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Direct Observation Medical Trainees

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Direct observation of medical trainees with actual patients by clinical supervisors is important for teaching and assessing clinical and communication skills [1]. Direct observation and feedback is noted to enhance interpersonal, communica¬tion, physical exam, history taking, medical decision making, and time management skills [2,3]. Feedback from direct observation is perceived as useful by both residents and facul¬ty and can be effective in address¬ing specific case-related and trainee needs [3]. By observing and assessing medical trainees with patients and providing feedback, faculty can help learners improve their skills and through better supervision help patients receive better of clinical care. While the routine direct observation of learners with patients is important it unfortunately continues to occur rarely and inadequately [4]. Why is this so? What are the barriers to routine direct observation of medical trainees?

One of the most common, if not the most common barrier, is lack of time, which includes not only lack of time for direct observation but also lack of time to give feedback to the learner. Faculty may feel they have not received adequate training in observing, assessing and giving feedback. Some may feel there is a lack of resources or systemic barriers to directly observing learners. Scheduling challenges, patient flow, hospital/office/clinic room configuration and competing demands all play a role in making it more difficult to incorporate direct observation into daily workflow and inhibit direct observation of learners by faculty. Learners, as well as faculty, may feel uncomfortable with direct observation. Financial compensation may also be a significant factor, especially in instances when faculty is not remunerated for their time. How can these barriers be addressed? What methods can be used to directly observe medical trainees?

Insufficient time is an obstacle, but can be addressed. Direct observation can occur in multiple, short, intermittent observations of different aspects of the visit over a period of time. A simplified observation tool can be used to overcome time constraints by observing multiple short observations of various aspects of an outpatient visit [5]. This leads to less time away from other learners, less disturbance to daily work flow, more frequent contact with the learner in an observational setting and the ability to demonstrate learner improvement over time. Multiple short observations may also address some of the systematic barriers to direct observation. If time is not a barrier the observation of a single encounter may be useful [6]. It may be easier to schedule a single observation; there is cohesion of the observation and the opportunity to give immediate feedback. However, in addition to a longer faculty time commitment a single observation may lead to longer time away from other learners, more impact on daily work flow and too many feedback points to address after a long observation. The issue of lack of adequate training can be addressed by faculty development activities that allow participants to try out new skills, receive feedback on their performance and network with peers to exchange ideas and best practices. With adequate faculty development preceptors should feel more comfortable directly observing learners. Direct observation should be expected and viewed as occurring on a routine basis. Scheduling direct observation as a regular and recurring event may prevent defensive reactions among learners. Additionally, a discussion between learners and faculty at the start of a rotation about the use of direct observation may make learners more comfortable with being observed and may lead to it occurring more frequently. With regard to financial compensation appropriate compensation for time involved may result in more frequent direct observation for a group of faculty.

Observed patient encounters are a critical part of medical education. Accrediting bodies, such as the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education (ACGME) require direct observation and documentation of learner skills for ongoing assessment [7,8]. More recently the ACGME and the American Board of Pediatrics have partnered to initiate the Pediatrics Milestone Project to further refine the 6 ACGME competencies and to set performance standards as part of the continued commitment to document outcomes of training and program effectiveness [9]. Direct observation will be vitally important to assess clinical performance and describe the knowledge, skills and attitudes of learners as they progress along their training [10]. By addressing barriers and providing methods and tools that can be used by faculty to directly observe medical trainees direct observation can become a routine part of formative and summative clinical learner evaluations.

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