Clinical Skills Verification in General Psychiatry: Recommendations of the ABPN Task Force on Rater Training

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Objective: The American Board of Psychiatry and Neurology (ABPN) announced in 2007 that general psychiatry training programs must conduct Clinical Skills Verification (CSV), consisting of observed clinical interviews and case presentations during residency, as one requirement to establish graduates’ eligibility to sit for the written certification examination. To facilitate implementation of these requirements, the ABPN convened a task force to prepare training materials for faculty and programs to guide them in the CSV process. This article reviews the specific requirements for the CSV experience within general residency programs, and briefly describes the recommendations of the task force for faculty training and program implementation.

Methods: Materials prepared by the ABPN Task Force include background information on the intent of the observed interview, a literature review on assessment methods, aids to train faculty in direct observation of clinical work, directions for effective feedback, notes regarding special issues for cross-cultural trainees, clarification of performance standards, and recommendations for structuring and conducting the assessments.

Results: Recommendations of the task force include the use of a variety of clinical settings for CSV assessments, flexibility in the duration of CSV interviews, use of formative and summative feedback after each CSV assessment, and frequent use of the CSV across all years of training. Formal faculty training is recommended to help establish performance parameters, increase inter-rater reliability, and improve the quality of feedback.

Conclusions: The implementation of the CSV process provides psychiatry training programs with an excellent opportunity to assess how interviewing skills are taught and evaluated. In the process, psychiatry educators have an opportunity to establish performance parameters that will guide the training of residents in patient interaction and evaluation.
developed by the group are available on the American Association of Directors of Psychiatric Residency Training (AADPRT) website (3). This report briefly describes the recommendations of the task force for faculty training and program implementation.

**CSV Parameters: Requirements and Recommendations**

The ACGME focus on specific competencies and how they are assessed has become a major driver of change in medical education over the past decade, and has led to extensive discussion of how to determine and document competency throughout training. Factual knowledge is easily demonstrated with a well-constructed multiple-choice examination, but assessment of the clinical skills required in real-world practice is more difficult to accomplish. The CSV is designed to allow residents to demonstrate three of the most basic of these skills: rapport-building, information-gathering, and clinical communication, by direct faculty observation. Although a variety of additional skills are essential for residency completion, ABPN certification, and competent clinical practice, these three were identified by the ABPN as requiring direct observation of clinical encounters for adequate assessment. The following recommendations are intended to maximize the value of the CSV, not only as an assessment tool, but especially as an educational process.

**Setting**

One traditional model for observed clinical interviews is the “mock Board” examination, in which a patient is selected in advance for a scheduled encounter, and one or more faculty members observe a time-limited interview during which the trainee is evaluated on the essential elements of a clinical evaluation. Because it has been used for many years to meet the RRC requirement that programs conduct periodic clinical assessments, the mock Board has the primary advantage of familiarity to faculty. It provides a measure of standardization to the evaluation by limiting the range of patients that might be involved and by controlling the interview environment. Also, some programs exchange residents for these evaluations so as to provide greater objectivity.

The mock Board has a number of disadvantages, however, that make it less than ideal for CSV. Patterned after the ABPN live-patient examination that the CSV replaces, it perpetuates a number of problems that CSV has the potential to address. A major problem is that patient selection tends to be narrow and limited to patients who are intact enough to consent and cooperate, available to interview, and willing to participate—qualities not always observed in the patients routinely seen by psychiatrists in other clinical settings. Equally problematic is the use of arbitrary time-limits (e.g., 30 minutes) on the interviews, altering the nature of the interview and limiting the validity of the assessment of residents’ clinical skills in other less structured settings. In many programs, the mock Board is offered as infrequently as once a year, providing an inadequate sample size to document competence. Finally, when the mock Board is focused primarily on pass/fail assessment, there is low potential for resident education. Although the mock-Board format can be used to meet ABPN and RRC requirements, its disadvantages as an educational tool argue against it.

As an alternative, CSV readily lends itself to an interviewing workshop or class. Like the mock Board, this involves prearranged patients and time-limited encounters, but it has several advantages over the mock Board. The most important of these is the opportunity for other residents to watch the interview and participate in a detailed discussion of the patient encounter as it occurs and, later, with the resident interviewer. The patient sessions may be video-recorded to allow the resident conducting the interview to observe his or her own style and to more actively take part in the later discussion. Residents often cite these workshops as uniquely helpful to their professional development (4–7).

Although the workshop format has much educational value as a formative exercise, its evaluative function is less acceptable. It is both time- and labor-intensive for faculty, who typically must have time allotted by their departments for the activity to occur. It is intensely anxiety-provoking for residents to be observed by faculty and peers, which may affect the quality of the interview. Residents in the workshop have many opportunities to observe and comment on interviews, but few opportunities to conduct an interview. The range of patients willing to participate is even narrower than for mock Boards, because of the increased demands of multiple observers and video-recording. The workshop format is thus an important component of observational evaluation, but should not be the only experience residents have for these encounters nor the only source of information that programs gather about resident performance.

A more practical and widely applicable model is to embed these assessments in the routines of clinical care across a variety of settings. Appropriate naturalistic environments include inpatient units, outpatient clinics, consultation/liaison services, and emergency rooms. Residents routinely see new patients in each of these settings and are expected to present the cases to faculty, who are often