In late September 2010, the NBME, along with the Educational Commission for Foreign Medical Graduates (ECFMG®) and the Federation of State Medical Boards (FSMB), co-hosted the 9th biennial conference of the International Association of Medical Regulatory Authorities (IAMRA). Held in Philadelphia at the Society Hill Sheraton, this three-day meeting was attended by 216 participants from over 30 countries, including, among others, Albania, Australia, Egypt, India, Iraq, Nepal, the Netherlands, Pakistan, Singapore, South Korea, the United Kingdom, and Zimbabwe. The 9th biennial conference is the first in a series of planned IAMRA conferences that will bring world experts together in an effort to develop global best practices for use in licensing and regulating physicians.

In a welcoming message to attendees, the CEOs of the host organizations noted, “We believe that in a time of increasing global interconnection in healthcare, it is important for geographically diverse organizations to stay in contact and communicate with one another. Our borders may be distinct politically, but from a global health perspective—especially in terms of public health—our nations are interconnected and aligned. Every healthcare and

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Scenes from the 9th Biennial IAMRA Conference

1. Conference attendees learn about item formats at the NBME offices
2. Attendees participate in facilitated small group discussion
3. Presentation by IAMRA Chair-Elect Fleur-Ange Lefebvre
4. Conference attendees enjoy the Mummers
5. Small groups in session
6. Fife & drum corps welcomes visitors to the NBME
7. The Mummers’ Strut!
medical regulatory organization needs to focus on its strengths and its role in protecting the public. The role our organizations can and should play is helping ensure that patients can trust the veracity and the integrity of the professionals they entrust their lives with—the world’s physicians and health professionals.”

Staff members from each host organization participated in three working groups: program planning (led by ECFMG), logistics (led by NBME), and marketing (led by FSMB). The program planning committee adopted a unique format, minimizing plenary presentations and engaging the participants in focused, facilitated small group work intended to create draft “best practice” principles in three relevant domains: initial licensure/registration, complaints/discipline, and maintenance of licensure. Three progressive small group sessions gave all attendees an opportunity to share their own experiences, identify common themes, and explore the real world challenges of establishing best practices. Following the small group sessions, a closing plenary session included summaries of the results of each content area and a discussion of next steps.

The conference also included a number of social events and entertainment. The Opening Reception featured a stirring performance by the world famous Philadelphia Boys Choir & Chorale. The following evening, attendees were invited to the NBME headquarters for the Hosts’ Reception and Exhibition. Conference attendees and their guests were welcomed into the lobby of the NBME by a fife and drum corps and Ben Franklin, and a buffet dinner featured US regional fare. This event also offered participants the opportunity to visit a number of exhibits by the host organizations and other associated organizations and to interact with
FOR STUDENTS

Sharing Isn’t Always Caring

When you take NBME subject exams, USMLE Steps and other assessments, you sign a statement agreeing to maintain the confidentiality of the test content. You agree not to memorize, copy, reconstruct, or disseminate what you will see on your exam. Take a moment to think about why such confidentiality is important. While the term “copyright infringement” might first cross your mind, we would like to remind you of some other reasons why maintaining exam confidentiality is important to you, to the public, and to the profession.

When you engage in activities involving discussion of actual exam content, you put your test scores (and possibly your career) in jeopardy. Formal and informal test preparation sources, Internet forums, social media and the like may appear to be fruitful sources of information about examinations, but you should be aware that engaging in these activities is risky. Inadvertent access to exam materials prior to testing could result in the invalidation of your scores, and knowingly engaging in this activity could result in a bar from exams and possibly the end of your medical practice career. The Internet is replete with prep courses and tutors promising guaranteed passes and high scores. Some of these enterprises may be legitimate and some may not. We urge you to be careful and cautious if you chose to engage in these forms of test preparation.

While you may view your exams as hurdles to overcome to achieve your career goals, think a minute about the public, your future patients. Healthcare consumers rely on the knowledge, skills, and professionalism of the individuals who care for them. Think about your family and your loved ones, all of whom are or will be healthcare consumers. They rely on the systems in place to ensure their healthcare providers have the requisite knowledge and skills to provide safe, effective care. The examinations you take as a student or resident play an important role in public protection, and they should be taken with honesty and integrity.

Medicine is a profession that has the privilege of self-regulation. The public expects that the profession, with its commitment to helping and healing, can be trusted to establish its own standards in education, training, licensure, and practice and that physicians themselves are best suited to define and uphold these standards. Thus, the profession and the individuals who belong to it are obligated to ensure that practitioners (and future practitioners) meet minimum standards of knowledge and skills necessary for the safe and effective practice of medicine. The public must be assured that physicians value professionalism and integrity. Your commitment to professionalism includes maintaining the integrity of the systems designed to protect the public.

Maintaining the confidentiality of your own examinations and reporting any unauthorized sharing of examination content or other unethical behaviors around professional assessment will benefit you, your family, the public, and the profession.

(IAMRA, continued from page 3)

staff. Tours of the Clinical Skills Test Center and mock encounters with standardized patients were also offered. Toward the end of the evening, attendees were treated to more Philly flavor—a performance by the Mummers. For their final evening, conference participants were invited to the National Constitution Center, the most interactive history museum in the United States. This evening featured exhibits on important events in US history, a multimedia presentation featuring a live actor, and “A Taste of Philadelphia” buffet dinner.

When available, presentations and proceedings from the conference will be posted at www.iamra.com.
Assessment of Communication Skills within Clinical Encounters

Over two million simulated encounters have been administered since the rollout of Step 2 CS in June 2004. Much has been learned from this experience, generating a rich opportunity for enhancement of our methods for assessing communication skills. Below we describe work directed at such evolution, including adoption of a literature-based model to guide case development and scoring; identification of behavioral descriptions grounded in empiric methods; and resultant changes anticipated for Step 2 CS.

Over the past 10 years, the evidence base for the importance of communication skills has grown much stronger, and good communication skills have been shown to produce desirable and efficient clinical outcomes, as well as satisfied patients.1 Such data tend to upgrade the importance of communication skills in the assessment continuum. Further, continued evolution of the doctor-patient relationship is calling for more patient-centered approaches, ones that involve patients in decision making and support them in adopting behaviors conducive to better health.2 This means that highly interrogatory and controlled encounters are insufficient for modern clinical encounters.

Finally, recent data demonstrate that new residents have significant responsibility for encounters with patients and their families and that they engage in much more independent, sensitive, and complex communications than has been previously thought.3 Such data suggest a need for assessment focused on the tasks performed in supervised practice, i.e., residency training.

A new team has been formed to develop and test revised assessment approaches. The team represents a collaboration between NBME and the Clinical Skills Evaluation Collaboration (CSEC) staff and two external consultants. The team pulls together expertise in communication skills assessment, the development of simulated encounters utilizing standardized patients (SPs), instrument design, and research methodology. An extensive literature review provided an evidence-based approach to developing an assessment construct. It also facilitated identification of academically based communication skills experts who assisted the team with refinement of the construct, based on the “six function model” of the clinical encounter (Table 1).4

The team has divided this model into basic and advanced components. The immediate focus is to develop an enhanced assessment scale based on the basic functions, along with modifying case development and SP training processes to better embrace the model. While there is similarity between these basic functions and the original Step 2 CS construct, there are important differences (Table 2). Later, the team will turn to the task of incorporating the more advanced functions into the assessment system.

The team has used a unique approach to move from construct development to instrument design. Multiple video recordings of encounters have been reviewed to identify specific behavioral expressions of the assessment construct. These behavioral expressions are being transformed into the design of a new instrument that will

Table 1: Six Function Construct
1. Fostering the Relationship
2. Information Gathering
3. Information Provision
4. Making Decisions
5. Supporting Emotions
6. Enabling Patient Behaviors

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cover the range of functions from the construct and guide SPs in recording their observations. Early pilot work will allow for testing of revised training methods and case development processes, as well as the new instrument. It is expected that the early pilots will inform revisions of processes as well as the instrument. There will be iterative research leading up to SPs fully adopting both portrayal and assessment tasks under conditions that simulate a high-stakes examination.

By early 2012, it is expected that this comprehensive consideration of all steps in the assessment system will produce enhancement to our assessment of communication skills within clinical encounters. These enhancements will include:

- clarification for the examinees of their role within the encounters, based on our improved understanding of the tasks they perform as residents;
- improved scenario-development processes that stimulate a broader and deeper range of essential communication skills;
- an improved assessment scale based on the basic functions that will focus on that which SPs do best: observe examinee behaviors;
- modified SP training processes to enrich portrayals and make assessment observations more precise; and
- maintenance of the standardization that is needed for high-stakes examinations across a far-flung assessment network.

Longer term, the more advanced functions will be incorporated. As the Comprehensive Review of USMLE (CRU)-driven process pushes us to consider additional methods of assessing communication skills, the assessment construct that has been developed will serve as an important foundation and guide.

### Bibliography

test item formats will not only address the specific recommendation related to interpreting medical literature but would also touch on another CEUP recommendation, ie, that foundational science (and the application of scientific reasoning and evidence-based decision making) be reflected across all three Steps.

Two new assessment formats are under development in support of this project. These new items may use the F-type format (ie, sequential item sets) or the standard multiple-choice question (MCQ) format of one best answer:

- Drug Ad Format – MCQ-based item sets that assess examinees’ ability to apply their knowledge of biostatistics, epidemiology, pharmacology and/or public health in appraising information provided in drug advertisements. Some sets will begin with a clinical scenario describing a patient care situation related to the abstract.

- Abstract Format – MCQ-based item sets that assess examinees’ ability to apply their knowledge of biostatistics, epidemiology, and/or public health in appraising information provided in an article abstract. Some sets will begin with a clinical scenario describing a patient care situation related to the abstract.

Interpreting drug advertisements and article abstracts and appraising the medical literature are common clinical tasks that provide a natural context for authentic assessment of these skills. In 2011, the NBME work will focus on three major areas: 1) development of test material; 2) development of software for test delivery; and 3) validity research.

The Wind Helix by artist Roy Wilson was commissioned in 1994 for the NBME’s then-new headquarters. The artwork, a kinetic fence of steel panels along the perimeter of the NBME site, has 600 welded arcs positioned to describe the double-helix design of the DNA molecule. Aluminum vanes within the design change position and color with the wind. In 2010, this double-helix design was incorporated into the walkways of the NBME garden.

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