A medical student asked, “Would a piano teacher give you a sheet of music and say, ‘Practice this, come back, and report how well you performed?’ No, but that’s how I feel clinical medicine is taught. Too frequently,” she said, “I examine patients alone and later report what I’ve found to my attending. It’s hard to know if what I’m doing is right.”

She had a good point. Too much clinical teaching — by this, I mean teaching interviewing techniques and physical examination skills — is performed without direct observation and timely feedback. When we consider clinical-skills teaching, framed as this medical student put it, the problem is self-evident. Without observation and feedback, students cannot be expected to correct mistakes or learn efficiently. At best, their learning is hit or miss, and they are at risk for perpetuating and reinforcing errors. Yet, observation requires preceptors’ time, a precious commodity in the fast-paced ambulatory care setting. To provide for optimal teaching while maintaining efficient patient flow, preceptors must master techniques that allow for brief, focused observations and assessments of student performance. One solution may be the use of the mini-clinical evaluation exercise (mini-CEX), at least sometimes, in the office setting.

The mini-CEX was developed by the American Board of Internal Medicine to provide faculty preceptors with a tool for making short, focused assessments of house officers’ clinical performance during inpatient rotations. Intended to take no more than 30 minutes, it is typically used once or twice during an inpatient rotation. During the mini-CEX, the student is observed conducting a focused history and physical examination (eg, evaluating a patient with fever and shortness of breath). The preceptor rates the following competencies: interviewing, physical examination, professionalism, clinical judgment, counseling, organization, and overall clinical competence using a 9-point scale (1 = unsatisfactory; 9 = superior). Scores are indicated by circling the appropriate score on the mini-CEX card (approximately 4 in x 7 in; Figure). Space at the bottom of the form is provided for a brief comment or 2 (eg, good use of open-ended questions, but should allow patient more time to answer). Later, the student and preceptor review the experience and discuss the student’s performance, and both sign the card. This exercise can improve consistency and reproducibility of the teaching process as well as create a record to be used for summary feedback provided to the student and course directors.

The use of the mini-CEX during typical hospital rotations is generally acceptable to faculty and house staff, but could it be used in the ambulatory care setting, where time constraints are even more demanding than during inpatient teaching sessions? Kogan et al asked this question.* In their study, which began in July 2002, the mini-CEX was used in both inpatient and outpatient settings. The objective was to determine the feasibility and acceptability of obtaining multiple ratings by faculty and house staff in both settings. Students were given booklets of 10 adapted mini-CEX forms at the start of a 9-week internal medicine clerkship (6-week inpatient, 3-week outpatient). The students were asked to collect 9 evaluations (1 every 2 weeks from inpatient faculty and residents, and 1 every 2 weeks from outpatient attendings). Students and evaluators rated their satisfaction with the mini-CEX. The rationale for performing the mini-CEX was reviewed with resident and faculty evaluators before the instrument was implemented.

Results of this pilot study indicated a high degree of feasibility and acceptance. The mean number of mini-CEX examinations completed was 7.3. Satisfaction by faculty/residents was rated 7.2 and by students 6.8, with 1 being “low” and 9 being “high” satisfaction. Observations and feedback required an average of 21 min and 8 min, respectively. The investigators intend to perform further study to assess the instrument’s reproducibility and validity as well as its utility for formally assessing clinical skills.

My experience using the mini-CEX in the office supports these results. I use it with geriatrics fellows in our ambulatory practice and have found it simple to use, acceptable regarding the amount of time it requires, and helpful for creating a record I later transmit to the program director. It creates a record that can be used to demonstrate progress, particularly in areas the fellow is working to

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improve. It also makes summative evaluations more credible because the assessment is based on recorded evidence rather than hazy memories or subjective impressions.

Not all assessment and feedback needs to be formal and recorded. This would be impractical, certainly in the office setting. However, at a minimum, preceptors should provide assessment and feedback that is sufficient, timely, regular, and relevant to the learner's goals. By occasionally using an instrument such as the mini-CEX in this process, we can let the learner see that we are deliberately watching and working to nudge their professional skills forward.

Reference

Correction
In the article Clinical Diagnostic Pearls (Vol. 3, No. 2A, S66-S71) the byline for the case study on page S68 should read, “Based on a presentation by Anca Avram, M.D.” In this case study, the dosing for clozapine was listed as 15 mg bid; the clozapine dosing should have read 50 mg bid. In the first paragraph on page S69, the fourth sentence should be deleted, as the patient was not readmitted to the hospital.