Evaluation in Family Medicine Residencies

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An early step toward the development of an evaluation strategy for the Family Medicine Residency at the University of Alabama's College of Community Health Sciences was to conduct a survey of other family medicine residencies in the United States to determine what types of evaluation methodologies and instruments were then being used. This survey revealed some interesting results, which will be briefly presented in this paper.

From a list of 190 approved family medicine residency programs in the United States which were sent an original questionnaire, 64 (34 percent) responded. While one must be cautious in drawing conclusions from such a limited sample, the types of evaluation mechanisms which were described by these programs can be divided into three categories.

Category 1

Thirty-five (55 percent) respondents used a minimal evaluation strategy in their program. This method of evaluation was usually observation of residents, with the completion of a simple rating form. Little or no direct testing was used and there was seldom any effort to gather any baseline data or attempt to do process evaluation. Also, there was little or no attention given to the competencies which residents might be expected to attain before completion of their program.

Category 2

Twenty-six (41 percent) of the respondents were in this category. These programs were characterized by the use of some direct testing of residents. Most often the testing took the form of self-assessment examinations, which were more often than not standardized tests obtained from various associations within medical practice. However, an occasional program would develop its own self-assessment examinations. Oral examinations were frequently employed in Category 2 programs with periodic conferences conducted, during which each resident was able to evaluate his/her own progress in the program. These programs had some logical method of program evaluation, although to some degree they were all inconsistent. Chart audits were frequently utilized and patient satisfaction evaluations were used on occasion.

Category 3

This category of evaluation in residency programs was attained by three (four percent) of the respondents. These residencies had a rather comprehensive evaluation mechanism with some pre-assessment of clinical skills for each resident. Most often this pre-assessment took the form of some initial testing together with attempts to develop personality profiles. There was some process evaluation in trying to determine the effect of the various service rotations on the competency of the resident. There were frequent progress conferences using data generated by various evaluative techniques to provide for remedial action. The wide variety of evaluation techniques used is perhaps the most outstanding characteristic of this category. Oral examinations, peer review, inspection of patient files, evaluation by other health professionals, video-tape evaluation sessions, review of patient-management problems, and patient satisfaction surveys were the most common methods used. The Category 3 programs also were concerned with the terminal performance of the residents which was most often determined by certification exams and National Board scores. The Category 3 programs were also interested in long-term evaluation of their residents after they had left the program.

Based on these responses a number of generalizations about in-service family medicine resident evaluations can be made.

1. The majority of the family medicine programs surveyed were doing, by their own admission, a relatively poor job of evaluation. Although there was concern on the part of residency directors for this aspect of their overall program, many individuals indicated that they did not have the time nor the resources to develop a comprehensive evaluation component.

2. The resources available to a residency program determine, in large part, the level of sophistication of the evaluation program; programs affiliated with educational institutions were more likely to have given special attention to the problems of evaluation. Such programs seemed to have the administrative support and ancillary service personnel to make feasible extensive evaluation of the residents in the family medicine program. Community hospital-based programs which rely heavily upon part-time faculty and have no available educational consulting unit most often had done little toward the development of a satisfactory evaluation mechanism.

3. Few residencies used the evaluation data generated by their various strategies to provide individual program planning for residents. Also, seldom did a program attempt to individualize the educational program for each resident with his/her future practice location as a foremost variable to be considered.

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