Evaluating Clinical Trainees in the Workplace.
On Supervision, Trust and the Role of Competency Committees
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AMEE Guide No. 27: Effective educational and clinical supervision
Clinical teaching with minimal and indirect supervision
Emesto A Figueroa-Nilo, Elisha Dantes/McKinley, Janet R. Jolly

The Quest Toward Unsupervised Practice
Promoting Autonomy, Not Independence
Commentary: Watching Closely at a Distance:
Key Tensions in Supervising Resident Physicians
Stewart Babbott, MD
Academic Medicine, Vol. 85, No. 9 / September 2010
How do supervisors make decisions about learners’ readiness for unsupervised practice?

- Competencies do not align with work tasks
- Assessments: inflation; accountability
- Increasingly complex training environment

Supervision and assessment based on entrustment

Supervision → Trust: Individual → Trust: Committee level → Competence

Conceptual frameworks

- Constructivists:
  - Knowledge construction in social context
  - Sociocultural theory
- Workplace learning framework (Billett)
- ‘Experience based learning’ - emerging clinical competence (Dornan)

Workplace learning

- Learning occurs through participation
- Learners construct knowledge guided by people and context
- Communities of practice

Lave & Wenger 1991; Billett 2000; Dornan 2007
Elements of workplace learning

Work practice: activities, values, goals
Affordances → Engagement
Individual knowledge, values, conceptions
TRUST

Approaches to workplace-based assessment

Psychometric approach
Valid, reliable assessment tool
Train, standardize raters

Alternative
Assessment as a judgment and decision making process

Govaerts, AHSE 2007

From Supervision to Trust

- Trust: gatekeeper to learner’s increasing level of participation and responsibility in the workplace
- Competency-based decisions using the level of supervision required

Supervision and assessment based on entrustment

Supervision, Trust: individual, Trust: committee level → COMPETENCE
What is trust in the clinical setting?

What is trust?
- Reliance on someone’s character, ability, strength, or truth
- one in which confidence is placed
- dependence on something future (Merriam Webster)
- Emergent state influenced by
  - Individuals’ thoughts, motivations
  - Interactions, context, situation

Tensions in establishing trust
- Supervisors may want to trust learners to allow for development of competence but feel obligated to supervise more
- Context favors brief interactions
- Tasks don't align with abilities, learning needs

Research questions
- How does trust develop between supervisor and trainee?
- How does trust guide supervision and assessment?
What factors influence supervisor trust in residents?

Factors related to:
- **Supervisor**: experience, skills, accountability
- **Trainee**: competence, knowing limitations, professional development
- **Task**: complexity, common/rare
- **Context**: time of day, census


Model: how trust enables clinical participation

- Similarity between trainee and supervisor
- Emotion
  - Facilitate trust building or
  - Interfere with accurate appraisal
- Shared expectations
- Continuity of relationship

Hauer et al., AHSE 2013

Discrepancy in competence expectations

- Attendings and residents' perceptions of proficiency over time (PGY1-5)

Sterkenberg, Acad Med 2010

Research question

- How do attendings understand trust and change supervision based on trust?
Study design

Qualitative study:
- 43 interviews – IM attendings
- What is the meaning of trust, how did you trust/not trust your ward resident?

Starting point: more trust

I usually let them work independently right from the get-go. I have a technique, which I call proximity management… I try to position myself close by and do my work from near where they are so that if they have questions they can just lean over and tap me on the shoulder.
Trust: information sources
- Comparison to a standard
- Self: ‘mirror’, ‘extension of my eyes & ears’
- Normative: residents at this level
- Direct observation of rounds
- Stakeholder input
  - Patients, families
  - Interns, students

Model of Trust Formation

Outcomes of trust
- Supervisor role shift - To consulting, teaching
- Resident greater independence
- Enhanced team functioning

He knew that I was available to help, but wasn’t going to make all the little micromanaging decisions… we worked together frequently as colleagues in addition to that hierarchical, ‘you’re the attending, I’m the resident’
Discussion

- Supervisors frequently use trust to inform supervision
  - individually judged, often in general terms
  - determined rapidly
- Clinical systems interfere with trust formation
- Trust benefits learning and team experience

Supervision and assessment based on entrustment

Research questions

- How is trust established at the program level?
- For what activities?
- Through what decision making process?

Trust - committee level

- Clinical competency committees now required in GME
- How do they understand their charge?
- How do they synthesize information into judgments of competence?
Clinical competency committee study

Interviews with 34 program directors, all specialties

Questions
- Describe your committee’s review of a struggling/non-struggling resident
- What is the main purpose of your committee?
- Pros and cons?

Two paradigms for competency committees

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<tr>
<th>Problem identification</th>
<th>Developmental</th>
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<tr>
<td>Common</td>
<td>Uncommon</td>
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<tr>
<td>Purpose: find and deal with problems</td>
<td>Purpose: support planned steps toward mastery</td>
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<td>“Tea-steeping” or “dwell time” view of training</td>
<td>Residents as learners</td>
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Problem identification model

We would look through the evaluations. We would probably just maybe briefly talk about this person’s strengths, but mostly almost not with any absolute purpose to it. Sometimes it’s just celebrating and relaxing as a group and then most of the time, for the ones who are meeting targets, it is then saying, putting in the minutes, that they’ve met the requirements and will be graduating on time.

Developmental model

It’s just really hard with 20 milestones and as we tried to do it for 8 residents in that one hour committee, we realized that there’s not nearly enough time to be able to do it, nor do we have enough information to be able to accurately rate where our residents are in the milestones.
Committee procedures

- Challenge to synthesize performance data
- Formal evaluations can raise “red flags”
- Informal information: hallway conversations, committee discussion add data:
  - “usually about a problem, not something that’s positive”
- Decision-making implied

Faculty perspective | Resident perspective
--- | ---
- Commitment to the process
- Pride in residents
- Questions about how milestones can help
- Stay under the radar
- Feedback signals a problem

Supervision and assessment based on entrustment

Supervisor training: Supervisors receive training in clinical supervision, feedback, assessment, trust

Graded, individualized responsibility: Trainee multi-modal assessment aligns with developmentally sequenced competencies

Trainees entrusted with tasks as they meet milestones and given increased opportunity for unsupervised practice

Culture: Climate encourages trainees to seek appropriate supervisory support

Foster culture of self-reflection, self-assessment and lifelong learning

Longitudinal relationship: Clinical schedules facilitate longitudinal contact

Hauer AHSE 2013

Recommendations for supervision based on entrustment
Assessment based on trust

- Anesthesia: >60 mini-CEXs for adequate reliability to rate competence
- 0/331 residents below expected competence

Changing rating scale to independence (supervision amount):
- adequate reliability with 9 assessments

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<tr>
<th>Level of Independence</th>
<th>Supervisor required in the theater code</th>
<th>Supervisor required in hospital</th>
<th>Supervisor not required</th>
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<tr>
<td>What level of supervision did the trainer require for this case?</td>
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Implications

Observing for trust
- Scales
- EPAs

Rating trust
- Rater training
- Interpretation, synthesis

Making trust count
- Signout
- Intentional learning activities

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