Perceptions of Formal In-Training Evaluation by Family Practice Residents

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With family practice as a specialty well into its ninth year of development, a striking *quantitative* measure of progress is the large and increasing number of family practice residency programs in university medical centers and community hospitals. There is also a growing concern for various approaches to measuring the quality of these new programs. This is a welcome and appropriate emphasis. All family practice residency programs are struggling to define and implement effective and acceptable methods of evaluation. Some programs have developed elaborate approaches to this problem.[1-7]

The dimensions of formal evaluation of residency training are wide and may include input from supervising faculty, other members of the health-care team, peers, and patients. Methods may likewise be diverse, including direct observation, simulation techniques, chart audit, in-training examinations, and other approaches. Program directors and others involved in residency training readily recognize the difficulties in measurement of resident performance.

If one assumes that resident compliance and acceptance is vital to any system of formal evaluation and that self-assessment skills learned during residency training may be an essential part of continuing medical education, then it is important to know more about resident activities and perceptions of current formal evaluation procedures. A review of the literature produced no specific studies directed to the survey of residents in either family practice or in other specialties on this issue. Therefore, a study was considered timely.

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Methods

It was decided to sample all geographic parts of the United States, with an equal emphasis upon programs in university medical centers and community hospitals. Because third year residents have had considerable experience as well as ample opportunity to reflect on the issues, they were chosen for the study as best qualified to provide feedback concerning their views of formal evaluation methods in their programs.

Twenty residency programs were selected for the study, representing all regions of the country, with an equal number (ten) in university and community hospital settings. Programs were selected which were well established (over four years) and had at least five resident positions in each year.

A survey instrument was designed and field-tested among small numbers of family practice residents. Program directors of the selected programs were contacted and invited to participate in the study. Each responded with a letter of support and provided names of all third year residents in training as of fall 1976. Five residents in each program were then invited to complete the survey instrument on an anonymous basis.

In response to the initial request, completed questionnaires were returned by 55 residents. Follow-up materials were sent to those who had not yet responded, resulting in a total response of 67 residents. Since several of the residency programs did not have five third year residents presently in training, the total possible "n" for this study was 92. Based on this number, the return rate was 73 percent. The possible "n" for university programs was 50, with 38 returns (75 percent); the possible "n" for community hospital programs was 42, with 29 returns (69 percent).

Chi-square studies were done on all of the data that were appropriate, ie, all but the questions involving multiple responses. No individual program data were compiled. Group data were collated for university-based and community hospital programs.

Results

Table 1 shows the breakdown as to who provides formal evaluation of resident performance with greatest frequency ("frequently, usually, or always") in hospital and ambulatory settings for the two groups of programs.

Table 1 reveals two differences between university and community hospital programs, both of which are somewhat predictable. Whether the setting is in-hospital or ambulatory, in

each instance it can be noted that university hospital programs make greater use of other specialty residents in resident evaluation, whereas community hospital programs make greater use of part-time or volunteer faculty in resident evaluation.

In general, the extent of agreement between the perceptions toward formal in-training evaluation of residents in university and community hospital programs was striking.

It is interesting to note that chart audits were rated by residents as most significant in educational value in comparison with other evaluation approaches. On a five-point scale ("5" being highest), the cumulative ratings by all residents for the educational value of each evaluative approach were as follows: chart audit – 3.77; in-training examinations – 3.18; and clinical assessment procedures – 3.05. There were no significant differences between the perceptions of university and community hospital residents in this regard.

With respect to residents' experience with *chart audits* using forms and criteria, 23 residents (61 percent) in university programs and 23 residents (78 percent) in community hospital programs reported *ambulatory or clinic audits* occurring at least quarterly; these same figures for *in-hospital audits* on at least a quarterly basis were 17 residents (45 percent) and 15 residents (52 percent) in these two groups, respectively. A surprising finding was that 17 residents (45 percent) in university programs and 8 residents (28 percent) in community hospital programs reported the complete absence of chart audits as an evaluative method in the ambulatory or clinic area.

Residents' overall opinion of evaluation in their programs centered toward the mean for both university (3.33) and community hospital programs (3.11) on a five-point scale, with "5" being "very valuable" and "1" being "no value."

The number and quality of responses by residents to open-ended questions were most impressive. Several predominant themes ran through the comments of residents from both university and community hospital programs: (1) the importance of increased emphasis on formal evaluation of resident training; (2) the desire for more frequent chart audit and use of chart review as an everyday teaching method; and (3) the necessity for *immediate* feedback to residents of the results of evaluation regardless of method used.

Table 1. Source of Formal Resident Evaluation by Setting and Program

	University Programs		Community Hospital Programs	
	In-hospital	Ambulatory	In-hospital	Ambulatory
Full-time faculty	30 (79%)	33 (86%)	25 (86%)	22 (76%)
Part-time or volunteer faculty	12 (32%)	15 (39%)	22 (76%)	19 (66%)
Family practice resident	8 (21%)	10 (26%)	6 (20%)	6 (20%)
Other specialty residents	20 (53%)	10 (26%)	8 (27%)	1 (3%)
Others	1 (3%)	5 (13%)	0 (–)	3 (9%)

Comment

Meaningful evaluation of resident training is perhaps the most difficult and challenging aspect of graduate medical education. Many factors bear on this issue, an important one being the issue of residents' attitudes and compliance.

The results of this study are important in several respects. (1) There is a high level of agreement among family practice residents in university and community hospital programs concerning their view of formal evaluation methods; (2) Formal evaluation of resident training is seen as important, as needing increased emphasis, and is generally viewed as constructive and nonpunitive; (3) Chart audit and regular chart review are seen by residents as having the greatest educational value; and (4) The immediacy of evaluative feedback to individual residents is seen as essential. All of these perceptions by residents reflect a mature attitude toward their learning. It is hoped that these findings can be helpful to program directors and other faculty involved with family practice residency programs in their continuing efforts to improve and further develop evaluation methods which can more effectively assure and augment residents' learning.

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