Assessment of family medicine residents

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There was once a time when resident assessments were conducted in a very strange way. After doing their best during their clerkships, residents would receive a single assessment from a single supervisor with the power to unilaterally rate their performance as "exceeds, meets, or does not meet expectations" without ever having provided any previous feedback. Sometimes these assessments were delivered by a third party, like a teaching secretary, leaving students with no other choice but to dutifully read and sign the document. The oldest among us can still remember that era.

Conversely, sometimes weak students who clearly had not met the standards of practice were given a passing grade. This scenario is understandable: failing a resident on his or her clerkship is not easy, especially if the supervisor has never made the resident aware of his or her weaknesses. The burden of proof is on the supervisor, who must be able to justify his or her decision and document his or her reasons for awarding the failing grade. It is much easier to turn a blind eye and pass the student instead. This phenomenon is widely known in education as "failure to fail."[1] As a result, some residents have become certified physicians regardless of their limited competencies, blatantly inadequate communication skills, and inability to collaborate with others.

Today, this type of assessment is impossible. The College's *Red Book* has established requirements for the accreditation of programs and specific expectations for resident assessments.[2]

The *Red Book* indicates that

> in-training assessment systems must be competency-based and mainly formative in nature, with honest, helpful, and timely feedback provided to each resident .... Assessment and feedback must not be limited to the end of an activity or clinical experience .... [They] must be documented and reflect resident performance with respect to the competencies in question .... All pertinent activities, both clinical and non-clinical, should be assessed, and the assessment should be specific to the activities, clearly reflecting the competency objectives of family medicine.[2]

Field notes are the cornerstone of resident assessments:

> Programs should use field notes (or equivalent) to gather qualitative comments on resident performance during daily clinical practice and should integrate them into their regular teaching and supervision. They should generate a sufficient number of field notes to provide and document meaningful, formative assessment and feedback.[2]

> [Summative reports] must be based on multiple independently documented observations from several observers in different situations, and be compiled and judged by more than one clinical faculty.[2]

Even if this approach is preferable to those used in the past, we should question whether so many observations might result in unintended consequences or whether they are even necessary. A study recently published in *JAMA Internal Medicine*[3] reveals as much. Not only did increased supervision fail to have any substantial effect on the rate of medical errors, but the study found that residents spoke less while their supervisors were present and reported feeling less efficient and less autonomous.

As such, it is pertinent to consider the intensity and frequency of supervision in family medicine. We should also consider the adverse effects of high-intensity and high-frequency supervision. For example, could a resident whose actions are constantly observed using daily (or even more frequent) field notes eventually become insecure and less productive? According to student associations and physician support programs, such a risk exists.

In andragogy, we know there is an inverse correlation between stress and learning. The absence of stress does not promote learning, but excessive stress is equally unfavourable. One assessment per month is certainly insufficient, but 2 or 3 field notes per day is undoubtedly too much. It would suit the interests of accreditation organizations and program directors to further reflect upon the frequency and intensity of the supervision family medicine residents receive.

Cet article se trouve aussi en français à la **page 561.**

References

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2. Division of Academic Family Medicine. *Specific standards for family medicine residency programs accredited by the College of Family Physicians of Canada. The red book.* Mississauga, ON: College of Family Physicians of Canada; 2016. Available from: **www.cfpc.ca/uploadedFiles/Red%20Book%20English.pdf**. Accessed 2018 Jul 4.
3. Finn KM, Metlay JP, Chang Y, Nagarur A, Yang S, Landrigan CP, et al. Effect of increased inpatient attending physician supervision on medical errors, patient safety, and resident education: a randomized clinical trial. *JAMA Intern Med* 2018;178(7):952-9.