



ICU Competency Why, and importantly, how

Dr Todd Fraser
Chief Medical Officer, Osler Technology

A blurred photograph of a hospital hallway. In the foreground, two people in teal scrubs and a white lab coat are moving quickly, their figures blurred. The hallway extends into the distance with a white tiled floor, a drop ceiling with recessed lights, and yellow walls. Signs for 'ROOM OCCUPIED' and 'EXIT' are visible. On the right, a white sink is partially visible. A white circular overlay with a thin black border is positioned on the left side of the image, containing the text 'Case Example' in a bold, black, sans-serif font.

**Case
Example**



**What does
competency
actually
mean?**



Do you
trust me?



Do you trust me?

A PIECE OF MY MIND

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How Many Have You Done?

The young physician had just snapped on a pair of gloves and was selecting a needle from the equipment tray. My husband asked politely how many of these he'd done before.

"Five years' worth," the doctor said, his back to us. "That enough?" It wasn't exactly what we'd asked, but it sounded good. I was sure this implied several hundred at the very least.

The procedure about to happen was an amniocentesis, in which a small amount of amniotic fluid would be needed from my pregnant uterus and tested for various inherited diseases. My anxiety meter clicked down a notch when the needle didn't hurt, then crept back up when he couldn't find the right spot. No biggie. I drew in a long, slow breath. My husband and I are both physicians, and we understand that sometimes you need a second shot, even with the most basic procedures. But ten minutes later, the doctor was rooting around with a third needle, muttering and cursing to himself, sweat pouring down his face. When the nurse whispered nervously that he should try a little lower, I started to panic.

If this experienced physician couldn't nail the spot, were there any other options? It would be crazy to throw in the towel—I was over 35, so by definition this pregnancy was high risk—and I didn't want to take a chance.

The physician excused himself. My husband and I waited anxiously, my palm damp next to his. A moment later, a middle-aged woman in a white coat entered

visiting attending physician, and told us that it wasn't safe to attempt an amniocentesis more than three times in one day.

For a moment, we thought we'd heard wrong. The young physician had led us to believe that he was the attending physician with five solid years of experience. He had not shared that he was a fellow in training, nor did he tell us that he was counting what may have been just a handful of amniocenteses in this so-called five years of experience.

We felt bamboozled.

A week later, after I'd spent a couple of days on bed rest, the second physician performed an amniocentesis, easy as pie; the results were fine and the rest of the pregnancy uneventful. We wrote a letter to the head of the obstetrics/gynecology department and received an

apology of sorts for the fellow's misrepresentation. Our daughter is now 14 and healthy.

So why does this still bother me, all these years later? This was not lawsuit-level lying. There was no bad outcome. There was no medical error per se. But we were left with a lasting unpleasant feeling that the truth had been bent too far.

To be sure, the question my husband asked—"How many of these have you done?"—is dreaded by physicians-in-training everywhere. It's not easy to know how to present one's lack of experience in a way that won't send the patient scrambling from the room. In medical training, we teach our students effective ways to phrase sensitive questions: regarding, for example, sexual preference ("Do you have sex with women, men, or both?") and domestic violence ("Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?").

But there are few how-to manuals for physicians (or students, or fellows) on the receiving end of personal questions. We learn tricks to fend them off ("Are you married?" "Let's focus on you today, not me.") or boomerang them back ("What do you think about Ben Carson, Doc?" "Well, what do you think?") Questions like my husband's, however, are fair game and deserve a real answer.

There's a spectrum of ways to express the same truth: At one extreme, the version where the physician highlights his or her cluelessness and lack of experience: "Not only have I not done that many of these, but

the other, the cocky and overconfident hard twist of the truth of the young physician I met 14 years ago.

In between, there's Emily Dickinson. More than a century ago, she wrote, "The Truth must dazzle gradually/Or every man be blind"—and suggested telling all the truth, but telling it "slant." In medicine, this means expressing the truth gently and in a manner that inspires confidence and trust, with one's words chosen carefully and thoughtfully. Imagine if the young physician wielding the needle had said, "I am a fellow in training, I feel comfortable doing this without my attending, I'll explain each step and if I have any difficulty, the attending will take over. Are you comfortable with that?" That's still the truth, but it's a palatable truth.

Slant the truth in medicine excessively and it glares. Slant it just right and it glows.

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Do you trust me?

What if you needed me to perform a tracheostomy on you?





A woman with reddish-brown hair, wearing blue scrubs and blue gloves, stands in the foreground of a hospital room, looking directly at the camera with a slight smile. In the background, another healthcare worker in white scrubs and blue gloves is attending to a patient lying in a hospital bed. The room is filled with medical equipment and supplies, creating a professional and clinical atmosphere.

Defining mastery

The Rise of Entrustable
Professional Attributes

TABLE 2 | **GUIDELINES FOR FULL ENTRUSTABLE PROFESSIONAL ACTIVITIES DESCRIPTIONS**

1. Title	Make it short; avoid words related to proficiency or skill. Ask yourself: Can a trainee be scheduled to do this? Can an entrustment decision for unsupervised practice for this EPA be made and documented?
2. Description	To enhance universal clarity, include everything necessary to specify the following: What is included? What limitations apply? Limit the description to the actual activity. Avoid justifications of why the EPA is important, or references to knowledge and skills.
3. Required Knowledge, Skills, and Attitudes (KSAs)	Which competency domains apply? Which subcompetencies apply? Include only the most relevant ones. These links may serve to build observation and assessment methods.
4. Required KSAs	Which KSAs are necessary to execute the EPA? Formulate this in a way to set expectations. Refer to resources that reflect necessary or helpful standards (books, a skills course, etc).
5. Information to assess progress	Consider observations, products, monitoring of knowledge and skill, multisource feedback.
6. When is unsupervised practice expected?	Estimate when full entrustment for unsupervised practice is expected, acknowledging the flexible nature of this. Expectations of entrustment moments can shape an individual workplace curriculum.
7. Basis for formal entrustment decisions	How many times must the EPA be executed proficiently for unsupervised practice? Who will judge this? What does formal entrustment look like (documented, publicly announced)?

Greater supervision

Lesser supervision



Requires complete supervision	Partial supervision	Minimal supervision	Ready for independent practice	Aspirational/ ready to supervise
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Lesser entrustment

Greater entrustment



Aviation model

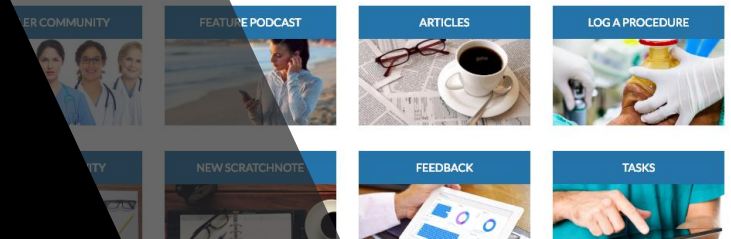
Currency
and recency
of practice



Where does Osler fit in?

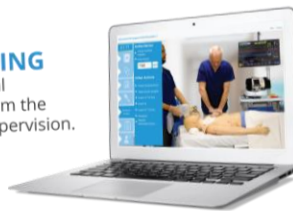


Welcome to Osler
Critical Care Edition



1 IMMERSIVE E-LEARNING

Designed to teach the essential information required to perform the skill for the first time under supervision.



5 REFRESH

Tailored refresher material allows users to maintain their certifications



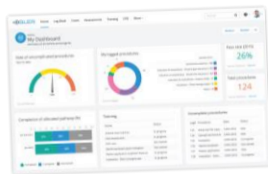
2 MOBILE ASSESSMENT FRAMEWORK

Evidence-based assessment checklists available at the bedside for supervisors to provide consistent assessment and immediate feedback.



3 CERTIFICATION

Visible and reportable certifications are issued when consistently practicing at independent standard.



4 MONITORING

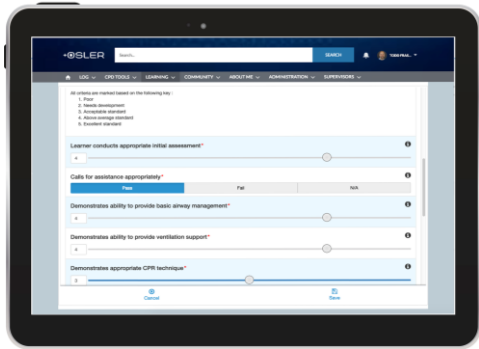
Sophisticated reporting tools track ongoing activity and outcomes, and allow global benchmarking.



Immersive e-Learning

Generates scaffold for clinical learning





Standardised Assessment Framework

Mobile enabled

Guest or known assessor

Encourages buy-in

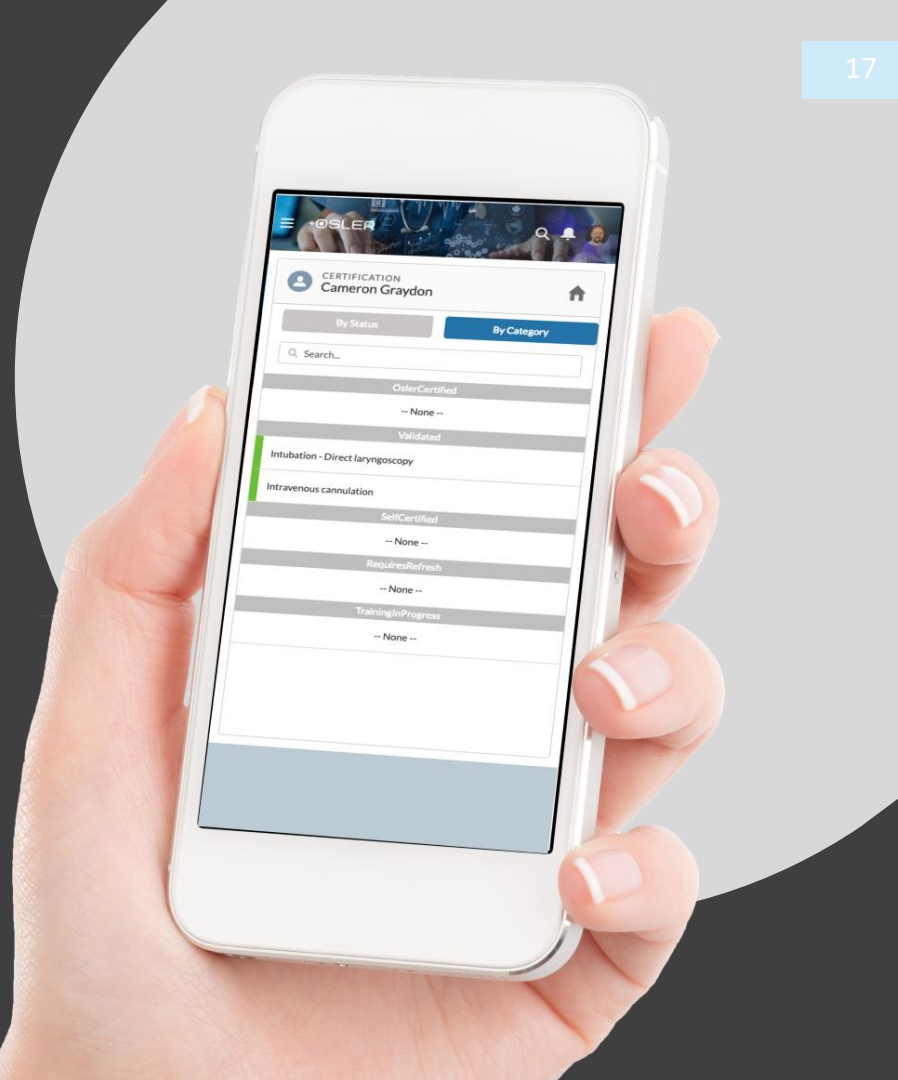
- From assessors

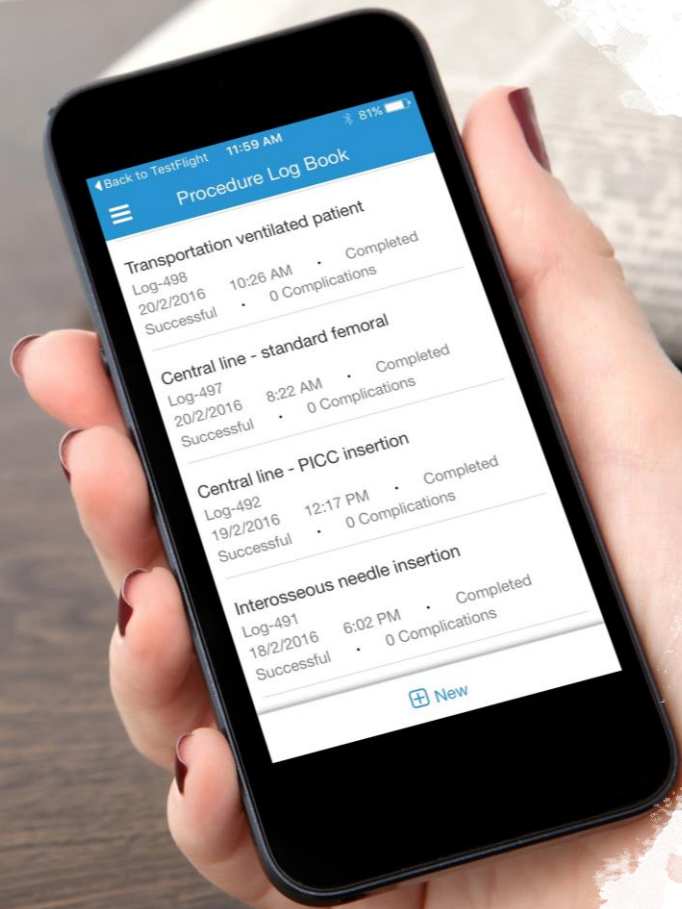
- From learners

Rich source of immediate feedback

Competency Portfolio

Objective, verifiable, portable record of training and experience





Back to TestFlight 11:59 AM 81%

Procedure Log Book

Transportation ventilated patient

Log-498
20/2/2016 10:26 AM Completed
Successful 0 Complications

Central line - standard femoral

Log-497
20/2/2016 8:22 AM Completed
Successful 0 Complications

Central line - PICC insertion

Log-492
19/2/2016 12:17 PM Completed
Successful 0 Complications

Interosseous needle insertion

Log-491
18/2/2016 6:02 PM Completed
Successful 0 Complications

+ New

Ongoing activity surveillance

Facilitates refreshment and self-reflection

Reporting

Monitoring and benchmarking of outcomes

Framework for future predictive analytics



