SPECIAL ANNOUNCEMENT

Evaluation of Clinical Competence in Hematology Training Programs

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The American Board of Internal Medicine (ABIM) has called on directors of hematology training programs to establish systems to evaluate, document, and substantiate those components of overall clinical competence considered essential for certification in the subspecialty. Many of these can be assessed only by repeated direct observations. In particular, proficiency is now required in the preparation of blood smears, bone marrow aspiration and biopsy, administration of chemotherapy, management of indwelling vascular access, lumbar puncture with chemotherapy, bleeding time, phlebotomy, and exchange transfusion. The goal of this expanded evaluation program is to ensure that the public and the profession can identify, through certification, physicians with demonstrated excellence in hematology.

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A FORMAL PROCESS for voluntary certification of hematologists was introduced by the American Board of Internal Medicine (ABIM) in 1972. Several years later, the ABIM published guidelines for training hematologists which recognized that individuals could be held to the standard implied by certification only if their training in hematology was of high quality. These guidelines promulgated by the ABIM became the basis for an explicit mechanism whereby hematology training programs that comply with published standards may now receive accreditation by the Residency Review Committee for Internal Medicine (RRC-IM). Beginning in 1989 only training accredited by the RRC-IM will be acceptable to the Board.

The ABIM and its Subspecialty Board on Hematology believe that more must be done to ensure that the public, through certification, has the ability to identify hematologists who have attained excellence as a result of their subspecialty training in an accredited program. Heretofore, the Subspecialty Board on Hematology has limited its assessment of candidates who have satisfactorily completed the requisite period of training and who are deemed eligible for certification to an evaluation of knowledge and judgement in the context of a written examination. Other components of clinical competence have been deemed essential, but are not amenable to assessment by this means. These components include refined history taking, expert and focused physical examinations, humanistic qualities (including the application of ethical considerations to the care of the chronically or terminally ill patient), the abilities of a consultant to communicate effectively with and educate patients and colleagues, the demonstration of professional attitudes and behavior, the provision of high quality medical care (including choice of appropriate tests), proficiency in selected procedures, and continuing commitment to scholarship. Each of these component skills can be assessed only by direct observation and appropriate documentation. Such assessment and documentation are required not only for certification, but also to provide a basis for recommendations by training program directors on behalf of former trainees seeking hospital privileges.

Many have used Board certification as a basis for conferring clinical privileges to perform the procedures of the subspecialty. In the absence of a formal and systematic assessment process, the certificate currently issued by the board does not guarantee that evaluation, documentation, and substantiation of these components of clinical competence have been carried out.

In an effort to broaden the foundation on which the certification decisions of the Board are based, program directors in hematology are now being asked to verify that their trainees satisfactorily demonstrate all of the component skills mentioned above and that they have done so during each of the required years of training. A candidate for certification who is judged at the end of required training to be unsatisfactory with respect to overall clinical competence or any component skill, including moral and ethical behavior in the clinical setting, will be obliged to take an additional year or more of acceptable training with substantiation of clinical competence before requesting admission to examination. Furthermore, the Board requires that a trainee who changes programs, particularly after a poor initial performance, inform the new program director of any previous unsatisfactory ratings so that remedial efforts can be directed toward elimination of all deficiencies.

Two important elements in this augmented evaluation process are the stipulation of humanistic qualities and certain essential procedural skills. To provide excellent patient care, physicians must have the welfare of their patients as their primary professional concern. Although certified internists have demonstrated integrity, respect, compassion, and sensitivity to the patient's perception of illness, acceptance of professional responsibility, and appropriate attitudes and behavior toward patients and colleagues, hematologists bear added responsibility to manifest these qualities. The emotional impact of managing the care and treatment of seriously ill patients, including those isolated in compromised host units, demands special sensitivity toward their needs and those of their families and friends. Whether to undertake expensive and life-threatening therapy requires knowledge and effectiveness in discussing the process of informed consent, clarity in enunciating the ethical issues involved, and thorough understanding of social support and palliative measures.

In particular, specialists in hematology should be able to provide substantive counseling to patients with genetic diseases regarding prognosis, disease severity, and when appropriate, the availability of prenatal diagnosis while maintain-
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ing sensitivity to individual values and expectations. For patients with malignant disease, hematologists should demonstrate an ability to balance the responsibility for providing a realistic appraisal of the clinical condition with the need for offering hope, thereby allowing patients to cope optimally with their diseases. Also essential is the ability of hematologists to deal effectively and humanely with the dying patient, and be available and informative to the patient's family and friends.

The Board has defined essential procedural skills as the learned manual skills necessary to perform diagnostic and therapeutic procedures within the subspecialty. Mastery of these skills includes technical proficiency as well as an understanding of their indications, contraindications, complications, and results. The need to substantiate that these skills have been acquired will become effective for those applying to the 1990 examination in hematology and thereafter. At the completion of the 2 years of required training, candidates for certification in hematology must present evidence of having attained satisfactory skills in:

- Preparation of blood smears
- Bone marrow aspiration and biopsy
- Administration of chemotherapy
- Management, including repair and/or maintenance of indwelling vascular access
- Lumbar puncture with chemotherapy
- Bleeding time
- Phlebotomy and exchange transfusion

Additional procedural skills required of a hematologist will be determined by type of practice, personal preference, availability of other skilled professionals at one's practice site, and local delineation of privileges. For these reasons the Board recognizes that fellowship training may include experience with procedures such as pheresis, bone marrow harvest, thin-needle biopsy, femoral vein catheterization, impedance plethysmography, and laboratory evaluation of blood and coagulation disorders. Familiarity with the indications, contraindications, complications, and interpretation of the results of these additional procedures is essential, even though proficiency in performing them is not required.

The board does not seek to dictate the number of times a procedure must be done to assure competency. The manual dexterity and competence of trainees vary, and procedures should be applied for the patient's benefit and not to fulfill some arbitrary quota. Each trainee is advised to maintain a formal log until proficiency is obtained, listing those procedures performed, including indications, basic findings, complications, and/or pathology reports. This log should be reviewed by the program director and should become a permanent part of the trainee's record in order to document training in and achievement of satisfactory technical skills. The methods used by a given program for supervising training and for observing, evaluating, and documenting procedural skills are left to the discretion of the program director.

To assist programs in the evaluation of clinical competence, the Board has developed guidelines for hematology program directors and trainees. Information gathered through the ABIM's hospital visit program indicates that many hematology training programs already make an explicit effort to evaluate and document these essential clinical skills.

The processes addressed in this communication bring the Board, the training program, and the candidate for certification into a tripartite relationship whose shared goal is to assure that comprehensive and thorough medical care is based on a high standard of demonstrated clinical competence. The value of certification as a tangible expression of the attainment of a superior level of ability will be enhanced by this broadening of the foundation on which certification rests.

REFERENCES

2. Special Requirements for Graduate Education in the Subspecialties of Internal Medicine, Accreditation Council for Graduate Medical Education, 1988-1989. Directory of Graduate Medical Education Programs, pp 41-45, 48
4. Evaluation of Trainees in Hematology, American Board of Internal Medicine, 1988.
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