curriculum</li> <li>• Professionalism competencies change over time and can</li> </ul>
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## SOFT COMPETENCY MILESTONES ALL FELLOWSHIPS

Professionalism:

- **Receiving and Giving Feedback**
- **Responsibility to Maintain Personal Emotional, Physical, and Mental Health**
- **Commitment to Institution, Department & Colleagues**

Interpersonal and Communications Skills:

- **Communication with Patients and Families**

Systems-based Practice:

- **Interprofessional and Transitions of Care**



**A fellowship milestones example**

Interpersonal and Communications Skills: Communication with Patients and Families				
Level 1	Level 2	Level 3	Level 4	Level 5
Effectively communicates routine information in a developmentally-appropriate manner	Effectively uses appropriate resources (e.g., translator, patient representative) to optimize communication	With direct supervision, manages patient and family conflicts in complex situations (e.g., cultural factors, end-of-life issues, custodial issues), including in communication with persons of different socioeconomic and cultural backgrounds	With conditional independence, manages patient and family conflicts in complex situations	Consistently ensures that effective communication and resolution of concerns occurs with patients and/or families
Obtains informed consent/assent for routine procedures using language appropriate to the patient's and family's level of understanding	Effectively participates in multidisciplinary communication	Demonstrates the ability to disclose medical errors or complications	With conditional independence, discloses medical errors or complications	Independently manages patient and family conflicts in all situations
Recognizes situations where communication of information requires the assistance of another individual and asks for help	Manages simple patient and family conflicts	Consults appropriate institutional resources (e.g., Risk Management, Bioethics Committee)	Independently discloses medical errors or medical complications	Independently manages patient and family conflicts in all situations
Identifies situations where patient and family conflicts exist, and appropriately seeks assistance with resolution			Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic and cultural backgrounds	Independently discloses medical errors or medical complications
Recognizes that institutional resources are available to assist with disclosure of medical errors				Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic and cultural backgrounds
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Comments:				

Level 2	Level 3	Level 4	Level 5
Effectively uses appropriate resources (e.g., translator, patient representative) to optimize communication	With direct supervision, manages patient and family conflicts in complex situations (e.g., cultural factors, end-of-life issues, custodial issues), including in communication with persons of different socioeconomic and cultural backgrounds	With conditional independence, manages patient and family conflicts in complex situations	Consistently ensures that effective communication and resolution of concerns occurs with patients and/or families
Effectively participates in multidisciplinary communication	Manages simple patient and family conflicts	With conditional independence, discloses medical errors or complications	Independently manages patient and family conflicts in all situations
Manages simple patient and family conflicts	Consults appropriate institutional resources (e.g., Risk Management, Bioethics Committee)	Demonstrates the ability to disclose medical errors or complications	Independently discloses medical errors or medical complications
Consults appropriate institutional resources (e.g., Risk Management, Bioethics Committee)			Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic and cultural backgrounds


## Take-home Points

- Assessment for milestones requires observations and judgments of performance in the workplace.
  - Competence is not a stable trait and is inherently subjective.
  - There are no 'valid and reliable' tools for workplace assessment; focus on understanding the users of the tools and developing rater expertise in assessment through deliberate practice.
- Develop a program of assessment as part of curriculum planning.

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## Challenges Teaching Professionalism-Communication Skills-Conflict Resolution

- Different from knowledge, technical skills
- Standard didactics insufficient to create behavior changes (many studies)
- Adult learners-wide range of styles, skill sets
- Hard to model during clinical care  
*(sometimes unplanned curriculum is a problem)*
- Progressive abilities not necessarily discrete or linear
- Scarcity of specialty-specific content experts
- Where in curriculum?
- How much time?



## Setting up a Professionalism Curriculum Module

- Material - meaningful and relevant-not checkbox
- Build on existing and include new concepts
- Need **specialty specific experts** teaching
- Requires learner participation, interaction, reflection
- Should be reinforced /re-taught periodically - incorporated throughout year
- Part of all assessments



## Conflict Resolution -Content Selected

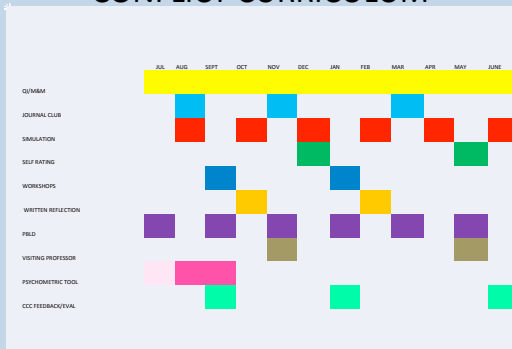
- 2 perioperative conflict review articles (anesthesiologist, surgeon)
- Personalized conflict style assessment tool –TKI (Myers Briggs)
- Team communication and miscommunication (synopsis of 3 articles)
- Styles of conflict resolution (Mouton-Blake)
- Crew resource management introduction
- Climate of safety and quality instrument
- Adverse events literature (4 articles)
- Critical Incident management
- Medical apology; conflict with families
- TJC policies (disruptive physician, critical incident, peer review, credentialing requirements)
- The difficult family (patient)
- Depositions, litigation
- Second victim (crosses here-actually part of wellness module)

### Teaching Methodologies-Conflict Resolution

1. Journal clubs (3)- with fellow focus questions
2. Personal survey tools completion (2)
3. Written Reflection (2)- conflicts (PD review)
4. WORKSHOPS (2) –*role plays*, mini lectures
5. Self rating of skills (2) (mentor reviewed w/ CCC data)
6. Simulation Center (5) incorporation
7. PBLD's –(6+) =conflict within the clinical case
8. Experts lecture (2) Visiting prof/campus resource
9. Weekly QI/M&M -conflict often a portion of each
10. Case Debriefs – (varies) we have 6 trained faculty & a culture that promotes “can we discuss an event?”

■ = participatory

### CONFLICT CURRICULUM



### Professionalism Assessment Methods (?)

- To date, we have utilized:
  - Written Self assessments (3)
  - Case stim recall-PD review of case reflections (2)
  - Faculty verbal feedback
  - Written faculty evaluations-individual
  - 360 assessments (2)
  - “dress rehearsal and debrief” at surgicenter (3 days end of year)

### Professionalism Assessments- Problems

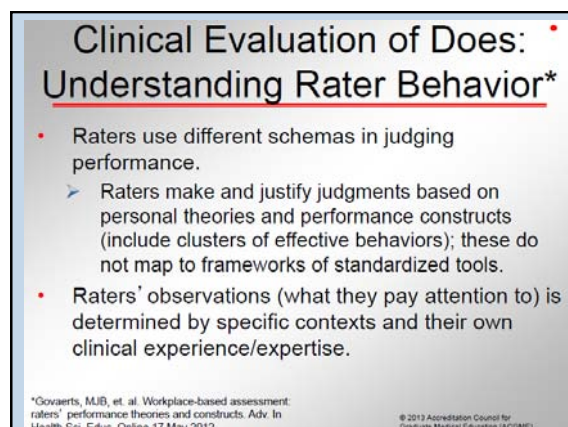
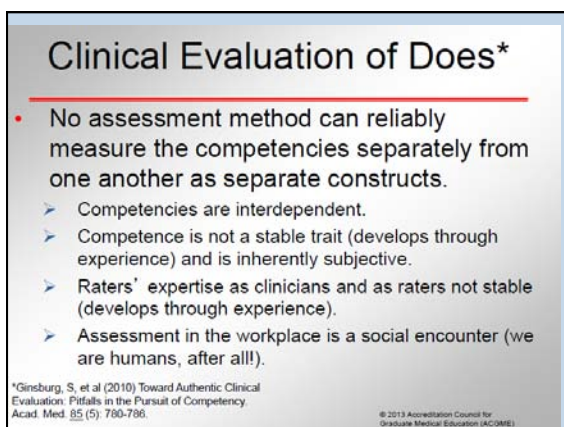
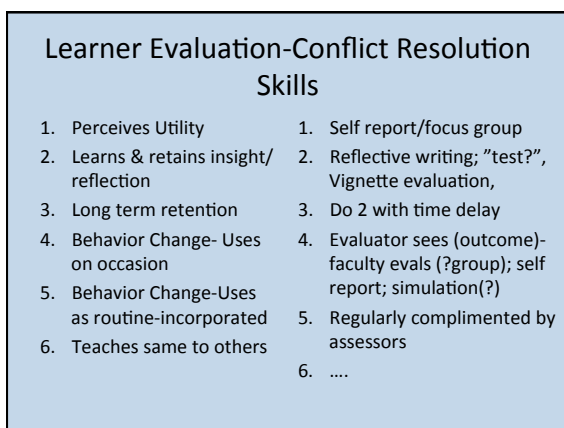
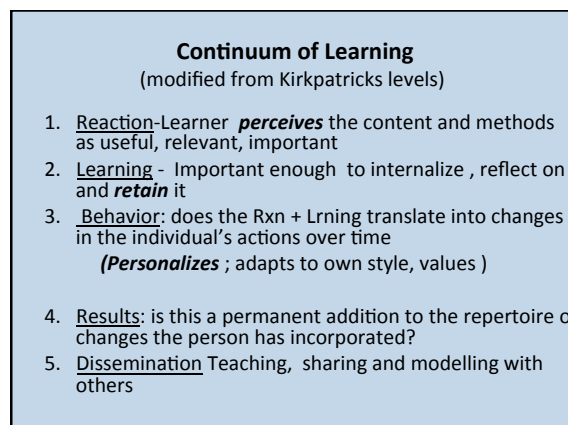
- Lack of detail
- Numeric check boxes only (meets/exceeds expectations)
- All wording sounds the same—“*does a nice job, great to work with, always pleasant!*”...
- What to do with widely varying faculty information (hawks/doves/the bad day)
- Hard to discern progression, even when it is seemingly there (per faculty sense)
- We don’t know what translates out to 1<sup>st</sup> job —“outcome”

### Traditional Evaluation

- Last 3 decades: Assessment-a psychometric epistemology -presumes psychological constructs can be deconstructed & assigned numeric values according to definable rules to obtain an accurate and concise description of ability that is valid and reliable
- Has served well for refining assessment of knowledge –and has led to tools (OSCE), miniCEx
- Has not worked for all competencies, and thus they are under-evaluated

### Assessment Tools –AAMC and ACGME

- Clinical Documentation Review
  - Clinical Performance Rating/Checklist
  - Exam - Institutionally Developed, Clinical Performance
  - Exam - Institutionally Developed, Written/Computer-based
  - Exam - Institutionally Developed, Oral
  - Exam - Licensure, Clinical Performance
  - Exam - Licensure, Written/Computer-based
  - Exam - Nationally Normed/Standardized, Subject
  - Multisource Assessment-360
  - Narrative Assessment
  - Oral Patient Presentation
  - OSCE
  - Peer Assessment
  - Portfolio-Based Assessment
  - Practical (Lab)
  - Research or Project Assessment
  - Self-Assessment
  - Simulation
  - Standardized Patient
  - Stimulated Recall
- = numeric, objective  
● = resource intensive



## Clinical Evaluation of "Does": Recommendations\*

- Start with what assessors (attending, nurse, etc.) will observe, experience, and can comment on, not with the competency you want to assess.
- Elicit explanations for ratings (e.g., specific example).
- Value all ratings (e.g., do not assume the rating from a 'dove' is due to halo effect).
- Balance ratings from "hawks" and "doves" by increasing the number of raters.

\*Ginsburg, S, et al (2010) Toward Authentic Clinical Evaluation: Pitfalls in the Pursuit of Competency. Acad. Med. 85 (5): 780-786.

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## Clinical Evaluation of Does: Recommendations\*

### Assessment Program Guidelines

- A single assessment is intrinsically limited (content specificity; doesn't establish change or growth)
- Assessment for 'does' cannot be standardized; it is the users of the forms, not the forms, that determine validity.
- ALL THOSE INVOLVED IN THE ASSESSMENT PROCESS SHOULD RECEIVE EXTENSIVE TRAINING:** faculty, other assessors, learners, judges.
- Combining roles of mentor/coach and judge in high stake decisions is a conflict of interest; risks inflation of judgment and trivialization of assessment process.
- Information from all low-stake assessments should feed into high stake decisions.

van der Vleuten, CPM, et al. (2012) A model for programmatic assessment fit for purpose. Medical Teacher. 34: 205-214

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## Clinical Evaluation of "Does": Faculty/Assessor Training\*

- Include all participants in the assessment system
- Orientation to assessment system
- Discussion to develop shared 'mental models' of competence, not just orientation to a form
- Ongoing discussions: feedback from assessors to learners; feedback to assessors on their feedback

**Deliberate practice to develop expertise in assessment**

\*Holmboe, ES, et al. (2011) Faculty development in assessment: The missing link in competency-based medical education. Acad. Med. 86 (4): 460-467.


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## Technique-structured Reflection

- Structured reflection
  - Written, solo individual
  - In Group -with a facilitator
- Can be a recall person event or a reaction to a cued event (written, video etc)
- Evaluation -application of a scoring rubric assess incorporation of concepts- variety or depth of reaction
- Requires evaluator to score and also to respond with reinforcement, query, modelling of better answers (resource intensive)
- Evaluators need expertise with content AND technique
- Tests learning-not necessarily the behavior trainee would show

## Technique-Simulation-Role play

- ? Tests behavior-Assumes that if the teachings are utilized in the scenario examined, they are used by learners in actual clinical settings
- Resource intensive
- Need both content and Simulation debrief expertise



HOLISTIC evaluation-Faculty Standardized Narratives								
	Group 1		Group 2		Group 3		Group 4	
Profile	Category descriptions	Profile	Category descriptions	Profile	Category descriptions	Profile	Category descriptions	
H	outstanding, dean resident, meets/exceeds expectations, not yet ready for practice, performs well in supported environment, minimal guidance required, beyond typical resident	A	very good recipient...role modeling great, but not perfect; needs some up needed	A	outstanding; one once in a lifetime; exemplary; keeper; leader in the field; would like to have on staff	H	excellent, high performer; outstanding; "shout one"	
A	needs guidance/feedback; identifiable areas can be improved with minor intervention/attention	H	meets expectations but needs improvement in certain areas; identifiable gaps but can be fixed	H	excellent, good patient care, exceeds expectations, above average; meets all the CanMEDs criteria	A	excellent, good patient care, exceeds expectations, above average; meets all the CanMEDs criteria	
K	some self problems in group setting with team building, maturity/personality issues, social boundaries/report issues, acceptable but needs improvement in certain areas; identifiable gaps but can be fixed	J	average; solid; team leader; safe; one major domain needs work; need a little instruction and will improve	J	meets expectations but needs improvement, has some issues but generally ok; minor deficiencies that needs to work on	F	acceptable, average; "could be fixed?" "can get better"	
R	borderline, motivational deficits, professionalism issues, few minimals but still gaps, minimal competence; doesn't go beyond minimals; just tries to fly through the month	K	They pass; critique by safe underwriter; needs improvement; remediation possible; no field flow; could improve with direction	K	can't translate book knowledge, really needs improvement, unsafe	M	unacceptable, poor, unsafe, far below average	
D	competence/professionalism issues/unprofessional, but communicator, unacceptable, some strengths; dangerous/unsafe, requires high degree of remediation; multiple deficits, fail, competence lacking	L	unsafe; critical flow; make your heart sink; personality gaps; unbridgeable competence can't trust	L	problematic, unsafe, fail, unsatisfactory	E	unacceptable, poor, unsafe, fail, below average	

ACADEMIC MEDICINE

Chart 1 Final Negotiated Ranking of 16 Profiles Generated by 14 Faculty Participants in 10 Final Groups, the Negotiated Categories Generated During the Group Discussions.

outperformer, dream resident, meets/exceeds expectations, not yet ready for practice, performs well in supported environment, minimal guidance required, beyond typical resident	R	very good except...; role models; great but not perfect; minor tune up needed	A	outstanding; see once in a lifetime; exemplary; keeper; leader in the field; would like to have on staff
needs guidance/fine-tuning, identifiable areas can be improved with minor intervention/attention	A		R	excellent, good patient care, exceeds expectations, above average, meets all the CanMeds criteria
lone wolf, problems in group setting/with team building, maturity/personality issues, social boundary/rapport issues, acceptable but needs improvement in certain areas, identifiable gaps but can be fixed	F		F	
borderline, motivational deficits, professionalism issues, bare minimum but still pass, minimal competence, doesn't go beyond minimum, just tries to fly through the month	K	average; solid; teachable; safe; one major domain needs work; need a little instruction and will improve	J	
competence/professionalism	N		C	meets expectations but needs improvement, has some issues but generally ok, minor deficiencies that needs to work on
	M	they pass; cruise by; safe underachiever; needs improvement; remediation possible; no fatal flaw; could improve with direction	N	
	D		P	
	Q		K	
	C		D	can't translate book knowledge, really needs improvement, unsafe
	P		Q	
	E	unsafe; critical	M	
			E	

### 360 Evaluations, Patient Evaluations

- Performed by others
- Collection can be arduous
- ? Patient report reliability (studies suggest need **6 or more** per trainee)
- 360's may offer more reliability , need fewer repeated measures:

Assessment of a 360-Degree Instrument to Evaluate Residents' Competency in Interpersonal and Communication Skills

Raksha Joshi, MS, F W. Ling, MD, J Jaeger, MPH Academic Medicine Vol 7 No 5 May 2004

(need min of **3 per trainee**; reliability 0.8 range)

### New MCW Assessment Effort

- **Structured faculty group interview** -prior to monthly faculty meeting ; likely adds 6 hours over year (30 min/month)
- Using Milestones accomplishments as prompts
- Use EMR report to refresh group re: clinical contact
- Small group of faculty leads-trained in
  - Interviewing technique
  - Narrative writing
  - Expert knowledge of the Milestones
  - Work in pairs-writing and editing
- Written report to fellow's mentor –then trainee  
*not too resource intensive (promoteable faculty activity), not everyone needs to be expert in the competency or the Milestones; lit suggests as reliable, valid as other tools*

### Questions/Discussion?



### Qualities of a Good Measuring Instrument

- **Validity:** the extent to which the instrument measures what it is intended to measure.
- **Reliability:** the consistency with which an instrument measures a given variable.
- **Objectivity:** the extent to which independent and competent examiners agree on what constitute a good answer for each of the elements of a measuring instruments
- **Practicability:** the overall simplicity of the use of a test both for test constructor and for students.