Assessment of Incoming Child and Adolescent Psychiatry Resident's Clinical Competency in Interpersonal Communication Skills & Professionalism: Use of the Standardized Patient

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Introduction

Standardized patients (SPs) have been used widely for over two decades to assess clinical skills of medical students (Barroows, 2003; Norcini & Boulet, 2003), but little has been described in postgraduate medical education.

The Accreditation Council for Graduate Medical Education (ACGME) established core competencies for all residents in Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice (ACGME, 1999). Graduating residents must demonstrate minimum competency in each of these six general competencies. It is the purview of individual training programs to establish criteria for mastery of the general competencies in each specialty.

Child and adolescent psychiatry (CAP) training begins roughly 4 to 5 years following medical school graduation. Trainees entering child and adolescent psychiatry may have had minimal experience with children, adolescents, and their families, as the main portal is from a general psychiatry training program. With only 2 years of residency training, time is precious and the entering trainee may arrive with minimal communication skills for working with children, adolescents, and their families.

Purpose and Hypotheses

A baseline assessment of the entering child and adolescent psychiatry resident’s interpersonal communication skills and professionalism will allow early identification of strengths and deficits.

It is hypothesized that beginning CAP residents will perform better with adult patients than with children, adolescents, or parent/child dyads.

Use of standardized patients in postgraduate medical education of child and adolescent psychiatry residents may be a tool to certify competency in the ACGME core of Interpersonal and Communication Skills and Professionalism.

Materials and Methods

A single case was piloted with a trainee and a trained SP to evaluate case content and utility of the SP/Patient Satisfaction Feedback Form.

Four one-hour SP “cases” were developed to evaluate trainees in physician/patient relationship, conduct of the interview, written communication (progress note), ability to receive feedback from trained SPs, and self-reflection. The first four cases were designed to assess the trainees ability to: 1) work with a pediatric patient in a “typical” medication clinic scenario; 2) evaluate an externalizing, acting out adolescent; 3) evaluate a teenager with occult abuse and; 4) obtain history from a parent who was trained to focus on his own issues. Thus each case was designed to assess entry level interpersonal/engagement skills, but each case had a “hidden” agenda that could elicit skills beyond baseline.

Standardized patients were trained by a child psychiatrist and a SP coordinator about the roles they were to play and how to assess the trainee. The script for the “Occult Abuse” case was graphic, and the SPs sought parental permission before training adolescent SPs on the case. The cases were then “piloted” by a graduating child and adolescent psychiatry resident or a junior faculty member to ensure authenticity.

A SP/Patient Satisfaction Form was adapted from the Southern Illinois SP Program, 2006 for the purpose of assessing the trainee’s performance. Categories included: Greeting, Demeanor, Rapport, Focus, Closing, and English Proficiency. Scoring for “Greeting” was “Not Done” (0) or “Done” (1) and the statements under “Greeting” included: “Introduced himself/herself” and “Asked how I wanted to be addressed”. The scoring for the remainder of the categories was A 4-point Likert scale with 1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree. There were no statements under Demanor by category.

Self-assessment forms for the trainees were developed for each case including questions such as: “What do you feel were your own personal challenges with this case”, and “What do you feel are your strengths with this case,” and “Were you able to establish a treatment alliance”, etc.

On the day of the assessment, each trainee began in a different “SP station”. Each encounter was recorded. Door instructions were outside each station and the trainee completed their self-assessment form (and possibly a brief writing exercise). The SP and trainee then met again for the SP to give verbal feedback.

Data from the SP/Patient Satisfaction Forms was compiled for each individual trainee, for each case, and for all cases and all trainees. The training director met with each trainee to review the experience, identify goals for training based on the experience, and send written feedback to the trainees’ individual supervisors.

Results

Four trainees completed a 4-station SP examination in July, 2007. Three of the trainees were first year CAP residents and the fourth trainee was a second year resident.

The SP/Patient Satisfaction Form and self-reflection tools aided in identifying individual goals for training; e.g., discomfort with depressed adolescent females, strengths in communicating with children, addressing confidentiality in treatment, etc.

Likert Scores were averaged for each category across all cases and trainees. (Table 1) After setting an arbitrary cut-off of < 3 for areas needing improvement and > 3.5 for areas of strength, subcategories were further evaluated. (Tables 2 & 3).

The data was then analyzed for specific cases. The two teenage cases (“Occult Abuse” and “Unruly Abuse”) each demonstrated categories needing improvement (Table 2). In the Parental History (“ADHD”), Parent only (“Defiant Child” cases no category averaged > 3.5, but specific questions had lower scores (Table 3).

The Greeting section revealed that the trainees introduced him/herself in 16/16 encounters, but only asked how the SP wanted to be addressed in 3/16 encounters (all three were in the Parent/Child case). By case, the greatest overall SP Satisfaction scores was the “Defiant Child” case (the case with the parent only) > “ADHD” case > “Occult Abuse” > “Unruly Teen”. Question #4 in Closing #4 “I would be willing to return to this for future care”. In the “ADHD” and “Defiant Child” cases, all trainees scored 3 or greater. In “Occult Abuse” case, 5 trainees scored 3 and 5 scored 3 for the “Unruly Teen” case.

Discussion

Having an SP evaluation of entering CAP residents appears to be a valuable tool to assess baseline interpersonal communication skills and professionalism. Each trainee personally endorsed the experience as positive and realistic, and greatly valued the feedback they received from the trained SPs.

In reviewing the results of the individual cases, our hypothesis that the trainees would demonstrate greater skills with the adult cases was born out. The greatest SP Satisfaction Scores were from the “Defiant Child” case where only the parent was seen. The lowest scores were with the adolescent female cases which validates our lore of the challenges of engaging with the adolescent. But one could also argue that the teens were “harder graders” than the adults. Individual scoring biases were also noted with the mother in the ADHD case particularly sensitive to the question under Rapport of “Approached delicate issues sensitively”, which could represent the need of the mother to protect her child.

Use of the SP may become a tool for assessing the core competencies of Communication and Interpersonal Skills and Professionalism required by the ACGME.

References

Accreditation Council for Graduate Medical Education. The General Competencies. Approved by the ACGME February 1998.