



HNET
Psychiatry

The Mini-CEX

A HNET Supervisor's Guide to the WBA Feasibility Study

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Health
Hunter New England
Local Health Network

1st year Registrars starting training

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Introduction

1. The Competency Based Fellowship Program will be introduced for new Registrars who commence training in New Zealand from late 2012 and Australia in early 2013.
2. Before that time, we plan to incorporate at least some of the instruments used in the CBF in our teaching practice (but not as 'hurdle tasks'). This is to familiarise ourselves and the pre-CBF Registrars with the instruments, to engage in feasibility testing and to improve our clinical teaching practice.
3. Already there have been 'pre-feasibility' trials of the Mini-CEX and Case Based Discussions in CAP (child and Adolescent Psychiatry) in the last term of 2011.
4. Now we will start 'feasibility' trials on a larger scale, for all first year registrars, term 1 2012, across Australia and New Zealand. HNET will be trialling the Mini-Cex which will be used as a 'formative assessment'.

Many thanks for those who will be supervising our new first years for assisting with this trial.

What is a 'Summative' Assessment?

'Summative assessments' ² are the sort of 'exams' familiar to us all. They occur at the end of a period of training, they test how much learning has occurred.

A 'high stakes' example would be the current fellowship (barrier) exams, but even end of term exams fit into this category.

There is a pass or fail, or at least a 'satisfactory' versus 'not satisfactory' and there is often a (summative) 'score', or scores which attempt to reasonably reflect the level of achievement of the candidate. The performance of the candidate is rated relative to their peers or some external standard.

There will be 'hurdle assessments' in the CBFP, but don't worry about them, just yet, let's learn about 'formative assessments' first.

What is a 'Formative' Assessment?

In the CBFP the formative assessments have been labelled 'Work Based Assessments'. There are four (Mini-CEX, the OCI –like ACE, Case Based discussions and Professional Presentations).

It is **crucial** not to confuse 'Formative' ² assessments and 'Summative' ² assessments.

They have a **very different intent**. This will result in a different approach to the assessment and the results and a different design.

Formative assessments are done **at the start** of a period of training; they assess the current abilities of the learner relative to their individualised goal, to be achieved at **the end** of the period of training.

They inform, or give form to, the subsequent learning and training.

An example will make this more understandable. Imagine you see a personal trainer



or a coach for **the very meeting.**

Both of you overtly or covertly decide on a goal, to be achieved from your training.

Then your 'coach' will test what you can already do, before you start.

This is what a **'formative' assessment** is.

Then you and your trainer will discuss the results relative to your goal (the feedback session), and the coach will give his or her suggestions as how to reach the desired goal of fitness or improved proficiency in whatever is the chosen sport.

This is much the same as what we will be trying to do with these WBA's

It is a much more *informal* process compared to a summative test and so hopefully not cause excessive anxiety, tension or embarrassment.

The focus **is on the gap** between where the trainee is at the start of the period of training and where you both want them to be at the end of your training...and how to fill this gap through learning and training.



This is where you are, this is where you need/want to be and here is how to get there!

Research³ has shown the **substantial benefits** of these sort of assessments on teaching and learning.

Competence or Excellence?

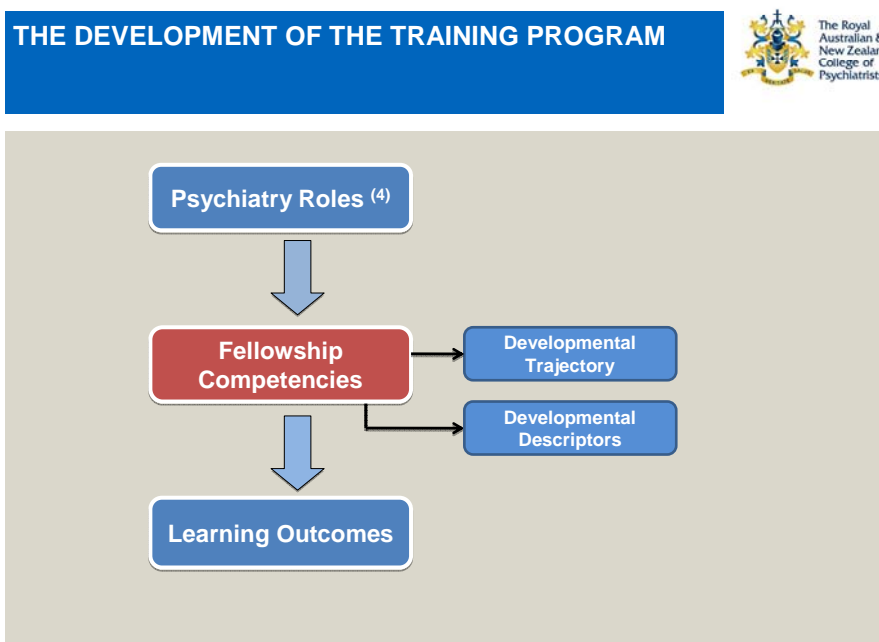
Here we will be talking about the **minimum level** aimed for at the end of this stage of training, there is no reason not to aspire higher. In such cases it is still important for trainees and supervisors to have a sense of *the minimum standard* expected by the end of the relevant period of training.

Stage 1 (Goal: achieving ‘Basic Competencies’)

Trainees entering the first part of training (Stage 1) will have some competencies but, for convenience, they are classed under the CBFP as ‘novices’ in specialised practice of Psychiatry

By the end of Stage 1 they are aiming to achieve what the CBFP has defined as ‘Basic Competencies’ in a range of specialised tasks. This approximates the level of a competent trainee who has successfully completed a year of full time training.

To resolve any uncertainty of the standard, Supervisors have as a resource available on the CBFP website ¹ the RANZCP Competencies mapped from the Canmeds Roles and expanded to describe the learning outcomes and developmental descriptors for the Competency Based Fellowship Program. These can hardly cover all eventualities and the determination of the standard will require the expert judgement of Supervisors



So at the start of training the trainees are measured relative to what is expected by the completion of this period of training...This helps to generate a learning plan, a road map for learning and training.



Summary, Formative Assessments

1. Are not pass or fail
2. Are teaching tools, the core is the feedback session and the learning plan.
3. Help clarify, for the trainee (and supervisor) the goals of training.
4. They may deal with important learning tasks (for example, the ability to give a professional presentation) that are not part of the barrier examinations
5. Are not designed as reliable summative assessments.
6. They should be more informal, less stressful than summative tasks.

Approach to a WBA's.

1. The trainee must have some ability in the task to be tested in it.
2. Reassure the registrar, this is an assessment to help them to understand how to get to the 'next level'.

3. Don't let the form over-ride your judgement and experience as a supervisor, or prevent you from mentioning important aspects not on the form. The WBA is supposed to be the **servant** of you and your trainee, not your master!
4. The exact scores are **not** crucial as they would be in a summative assessment; the core is the feedback session and learning plan.
5. Take an informal, matter of fact, attitude to the assessment and feedback.
6. It may be embarrassing for a Trainee to think they are less than perfect in all things but receiving *nothing but positive feedback* may feel nice but it will not be giving the sort of guidance they need and are entitled to.
7. Refresh your memory on how to give negative feedback ^{6,7}.

The Mini-CEX, introduction

The 'Mini-CEX' was designed in the early 60's, for the assessment of skills in internal medicine. It inherited its name from the now all but forgotten 'CEX', or 'Clinical Evaluation Exercise', a 'long case' alternative (involving one hour, including interview and physical examination and then followed by a formal presentation and discussion with a supervisor.)

The mini-CEX was developed back then, due to concerns of the time involved, ('internal medicine residents' ended up having very few CEX's during their training!)

Also the Mini-Cex has greater flexibility.

The issue of reliability, unfortunately, has continued to plague all such instruments leading to the development of the OSCE stations for summative assessments.

The CBFP mini-CEX

The mini-CEX is the simplest of all WBA's and as mentioned will be the one trialled at HNET.

Imagine asking your first year registrar to obtain informed consent from a patient for their treatment and you observe them...or do a brief risk assessment...or to interpret pathology results...or even handover a case.

They know something about it, they have seen you do it, now this is a chance for them to **show** what they can do (there is really no expectation that the two of you won't find things that can be improved)!

After this, the two of you go into a room; the registrar will present their findings or their impression of how they went and what they could improve and then you give feedback on how they went and how they can improve.

All Supervisors do this, the mini-CEX simply helps focus and formalise what supervisors already do, and helps ensure that this standard of supervision is applied across all training sites.

The rating form for the Mini-CEX is simply to aid this process.

It allows you to focus first on the performance of the trainee **without immediately sliding into a teaching role!** Yes *try to resist* taking over in the middle of the WBA unless you need to do so for safety reasons.

It gives you a framework for your assessment and feedback.

The point of the exercise is not to fill in the form!

The point is for you to assess your trainee and give them a sense of what sort of areas they need to work on to get to the next level of competency.

The form is designed to assist, **not replace**, the judgement of experienced Supervisors.

Procedure, Mini-Cex

1. Timing

The full procedure should be able to be done within the Supervision 'hour', including adequate feedback and the important formulation of a learning plan.

This means limiting the time spent with the patient

All interactions with the patient will include an explanation, even a physical examination. To do a mental status examination for example will generally require the trainee to have a discussion with the patient, about symptoms, progress etc.. In this instance the Trainee will need to have time to briefly present their findings so you can rate them, 10 min? , before the feedback can be done. All this must be factored into the time allowed.

As a result of this, the time with the patient is limited, generally 15 minutes to 20 or 25 minutes (not more than 30 minutes) so there is enough time for discussion and feedback...the most important part of the whole exercise!

The time the trainee has with the patient needs to be agreed before hand.

Performing adequately with in a limited time frame is an acquired skill.

2. No interruptions.

3. It is the trainee's responsibility to organise, but the Supervisor is not prevented from assisting or giving reminders.

4. Patients are to be treated at all times with courtesy and respect according to established ethical principles.
5. The ability of an impaired patient to give consent will depend on a number of factors including the complexity of what they are being asked. You need the patient's consent but most will be happy to assist.
6. If the Trainee runs over time, use your judgement, depending on the circumstances, as to what to do.
7. If practical, organise in advance, and outline *briefly* the task with the trainee and choose a reasonable time frame. It will be necessary to explain the Mini-CEX if the trainee is not familiar with it.
8. A copy of the assessment will normally be given to the trainee with the feedback. But in the trial all evaluation forms are de-identified and returned to the CBFP for processing.
9. Remember, in scoring a (behavioural) 'checklist'⁷ is best at novice and advanced beginner level, but not always expert level. In some situations experts can make accurate assessments without asking as many questions. More subjective measures are needed for recognising expertise in such circumstances.

Some examples of Stage 1 Mini –CEX's.

1. suggested for stage 1 by CBFP

MSE, bed side cognitive assessment , risk assessment, Physical Examination (Cardio and EPSE) side effect assessment, talking to the family, consent to treatment, interpretation of investigations.

2. Feel free to be inventive, choose an activity you feel is appropriate.

Any circumscribed interaction between the Registrar and the patient (and sometimes others) that can reasonably be done in a short time frame and involves an important skill to be learnt by the end of first year of full time training can be chosen. The standard will be some one who has just successfully completed a year of training.

This process should not be driven by the form

I suspect the form is a left over from the time the CBFP WBA's being considered for 'summative assessments'.

You need to give the College your feedback on the form as well.

1. A nine point rating scheme has remained, along with descriptions of 'below the standard', 'meets the standard' and 'above the standard'. As a result, the expectation would be that most registrars, if tested early in their training, should **be below the standard expected** at the end of their period of training, assuming we are applying the standard correctly.

I am concerned this is a little misleading, but this has **not** been a common view amongst colleagues, so it is something that needs to be resolved in the trial.

- I am concerned that telling them trainees that they are 'below the standard' may be misunderstood.
- I am concerned this may tempt consultants to erroneously mark trainees at the level expected **at the start** of the period of training, rather than expected by the end.
- We need to be aware that a single result should not, in isolation, be given more credence than warranted.

2. There is a lot of information on the form , 'brief description of the case' And 14 tick box descriptions e.g. "Assessment of a psychiatric emergency..." ect. How much information will eventually be sent back to the college and DOT is still a matter of discussion but at present it will be minimalist, a tick box on the half term and final term report if a WBA is done (2 per term will be mandatory to encourage trainees and Supervisors to get used to them).

So, much of the information on the form is only kept by the trainee in their portfolio; a new Supervisor will probably review this at the start of the term.

Is that reasonable for 'formative assessments'?

How useful is this sort of detail on the form?

1. The Royal Australian and New Zealand Competency Based Fellowship Program <http://cbfp.ranzcp.org/>
2. The CBFP glossary <http://cbfp.ranzcp.org/glossary>
3. Black P & Wiliam D. (*note one 'I' in Wiliam*) Inside the Black Box: Raising standards through classroom assessment. *Phi Delta Kappan*, 80 (2): 139-148.
4. Port, N. Negative feedback, The key to life and happiness
[http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/81656/Negative feedback to give and receive 16 3 11.pdf](http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/81656/Negative_feedback_to_give_and_receive_16_3_11.pdf)
5. CBFP WBA and feedback resource.
[http://cbfp.ranzcp.org/images/stories/attachments/Train Trainer/wba assessment feedback resource.pdf](http://cbfp.ranzcp.org/images/stories/attachments/Train_Trainer/wba_assessment_feedback_resource.pdf)
6. A Webinar conducted by Martin Cohen is available <http://cbfp.ranzcp.org/>
7. Hodges B, Regehr G, McNaughton N. "OSCE checklists do not capture increasing levels of expertise." *Academic Medicine* 1999 Oct;74(10):1129-34.