Twelve tips for implementing tools for direct observation of medical trainees’ clinical skills during patient encounters
Karen E. Hauer, Eric S. Holmboe, and Jennifer R. Kogan
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Background: Direct observation of medical trainees by their supervisors with actual patients is essential for trainees to develop clinical skills competence. Despite the many available tools for direct observation of trainees by supervisors, it is unclear how educators should identify an appropriate tool for a particular clinical setting and implement the tool to maximize educational benefits for trainees in a manner that is feasible for faculty. The use of multiple assessment tools, including tools for director observation of trainees with patients, allows for summative assessment of competence in multiple domains, particularly patient care and communication skills.

Methods: Based on their previous systematic review of the literature, the authors provide 12 tips for selecting and incorporating a tool for direct observation of trainees’ clinical skills by their supervisor in actual patient encounters.

1. Define competencies and objectives for the program to guide use of a tool for direct observation. A framework can then guide the articulation of developmental benchmarks characterizing the expected level of performance at specific intervals during the training program.
2. Determine whether the purpose of the direct observation program is formative or summative assessment. Unlike many formative assessment tools, direct observation tools implemented for summative assessment entail observation and ratings that are used in evaluating the trainees.
3. Identify an existing tool for direct observation rather than creating a new one. For high-stakes summative assessments, a well-studied tool that yields reliable and valid data is needed, whereas for low-stakes formative assessment, a tool may be useful for feedback despite lack of information about reliability and validity.
4. Create a culture that values direct observation. Faculty educational “champions” should be identified to role model the importance of observation, teach others to do it well, and mentor other faculty in the process.
5. Conduct faculty development on direct observation, e.g. using videotaped examples of learner performance, observers can develop evaluation standards for superior, satisfactory, marginal, and unsatisfactory performances to calibrate their ratings with other raters and then practice ratings with more example encounters.
6. Build meaningful feedback into the direct observation process and train faculty to provide effective feedback. Particular emphasis should be placed on giving clear, timely, specific, behaviorally-based constructive feedback that focuses on a behavior that the learner has the capacity to change.
7. Require action planning after each direct observation. Action planning should prompt reassessment in the context of developmental benchmarks within the program. A tool with a rating scale that can be calibrated to the level of learner can be used to reflect skills acquisition over time.

8. Orient learners to the process of direct observation and feedback. Feedback is a dynamic, two-way process and will be more productive if learners are trained to self-assess prior to the feedback.

9. Apply the tool multiple times per trainee. For high-stakes summative evaluation, at least 10-12 assessments with a tool are needed; however, a minimum of 4 assessments may suffice if trying to determine minimal competence.

10. Develop systems that accommodate direct observation of clinical skills. For example, a faculty member might join a trainee for part of morning rounds to see a patient, rather than seeing that patient independently later in the day.

11. Measure outcomes of the direct observation of clinical skills program. Demonstrating that trainees apply skills learned through direct observation in future patient care, and that those behaviors enhance patient care quality, are challenging but important goals.

12. If a new tool is developed for use, try to assess its validity. Assessment of new tools may require collaboration with experts in psychometrics, evaluation and assessment.

Conclusions: Educators can enhance clinical skills education with strategic incorporation of tools for direct observation into medical training programs. Identification of a psychometrically sound instrument and attention to faculty development and the feedback process are critical to the success of a program of director observation. A sustainable program of direct observation requires a reconceptualization by faculty on how to conduct observations, dedicated time and clinical space for observations to occur and supported faculty time to conduct observations and feedback in clinical settings.

Implications for TUSM: The need to promote observation of student performance in the clinical setting is always highlighted at clerkship meetings. Indeed, observation is the best approach to assess trainee’s clinical and professional performance. Existing observation tools can assist educators with this process. Yet, as the authors state, tools or observation guides used to facilitate this process must be aligned with the learning objectives/clinical competence we want our students to achieve and demonstrate by the end of each rotation. Establishing a culture of observation of trainee’s professional skills at our clinical learning environments will help us make these observations happen. The OEA is committed to assist TUSM faculty to promote this culture at their educational settings by providing faculty development on observation skills that includes frameworks and consultations on observation tools.