

# Opinion/Education: The ABPN is the neurology resident's best friend

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The American Board of Psychiatry and Neurology (ABPN) is in the midst of major changes in the way in which candidates are credentialed and evaluated for board certification. These changes will have a major impact on current residents-in-training. Such changes are largely driven by the desire of the ABPN to provide a certification process that is framed in fairness, validity, and reliability, and at the same time respects the problems inherent in psychologically and financially stressful oral examinations. It is essential that communication and dialogue among the ABPN, the program directors, and the residents remain a priority. The following discussion summarizes ongoing changes with regard to ABPN certification and attempts to articulate why these changes are good for the field and may be viewed with particular enthusiasm by residents-in-training.

**NEW LEADERSHIP** Dr. Larry Faulkner has assumed the role of Executive Vice-President of the ABPN. The ABPN is comprised of eight psychiatrists (the Psychiatry Council) and eight neurologists (the Neurology Council). Dr. Faulkner served for 8 years as a Director in Psychiatry for the ABPN, and during that time he developed close ties with the Neurology Council. Prior to assuming the leadership position with the ABPN, he was Dean of the University of South Carolina School of Medicine, and he is familiar with most aspects of academic medicine, including those related to residency training. Dr. Faulkner brings to the ABPN energy, insight, and an understanding of a great deal of practical organization. Dr. Michael Johnston is the 2007 Chair of the Neurology Council of the ABPN. He is in the final year of an 8-year term serving as a Neurology Director of the ABPN. Filling out the ranks of neurologists in order of seniority as Directors on the Board are Patricia Coyle (who becomes Chair in 2008), Bob Pascuzzi, Steven DeKosky, Michael Aminoff, Janice Massey, Patricia Crumrine, and Ralph Jozefowicz.

**Why is this good for the resident?** Drs. Faulkner, Johnston, and colleagues have been passionate advocates for our profession, are all very good listeners, and are committed to leading the ABPN in a direction that best serves neurologists and their patients. They are particularly sensitive to the views and well-being of our residents. They want to hear from you. They will act with your best interests in mind. Go see them and the other Neurology Directors at the ABPN resident session during the AAN spring meeting. The ABPN also maintains an information booth at the AAN and ANA meetings and residents can obtain information and contact the ABPN at [www.abpn.com](http://www.abpn.com).

**PART I ABPN EXAMINATION IS NOW COMPUTERIZED** As of 2005, the part 1 examination has become a computer-based examination given at Pearson test centers.

**Why is this good for the resident?** As there are hundreds of test centers around the country the candidates will find the process to be much more convenient. For most candidates it should be a net cost savings; in the past many residents had to travel to distant towns to take the "written" examination. Computerization will also allow more rapid scoring and subsequent feedback to the candidates. The computer also opens up the opportunity for future examinations to directly test more clinically relevant skills, such as videos of movement disorders, seizures, eye findings, gait disorders, and patient histories.

**THE CLINICAL SKILLS EVALUATION HAS MOVED INTO THE RESIDENCY TRAINING PROGRAM** The new method of clinical skills evaluation is required for current neurology and child neurology residents in training as a prerequisite for board certification. The formal wording from the ABPN is as follows:

Effective for residents entering residency training in neurology (PG-2) or child neurology (PG-3) as

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of July 1, 2005, documentation of satisfactory performance in the evaluation of clinical skills will be required as part of the credentialing process for ABPN certification. Neurology or child neurology residents entering residency training prior to July 1, 2005, must utilize the current certification process and will have up to February 1, 2013, to complete this process. Candidates who do not meet this deadline will be required to complete a minimum of five clinical skills evaluations.

For neurology residents, three of the evaluations should be completed no later than the PG-3 year, and all five of the evaluations should be completed no later than the PG-4 year. For child neurology residents, three of the evaluations should be completed no later than the PG-4 year, and all five of the evaluations should be completed no later than the PG-5 year.

At the request of the neurology program directors, in 2005 the ABPN created tools to assist with the documentation of clinical skills evaluations. The Neurology Clinical Examination Exercise (CEX) has been named the Neurology Examination Exercise or NEX. These forms can be downloaded from the ABPN Web site. Two forms/tools have been developed and approved by ABPN following substantial input and discussions from the field. The ABPN has no preference for one tool over the other. Instructions and orientation for evaluators have been developed by ABPN and posted on the ABPN website. The ABPN recognizes that some programs may already have an assessment tool and methodology that meets or exceeds all of the criteria of the ABPN. Programs with equivalent forms/tools for clinical skills evaluation may submit their forms to the ABPN for approval.

**Practical issues for residents.** 1) You need to get these completed if you entered residency training in neurology (PG-2) or child neurology (PG-3) on or after July 1, 2005. At Indiana University, we provide the residents with copies of the evaluation forms and the outline for how many need to be completed and by when. We have encouraged the residents to take ownership of getting these encounters observed. The residents will request that their staff observe an encounter and hand them the form. My suggestion is for the resident to encourage their faculty members to watch them evaluate patients every month.

2) Do not wait until the end of the year. Even if you are observed and have an inadequate performance you will get feedback and learn from it and then will be better prepared to pass these encounters on subsequent attempts.

3) If residents are capable and competent there is no reason why they should not have some of

these clinical encounters observed and critiqued in the first year of neurology training.

4) Remember: this is a prerequisite to sit for your ABPN Examination, just like having documentation of training in an approved training program with requirements as outlined by the ABPN.

5) A centralized tracking system is being established to provide documentation of these clinical skills evaluations to the board for credentialing purposes. Residents and Program Directors will be able to monitor the residents' progress.

**Why is this good for the resident?** 1) This exercise replaces the live patient hour of the ABPN Part II examination. Therefore, you will not have to pass an hour exam in which you evaluate a unique patient in an unfamiliar town in front of two examiners.

2) You also will find this to be a learning experience with feedback provided to you on your clinical skills by your faculty.

3) Furthermore, you will be evaluated in residency when it is more appropriate to establish competency with basic clinical skills. Basic flaws in history-taking, examination, formulation, and doctor-patient relationship will be recognized and corrected while still in clinical training. And instead of running the risk of failing during an ABPN oral examination, you will have the opportunity to learn from your experience in residency, and you can correct any shortcomings and be re-evaluated in another encounter.

4) You will be observed in a variety of clinical settings as opposed to a single clinical setting.

5) Studies have shown the reliability in having multiple patient encounters observed by multiple faculty members over time.

6) Clinical skills will be emphasized and evaluated more broadly in the residency period.

7) The tracking system will allow direct communication between the ABPN and residents, including updates on deadlines and policies.

#### **THE VIGNETTE SECTION OF THE EXAMINATION WILL CHANGE**

There are 2 hours of vignettes in the current Part II examination. These vignettes are in the process of being transitioned into computer-based questions and enhanced with photographs, scans, tracings, and videos, and in the future they will be tested at the same time as the Part I examination effective for residents entering residency training in neurology (PG-2) or child neurology (PG-3) as of July 1, 2005.

## IN ESSENCE, THERE WILL BE A SINGLE CERTIFYING EXAMINATION BEGINNING IN 2008

The Part I examination will then test basic neuroscience, psychiatry, and clinical neurology.

All residents completing training prior to June 2008 will follow the traditional pathway for ABPN certification. The current Part II examination will therefore remain available for as long as necessary in order to accommodate those entering training prior to July 1, 2005.

**Why is this good for the resident?** 1) The computer-based examination will be more standardized than the current vignette Part II hours. Everyone will get the same cases, the same environment, and there will no longer be unique "examiners."

2) The vignettes will be better: more realistic and relevant as they will include videos, photographs, and scans as opposed to the current format of written descriptive paragraphs.

3) The overall cost for candidates will decrease. The candidates will be taking one ABPN examination instead of two. Additionally, the travel expenses and time away from training or practice as is currently necessary for the Part II examination will disappear.

4) The stress and anxiety associated with the current oral examination will be eliminated.

### TIMING OF THE PART I EXAMINATION

With the movement last year of the Part I examination into a computer-based delivery system, the ABPN has more flexibility with regard to the timing of the examination. Currently, the examination is given in the fall and candidates are eligible to take the examination in October/November following completion of their training. The question of timing has been addressed in multiple circles. One proposal is to offer the examination at the end of residency (June of the final year of training). The ABPN simply would like to offer the examination at the time that is felt to be optimal for the field. While it would take some preparation and planning (perhaps several years) to transition to a different time from October/November, it is the case that if there is a consensus among candidates, program directors, fellowship directors, and other constituents, the ABPN would try to adjust the timing of the examination. I would advise the residents to study the pros and cons of the timing of Part I and search for a consensus. While there are many groups that will provide an opinion, the impact of the views of the residents should not be underestimated.

A number of points have been emphasized by program directors in favor of keeping the examination in the October/November time slot (following completion of residency training). Those points include the following:

1) If the examination is given in June of the final residency year it will force a shift away from patient care responsibilities and toward studying and preparation for the examination.

2) To pass the examination, one must not only complete training but also study for an additional segment of time (and it would be too difficult for candidates to prepare adequately with the shortened schedule).

3) To give the examination in June of the graduating year might be difficult for candidates who are in many cases planning moves to new locations and finishing up curricular requirements.

Points in favor of shifting the examination into June of the senior year of residency include the following:

1) It may lead to better use of the educational opportunities, conferences, reading, and courses offered during residency.

2) The examination would be given closer to the time of didactic core material.

3) The examination being given in the fall after completion of residency leads to a conflict with studies in fellowship or in general practice of neurology.

4) There is precedent for other specialties offering their cognitive knowledge-based examination during residency (neurosurgery and radiology, for example).

It should be noted that our colleagues in psychiatry are seriously considering a shift of their Part I examination to the end of residency. The topic remains worth our collective consideration and discussion. In addition to the program directors discussing the issues and developing a position of consensus we must also respect the views of the candidates (largely residents). Furthermore, fellowship training directors and practice groups (who are hiring new junior colleagues) should also have a voice.

**Why is this good for the resident?** Instead of doing something just because it has pretty much always been done that way we have an option to shape the future of our board certification process. The residents have been identified as a group whose opinion should count as much as any other in the decision-making process. The resident voice is desired and will be respected. This issue is of very practical importance for the residents.

We are in the midst of substantial changes in the ways in which clinical skills are assessed in residency and competency is established during the process of board certification. These changes will have a direct positive impact on the field and in particular on residents currently in training. Figuratively speaking, the ABPN has indeed become one of the neurology resident's best friends.

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