

Faculty Evaluation by Residents in a Family Medicine Residency Program

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Accountability in graduate medical education is dependent on the willingness of the residents and faculty to make their expectations and commitments explicit and to be held responsible for fulfilling their commitments. In an effort to encourage accountability, residents in the University of Oklahoma Family Practice Residency Program evaluated the effectiveness of faculty members as learning facilitators. Several dimensions of the learning facilitator role were examined at a resident retreat and the results of the initial evaluations were discussed individually with each faculty member. A subsequent evaluation was conducted one year later, and a comparison of the results of the two evaluations suggests that such efforts can serve to stimulate modification of selected behaviors and thereby improve the quality of teaching in family practice residencies.

In recent years the medical profession has witnessed the evolution of performance audits and review organizations as mechanisms designed to assess quality in the delivery of health-care services. These developments can be viewed as responses to consumer demand that the medical profession be held accountable for the quality of its services. A similar demand for provider accountability has surfaced in undergraduate medical education, as seen by the emergence of student evaluations of instructors.¹⁻³ The purpose of such evaluations is to identify instructors' strengths and weaknesses in order to improve the quality of teaching.

In postgraduate medical education there is greater ambiguity in the provider-consumer relationship than

exists in either the doctor-patient or student-teacher models. Because of the nature of the relationship between faculty and residents, the roles of teacher and learner may often be interchanged. As a result of working together on an almost daily basis for three years, which occurs in some family practice residency programs, initial teacher-to-student relationships often evolve into colleague-to-colleague and/or friend-to-friend interactions. The resident-to-faculty relationships can, therefore, more accurately be characterized as a partnership in which both parties seek increased knowledge and skills for the purpose of improving the quality of medical services provided. In such a relationship accountability exists to the extent that the partners are willing to make their expectations explicit and to be held responsible for fulfilling their educational commitments.⁴

Student evaluations of faculty performance in classroom and small group settings have been conducted in an effort to improve the "quality of teaching."¹ Steps have also been taken

to include faculty and peers in the evaluation of instructors.^{2,3} The impetus for such efforts most often originates from faculty members themselves or from medical education committees. Residents, despite being physicians in training and fellow colleagues in health-care delivery, have been slow in developing programs for evaluation of the instructors who are a major source of their postgraduate medical education. This is not surprising, as they have been equally slow in getting representation on the national boards, residency review committees, and other areas which critically influence their lives and futures. The pattern appears to be changing, however, as programs emerge which involve active participation by the resident in decision-making policies.^{5,6}

Until now, however, no report has been made of resident-originated evaluation of faculty. This may be due in part either to traditional educational models in which the instructors assume authority and prefer to stay in command, or the possibility that residents have a reluctance to evaluate the performance of individuals whom they regard as friends. Residents might also feel that the traditional evaluation procedures employed by students overemphasize lecturing ability, while giving insufficient attention to interpersonal communication skills.

Consequently, when residents at the University of Oklahoma Family Practice Program decided to evaluate their faculty during a resident retreat in April 1975, they focused on evaluating the effectiveness of each faculty member as a learning facilitator. Such a focus reflects the residents' conviction that the role of the faculty member is a function of not only the skills, experience and motivation of the faculty member, but also of the needs and expectations of each resident.

Methods

The residents felt that an evaluation of the faculty would serve the goal of accountability by helping to make explicit both the expectations of the residents and the educational commitments of the faculty. The data in the evaluation forms would yield an indication of the degree to which resident expectations were being fulfilled by

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Table 1. Faculty Evaluation

	5*	4	3	2	1
Professional					
Fund of knowledge					
Clinical judgment					
Technical ability					
Reliability as a consultant					
Resident Relationships					
Availability to resident					
a) on call					
b) in clinic & spare time					
Willingness to assist					
a) on call					
b) in clinic					
Feedback to resident and critical commentary					
Interpersonal relationship to resident					
Interpersonal					
Receptive to new ideas					
Relationships to employees					
Equality in resident dealings					
Teaching initiative					
Receptive to criticism					

*5 = Superior
 4 = Above average
 3 = Average
 2 = Below average
 1 = Inadequate

Miscellaneous

1. Dealings with staff patients in hospital:
 - a. Do you enjoy following his patients in the hospital? yes no
 - b. If no, why not?
 - feel like an intern
 - feel like an MS-4
 - only unpleasant work and no learning
 - other _____
 - c. If yes, why?
 - d. Comments:
2. Dealings with your patients in hospital:
 - a. Do you enjoy him as attending on your hospital patients? yes no
 - b. If no, why not?
 - writes order without consulting you
 - interferes with your care as primary physician
 - ignores your patient
 - inadequate assistance when needed
 - other _____
 - c. If yes, why?
 - d. Comments:

each faculty member. In addition, the evaluation results would help to identify areas in which each faculty member was perceived to be weak or strong. Through presentation of the summary of findings individually to each faculty member, identification of specific faculty performance could be made. The measure of accountability could then be taken on the basis of the willingness of each faculty member to change in an effort to meet his commitments more effectively.

An evaluation form was designed by the residents which included four general aspects of faculty effectiveness as learning facilitators: (1) effectiveness in medical and clinical situations, (2) effectiveness in resident-faculty relationships, (3) effectiveness in resident-faculty-patient relationships, and (4) effectiveness in interpersonal relationships (Table 1). At the resident retreat each resident was asked to complete an evaluation form for each full-time faculty member. The resident gave a score to each faculty member in each category, with "superior" indicated by a score of five and "inadequate" indicated by a score of one. The evaluations were discussed in groups of four residents to note similarities, and then in a group including all residents to summarize findings. The scores were then averaged and a final score was given for each category. Following the retreat, the senior and chief resident together formally discussed the results of the evaluation with each faculty member. Positive and negative conclusions were presented and suggestions for improvement were offered.

Results and Implications

The effectiveness of the Family Practice Program at the University of Oklahoma is due in part to the nature of the resident-faculty relationships. Since the residency program at Oklahoma was established in 1969 the residents have had equal voting rights in the monthly business meetings — a progress-reporting and problem-solving session involving the faculty, residents, and representatives from each clinic department. Residents also are on the Executive Committee, consisting of full-time faculty members, the clinic manager and the resident representatives. However, problems concerning the teaching performance

Table 2. Comparative Faculty Evaluation		
	1975 Averaged Score	1976 Averaged Score
Faculty Member # 1		
Availability to resident on call	1.9	3.2
Willingness to assist on call	1.6	2.9
Faculty Member # 2		
Clinical judgment	2.0	3.0
Technical ability	1.9	2.6
Faculty Member # 3		
Do you enjoy following his patients in the hospital?	No	Yes
Do you enjoy him as attending on your hospital patients?	No	Yes

of faculty members were considered primarily in resident gripe sessions. This was clearly an ineffective method of handling teaching problems since it did not involve resident-faculty transactions. Therefore, an evaluation of faculty effectiveness as learning facilitators was conducted, although with considerable apprehension on the part of several residents. The faculty, however, were found to respond warmly, favorably and even enthusiastically. They had been conducting resident evaluations for several years, and these had been received by the residents as welcome and constructive aids in assessing the faculty's expectations of the resident and the resident's own commitment to learning and development as a family physician. By reciprocating and offering faculty assessment, residents provided faculty with reliable feedback and the partnership nature of the faculty-resident relationship was reaffirmed and strengthened.

One index of accountability is the willingness of individuals to change their behavior if evaluations reveal they are failing to fulfill their expected commitments. For three of the four full-time faculty members, residents at the first session identified major areas which required improvement in order to satisfy resident expectations. One year later each area was again evaluated and all three faculty had improved (Table 2). It appeared that the goal of

accountability had been served, since residents had made their expectations explicit, faculty commitments had been identified, and faculty members had taken the responsibility of fulfilling their educational commitments.

Although it may be agreed that accountability is desirable in medical instruction, is it feasible in a residency program? Preliminary results from the Family Practice Residency Program at the University of Oklahoma indicate that the pursuit of accountability is feasible and could constitute an important addition to residency training.

References

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Although some sections are current, the prevailing impression one receives is of an older textbook. The majority of articles cited in the bibliographies are over five years old, and many are considerably older than ten years. Some are classical articles, but many are not. There are some inaccuracies in the text, and many of the recommended therapies (eg, otitis media, meningitis, bronchiolitis, and lead poisoning) are not accepted in this country and in some instances, have been discarded in favor of treatments proven more effective by research.

This book, while undoubtedly serving a purpose for some audiences, cannot be recommended for the American physician when so many other pediatric texts are readily available.

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Psychological Care of the Medically Ill, A Primer in Liaison Psychiatry. Edited by James J. Strain and Stanley Grossman. Appleton-Century-Crofts, New York, 1975, 223 pp., \$12.50.

It is always difficult to organize the efforts of a number of contributors, but these editors seem to have succeeded in doing so. They have presented a collaborative medicopsychological approach to the medically ill, designed as a primer for psychiatric residents. There is also little doubt that it should be of value to all individuals involved in patient care. It is for those who care *about* patients as well as for them. The text is appropriate not only for the student, the resident, and the practicing physician,

but also for allied health professionals. It is goal-directed to improve communications between the various segments of the medical profession in integrating the emotional needs of patients with organic diagnosis and management. While especially appropriate for those in the discipline of family practice, it appears that there is a message directed to the tertiary care specialist. We see a plea for the synthesis and integration of normal psychological reactions with physiological concepts of disease directed towards more holistic patient care.

Support is given to the fact that improved psychological care for the medically ill not only postpones chronicity but diminishes the frequency and length of hospitalization. The liaison psychiatrist is not only a doer, but also a missionary voice in the wilderness of the complex social structure of hospitals.

This primer should be read by every physician who cares for patients and by every health-care professional who is concerned with the delivery of good total health care.

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Principles of Clinical Electrocardiography (9th Edition). Mervin J. Goldman. Lange Medical Publications, Los Altos, California, 1976, 412 pp., \$9.50.

This text on clinical electrocardiography is well-organized and reads easily. It covers and develops the basic fundamentals of electrophysiology and electrocardiography. It is literally filled with illustrations which are well done and give the reader an excellent opportunity to see how the individual components of the ECG complexes are formed. It also covers those frequently

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encountered problems such as arrhythmias, conduction defects, myocardial ischemia and infarcts, hypertrophy, and cardiac pacing. One chapter is devoted to interpreting the ECG indicating the historical criteria needed, the technique of reading, and a suggested reporting format.

I concur wholeheartedly with the author when he states that, "I really think the person best qualified to read and interpret the ECG is the physician who is taking care of the patient." This book has relevance to family practice and would be a good resource text on basic ECG for the family physician. It would also be helpful to the family practice resident, medical student, and those health professionals who provide care for patients with cardiovascular problems.

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Clinical Exercise Testing: A Guide to the Use of Exercise Physiology in Clinical Investigation. *Norman L. Jones, E. J. Moran Campbell, Richard H. T. Edwards, et al. W. B. Saunders Company, Philadelphia, 1975, 214 pp., \$15.50.*

The authors attempted to direct this book at two rather different groups of readers: clinicians who wish to know something of the value, indications, and interpretation of exercise tests; and clinicians and clinical physiologists who have responsibility for cardiorespiratory investigation laboratories and wish to expand their knowledge of exercise testing. They have been most effective in their approach to the latter group, but I feel that the book is much too technical for the practicing family physician. It is not a practical, straightforward guide to the clinical application of exercise stress testing as performed by the family physician.

The book is well written and logically organized. Illustrations are extensive and of high quality. Tables of

methods of calculation, conversion factors, and normal standards are an excellent source of reference. The authors deal very well with detailed questions of equipment, procedure, and interpretation of results. The book definitely belongs in the reference library of clinicians and physiologists actively working in this field.

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A Syllabus of Problem-Oriented Patient Care. *Francis A. Neelon and George J. Ellis. Little, Brown and Company, Boston, 1974, 121 pp., \$4.95 spiralbound.*

This short manual provides instruction as to how one can construct, maintain, and use problem-oriented records. Little attention is given to the theoretical and philosophical bases for the problem-oriented system. Nevertheless, a "doctrine of care" is suitably presented by describing several specific types of medical care in relation to comprehensive care. A clearly understood definition of care and its types can only serve to strengthen the bond between clinician and patient.

The authors divide the book into chapters on the data base, problem formulation, progress notes, discharge summary, and outpatient clinics. Many of the illustrations and examples involve endocrinological problems which represent the specialty field of the authors. The organization and content of this material, however, can be transposed to any clinical setting. This book would be of interest to practicing family physicians, residents, medical students, and allied health professionals. It is recommended for any beginners in problem-oriented medical records.

Although the major applicability of this material is for hospitalized patients, the principles can be directed for outpatient or ambulatory care. This book does not, however, fill the needs for flow charting of common office problems seen by family physicians.

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