Determining Resident Clinical Performance

Getting Beyond the Noise

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ABSTRACT

Background: Valid and reliable (dependable) assessment of resident clinical skills is essential for learning, promotion, and remediation. Competency is defined as what a physician can do, whereas performance is what a physician does in everyday practice. There is an ongoing need for valid and reliable measures of resident clinical performance.

Methods: Anesthesia residents were evaluated confidentially on a weekly basis by faculty members who supervised them. The electronic evaluation form had five sections, including a rating section for absolute and relative-to-peers performance under each of the six Accreditation Council for Graduate Medical Education core competencies, clinical competency committee questions, rater confidence in having the resident perform cases of increasing difficulty, and comment sections. Residents and their faculty mentors were provided with the resident’s formative comments on a biweekly basis.

Results: From July 2008 to June 2010, 140 faculty members returned 14,469 evaluations on 108 residents. Faculty scores were pervasively positively biased and affected by idiosyncratic score range usage. These effects were eliminated by normalizing each performance score to the unique scoring characteristics of each faculty member (Z-scores). Individual Z-scores had low amounts of performance information, but signal averaging allowed determination of reliable performance scores. Average Z-scores were stable over time, related to external measures of medical knowledge, identified residents referred to the clinical competency committee, and increased when performance improved because of an intervention.

Conclusions: This study demonstrates a reliable and valid clinical performance assessment system for residents at all levels of training.

RELIABLE measures of clinical performance are needed to enhance and direct learning, determine which trainees are ready for advanced training, and identify which are in need of remediation.1,2 Unfortunately, evaluations of resident clinical performance suffer from a number of limitations,3–5 such as trainees not being directly observed,3 faculty leniency and grade range restriction,6–8 concerns about validity of what is being assessed,9–11 and the finding that even highly valid tests of medical knowledge may not12,13 or may only modestly14–17 predict competence in patient care. There are also issues of generalizability because Objective Structured Clinical Examinations (OSCEs)18 and simulation-based examinations19,20 sample only a subset of the domain of interest, and performance may not generalize to different circumstances.10,21,22 Further-

What We Already Know about This Topic

• Evaluating clinical performance of resident trainees is essential to education, but the validity of evaluation methods has been questioned.

What This Article Tells Us That Is New

• In a 2-yr period, more than 14,000 electronic evaluations were submitted by faculty. Significant grade inflation could be removed by normalizing scores to each faculty member, yielding a more reliable and valid assessment of resident clinical skills.
more, even when faculty members observe the same clinical performance, they may disagree about their observations23 or what constitutes an acceptable performance24 or response to a situation.25 Lastly, and of considerable importance, is that physicians’ scores on high-stakes OSCEs may not predict what they do in actual practice.26 Thus, measures of competence (what a physician can do) may not relate to performance (what a physician actually does in everyday practice).27,28

This article describes an approach to assessing anesthesia resident clinical performance using the Accreditation Council for Graduate Medical Education (ACGME) core competency framework, is based on what residents do in everyday practice, depends on direct observation, uses many different evaluators representing a wide range of situations, is linked to written formative feedback, and yields a large number of evaluations. It was hypothesized that clinical performance scores could be corrected for faculty member leniency (positive bias) and idiosyncratic grade range usage and then averaged to yield a normalized resident performance metric that was valid and that distinguished clinical performance levels with known degrees of statistical confidence. The clinical performance metric is stable over time, reliably identifies low performers, detects improvement in performance when an educational intervention is successful, is related to an external measure of medical knowledge, and identifies poor performance due to a wide variety of causes.

Materials and Methods

The Massachusetts General Hospital Institutional Review Board waived the need for informed consent and classified this study as exempt.

Evaluation Instrument and Evaluation Process

The department’s Education Committee created an initial evaluation instrument that was sent to the full faculty for comment. Faculty input was incorporated, and an updated version was sent to all residents for additional comment. Resident feedback was incorporated, and the Education Committee created a final version of the instrument. The resident evaluation form has five distinct sections (appendix) and is confidential for the evaluator.

Absolute/Anchored ACGME Core Competencies Section.
The six ACGME core competencies are used, but patient care is divided into cognitive and technical sections yielding seven competency scores. The absolute/anchored scale uses a Likert scale (1–7) with descriptors of how much help the resident needed relating to each competency. A score of 5 was defined as performing independently and without the need for help.

Relative ACGME Core Competencies Section.
The relative scale asks how the resident performed compared with other residents in residency in the same training year. The relative scale uses a Likert scale (1–5) with descriptors of how the resident performed compared with peers. A score of 3 is defined as performing at peer level (average) compared with other Massachusetts General Hospital anesthesia residents in the same clinical anesthesia year (CA-year).

Z-scores

Z-scores normalize a single resident evaluation to the unique scoring attributes of the faculty member providing the evaluation. Evaluations submitted within a specified date window are used to determine the characteristics of each faculty member’s scoring attributes. Z-scores were determined using absolute/anchored core competency scores (Z_{abs}), relative-to-peers core competency scores (Z_{rel}), or case confidence scores (Z_{conf}). Each faculty member’s Likert scores were used to determine his or her personal mean and SD for each CA-year. Individual resident Z-scores were calculated as:

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Z = \frac{(\text{Resident Score [CA-year]} - \text{Faculty Member Mean [CA-year]})}{\text{Faculty Member SD [CA-year]}}
\]

Resident Score (CA-year) is the Likert Score assigned to a particular resident by a faculty member. When more than one core competency section is included, the average of the Likert scores from the selected core competencies is used.
Faculty Member Mean (CA-year) is the mean Likert score given to residents of a similar CA-year by this faculty member. Faculty Member SD (CA-year) is the SD of Likert scores given by this faculty member to residents of this CA-year.

Z-scores provide a measure of distance from the grader’s mean score in terms of SD units. For example, a Z-score of −0.5 means that the faculty member scored the resident one half SD less than he or she normally scores residents of this same CA-year. Z-scores are essentially effect sizes because they are differences normalized by the SD. Any combination of core competencies can be used in the calculation of a Z-score. When core competencies are not mentioned, a Z-score refers to an average based on all of the core competencies. Faculty member confidence data were converted to Z-scores by first determining the breakpoint at which the faculty member converted from “yes” to “no” along the sequence of eight graded cases. For example, if a faculty member said yes to the first three cases and no for the remaining five cases, the breakpoint would be 3. This allows the determination of the mean and SD of the breakpoints for each faculty member for each CA-year.

In-training Examination Z-scores
Z-scores for the American Society of Anesthesiologists/American Board of Anesthesiology In-Training Examination (ITE) (ZITE) were computed for each resident by first subtracting the resident’s individual ITE scores from his or her Massachusetts General Hospital residency class mean (CA-year–matched classmates) and then dividing by the class SD.

Statistical Analysis
Statistical results were determined using StatsDirect Version 2.6.6 (StatsDirect Ltd., Cheshire, United Kingdom), Excel (Version 2003), SAS Version 9.2 (SAS Institute, Cary, NC), or Origin Version 7.5 SR4 (OriginLab, Northampton, MA). Effect sizes were determined by Cohen’s d and provide a measure of the size of a difference compared with the variation in the data. Effect sizes are classified as small (Cohen d = 0.2), medium (Cohen d = 0.5), or large (Cohen d = 0.8). Regression analyses are characterized by r and r² (explained variance) values along with the number of data points used in the regression. Slopes were determined using linear regression. Slopes were compared using a Z-test statistic. Repeat tests on the same sample are compared with paired t tests. Independent samples are compared with unpaired t tests assuming unequal group variance. Single-sample t tests compared a specified reference value to a sample of values. Sample variances were compared using an F test. Chi-square analysis was used for categorical data and Yates’ correction was applied if expected frequencies were less than 10. Scores for relative AGME core competencies were compared in a linear mixed model (LMM) with fixed effects for resident year (CA-1, -2, or -3); length of training within year at the time of the evaluation to accommodate improvement in scores over the course of training; and the interaction between resident year and length of training, random participant- and faculty-specific intercepts, and variance heterogeneity by faculty member. Nonlinearity in the trends over length of training was assessed using a cubic spline, but the fit was not improved based on Akaike information criterion. Point and interval estimates from this analysis were compared with results obtained from analyses of Z-scores. LMM estimates of participant-specific CIs were roughly 20% wider and more variable than matched Z-score estimates, but inference for comparisons among resident years was unchanged. P values were two-sided. The term “bias” is used throughout the study to denote the systematic tendency to assign performance scores that are higher than is normatively possible. With this particular usage, bias implies leniency. The terms “reliable” or “reliably” refer to dependable findings. With this usage, a score with a narrow 95% CI would be called reliable.

Results
Completed Evaluations
Between July 1, 2008, and June 30, 2010, 14,469 evaluations were submitted. This represents an overall (all requested, all returned) compliance rate of 49%. Evaluations were submitted by 140 different faculty members, who entered at least 5 evaluations on a total of 108 different residents, who each had at least 10 evaluations. There were 5,404 CA-1, 4,319 CA-2, and 4,746 CA-3 resident evaluations. On average, each CA-1, CA-2, and CA-3 resident received 101, 70, and 73 evaluations, respectively. On average, each CA-1, CA-2, and CA-3 resident was evaluated by 49, 40, and 41, respectively, different faculty members. Comments were entered on 59.1% of all returned evaluations. Comments averaged 225 ± 209 characters.

Faculty Members Characterize Resident Performance with a Positive Bias
The relative performance Likert scale defined 3 as “peer average” for each CA-year. This is explicitly stated on each evaluation form. The average relative score assigned for all core competencies by each faculty member contributing at least 10 evaluations was determined using all data. The average faculty member assigned a relative score of 3.36, 3.51, and 3.68 to CA-1, CA-2, and CA-3 residents, respectively. Histograms of the average relative score assigned by each faculty member by CA-year are shown in fig. 1. Using the expected value of 3.00 and the known SD of the faculty score distributions yields effect sizes for the bias of 0.91,ug, and 1.41 (P < 0.001 by single-sample t test, all cohorts) for scores assigned to the CA-1, CA-2, and CA-3 residents, respectively. These are large effects because average scores are approximately 1 SD above the expected value of 3.00.

Faculty members also increase their bias as they score more senior residents. For faculty members who provided both CA-1 and CA-2 evaluations, average CA-2 relative scores were higher (CA-1 = 3.36 vs. CA-2 = 3.48, N = 78
Bias Varies by Faculty Member

All faculty members have their own amount of bias. Their average relative-to-peers scores are widely distributed (SD = 0.46, fig. 1). Scores from a relatively unbiased faculty member are compared with scores from a more biased faculty member in figure 2A. In addition to the variation in bias, faculty members also use different amounts of the score range. The used score range can be quantified by the SD of the scores given by each faculty member. Figure 2B shows a histogram of SD for all faculty members having 10 or more evaluations for each of the CA-years (SD = 0.22). Faculty members use different amounts of the score range, as demonstrated by the lower average SD in scores given by one faculty member (SD = 0.26, N = 117 evaluations, CA-1 year, black arrow fig. 2B) compared with the higher average SD in scores given by another faculty member (SD = 0.68, N = 104 evaluations, CA-1 year, gray arrow fig. 2B).

Z_{rel} Scores Correct for Individual Faculty Member Bias and Unique Score Range Use

Because faculty members are biased to various degrees (fig. 1) and they each use different amounts of the score range (fig. 2B), a Z-score transformation was applied to the relative-to-peers scores (see Methods). Each faculty member’s Z_{rel} scores thus have an overall mean of 0.0 and SD of 1 for each CA-year. All Z_{rel} scores for all residents were averaged (N = 13,639 evaluations), and the grand mean was 0.00000 with SD of 0.98623.
Because there is significant "noise" in each Zrel score, any signal averaging reveals a reliable clinical performance score from a noisy background. The first 100 sequential Zrel scores yield a running average with a tighter nominal 95% CI as more signals (Zrel scores) are averaged. A histogram of Z-scores for this individual shows how Z-scores are distributed about the mean (fig. 4B).

Signal Averaging Reveals Reliable Performance Scores

Because there is significant "noise" in each Zrel score, any single Zrel score will not provide a dependable assessment of resident clinical performance. However, averaging noisy signals will cause accumulation of the real signal while averaging out the noise component. Figure 4A demonstrates how sequential Zrel scores yield a running average with a tighter and tighter nominal 95% CI as more signals (Zrel scores) are averaged. A histogram of Z-scores for this individual shows how Z-scores are distributed about the mean (fig. 4B).

Average Zrel Scores Determine Resident Performance as Well as a Sophisticated LMM

Average Zrel scores and associated CIs do not take into account the repeated measures inherent in scoring the same resident on two or more occasions or scoring multiple residents by the same rater. To determine whether repeated measures were altering the estimates of resident clinical performance, average Zrel scores (based on 20 or more samples) were compared with performance estimates determined using relative-to-peers data in a LMM. Zrel scores provided a performance metric that was nearly identical to one determined using a LMM (r = 0.96, r² = 0.92, N = 107 residents, P < 0.001). The ratio of the resident variance component to residual variation was 27%. Thus, the repeated measures are not fully independent, and the CIs determined by simple averaging of Zrel scores will be narrower when repeated measures are included. The magnitude of this effect was determined by comparing CIs deter-
minded using $Z_{rel}$ scores to those determined by the LMM. On average, the 95% CIs were 17.7% wider when determined using the LMM than when determined using $Z_{rel}$ scores ($N = 107$ resident’s 95% CIs, $P < 0.001$ by paired t test). The variance in the 95% CI was also higher when determined using the LMM (variance in $Z_{rel,score}$ 95% CI = 0.0016, variance in LMM 95% CI = 0.0031, $P < 0.001$ by F test).

There Is More Certainty in Determining Below-average Performances

When the SD of $Z_{rel}$ is small, it indicates lower variation in the underlying $Z_{rel}$ scores used to determine the mean. This leads to more certainty in the average score. When the SD of each resident’s mean $Z_{rel}$ score was regressed against the mean $Z_{rel}$ score for the 107 residents with 20 or more $Z_{rel}$ scores, the regression showed that the lower the $Z_{rel}$, the lower the SD ($r = 0.60$, $r^2 = 0.37$, $N = 107$ residents, $P < 0.001$). Thus, there is less variation in individual $Z_{rel}$ scores for the lowest-performing residents than for the highest-performing residents. The number of evaluations submitted each month per resident did not differ between residents whose mean $Z_{rel}$ was above 0 (9.88 evaluations per month, $N = 543$ resident-months) and those whose mean $Z_{rel}$ was below 0 (9.98 evaluations per month, $N = 696$ resident-months) (unpaired t test, $P = 0.67$).

$Z_{rel}$ Scores Are Stable When No Performance Interventions Occur

The temporal stability of each resident’s $Z_{rel}$ score was assessed by comparing his or her average $Z_{rel}$ score during one 6-month period with the average $Z_{rel}$ score 1 yr later during another 6-month period. All resident’s having 15 or more evaluations during both 6-month periods (Period 1: October 1, 2008–March 31, 2009, Period 2: October 1, 2009–March 31, 2010) and who did not receive a performance intervention from the CCC were included. Forty-seven residents met these inclusion criteria. There was a strong relationship between the $Z_{rel}$ scores from Period 1 and subsequent $Z_{rel}$ scores from Period 2 ($r = 0.75$, $r^2 = 0.56$, $N = 47$ residents, $P < 0.001$, fig. 6). When the single outlier resident was removed, the relationship was strengthened ($r = 0.81$, $r^2 = 0.71$, $N = 46$ residents, $P < 0.001$).

$Z_{rel}$ Scores for Medical Knowledge Are Related to an Independent Metric of Medical Knowledge: The American Society of Anesthesiologists/American Board of Anesthesiology ITE

$Z_{rel}$ scores based solely on the core competency of Medical Knowledge ($Z_{rel, MK}$) were compared with the American Society of Anesthesiologists/American Board of Anesthesiology ITE examination. There were three cohorts of residents having both $Z_{rel, MK}$ scores and same-year ITE $Z$-scores ($Z_{ITE}$) (see Methods). The 2008 ITE was held in July. The 2009 and 2010 ITEs were held in March. The average $Z_{rel, MK}$ score for each resident was determined using evaluations submitted in the months after the exam (March through June). For each cohort, faculty member reference data were determined using their scores from the corresponding academic year (July–June). The 2008, 2009, and 2010 $Z_{rel, MK}$ scores were significantly correlated to the independently determined $Z_{ITE}$ scores for each year examined (2008: $r = 0.38$, $r^2 = 0.14$, $N = 71$ residents, $P = 0.001$; 2009: $r = 0.33$, $r^2 = 0.12$, $N = 76$ residents, $P = 0.002$; 2010: $r = 0.30$, $r^2 = 0.09$, $N = 69$ residents, $P = 0.01$).

$Z_{rel}$ Scores Independently Predict Referral to the CCC

Before the implementation of the new evaluation system, a number of residents had been referred to the CCC. The process leading to referral was multifactorial and included verbal communication, concerning written rotation evaluations, and electronic mail messages describing concerning performance. Once the $Z_{rel}$ score system was functional, the system was used to see if it would identify residents who had been independently referred to the CCC. Residents with a $Z_{rel}$ score greater than 0 were infrequently referred to the CCC (1 referred and 36 not). Residents with a $Z_{rel}$ score of 0 or less were more often referred to the CCC (19 referred and 25 not). A $Z_{rel}$ score of 0 or less was associated with an odds ratio of 27 in favor of being referred to the CCC ($P < 0.001$, two-tailed, chi-square with Yates’ correction).

$Z_{rel}$ Scores Predict CCC Flag Density of Below-average Performers

The evaluation form has five questions from the CCC that raise concern if answered “yes.” CCC flag density is the fraction of evaluations having any of the CCC questions answered yes. For residents whose mean $Z_{rel}$ score was less than 0, there was a strong inverse relationship between $Z_{rel}$ score and CCC flag density ($r = 0.90$, $r^2 = 0.82$, $N = 57$ residents, $P < 0.001$). For residents whose mean $Z_{rel}$ score was 0
Fig. 7. Confidence increases as residency progresses. The mean maximum confidence (defined as the most advanced case the faculty has confidence in having the resident perform in an unsupervised fashion) is shown for all residents for all 36 months of residency (N = 5,006 evaluations). Confidence rises throughout residency but rises fastest during the first 12 months. The Y axis spans the case complexity used in the evaluation form: case 1 is relatively easy and case 8 is extremely challenging. Error bars are the 95% CI on the mean.

or greater, there was no relationship between Z_{rel} score and CCC flag density (r = 0.24, r^2 = 0.06, N = 51 residents, P = 0.10).

**Faculty Confidence in Having Residents Provide Unsupervised Care Increases as Residency Progresses**

Faculty members provide a measure of their confidence in having the resident independently perform a series of eight cases of increasing difficulty. Of the evaluations completed, 5,006 had scores allowing a meaningful measure of when confidence was lost (see Methods). Confidence increased as months in residency increased (fig. 7). Confidence increased most rapidly during the first year of residency (slope = 0.25 cases/month, r = 0.39, r^2 = 0.15, N = 1,941 evaluations, P < 0.001) and slowed during the second year (slope = 0.09 cases/month, r = 0.16, r^2 = 0.03, N = 1,421 evaluations, P < 0.001) and third year (slope = 0.12 cases/month, r = 0.27, r^2 = 0.07, N = 1,644 evaluations, P < 0.001) of residency. The rate of increase in confidence was significantly higher during the first year of residency compared with either the second (P < 0.001, Z-test statistic) or third year (P < 0.001, Z-test statistic) of residency. The rate of increase was not different between the second and third years of residency (P = 0.088, Z-test statistic).

**Confidence Scores Increase More than Relative Scores as Residents Become More Senior**

Faculty members score residents increasingly above average as residents become more senior, although this is normatively impossible. If confidence scores rise disproportionately more than relative scores, this implies a real increase in actual performance and not just an increase in bias. Scores from evaluations containing both confidence and relative-to-peers data were normalized by their respective scale ranges such that 0.0 and 1.0 were the lowest and highest scores attainable. As residents progressed through residency, their normalized relative-to-peers scores increased (slope = 0.0044 normalized units/month, N = 4,982 evaluations, P < 0.001), as did their normalized confidence scores (slope = 0.018 normalized units/month, N = 4,982 evaluations, P < 0.001). The overall rate of increase was 4.0 times faster for the confidence data than for the relative-to-peers data (P < 0.001, Z-test statistic). Figure 8 shows the differential growth in normalized confidence scores compared with normalized relative-to-peers scores as residency proceeds.

A **Performance Intervention Can Significantly Improve Z_{rel} Scores**

Before this new system was used, a resident was referred to the program director using customary mechanisms. This resulted in an intervention in which performance issues were defined, written expectations were set forth, and consequences were defined. The program director, chair of the department, chair of the CCC, resident, and resident’s mentor knew of the intervention. The faculty was otherwise unaware of the intervention. When the Z_{rel} score system became functional, previously collected data revealed that the faculty had independently assigned below-average Z_{rel} scores to this resident in the time leading up to the intervention (Z_{rel} = -0.47, upper bound on 95% CI did not include 0). The resident’s Z_{rel} score increased significantly after the intervention (Z_{rel} = 0.12, 95% CI included 0, P = 0.003, unpaired Z-test). Figure 9 shows the Z_{rel} scores by month before and after the intervention. A second situation occurred after the Z_{rel} score system was in use. The CCC detected a resident with very low Z_{rel} scores, and a confidential educational intervention occurred. This included a written statement of specific concerns and expectations for improvement. The resident’s Z_{rel} score for the 6 months leading up to
Table 1. Features of the Clinical Performance Evaluation System

- Direct observation of clinical performance
- Broad systematic sampling
- Multiple raters
- ACGME core competency framework
- Separation of formative feedback and evaluative numbers
- Encourages weekly evaluation
- Occurs in a naturalistic setting with relatively unobtrusive observation
- Corrects for grade inflation (bias) and differential grade range use
- Relates to high stakes medical knowledge tests (ITE) and referral to a CCC
- Uses only five or seven rating choices per item
- Specifies meaning of ratings

ACGME = Accreditation Council for Graduate Medical Education; CCC = clinical competency committee; ITE = In-Training Examination.

Z-scores Correct for Biases

The relative-to-peers component of the evaluation system asks faculty members to score a resident’s performance relative to his or her peer group (same CA-year within the same residency) for each competency. Nearly every faculty member provided scores that were well above average (fig. 1). This bias was exaggerated when faculty members evaluated more senior residents. The finding that normative scores are inflated into the “above average” range is an example of the “Lake Wobegon” effect, which is not unique to physicians. Because of the unique use patterns by each faculty member, it became apparent that a normalization process was needed to recenter the scores and adjust for differing score range use. Z-scores accomplish both of these requirements. In addition, because bias increased with CA-year, faculty scores were normalized for each CA-year. The
Z-score transformation reduces the amount of construct-irrelevant variance in the data. Z-scores can be averaged and compared in units of SD. The Z-score transformed data behave as expected with a grand mean of 0 and a SD of nearly 1.

A Single Z_rel Score Has Only a Small Amount of Clinical Performance ‘Truth’ Associated with It

A key finding of this study was the low correlation between first and second Z_rel scores when a faculty member evaluated the same resident on two occasions (fig. 3). This indicates at most a modest halo effect because faculty member scores differ significantly between subsequent evaluations of the same resident. Overall, approximately 23% of the second performance score can be explained by the first performance score. This small component likely contains the actual performance measure. This leaves 77% of the score as noise or unexplained variance. The low correlation between first and second Z_rel scores may be partly attributable to the differences in the situations leading to each Z_rel score. Clinical performance is highly affected by the circumstances of the event. This concept is known as “context specificity” and explains why performance on one OSCE station predicts only a modest amount of the performance on the exact same OSCE station when using a different standardized patient. Essentially, people fail to adequately consider the role of the situation in determining behavior and performance.

Signal Averaging Is the Key to Determining Clinical Performance

Noisy signals such as Z_rel scores are well handled by signal averaging, which reduces the noise and reveals the signal. Figures A and B display significant variation in Z_rel scores but a running average that converges on a “true” Z_rel score with a small error signal. This allows an estimate of overall relative performance to emerge from the noise. Because of repeated measures, the Z_rel score CIs of below-average performers typically reach statistical significance with a smaller number of evaluations than if an LMM had been used. Thus, the Z-score system will detect low performers sooner and enable educators to get them the help they need.

Do Z-scores Really Provide a Measure of Clinical Performance?

There are four lines of evidence supporting Z_rel scores as a measure of actual clinical performance. First, Z_rel scores determined using just the scores for medical knowledge (Z_rel,MK) were related to an independent determination of medical knowledge. The strength of the relationship indicates that Z_rel,MK scores explain approximately 10–15% of the variance in ITE scores. Second, the likelihood of being referred to the CCC was independently related to mean Z_rel scores. Residents with a Z_rel score of 0 or less were referred to the CCC with an odds ratio of 27. The author’s CCC now uses Z_rel scores to detect low performers. Third, as residents progress through residency, the normalized confidence scores increased 4.0 times faster than the normalized relative scores (fig. 8). If scores were simply related to progressive bias or construct-irrelevant variance, the ratio of normalized confidence to normalized relative scores would remain constant. Fourth, CCC flag density, an independent measure of concern with clinical performance, is strongly related to lower Z_rel scores.

The finding that residents with higher average Z_rel scores have more variance in their Z_rel scores is intriguing. One explanation may be that it is difficult to consistently deliver an above-average performance, and this may add variance to their scores. It is also possible that the faculty have more agreement on what constitutes poor performance than what constitutes excellent performance.

Why Are Z_rel,MK Scores Only Slightly Related to ITE Scores?

A modest but real relationship was found between the Z_rel score assessment of medical knowledge and the ITE-based assessment of medical knowledge. Faculty members are unaware of residents’ ITE scores except for those few that they mentor, so the correlation is not caused by the faculty’s knowledge of residents’ ITE scores. Although United States Medical Licensing Examination scores predict future standardized test results, such as ITEs, they are poorly related to all related to clinical performance. Even when the medical knowledge being tested is related to the actual clinical scenario of an OSCE, it hardly predicts performance on that OSCE. Thus, weak correlations between Z_rel,MK and ITE scores are expected and may be attributable to a number of factors. Faculty members may not actively probe residents to determine the true extent of their medical knowledge. Furthermore, when residents and faculty members interact, they are using practical or applied medical knowledge, as opposed to the theoretical medical knowledge tested by standardized examinations. Most medical decisions in natural settings have significant amounts of uncertainty, are prone to bias and cognitive errors, and require significant amounts of judgment. This is in sharp contrast to ITE questions, which have only one correct answer. There is a significant amount of research showing that cognitive ability (intelligence) is poorly or not related to the ability to avoid biased thinking. Thus, the Z_rel assessment of medical knowledge may be an excellent proxy for day-to-day clinical decision-making and serve as a metric for what residents do in practice, an important measure.

Z-scores Are Stable Unless the Resident Is Coached onto a New Plane of Performance

The stability of Z_rel scores over the course of 1 yr is significant (fig. 6). The mean Z_rel score from the first time period explained 56% of the variance in the mean Z_rel score 1 yr later, indicating that scores generally are stable. Recent studies indicate that certain personality traits are related to better and
worse clinical performance.\textsuperscript{37,48} If this is true, stability in relative clinical performance can be explained partially by the general stability of personality traits.\textsuperscript{49}

**Z-scores Change When a Resident’s Performance Changes**

If clinical performance is not malleable, there is little reason to provide feedback. This article provides two clear examples of clinical performance improvement associated with a feedback intervention. There are three important features found in these examples (see fig. 9 for one example). First, the $Z_{rel}$ score system independently identified the resident. Second, the resident’s $Z_{rel}$ scores increased after the intervention without the faculty being aware of the intervention. This indicates that the faculty view performance for what it is and do not allow previous reputation to taint significantly the evaluation process. Third, it associates feedback and an educational intervention with improved clinical performance, a key role of residency.\textsuperscript{50} It is likely that the evaluation system served to identify a performance problem and track its improvement. The educational interventions, in conjunction with developmental feedback, are what likely caused the performance improvement.

**Is There a Particular Score Defining Adequate Performance?**

When the residents have average $Z_{rel}$ scores of less than approximately $-0.3$ and the 95\% CI does not include 0 (\textit{i.e.}, their performance is reliably below average), the author’s CCC carefully examines the corresponding comments to determine the nature of the low performance. It has been found that there are many routes to low performance, including poor medical knowledge, low effort, unprofessional behavior, interpersonal and communication difficulties, poor motivation to improve, confidence in excess of competence, defensiveness, anxiety, low confidence, poor decision-making, and so forth. The comments are used to help develop educational interventions that target the area in need of improvement. Residents exhibiting noncognitive and nontechnical causes of low performance (such as low motivation for learning, defensiveness, anxiety, and so forth) are readily identified using this system. However, the underlying causes sometimes can be difficult to identify. The comments section usually provides strong hints to the cause but not always. In situations in which the precise noncognitive cause for low performance cannot be identified, outside learning specialists, psychiatrists, cognitive behavioral therapists, and personal coaches have been used. The results usually have been quite rewarding. Additional information is limited to protect the privacy of individual residents.

The ACGME has reframed residency training to focus on outcomes instead of process.\textsuperscript{32} Despite this call, there are few outcomes that independently measure competency and fewer still that measure performance. Unfortunately, even when OSCEs or other highly reliable metrics are used to determine clinical competency, there is only a weak relationship with actual clinical performance.\textsuperscript{21,26,51} This indicates the need for more naturalistic measures of performance,\textsuperscript{2,5,28,52–55} such as the one described in this article. Once clinical performance becomes measurable, there remains the task of standard setting. Standard setting is largely context sensitive; for example, a physician deemed acceptable by today’s standards may not be considered acceptable by future standards. Thus, normative standards still have an important role in determining adequacy of performance.\textsuperscript{31,56}

**Limitations of the Study**

This study is limited by its inability to establish absolute performance levels. However, the relationship between relative and absolute performance appears to be real based on the ability of $Z_{rel}$ scores to predict ITE scores and CCC referrals. $Z_{rel}$ scores assume normally distributed data, and faculty member scores may not always be normally distributed. Individual $Z_{rel}$ scores contain only a modest signal, so large sample sizes are required to attain reliable measures of clinical performance. The $Z_{rel}$ system does not take into account repeated measures; however, using an LMM to correct for repeated measures did not significantly affect the estimates of clinical performance. Importantly, averaging $Z_{rel}$ scores typically results in more narrow CIs than those determined using an LMM. This may result in earlier detection of poor performance. The LMM is an excellent tool but does not easily lend itself to practical use. The current study is receiving approximately one half of the evaluations requested. This means there is a risk of a sampling error. Many different faculty members contribute to each resident’s $Z_{rel}$ score, so it is unlikely that the error is large. Another limitation is the delay in requesting an evaluation. The delay is, on average, one half a week but can be as short as 1 day or as long as 1 week, depending on when during the previous week the interaction occurred. A more concerning delay occurs when faculty members delay completing the evaluation. This can amount to many weeks or even months. Currently, outstanding evaluations are deleted after 3 months.

This study demonstrates that when faculty members evaluate resident clinical performance in a naturalistic setting that encompasses a variety of clinical situations, they assign scores that suffer from significant grade inflation and varying degrees of grade-range usage. The unique grading characteristics of each faculty member were used to normalize the scores that each faculty member assigned. Resulting single $Z_{rel}$ scores were shown to contain a modest amount of true clinical performance information. The low information content of single scores was largely circumvented by averaging many independent scores to arrive at a metric that was related to clinical performance measures, including referral to the CCC, medical knowledge scores (ITE scores), and growth in faculty confidence in allowing residents to undertake independent and unsupervised care of increasingly complex patients. The strength of the system is its ability to average out
irrelevant variance, which leaves a useful metric of clinical performance. The metric was stable over time. Although the metric is normalized and thus does not measure absolute clinical performance, it is able to detect poor clinical performance, which faculty members, in aggregate, appear to agree upon. When mean $Z_{rel}$ scores are less than approximately $-0.5$, it signals the need to look into the cause(s) of the poor performance, and the comments section can help identify what can be done to improve performance. Two exemplar residents with low clinical performance scores each received an educational intervention based on the information contained in the comments sections, and both experienced significant improvement in performance after the intervention.

The author thanks the faculty members who spent time and effort evaluating residents and extends a special thanks to those who wrote comments aimed at improving resident performance. The author also thanks Eric A. Macklin, Ph.D. (Instructor, Harvard Medical School, Assistant in Biostatics, Department of Medicine, Massachusetts General Hospital, Boston, Massachusetts), for statistical advice.

References

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Appendix

WEB-BASED RESIDENT EVALUATION
GENERAL FORM
RESIDENT EVALUATION BY STAFF

Evaluator:  Subject:
Status: Rotation: Employer:

DATE OF THIS EVALUATION:

EVALUATION DESIGNATIONS

ABSOLUTE/ANCHORED COMPETENCY DESIGNATION

A competent physician (rating of 5, 6 or 7) performs independently in a fashion that is consistent with the standard of care in the United States today. Ratings of 5, 6 or 7 imply that a resident does not require attending supervision. Thus, ratings of 5, 6 or 7 imply that the resident is ready to leave the residency.

1 = needed significant attending assistance, input or correction
2 = needed moderate attending assistance, input or correction
3 = needed only minimal assistance, input or correction (emerging as competent)
4 = needed very infrequent assistance, input or correction (emerging as competent)
5 = performed in a fully independent manner, did not need any faculty, input or correction
6 = able to serve as a consultant to other physicians, able to defend all actions and decisions
7 = expert and able to serve as a resource to fully trained anesthesiologists
N/A = Not able to evaluate resident on this competency

RELATIVE PERFORMANCE DESIGNATION

This designation normalizes the resident's performance to other Massachusetts General Hospital residents who are at the same level of training.

1 = distinctly below peer level
2 = somewhat below peer level
3 = at peer level (most residents should be at this level)
4 = somewhat above peer level
5 = distinctly above peer level
N/A = Not able to evaluate resident on this competency

Sample items to consider for each Core Competency:

Medical Knowledge
Knows mechanism of actions of induction drugs, including primary side effects
Knows indications and complications of various monitoring devices
Knows physiology of pertinent organs systems
Knows medical diseases and implications for anesthetic plan

Patient Care
Designs and defends anesthetic plan
Shows appropriate vigilance, judgment and decision-making for perioperative events, including procedures
Develops contingency plans for foreseen and unforeseen outcomes

Practice-Based Learning
Carries out post-operative checks with the intent to learn how to improve the care for subsequent patients
Critically examines decisions and actions for optimal performance
Uses evidence-based medicine to the extent available

Professionalism
Is fully prepared in the mornings
Acts in a manner consistent with a medical professional
Takes timely breaks
Demonstrates a good work ethic
Is aware of and attends to the goals and objective for the rotation
Carries out tasks that may not have direct personal gain (pre-ops for a colleague)

Interpersonal & Communication Skills
Interacts with patients and perioperative personnel in a caring and thoughtful fashion
Explains and defends decisions in a defensible and understandable form
Writes complete and insightful preoperative notes
Consults surgeons and attending anesthesiologist in a functional time frame

Anesthesiology 2011; 115:862–78

Keith Baker

Downloaded From: http://anesthesiology.pubs.asahq.org/pdftoaccess.ashx?url=data/journals/jasa/931108/ on 01/12/2019
**Systems-Based Practice**
Recognizes and acts in a manner that acknowledges that they are part of a larger system and that patient care is based on this system. Caring for waitlist cases with a positive attitude is a manifestation of this understanding.
Recognizes ways to improve the system, even if it does not pertain to their case
Recognizes and follows HIPAA regulations
Recognizes and appropriately interfaces with infection control issues
Prepares cases for case conference and QA processes when appropriate

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<tr>
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**Comments**

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**What are particular strengths of this resident?**

**Comments**

Remaining Characters: 5000

**Residents want to know how they can improve. Note specific areas or items that this resident should focus on improving:**

**Comments**

Remaining Characters: 5000

### Clinical Competency Evaluation:

This information is available to the Competency Committee. If you answer 'Yes' to any questions, PLEASE add a comment.

When working with this resident, I have concerns regarding patient safety:

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I have concerns regarding this resident's honesty, ethics or character

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I am concerned that this resident lags behind peers or may need extra help

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I have concerns about this resident as a team player

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I have concerns about this resident's openness to teaching and improvement

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**Comments**

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Do you have confidence that this resident can perform the following cases in an independent and unsupervised setting?

**MAC for skin biopsy (healthy patient)**
- Yes
- No
- N/A

**GA with an LMA for Knee arthroscopy (healthy patient)**
- Yes
- No
- N/A

**Appendectomy (full stomach, otherwise healthy)**
- Yes
- No
- N/A

**Ex Lap for perforated viscus (otherwise healthy)**
- Yes
- No
- N/A

**Elective colectomy with coronary artery disease and chronic renal insufficiency**
- Yes
- No
- N/A

**Elective craniotomy with increased Intracranial Pressure and asthma**
- Yes
- No
- N/A

**Blunt trauma including head injury and liver injury**
- Yes
- No
- N/A

**Leaking abdominal aortic aneurysm with decompensated congestive heart failure and acute atrial fibrillation**
- Yes
- No
- N/A

Have you reviewed this evaluation with the resident?
- Yes
- No
- N/A

Please alert Program Director and Preceptor to this evaluation.
- Yes
- No
- N/A