The Royal Australian and New Zealand College of Radiologists

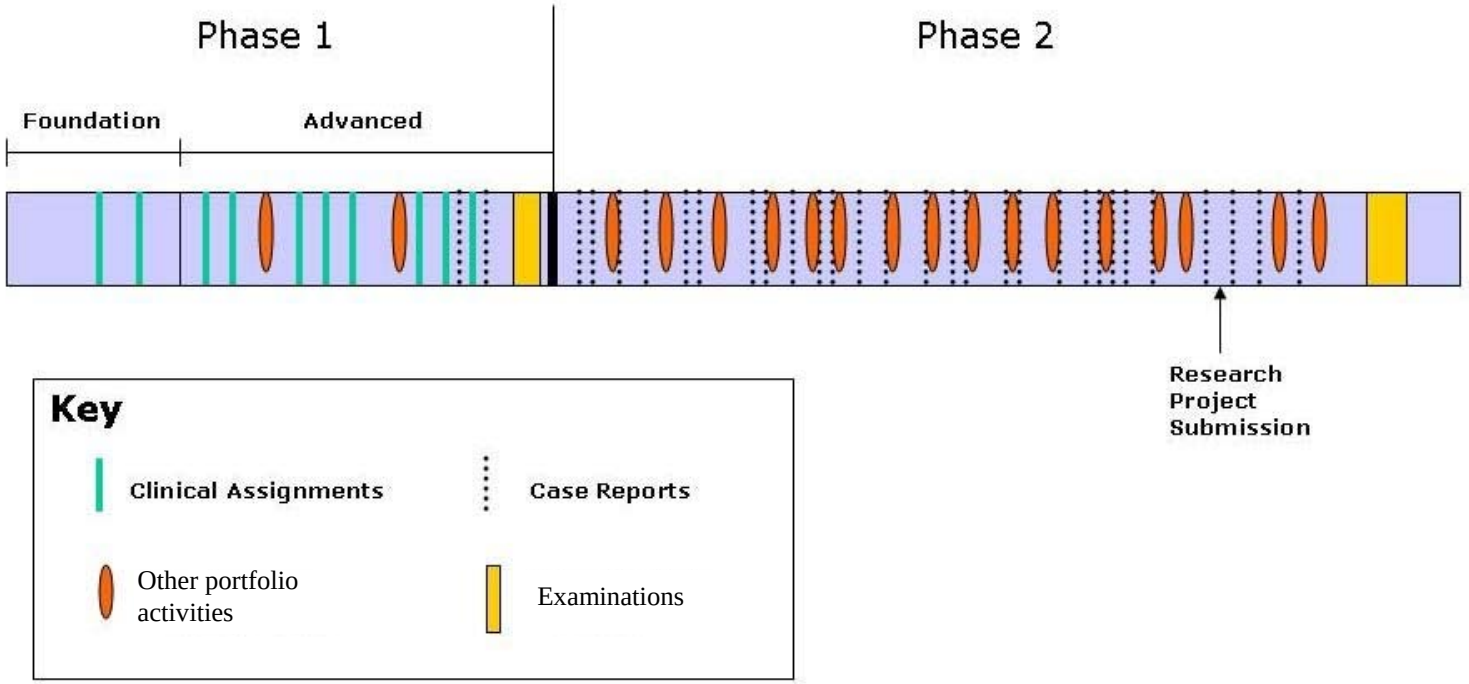
Faculty of Radiation Oncology Directors of Training Workshop

Overview of Assessment

Friday 20 June 2008, Sydney

The Royal Australian and New Zealand College of Radiologists

Training Program Structure "Chromosome"



Why change assessments?

- New curriculum provides opportunity to review assessments
- Faculty's goal was more in-training ('continuous') assessment
  - Reduces reliance on formal exams
  - Guides direction of study and focus at each stage
  - Allows direct linkage of learning objectives and assessment
  - Encourages more feedback between DoT and trainee and clearer goal-setting
  - Allows remediation early; in rare cases career path counseling

Why change assessments?

- CanMEDs model for curriculum means that important non-medical skills and knowledge can formally be assessed
- Current assessments all focus on medical expert competencies
- AMC standards require use of a range of assessment methods
- Modern educational theory gives insight into more effective way of teaching, learning and testing
- We want to ensure the highest standard of final product in our specialty

What will this mean?

- A little more work
- Some training in use of assessment tools
- Standardised and clear evaluation tools to assist DOT assessments of trainees and guide learning plans
- Assessment of whether goals and progress are satisfactory
- Mechanisms for flagging problems early
- NOTE THAT MOST ACTIVITIES ARE ALREADY OCCURING IN MOST CENTRES

What will DOTs need?

- Resources to support DOTS (handout)
- Training for new assessments
- Support within departments to conduct role adequately
- A clear mechanism for DOTs to identify problems with their role, trainees and programs so prompt response occurs

Testing ‘other’ CanMEDS roles

- Communicator, collaborator, health advocate, manager, professional and scholar require different types of assessment methods than medical expert
- Several other medical specialties developing or using, as standard, newer methods to assess these competencies
- Still retain clinically-based ‘exit’ examination to assess clinical competence
- Other ITA may assess medical decision-making in more ‘real-life’ manner

Portfolios – What are they?

- Common approach now in undergraduate medicine and in other Colleges
- Portfolio = collection of documented activities demonstrating both breadth of experience and competence across all roles
- Different types of assessments guide study and test different competencies
- These are compiled as an evolving record of trainee's progress
- Mandatory and elective items, therefore different for every trainee
- Other activities with educational component recorded in portfolio

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Assessment methods in Phase 1

1. *Mini-CEX (mini-clinical evaluation exercise)
2. Practical oncology sessions
3. *DOT assessment of trainees
4. Trainee assessment of training sites
5. *Multi-source feedback (MSF)
6. Clinical assignments
7. Phase 1 examination

Assessment methods in Phase 2

1. Mini-CEX
2. Practical oncology sessions
3. DOT assessment of trainees
4. Trainee assessment of training sites
5. Multi-source feedback (MSF)
6. Case reports
7. Research requirement
8. Study design and statistics assignment
9. Phase 2 examination

Portfolio assessment

- The portfolio, as a collection of assessments and learning experiences is assessed
- Satisfactory completion provides ‘barrier’ at end of Phase 1 and prior to Phase 2 exams
- Role here for Training Networks
  - Support for DOTs
  - Standardisation
  - Acting in advisory role and providing authority
  - Ensuring exposure of trainees to full spectrum of learning activities

Mini-CEX

- Rated observation of, and feedback, to a trainee undertaking a clinical interaction
- 6 dimensions plus overall rating (medical interviewing, physical examination, professionalism, counselling, clinical judgement, organisation)
- Fits well with current model of teaching – deals with trainee's care of patients in day-to-day situations e.g. clinic, planning, ward
- Training for assessors approx. 1hr
- Consultant working with trainee (NOT always DOT)
- Immediate feedback to trainees critical

Practical sessions

- Practical experience outside direct day-to-day oncology patient management
- Many (all) activities already part of training
- Include:
  - Attachment to RT/physics team in planning and on treatment machine
  - Attachment to radiology – cross-sectional anatomy
  - MDT participation as presenter – documentation of experience
  - Attendance at major oncological procedures
  - Attendance at chemotherapy sessions
  - Participation in palliative care clinic or attachment to ward
  - Details of exact requirement e.g. mandatory vs elective and record/assessment still being developed

DOT assessment of trainees

- Currently variable in quality and quantity
- Standard template based directly around curriculum learning objectives
- Training in giving feedback provided
- Portfolio provides a range of objective assessments made largely by others
  - Easier for DOT to deliver critique
- Basis of discussion surrounding progress and goals
- 6 monthly with interim term assessment by clinical supervisor

Trainee assessment of site

- Chance for trainees to provide feedback on training sites, terms and programs
- Anonymous but mandatory – College office verifies that these have been completed
- In radiology, has provided ‘red flag’ indicator of problem sites which triggers accreditation visit

Multi-Source Feedback

- 16 -20 assessors from 4 identified groups (senior and junior medical and all other disciplines including clerical) provide rating of trainee on 9 dimensions
- Useful for non-expert capabilities especially assessing ability to be effective team member
- Feasibility study showed that it could be performed and gives useful information
- Feedback from assessors positive (ie all groups welcomed opportunity to comment)
- To be completed annually; completion of MSFs is a requirement to progression to Phase 2

Clinical assignments

- Reports based on real patient case
- Series of questions testing oncology sciences using 5 ‘teaching’ cancer sites (head/neck, breast, prostate, skin, lung)
- Does not require trainee to be in particular rotation or to be clinical expert in management
- Covers anatomy, pathology, radiation oncology physics & radiation and cancer biology
- Every 6-8 weeks through Phase 1 (first 2 covering foundation concepts)
- DOT ensures marking completed based on rigorous criteria; NOT all by DOT
- Centralised QA to ensure standardisation

Phase 1 examination

- Reduced weighting - only one component of portfolio sign-off
- Single, 3 hr paper, ?open book
- Tests Oncology Sciences topics; more integrated questions testing understanding of interaction of concepts an implications for clinical setting
- Held annually in Aug/Sep
- Only Phase 1 assessment that is not a formal barrier to progression on first attempt

Case reports

- Replace log book
- More systematic record of cases and management; useful as a learning reference
- Most will relate to RT treatments; some deal with patients having chemotherapy and/or surgery
- Covers 16 categories as described in medical expert supplement topic table
- Approx. 2 pages based on sample templates of content
- Minimum of 64 reports (4 per category: 2 major and 2 lesser focus)
- Expanded versions of case reports document attendance and learning around specialised RT procedures e.g. TBI, gynae. brachytherapy etc
- Trainees encouraged to do as many as experience and time allow

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Research requirement

- Current requirement

Study design & statistics assignment

- Current requirement
- Under review

Phase 2 examination

- Current requirement
- Eligibility to sit subject to satisfactory portfolio assessment
- Recent process of refining components will continue and modifications likely to occur over time (with ample warning!)

Status of development

- Phase 1 assessments to be managed by group (P1IGlet) comprised of previous examiners and others – assignment writing commencing shortly
- Details of some assessments, largely Phase 2, are still in development
- TPAC (includes Chief Phase 1 & Part 2 examiners & other assessors) are responsible for detail via P2IG and P1Iglet groups

We would like your input

- Mini-CEX – training for assessors
  - state-based?, site by site?
- Clinical assignments – clear guidelines provided for marking
  - What will be the impact on you?
  - Will your colleagues support you?
- Practical sessions
  - Comment on inclusions
  - Impact on department and practical issues?
- Phase 1 exam – annual
  - impact on training program and service issues
- What resources can the College provide DOTs and departments?

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