Guidance for using the Clinical Evaluation Exercise (CEX) / for Consent (CEXC)

Summary and overview

The Clinical Evaluation Exercise (CEX) and Clinical Evaluation Exercise for Consent (CEXC) are each one of a number of exercises used in the clinical setting to help the teaching and assessment of a clinical skill. In common with the other workplace-based assessments (WBAs), their primary purpose is to provide structured teaching and feedback in a particular area of clinical practice.

The CEX/CEXC is a consultation conducted by a trainee, which is observed and critiqued by a trainer/assessor. It should be used throughout training in a variety of settings (see page 4), including outpatients, the ward and interviews with patients and/or relatives. The assessor's evaluation is recorded on a form in order to provide the trainee with structured feedback during debriefing. The aim should be to make the exercise part of routine surgical training practice.

Each CEX/CEXC assessment contributes to the trainee's portfolio and helps inform the report of the Assigned Educational Supervisor (AES) at the completion of each placement.

Acknowledgement: The CEX was originally designed and promulgated by the American Board of Internal Medicine

CEX in the context of workplace-based assessment

A number of WBAs have been designed and made available for use during surgical training. Taken as a whole, there should be a WBA that will suit every training situation. For example: DOPS for short procedures or part procedures; CEX/CEXC for directly observed clinical consultations; CBD for probing the clinical reasoning abilities of the trainee and so on. It is important that their purposes and *modus operandi* are understood. They should not be used in a mechanistic way. First and foremost, they should stimulate the assessor to observe all the aspects of the practice of the trainee and in so doing to gain adequate insights into the specific training needs of each trainee. Therefore, these WBAs are assessments *for* learning.

Towards the end of each placement the AES will use his/her knowledge of the trainee, the views of fellow consultant clinical supervisors and the training portfolio (of which the accumulated WBAs are a part) to form a judgement as to the overall progress achieved by the trainee. The annual review panel will use the evidence in the training portfolio, particularly the reports of AESs in each placement, to inform their decisions.

Who should assess CEX/CEXC**?**

Each trainee should be evaluated on several different occasions by different assessors. The range of assessors should always include the AES but will mostly comprise the consultant trainers (clinical supervisors) and other members of the multi-disciplinary team where appropriate.

Assessors should be trained in when and how to use the CEX/CEXC and be expert in the clinical problem/task. Assessors need not have prior knowledge of the trainee and in some instances it may be important that they do not. In general, however, assessments of this kind will be carried out by the trainers since they provide useful insights on the training that is required.

When and how often should CEX/CEXC **be carried out?**

Given the great variation in the rate of progress between individuals, absolute numbers of individual assessments are not prescribed. In clinical practice a number of observed activities, even if completed to a satisfactory level, are insufficient if not underpinned by adequate experience.

As a guide, a minimum of 40 WBAs (not including those done in a simulated setting) should be conducted throughout each training year. The proportion and case mix of CEX/CEXCs will depend on the specialty and level of training. The overall number in each placement should be agreed between the trainee and the AES and should be based on individual trainee need.

Ideally, trainees and trainers should use the assessment instruments during every training exercise i.e. at every possible opportunity. During piloting, it was found that CEX could be used almost routinely during any training session, without significant disruption of work schedules. The great benefit of WBAs such as the CEX/CEXC is that by obliging the supervising clinician to review the performance of the trainee across the full range of components involved in a consultation, a comprehensive picture of the trainee's strengths and weaknesses can be obtained and kept under review during the whole placement.

The GMC has not accepted the proposal for minimum specified experience in terms of numbers and it will be a matter of judgement for AESs and annual review panels to determine whether the experience element is sufficient when signing off their reports.

Using the CEX/CEXC

The trainee's Learning Agreement should indicate the case mix relevant to CEX/CEXC. Ideally there should be evidence of competence in different clinical problems from a range of clinical settings covered by the curriculum.

The process may be initiated by the trainer/assessor or the trainee, but since there will usually be a number of trainers/assessors involved during each placement, it remains the responsibility of the trainee to take a proactive approach and to ensure that sufficient exercises are completed. The encounter should be representative of the trainee's workload.

Patient safety and well-being remain paramount throughout. The supervising assessor, usually a consultant, should ensure that the patient is informed, has provided consent for the exercise and suffers no increased risk or discomfort. The supervisor retains responsibility for patient care throughout and will intervene as the situation requires.

The process comprises the trainer/assessor observing the trainee during a consultation of whatever type; an outpatient consultation, interviewing a patient on the ward pre-operatively or interviewing relatives would all be appropriate. The form will provide some structure to the exercise from the point of view of feedback as well as a record for the training portfolio.

The assessor should observe the trainee undertaking the consultation and doing what they would normally do in that situation. Most encounters should take no longer than 15-20 minutes and should be concluded with a 5-10 minute debriefing, feedback and completion of the CEX/CEXC form. Assessors should record a rating for each competency on the assessment form.

Completing the form

The online form must be completed. For convenience, a printed version of the assessment form can be used during the session after which the trainee must transpose the assessment into his/her electronic learning portfolio at the earliest possible opportunity. The assessor must validate the assessment online in order for the assessment to be considered completed. If used, a copy of the paper form should be kept by both parties as a means of recalling the note of the discussion.

- **Feedback**

Feedback should take about 5-10 minutes. It should be conducted in a suitable, quiet environment immediately after the assessment and should be constructive. The assessor should summarise the feedback given together with agreed actions. It is essential that trainees reflect on feedback and take a proactive approach to improving their practice.

It must be emphasised that the most important purpose of the assessment exercise is to provide the trainee with formative feedback (i.e. information that forms and develops the trainee's practice), offering a significant impact on learning.

Ratings are used only for the purpose of identifying strengths and weaknesses and providing accurate feedback on that performance. Assessors should expand on the reasons for any ratings of *Development required* and make practical suggestions for any remedial steps if it is felt that the rate of progress is insufficient.

In this connection, it should be borne in mind that the AES has the facility to make substantial changes to the clinical timetable and sessional exposure that a trainee has during a placement, if it is deemed in the best interests of the trainee. It is expected that the clinical supervisors in any one placement work as a team and if an assessor, trainer or trainee feels that any such change might be indicated, then this should be brought to the notice of the AES at the earliest opportunity.

- **Clinical setting**

The assessor should state the setting in which the case is based, for example *Out-patients*.

- **Summary of the clinical problem**

It is optional for trainees to write a couple of lines about the nature of the case to aid re-call at a later date. Entries must ensure the confidentiality of patient information.

- **Focus of clinical encounter**

Tick the categories that have been assessed. Not all elements need to be assessed on each occasion. Evaluation should include an assessment of the trainees' examination skills and their abilities to reach an initial diagnosis using sound clinical reasoning.

- **Complexity of case:**

The assessor should rate the complexity of the case according to the stage of training to which it is considered to be most appropriate.

- **Competency ratings**

The full range of the rating scale should be used for each area according to the trainee's performance. Comparison should be made by the assessor between the trainee being observed and the level of performance expected of a doctor who is ready to complete the stage. It is expected that some ratings of *Development required* will be a reflection of a deficit in experience.

- **Global summary 0-4:**

The global summary should only be used if the assessor has reviewed all areas with the trainee. If there is sufficient evidence to make a judgement, the assessor should rate the trainee's overall performance according to a scale of training stages.

The standards to be applied to the CEX/CEXC **assessments**

The assessment should be judged against the standard expected at completion of the stage of training (e.g. core CT1-2 / Initial stage), defined in the syllabus.

One of the purposes of the assessment is to enable trainees to demonstrate to their trainers that they are maintaining progress during the placement and that they are on course to reach the standard required by the syllabus and their Learning Agreement for successful completion of the stage. Ultimately it is a matter for the AES / Clinical Supervisor and the Training Programme Director, based on their experience, to make that judgment for each trainee.

Appropriate assessment settings

Stage	Early years	Intermediate Stage	Final Stage
Examples of CEX/CEXC settings	• Clinic • Ward • A&E • Dealing with a patient/relative who has a complaint • Breaking bad news in planned settings	• Clinic • Leading a ward round • Ward – severely ill patients and their relatives • A&E – severely ill patients and their relatives • Dealing with the dying patient • Guiding a junior trainee in clinic • Breaking bad news in unexpected settings	• Leading a clinic • Leading a ward round • Ward - emergency situations • A&E – emergency situations • Interviews with patients/relatives • Dealing with the dying patient • Guiding a junior trainee in clinic • Breaking bad news in complex settings and highly sensitive situations • Conflict resolution

KEY POINTS

Summary of the method

- Observed trainee-patient clinical encounter
- Evaluation of the trainee's ability to take a history, examine, reason, organise and communicate

Minimum number of assessments per year

- CEX/CEXCs should contribute to a minimum of 40 WBAs in each year of training, representing different clinical problems.

Who should assess CEX/CEXC**?**

- The trainee's current AES must be one of the assessors.
- Other consultants, specialty registrars, staff grades and other health care professionals who are trained and expert in the clinical problem/task.
- Assessors do not need to have prior knowledge of the trainee.

Time needed

- Most encounters require approximately 15-20 minutes.
- 5-10 minutes for debriefing and feedback.