

**AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
CLINICAL SKILLS EVALUATION OF RESIDENTS IN
NEUROLOGY AND CHILD NEUROLOGY
July 2006**

General Principles

The American Board of Psychiatry and Neurology (ABPN) mandates that demonstration of clinical skills competency is a basic requirement in order to apply for certification in the specialties of neurology and neurology with special qualification in child neurology. Competency in these skills should be achieved during residency. The ABPN requires that residents demonstrate competency in the following areas:

- A. Medical interviewing
- B. Neurological examination
- C. Humanistic qualities, professionalism, and counseling skills

Demonstration of competency in evaluating a minimum of five different patients (as specified below) during residency training is required. An individual training program may elect to do more such evaluations.

Required Clinical Skills Evaluations

Adult Neurology Residents

- 1) Critical care: One critically ill adult patient with neurological disease (may be in either an intensive care unit or emergency department setting or an emergency consultation from another inpatient service)
- 2) Neuromuscular: One adult patient with a neuromuscular disease (may be in either an inpatient or outpatient setting)
- 3) Ambulatory: One adult patient with an episodic disorder, such as seizures or migraine (most likely in an outpatient setting)
- 4) Neurodegenerative: One adult patient with a neurodegenerative disorder, such as dementia, a movement disorder, or multiple sclerosis (most likely in an outpatient setting)
- 5) Child patient: One child patient with a neurological disorder (most likely in an outpatient setting)

Child Neurology Residents

- 1) Critical care: One critically ill child patient with neurological disease (may be in either an intensive care unit or emergency department setting or an emergency consultation from another inpatient service)
- 2) Neuromuscular: One child patient with a neuromuscular disease (may be in either an inpatient or outpatient setting)
- 3) Ambulatory: One child patient with an episodic disorder, such as seizures or migraine (most likely in an outpatient setting)
- 4) Neurodegenerative: One child patient with a neurodegenerative disorder, such as an inherited degenerative disease (most likely in an outpatient setting)
- 5) Adult patient: One adult patient with a neurological disorder (most likely in an outpatient setting)

At least one of the above child patients must be:

- An infant or child aged younger than two
- A child aged six to ten
- An adolescent (aged 11 – 15)

The selection of patients (outlined above) by type and age is at the discretion of the residency director.

Selection of Patients

If possible, the patients should be unknown to the resident. While it is preferable that the patients have not been seen previously by any resident, patients previously seen at the institution may be asked to participate in the evaluation process. Whenever possible, patients with conversion disorders or somatoform disorders should not be selected. The selection of patients is at the discretion of the residency director.

Evaluators

Each resident must be evaluated by a minimum of three ABPN-certified neurologists/ child neurologists who are faculty members. Adult neurologists must perform the adult neurology evaluations, and child neurologists must perform the child neurology evaluations. The faculty member must observe the resident's performance and score the resident's medical interviewing skills; neurological examination skills; humanistic qualities, professionalism, and

counseling skills. The resident's ability to present and formulate the case should also be evaluated, but that assessment is not to be factored into the overall evaluation.

Duration of Each Encounter

Each evaluation session should last approximately one hour. The residents should be given up to 45 minutes to do the history and neurological examination. Thereafter, he/she should have 10-15 minutes to present a summary of the important findings on history and neurological examination. The remainder of the time should be spent in discussion and feedback from the faculty member who observed the encounter.

While the faculty member may wish to discuss the diagnosis, differential diagnosis, and plans for evaluation and treatment with the resident, these steps are not required by the ABPN. The resident does not need to demonstrate proficiency in these aspects of the encounter to pass the clinical skills evaluation. These competencies will be tested by the ABPN on the certification examination.

Timing of the Evaluations

The ABPN encourages administering these evaluations early in residency training. The ABPN anticipates that many residents may not "pass" all their evaluations on the first attempt. Early evaluation provides an opportunity for the residents to rectify any deficiencies and to successfully complete the process in order to apply to take the certification examination.

Evaluation Forms and Scoring Criteria

Approved evaluation forms are posted on the ABPN web site (<http://www.abpn.com/forms.htm>). Two forms are currently available (NEX v.1 and NEX v.2). Programs can add additional items for their own purposes. Criteria for scoring the components of the clinical skills evaluation are provided below.

Determination of Passing the Evaluation

The individual faculty member will determine if the resident passed all three core components (A. medical interviewing, B. neurological examination, and

C. humanistic qualities, professionalism, and counseling skills) of the clinical evaluation.

A passing score is required for all three components (A, B, and C) for an overall passing score. Regardless of when during training the resident takes the evaluation, the standard for passing remains the same.

Because the resident may take each of these clinical skills evaluations multiple times if necessary (which will not affect the resident's eligibility for taking the ABPN certification examination), there should not be pressure to pass a resident's performance on an evaluation. If the performance is less than desired, the resident and faculty can schedule other encounters and use these experiences as teaching exercises.

Submission of Documentation to the ABPN

The ABPN requires written attestation from the training director that the resident has successfully passed all five clinical skills evaluations at the time of application for certification. The number of times that the resident takes one of the clinical skills evaluations is not required. It is recommended that the program retain the evaluation forms as part of the resident's training file.

Components of the Clinical Skills Evaluation and Scoring Criteria

A. Medical Interviewing Skills

The ability to obtain a clear history is a fundamental component of the core competency of patient care. The art of being an excellent neurologist is the ability to make an accurate localization of the patient's neurological illness and to reach a most likely diagnosis based on the patient's history. The ABPN expects that residents have achieved competency in this skill prior to being permitted to take the certification examination. The faculty member should observe the resident's skills and thoroughness in obtaining the history.

The ABPN recognizes that neurologists may use several different strategies to obtain the history from a patient and that the approach may vary among different patients. Thus, the ABPN requires that residents successfully demonstrate the ability to perform a thorough and accurate history in a minimum of five encounters.

The resident is expected to ask about the chief complaint, the history of the present illness, past medical history, family history, social history, and a review of systems. The quality and completeness of the information collected from all components of the history should be evaluated. The ABPN expects the resident to skillfully obtain the history. While the emphasis of the history should relate to the patient's neurological illness, relevant components of the other aspects of history should be mentioned. For example, if the patient has had a stroke, it is relevant to ask about hypertension, heart disease, a family history of stroke, smoking, and recent cardiac complaints.

Depending upon the patient, the resident can use very direct or open-ended questions. The technique used by the resident to obtain the historical information reflects the resident's ability to communicate with the patient as well as his/her ability to change techniques to obtain the necessary information.

The resident should not review prior medical records in order to obtain the patient's history. The focus of this evaluation is on the ability of the resident to obtain the history from a "new" patient or family members/observers, as would be done in practice.

The resident is expected to obtain information about the duration and course of the neurological illness and the types of neurological symptoms. While a chronological approach often is desirable, different strategies are acceptable. If appropriate, the resident should obtain information about any incident or event that may have precipitated the neurological problems. If it is a long-standing illness, the resident should ask about recent changes. If it is an episodic disorder, information about the number and types of events, provocations, duration of symptoms, etc. should be obtained. The resident should ask questions that probe for both positive (presence of) or negative (absence of) important symptoms or components of the neurological history. These include pain, loss of consciousness, weakness, etc. Information about prior treatment (medications, surgery, etc.) can provide important diagnostic clues. Did the resident miss important historical clues offered by the patient? Did the resident follow-up on components of the history?

At the end of the history, both the resident and the observing faculty member should have a clear understanding of the nature of the patient's neurological illness.

Score	Scoring Criteria for Medical Interview
8 (Outstanding)	The history was performed without criticism. The history provides a clear understanding of the patient's neurological illness.
7 (Excellent)	A few minor deficiencies or errors in the history
6 (Very good)	Minor deficiencies or errors in the history
5 (Acceptable)	Deficiencies or errors in history but enough information is obtained to formulate the case
4 (Borderline but unacceptable)	Had deficiencies or errors in obtaining the history which resulted in missing information
3 (Unsatisfactory)	Major deficiencies or errors in obtaining the history resulting in missing important information. Performance below other residents at same level of training.
2 (Poor)	Omitted major portions of the history, resulting in inadequate understanding of the case. Performance below expectations for level of training.
1 (Very poor)	History was so poorly done that the resident could not understand the case. Performance far below expectations for level of training.

A score of 5 or greater is required to pass this component of the clinical skills evaluation.

B. Neurological Examination Skills

The ability to perform a thorough examination is a major component of the core competency of patient care. For a neurologist, the ability to do a neurological examination is a fundamental clinical skill.

The ABPN recognizes that there are different approaches to the neurological examination and no particular style, sequence, or organization is required. However, the ABPN expects the neurological examination to be thorough and to assess mental status, station and gait, motor, sensory, coordination (cerebellar), cranial nerves, and reflexes. In some circumstances, such as a wheelchair bound patient, parts of the examination may be omitted. While the ABPN expects that all aspects of the examination will be performed, components of the examination should reflect the nature of the patient's problem (as obtained from the history). Some adjustments should be expected. For example, the resident may wish to do

a more detailed mental status examination in a patient with a chief complaint of memory loss than in a patient with symptoms of a tardy ulnar palsy.

The resident should not be expected to do a general physical examination. In some circumstances, components of the general examination may be relevant to the patient's presentation. For example, the resident may wish to auscultate for bruits in a patient with a TIA.

The resident's interactions with the patient during the examination should be assessed. Was the resident rough? For example, did the resident examine a painful leg to the obvious discomfort of the patient, despite being warned not to do so? Did the resident do components of the examination in the correct manner? Did the resident use the appropriate instruments and were the instruments used correctly? Were major relevant portions of the examination missed? Did the resident detect the relevant neurological signs? Did the resident ignore or misinterpret some of the neurological findings? Did the resident adjust the examination in response to previously detected signs? Did the findings of the examination prompt the resident to ask additional history? Did the findings of the examination prompt reconsideration of the location or nature of the neurological illness?

At the end of the examination, both the resident and the faculty member should have a clear understanding of the location and nature of the patient's neurological illness. The findings on the examination should be compatible with the patient's neurological history.

Score	Scoring Criteria for Neurological Examination
8 (Outstanding)	The neurological examination was performed with no detected shortcomings
7 (Excellent)	A few minor deficiencies or errors in the neurological examination
6 (Very good)	Minor deficiencies or errors in the neurological examination
5 (Acceptable)	Deficiencies or errors in the neurological examination but obtained enough information to formulate the case
4 (Borderline but unacceptable)	Had deficiencies or errors in performing the examination resulting in missing information
3 (Unsatisfactory)	Major deficiencies or errors in performing the examination resulting in missing important information. Performance below other residents at same level of training.

2 (Poor)	Omitted major portions of the examination resulting in inadequate understanding of the case. Performance below expectations for level of training.
1 (Very poor)	Examination was so poorly done that the resident did not understand the case. Performance far below expectations for level of training.

A score of 5 or greater is required to pass this component of the clinical skills evaluation.

C. Humanistic Qualities, Professionalism, and Counseling Skills

The ability to communicate effectively with patients and families is one of the six core competencies for physicians. Effective communication is a key component of a physician’s interpersonal skills and in the development of an appropriate patient-doctor relationship. In order to determine if residents are able to communicate clearly and thoroughly with patients in a number of clinical settings, including critically ill patients, the ABPN is requiring evidence that the resident has passed this core competency.

The communication skills of the resident should be assessed throughout the patient encounter. The communication can include both verbal and non-verbal means. For example, being rough during the examination can convey a lack of skill in communication. The resident’s performance should be scored in light of the patient’s ability to cooperate with the examination. While there is no set criterion for passing this competency, the overall performance should be the basis for grading this clinical skill.

The resident should be sensitive to ethnic, racial, religious, or cultural issues. The resident also should be aware of educational, language, or community issues that may affect the patient’s ability to communicate. The resident should take steps or employ strategies that deal with these issues and at the same time permit an accurate history and examination. If the patient does not speak English, the resident should seek other ways to communicate with the patient, such as the use of a translator or talking to family members who are proficient in English.

The dialogue between the patient and the resident should be evaluated. Did the resident make the patient and family feel as comfortable as possible in the situation? Did the resident interact in a neutral or positive way with the patient?

Did the resident demonstrate respect for the patient and family? Was the resident rude, brusque or demanding? Did the resident interrupt the patient during the history? Did the resident fail to follow-up on the patient's comments? Did the resident allow the patient to respond to questions? Did the resident revise or reformat questions when it appeared that the patient did not understand? Did the resident direct questions to family members if it appeared that the patient did not have information about part of the history? Did the resident explain the components of the neurological examination and give clear instructions?

Score	Scoring Criteria for Humanistic Qualities, Professionalism, and Counseling Skills
8 (Outstanding)	Effective communication skills and patient-doctor interactions
7 (Excellent)	A few minor problems in communication or patient-doctor interactions
6 (Very good)	Minor problems in communication or patient-doctor interactions
5 (Acceptable)	Had problems in communication or patient-doctor interactions but still established rapport
4 (Borderline but unacceptable)	Had problems in communication or patient-doctor interactions, rapport with patient was borderline or not good
3 (Unsatisfactory)	Major problems in communication or patient-doctor interactions, unable to establish rapport with patient
2 (Poor)	Major problems with communication, rude or unpleasant to patient
1 (Very poor)	Interactions or communication with the patient were so bad that the faculty member needed to intervene

A score of 5 or greater is required to pass this component of the clinical skills evaluation.

D. Overall Evaluation

The individual faculty member will determine if the resident passed all three core components (A. medical interviewing, B. neurological examination, and C. humanistic qualities, professionalism, and counseling skills) of the clinical evaluation.

A passing score is required for all three components (A., B., and C.) for an overall passing score. Regardless of when during training the resident takes the evaluation, the standard for passing remains the same.

E. Presentation/Formulation

The resident’s ability to present and formulate the case should also be evaluated, but that assessment should not be factored into the overall evaluation.

Score	Scoring Criteria for Presentation/Formulation
8 (Outstanding)	No major deficiencies in the description of the key findings of the history and neurological examination
7 (Excellent)	One minor deficiency in the description of the key findings of the history or neurological examination
6 (Very good)	Two minor deficiencies in the description of the key findings of the history or neurological examination
5 (Acceptable)	A few minor deficiencies or one major deficiency in the description of the key findings of the history or neurological examination
4 (Borderline but unacceptable)	Several minor deficiencies or two major deficiencies in the description of the key findings of the history or neurological examination; missed some points
3 (Unsatisfactory)	Several major deficiencies in the description of the key findings of the history or neurological examination; missed several points
2 (Poor)	Multiple major deficiencies in the description of the key findings of the history or neurological examination; summary of findings was incomprehensible
1 (Very poor)	Numerous major deficiencies in the description of the key findings of the history or neurological examination; summary of findings was incomprehensible

A score of 5 or greater is required to pass this component of the clinical skills evaluation, though it is not required for the overall evaluation.