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Article abstract

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This article explores a direct-observation simulation swapping resident and consultant roles as a measure to assess competence during the final "transition to practice" phase of residency. As indicated by the Royal College, assessment of competency in this stage should include direct observation; however, this is challenging to implement, both from the perspective of a busy clinical environment, but also logistically, as a final-stage resident is still a learner in a consultant clinic. Our suggested approach allows for both real-world experience for the resident as well as direct observation and assessment by the consultant, thus providing the resident with targeted, actionable feedback, as well as ensuring the final-stage resident is competent for practice.

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Une vraie transition vers la pratique : une simulation de rôles inversés

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Énoncé des implications de la recherche

Cet article explore une simulation utilisant l'observation directe et où les rôles de résident et de consultant sont inversés comme moyen d'évaluation des compétences durant l'étape finale de la résidence, la « transition vers la pratique ». Le Collège royal indique qu'à ce stade, l'observation directe doit faire partie de l'évaluation des compétences; or, cette modalité d'évaluation est difficile à mettre en œuvre dans un environnement clinique animé et un contexte logistique où le résident est encore un apprenant dans une clinique de consultants. L'approche que nous proposons permet à la fois au résident d'acquérir une situation réelle et au consultant de faire une observation directe pour l'évaluation, et d'offrir une rétroaction ciblée et utile, tout en s'assurant que le résident en fin de parcours a les compétences requises pour pratiquer.

"Hi, I'm Fred. I'm the PGY-1 resident assigned to your clinic today. I've read about Mrs Smith, are you okay if I go see her now?"
"Of course, please see her and then discuss your plan with me!"
"Okay! So…I can go?"
"Yes!"
"I'm okay to go see her just like I am right now?"
"Yes….?"
"HANG ON – would you really let your resident dress like this?!"

What started out as a routine conversation between a resident and consultant seems to have taken quite a turn. As the "resident" points out flaws in management to the "consultant," their roles appear in fact reversed, a direct contraindication to the usual feedback flow. What is happening here?

The answer: a real-world simulation aimed at deliberately observing an oncology resident running a busy outpatient practice while teaching trainees. This is a task current competency-based medical education (CBME) curricula do not deliberately address, despite the expected presence of trainees in one's future academic practice. Indeed, residents may lack confidence about their abilities to function independently as they approach consultancy, and incorporating teaching as newly-minted consultant adds yet another challenge to this transition.[4]

The final stage in the "competency by design" (CBD) CBME curriculum is "transition to practice" (TTP), which entails a resident close to independent practice demonstrating the skills needed to function as consultant.[1] The assessment of this competency is indicated by the medical oncology TTP EPAs laid out by the Royal College;[3] however, finding

opportunities for direct observation of a resident in a consultant's role can be challenging.

Consequently, we attempted a "real-world" TTP simulation, with a senior resident running a consultant clinic, while the consultant simultaneously adopted a resident role. The specific EPA used was "managing an outpatient practice," to which was added "supervise/teach a trainee." Simulation is acknowledged as an excellent learning tool in healthcare settings;[5] this real-time simulation allowed for direct observation of a resident running an oncology outpatient clinic.

The simulation was conducted over four weeks. Working in the clinic were an oncology nurse, general practitioner in oncology (GPO), senior oncology consultant, and senior resident (n = 1) in the TTP stage, which presented an excellent landscape to observe "competing demands" that might not be present in a resident-led clinic or exam situation. The nurse and GPO maintained their roles towards the newly-minted "consultant," while, the consultant-turned-resident waited to be assigned patients to see and "review" with the resident-turned-consultant.

The simulation differed in several key ways from other ways to assess TTP. The primary TTP assessment method in medical oncology has been the resident-run longitudinal clinic; however, direct observation in these clinics is sporadic, whereas here the presence of the consultant allowed for more constant observation/feedback. Additionally, the presence of the consultant-turned-resident and other seasoned healthcare workers in their respective roles added a new dimension–namely, flexibility to enact more "real-world" scenarios during a designated time frame–as well as the ability to observe the resident's skill as a teacher/supervisor. Importantly, this represents an aspect of clinical medicine not formally taught under the current medical oncology EPA milestones.

The consultant-turned-resident (Fred) also decided to engage in several egregious errors and cultural *faux pas*. After requesting direction, he was presented with a chart and asked to review prior to assessing the patient, as would be expected for a trainee at his stage. However, after completing his case presentation, Fred asked, "Can I go in like this?" The resident-turned-consultant's tentative "…yes?" earned her a lecture (much to the amusement of several nurses) regarding how graphic sloth t-shirts are not appropriate clinic wear (Figure 1), and how a proper consultant should be able to direct wayward trainees.

Fred continued to exhibit problematic behaviours during the clinic. Perhaps most notable was the unwell patient he "discharged" with an inappropriate treatment plan he had already initiated, a situation exacerbated by a flippant rebuttal when the resident-turned-consultant suggested this might not have been the best approach. Her subsequent sharpness in directing Fred to bring the patient back actually took the consultant-turned-resident back to his resident days, as he forgot momentarily that this was a simulation, and that he was not *actually* in trouble!
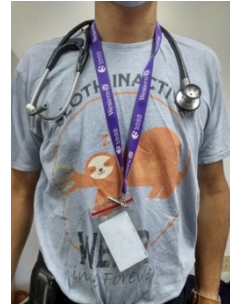

Figure 1. Sloth t-shirt
A visual example of inappropriate clinic wear.

During and after the simulation, both the consultant and resident reflected the experience had been valuable, and the resident was able to receive helpful, specific feedback she had not had previously in their training. She acknowledged the role-reversal felt natural, as though she was (finally) slipping into a role of a consultant and teacher. The consultant, in his own reflection, considered it somewhat challenging to simultaneously play a [difficult] trainee, contemplate his entrustment of the actual resident in a consultant role, and monitor the patient care being provided. There were moments when the role-reversal was so realistic that it was difficult to maintain these multiple levels of situational awareness.

Junior attending roles are uncommon in medical oncology training, particularly due to the nature of the outpatient work and longitudinal patient-consultant relationship; this simulation provides a way to assess a senior resident's readiness for academic practice. The (actual) consultant was able to assess the (actual) resident in real-time, and the resident was afforded the opportunity to practice/ receive feedback on clinic management and teaching skills.

If such simulation were to become a routine part of TTP teaching, perhaps there would be fewer new (and old) consultants struggling with, and unprepared for, the task of teaching while running a busy clinic–especially if their trainee presents dressed in a sloth t-shirt.

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