American Board of Psychiatry and Neurology, Inc.

A Member Board of the American Board of Medical Specialties (ABMS)

Requirements for Clinical Skills Evaluation in Neurology and Child Neurology

General Principles

Clinical skills evaluations (CSEs) are required for all physicians wishing to become certified in neurology or neurology with special qualification in child neurology. The American Board of Psychiatry and Neurology (ABPN) requires that physicians demonstrate mastery of the following three clinical skills to apply for certification in the specialties of neurology and neurology with special qualification in child neurology:

- Medical interviewing skills
- Neurological examination skills
- Humanistic qualities, professionalism, and counseling skills

Demonstration of competency in evaluating a minimum of five different patients (as specified below) during residency training is required of current residents. Training programs may elect to do more evaluations. They may also assess additional competencies in the evaluation.

Clinical Skills Completed During Residency Training

The clinical skills evaluation (CSE) requirement became effective for residents who entered residency training (PGY-2 for neurology, PGY-3 for child neurology, PGY-2 combined programs) on or after July 1, 2005.

The fifth clinical skills evaluation must be completed within five years of the first evaluation, and the evaluations are valid for seven years after completion of residency training.

Clinical Skills Completed After Residency Training

Neurologists who began residency training prior to July 1, 2005 (PGY-2) may apply for the Neurology Certification Examination provided they complete the required clinical skills evaluations by July 31 of the year of the examination. These neurologists are required to submit documentation from the program director of an ACGME-accredited neurology program verifying successful completion of five clinical skills evaluations. Documentation must be received in the Board office by July 31 of the year of the examination.

Child neurologists who began residency training prior to July 1, 2005 (PGY-3) may apply for the Child Neurology Certification Examination provided they have completed the required clinical skills evaluations. These child neurologists are required to submit documentation from the program director of an ACGME-accredited child neurology program verifying successful completion of five clinical skills evaluations. Documentation must be received in the Board office by July 31 of the year of the examination.

Residency directors may administer clinical skills evaluations for graduates of their programs or graduates of other programs. All the requirements and documentation for in-training evaluations will apply. The fifth clinical skills evaluation must be completed within five years of the first evaluation, and the evaluations are valid for seven years after completion of the fifth clinical skills evaluation.

Components of Clinical Skills Evaluations

Adult neurologists must successfully evaluate five patients:

1) Critical care: One critically ill adult patient with neurological disease (may be in either an intensive care unit or emergency department setting or an emergency consultation from another inpatient service)
2) Neuromuscular: One adult patient with a neuromuscular disease (may be in either an inpatient or outpatient setting)
3) Ambulatory*: One adult patient with an episodic disorder, such as seizures or migraine (most likely in an outpatient setting)
4) Neurodegenerative: One adult patient with a neurodegenerative disorder, such as dementia, a movement disorder, or multiple sclerosis (most likely in an outpatient setting)
5) Child patient: One child patient with a neurological disorder (most likely in an outpatient setting)

Child neurologists must successfully evaluate five patients:

1) Critical care: One critically ill child patient with neurological disease (may be in either an intensive care unit or emergency department setting or an emergency consultation from another inpatient service)
2) Neuromuscular: One child patient with a neuromuscular disease (may be in either an inpatient or outpatient setting)
3) Ambulatory*: One child patient with an episodic disorder, such as seizures or migraine (most likely in an outpatient setting)
4) Neurodegenerative: One child patient with a neurodegenerative disorder, such as an inherited degenerative disease (most likely in an outpatient setting)
5) Adult patient: One adult patient with a neurological disorder (most likely in an outpatient setting)

At least one of the above child patients must be from each of these age groups:

- An infant or child younger than two years old
- A child age two to ten years old
- An adolescent (age 11 – 18)

The selection of patients (outlined above) by age is at the discretion of the residency program director.

* The ambulatory patient CSE may be completed with an actual patient via live video streaming if the clinical setting uses telehealth as part of its patient care offerings and if the ambulatory patient is clinically appropriate to be seen via telehealth (e.g., an established patient whose evaluation does not require physical examination elements that cannot be done remotely). The other CSEs must be completed with an actual patient in person; thus, a maximum of one out of the five required CSEs may be completed via a telehealth patient evaluation.

For all CSEs, please note that the ABPN-certified neurologist/child neurologist assessor must be *physically present in the same room as the trainee for the entire patient evaluation*, whether the patient is seen in person or remotely. As well, all patient evaluation must be with a live actual patient; videorecorded interactions or simulated/standardized patients cannot be used as the basis for the clinical skills evaluation.

Selection of Patients

The patients must be unknown to the physician. While it is preferable that the patients have not been seen previously by any resident, patients previously seen at the institution may be asked to participate in the evaluation process. Whenever possible, patients with conversion disorders or somatoform disorders should not be selected. The selection of patients is at the discretion of the residency director.

Non-English speaking patients may be used in the patient interview and examination portion of the CSE, if the physician and the evaluator(s) also speak that language. Translators are not acceptable. The rest of the CSE must be conducted in English.

Evaluators

Each of the five evaluations must be conducted by an ABPN-certified neurologist/child neurologist. All evaluators must be current diplomates of the ABPN. Evaluations involving adult patients may be done by either adult or child neurologists. Evaluations involving child patients must be completed by child neurologists. At least three of the five evaluations must be conducted by different ABPN-certified neurologists/child neurologists. The evaluator must observe the physician's performance and score the physician's medical interviewing skills; neurological examination skills; humanistic qualities/professionalism/counseling skills; and presentation/formulation.

Duration of Each Encounter

Each evaluation session should last approximately one hour. The physician should be given up to 45 minutes to conduct the history and neurological examination. Thereafter, he/she should have 10-15 minutes to present a summary of the important findings on history and neurological examination. The remainder of the time should be spent in discussion and feedback from the evaluator who observed the encounter.

While the evaluator may wish to discuss the diagnosis, differential diagnosis, and plans for evaluation and treatment with the physician, these steps are not required by the ABPN. The physician does not need to demonstrate proficiency in these aspects of the encounter to pass the clinical skills evaluation.

Timing of the Evaluations

The evaluations may be administered to residents at any time during residency training; however, the ABPN encourages administering them early in training. The ABPN anticipates that many residents may not perform acceptably on all their evaluations on the first attempt.

Evaluations of former residents or other neurologists/child neurologists may be administered at any time convenient to the residency program. Verification of successful completion of the clinical skills evaluations must be submitted to the ABPN by July 31 of the year of the examination.

Evaluation Forms

Evaluations must be completed on ABPN-approved forms, and two versions (NEX v.1 and NEX v.2) are posted on the ABPN website. Residency programs can add additional competencies/items for their own purposes. If programs develop their own forms, they must be submitted to the ABPN for approval.

Determination of Acceptable Performance

The individual evaluator will determine if the physician performed acceptably on all three components (medical

interviewing, neurological examination, humanistic qualities/professionalism/counseling skills) of the clinical evaluation.

An acceptable score is required for all three components. Regardless of when during training a resident takes the evaluation, the standard for acceptable performance, that of a competent practicing neurologist/child neurologist, remains the same. Because a physician may take each of these clinical skills evaluations multiple times if necessary (which will not affect the physician's admissibility to the ABPN certification examination), there should not be pressure to score a physician's performance as acceptable on an evaluation.

If a resident is unsuccessful in completing the evaluations, any remediation activities are the responsibility of the training program. No such requirement applies to physicians no longer in training.

Submission of Documentation to the ABPN

Prior to approval of an application for certification, the ABPN requires attestation of successful completion of the five clinical skills evaluations from the residency director. Documentation must include the category of patient, the exact dates of successful completion, and the full names of the ABPN-certified evaluators. For child neurologists, the age of the patient must also be recorded. It is recommended that the program retain the evaluation forms as part of a resident's training file. The ABPN reserves the right to audit the evaluation process. The evaluations are valid for seven years following completion of residency training. The evaluations of other neurologists/child neurologists are valid for seven years following completion of the final evaluation. The fifth clinical skills evaluation must be completed within five years of the first evaluation.

Documentation for neurology candidates must be received from the program director of an ACGME-accredited neurology residency program. Documentation for child neurology candidates must be received from the program director of an ACGME-accredited child neurology residency program. Documentation of evaluations of physicians no longer in training must be in the same manner as that of current residents. All documentation must be received in the ABPN office by July 31 of the year of the examination.

Components of the Clinical Skills Evaluation and Scoring

Criteria A: Medical Interviewing Skills

The ability to obtain a clear history is a fundamental component of the core competency of patient care. The art of being an excellent neurologist is the ability to make an accurate localization of the patient's neurological illness and to reach a most likely diagnosis based on the patient's history. The evaluator must observe the physician's skill and thoroughness in obtaining the history.

The ABPN recognizes that neurologists/child neurologists may use several different strategies to obtain the history from a patient and that the approach may vary among patients. Thus, the ABPN requires that physicians successfully demonstrate the ability to perform a thorough and accurate history in a minimum of five encounters.

The physician is expected to ask about the chief complaint, the history of the present illness, past medical history, family history, and social history and conduct a review of systems. The quality and completeness of the information collected from all components of the history should be evaluated. The ABPN expects the physician to skillfully obtain the history. While the history should emphasize the patient's neurological illness, relevant components of other aspects should be mentioned. For example, if the patient has had a stroke, it is relevant to ask about hypertension, heart disease, family history of stroke, smoking, and recent cardiac complaints.

Depending upon the patient, the physician may use very direct or open-ended questions. The technique used by the physician to obtain the historical information reflects the physician's ability to communicate with the patient as well as his/her ability to change techniques to obtain the necessary information.

The physician must not review prior medical records in order to obtain the patient's history. The focus of this evaluation is on the ability of the physician to obtain the history from a "new" patient and/or family members, as would be done in practice.

The physician is expected to obtain information about the duration and course of the neurological illness and the types of neurological symptoms. While a chronological approach often is desirable, different strategies are acceptable. If appropriate, the physician should obtain information about any incident or event that may have precipitated the neurological problems. If it is a long-standing illness, the physician should ask about recent changes. If it is an episodic disorder, information about the number and types of events, provocations, duration of symptoms, etc. should be obtained. The physician should ask questions that probe for both important positive (presence of) and important negative (absence of) symptoms or components of the neurological history. These include pain, loss of consciousness, weakness, etc. Information about prior treatment (medications, surgery, etc.) can provide important diagnostic clues. Did the physician miss important historical clues offered by the patient? Did the physician follow-up on components of the history?

At the end of the history, both the physician and the evaluator should have a clear understanding of the nature of the patient's neurological illness.

Score	**Scoring Criteria for Medical Interview**
8 (Outstanding)	History performed with no deficiencies or errors and provided a clear understanding of the patient's neurological illness.
7 (Excellent)	A few minor deficiencies or errors in the history.
6 (Very good)	Minor deficiencies or errors in the history.
5 (Acceptable)	Deficiencies or errors in the history but enough information obtained to formulate the case.
4 (Borderline but unacceptable)	Deficiencies or errors in the history resulting in missing information.
3 (Unsatisfactory)	Major deficiencies or errors in the history resulting in missing important information.
2 (Poor)	Omitted major portions of the history resulting in inadequate understanding of the case.
1 (Very poor)	History done so poorly that the physician could not understand the case.

A score of 5 or greater is required to pass this component of the clinical skills evaluation.

Criteria B: Neurological Examination Skills

The ability to perform a thorough examination is a major component of the core competency of patient care. For a neurologist, the ability to do a neurological examination is a fundamental clinical skill.

The ABPN recognizes that there are different approaches to the neurological examination and no particular style, sequence, or organization is required. However, the ABPN expects the neurological examination to be thorough and to assess mental status, station and gait, motor, sensory, coordination (cerebellar), cranial nerves, and reflexes. In some circumstances, such as a wheelchair bound patient or a telehealth evaluation, parts of the examination may be omitted. While the ABPN expects that all aspects of the examination will be performed, components of the examination should reflect the nature of the patient's problem (as obtained from the history). For example, the physician may wish to do a more detailed mental status examination in a patient with a chief complaint of memory loss than in a patient with symptoms of a tardy ulnar palsy.

The physician should not be expected to do a general physical examination although in some circumstances, components of the general examination may be relevant to the patient's presentation. For example, the physician may wish to auscultate for bruits in a patient with a TIA.

The physician's interactions with the patient during the examination should be assessed. Was the physician rough? For example, did the physician examine a painful leg to the obvious discomfort of the patient, despite being warned not to do so? Did the physician do components of the examination in the correct manner? Did the physician use the appropriate instruments, and were they used correctly? Were major relevant portions of the examination missed? Did the physician detect the relevant neurological signs? Did the physician ignore or misinterpret some of the neurological findings? Did the physician adjust the examination in response to previously detected signs? Did the findings of the examination prompt the physician to ask additional history? Did the findings of the examination prompt reconsideration of the location or nature of the neurological illness?

At the end of the examination, both the physician and the evaluator should have a clear understanding of the location and nature of the patient's neurological illness. The findings on the examination should be compatible with the patient's neurological history.

Score	**Scoring Criteria for Neurological Examination**
8 (Outstanding)	Neurological examination performed with no detected shortcomings.
7 (Excellent)	A few minor deficiencies or errors in the neurological examination.
6 (Very good)	Minor deficiencies or errors in the neurological examination.
5 (Acceptable)	Deficiencies or errors in the neurological examination but enough information obtained to formulate the case.
4 (Borderline but unacceptable)	Deficiencies or errors in performing the neurological examination resulting in missing information.

3 (Unsatisfactory)	Major deficiencies or errors in performing the neurological examination resulting in missing important information.
2 (Poor)	Omitted major portions of the neurological examination resulting in inadequate understanding of the case.
1 (Very poor)	Neurological examination was so poorly done that the physician did not understand the case.

A score of 5 or greater is required to pass this component of the clinical skills evaluation.

Criteria C: Humanistic Qualities/Professionalism/Counseling Skills

The ability to communicate effectively with patients and families is one of the six core competencies for neurologists/child neurologists. Effective communication is a key component of a physician's interpersonal skills and in the development of an appropriate patient-doctor relationship.
The communication skills of the physician should be assessed throughout the patient encounter. The communication can include both verbal and non-verbal means. For example, being rough during the examination can convey a lack of skill in communication. The physician's performance should be scored in light of the patient's ability to cooperate with the examination. While there is no set criterion for passing this competency, the overall performance should be the basis for grading this clinical skill.

The physician should be sensitive to ethnic, racial, religious, or cultural issues. The physician also should be aware of educational, language, or community issues that may affect the patient's ability to communicate. The physician should take steps or employ strategies that deal with these issues and at the same time permit an accurate history and examination. If the patient does not speak English, the physician should seek other ways to communicate with the patient, such as the use of a translator or talking to family members who are proficient in English.

The dialogue between the patient and the physician should be evaluated. Did the physician make the patient and family feel as comfortable as possible in the situation? Did the physician interact in a neutral or positive way with the patient? Did the physician demonstrate respect for the patient and family? Was the physician rude, brusque or demanding? Did the physician interrupt the patient during the history? Did the physician fail to follow-up on the patient's comments? Did the physician allow the patient to respond to questions? Did the physician revise or reformat questions when it appeared that the patient did not understand? Did the physician direct questions to family members if it appeared that the patient did not have information about part of the history? Did the physician explain the components of the neurological examination and give clear instructions?

Score	**Scoring Criteria for Humanistic Qualities/Professionalism/Counseling Skills**
8 (Outstanding)	Effective communication skills and patient-doctor interactions.
7 (Excellent)	A few minor problems in communication or patient-doctor interactions.
6 (Very good)	Minor problems in communication or patient-doctor interactions.

5 (Acceptable)	Had problems in communication or patient-doctor interactions but still established rapport.
4 (Borderline but unacceptable)	Had problems in communication or patient-doctor interactions, rapport with patient was borderline or not good.
3 (Unsatisfactory)	Major problems in communication or patient-doctor interactions, unable to establish rapport with patient.
2 (Poor)	Major problems with communication, rude or unpleasant to patient.
1 (Very poor)	Interactions or communication with the patient were so bad that the evaluator needed to intervene.

A score of 5 or greater is required to pass this component of the clinical skills evaluation.

Criteria D: Presentation/Formulation

The ABPN does not require that neurologists/child neurologists perform acceptably on this component, but it has been included on the rating forms and guidelines for scoring because physicians will have to present the results of the history and physical examination.

Score	Scoring Criteria for Presentation/Formulation
8 (Outstanding)	No major deficiencies in the description of the key findings of the history and neurological examination.
7 (Excellent)	One minor deficiency in the description of the key findings of the history or neurological examination.
6 (Very good)	Two minor deficiencies in the description of the key findings of the history or neurological examination.
5 (Acceptable)	A few minor deficiencies or one major deficiency in the description of the key findings of the history or neurological examination.
4 (Borderline but unacceptable)	Several minor deficiencies or two major deficiencies in the description of the key findings of the history or neurological examination; missed some points.
3 (Unsatisfactory)	Several major deficiencies in the description of the key findings of the history or neurological examination; missed several points.
2 (Poor)	Multiple major deficiencies in the description of the key findings of the history or neurological examination; summary of findings was incomprehensible.
1 (Very poor)	Numerous major deficiencies in the description of the key findings of the history or neurological examination; summary of findings was incomprehensible.