

A practical guide to assessing clinical decision-making skills using the key features approach

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AIM This paper in the series on professional assessment provides a practical guide to writing key features problems (KFPs). Key features problems test clinical decision-making skills in written or computer-based formats. They are based on the concept of critical steps or 'key features' in decision making and represent an advance on the older, less reliable patient management problem (PMP) formats.

METHOD The practical steps in writing these problems are discussed and illustrated by examples. Steps include assembling problem-writing groups, selecting a suitable clinical scenario or problem and defining its key features, writing the questions, selecting question response formats, preparing scoring keys, reviewing item quality and item banking.

CONCLUSION The KFP format provides educators with a flexible approach to testing clinical decision-making skills with demonstrated validity and reliability when constructed according to the guidelines provided.

KEYWORDS *decision making; clinical competence/*standards; educational measurement/*methods/standards; problem-based learning; *education, medical; questionnaires; Canada.

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INTRODUCTION

In this article, we introduce the concept of a key feature, which is the cornerstone of a problem format known as the key features problem used in written examinations of clinical decision-making skills.¹ We then focus on practical guidance in creating key features problems to test clinical decision-making skills at both undergraduate and postgraduate levels.

Bordage and Page² first introduced the term 'key feature' in 1987, following a critical analysis of research on the nature and assessment of clinical decision-making skills published in 1985.³ At that time, most assessments of these skills used small numbers of lengthy clinical problems (sometimes only 1), on the premise that the skills were generic and largely independent of the factual knowledge and procedural skills demanded in any particular problem.⁴ The most popular such assessment format was the patient management problem (PMP), a written problem which consisted of a clinical scenario, followed by sections of items which elicited candidates' responses in relation to history taking, physical examination, investigations and diagnosis. One PMP could take up to 90 minutes to complete.⁵

Although its high authenticity and face validity made it popular, it became clear that the PMP format had serious drawbacks. First, the reliability of the test was very low³ and it was evident that content specificity was just as much a factor in testing clinical decision-making skills as in all other areas of clinical competence. In practical terms, this required many hours of testing in order to obtain a reliable result. In addition, the scoring of PMPs often rewarded thoroughness of data gathering, rather than ability to make appropriate decisions. Moreover, the expected differences in performance between junior and experienced doctors were not found. Finally, scores

Overview

What is already known on this subject

The value of testing clinical decision-making skills using the key features problem format has been increasingly recognised over the last decade. The approach is feasible and offers high reliability and support for face and content validity if items are well constructed.

What this study adds

The key features approach is gaining interest amongst educators in health sciences curricula; however, few have practical experience in writing high quality problems. In this paper we present a practical guide to writing and scoring key features problems in health sciences. Various attributes of the approach are highlighted, including the flexibility of the format in testing decision-making skills in a wide variety of domains.

Suggestions for further research

Further examination of predictive validity and effects on candidates' preparation for testing would be valuable.

on PMP tests correlated highly with scores on knowledge tests, suggesting that they added little additional measurement information.^{4,6}

A NEW APPROACH

In order to overcome these difficulties, Page and Bordage⁶ suggested that, in any clinical case, there are a few unique, essential elements in decision making which, alone or in combination, are the critical steps in the successful resolution of the clinical problem. They labelled these elements 'key features'.² This concept led to the creation of a new test of clinical decision-making skills, which elicited candidates' responses concerning only the critical steps in the resolution of each problem – the problem's key features. Testing only critical steps enabled candidates to be tested on a much larger number of clinical problems than was the case with the PMP format. The new test format was called the

'key features problem' (KFP) and was shown to have a potential reliability of 0.8 in 4 hours of testing.⁶

The KFP format proposed by Page and Bordage⁶ also added to other written test formats in that it allowed more than 1 correct answer as required by the question. These involved either 1 or more very brief written answers, or 1 or more items selected from a long list. The flexibility in allowing for more than 1 correct answer often mirrors real-life practice more closely than is possible in single answer written formats, such as multiple-choice questions (MCQs) or extended matching questions. In addition, the KFP format also maintained the advantages of the longitudinal nature of the PMP format in that following a problem through various stages enabled testing of candidates' clinical decisions over the course of a clinical scenario. This is similar to other sequential formats, such as the modified essay question format, and again mirrors real-life clinical practice more closely than is possible in more basic test constructions such as MCQs. Key features problem test formats may be presented in either paper-based or computer-based formats. The latter suits high volume, high stakes testing, and allows for low cost incorporation of pictures into the problems, but overall is more expensive to deliver.

Key features problems are now used in a variety of testing situations. While the reliability of the format is good, in high stakes testing the format is presented as part of a suite of assessment approaches. For example, the Medical Council of Canada uses a 4-hour KFP format test in the Part 1 Qualifying Examination for licensure, together with a 3.5-hour MCQ test. Candidates for the Royal Australian College of General Practitioners (RACGP) Fellowship Examination for certification sit a 3-hour KFP paper, together with a 4-hour written test and a 3-hour objective structured clinical examination (OSCE). Key features problem formats are also employed by the University of Toronto as part of its internal examinations for medical students and by the American College of Physicians in the Medical Knowledge Self-Assessment Program (MKSAP) for continuing medical education purposes.

SAMPLE KEY FEATURES PROBLEM: —DIARRHOEA

The following problem (Fig. 1) has been reproduced from a guide to writing KFPs prepared for the

A 35-year-old mother of 3 presents to your office at 17.00 hours with complaints of severe, watery diarrhoea. On questioning, she indicates that she has been ill for about 24 hours. She has had 15 watery bowel movements in the past 24 hours, has been nauseated, but not vomited. She works during the day as a cook in a longterm care facility but left work to come to your office. On her chart, your office nurse notes a resting blood pressure of 105/50 mmHg supine (a pulse of 110/minute), 90/40 standing, and an oral temperature of 36.8 °. On physical examination, you find she has dry mucous membranes and active bowel sounds. A urinalysis (urine microscopy) was normal, with a specific gravity of 1.030.

1 What clinical problems would you focus on in your immediate management of this patient? List up to 3

2 How should you treat this patient at this time? Select up to 3

- 1 Antidiarrhoeal medication
- 2 Antiemetic medication
- 3 Intravenous 0.9% NaCl
- 4 Intravenous 2/3–1/3
- 5 Intravenous gentamicin
- 6 Intravenous metronidazole
- 7 Intravenous Ringer lactate
- 8 Nasogastric tube and suction
- 9 Nothing by mouth
- 10 Oral ampicillin
- 11 Oral chloramphenicol
- 12 Oral fluids
- 13 Rectal tube
- 14 Send home with close follow-up
- 15 Surgical consultation
- 16 Transfer to hospital

3 After management of the patient's acute condition, what additional measures, if any, would you take? Select up to 4 or select #11, none, if none are indicated

- 1 Avoid dairy products
- 2 Colonoscopy
- 3 Enteric precautions
- 4 Gastroenterology consultation
- 5 Give immune serum globulin to patients at longterm care facility
- 6 Infectious disease consultation
- 7 Notify Public Health Authority
- 8 Stool cultures
- 9 Strict isolation of patient
- 10 Temporary absence from work
- 11 None

Figure 1 A sample key features problem.

Medical Council of Canada.⁷ The key features tested by the questions are:

- 1 recognise dehydration (tested) and its level of severity (not tested);

- 2 manage dehydration appropriately, and
- 3 evaluate the possible communicability of the underlying disease (family or hospital spread, possible common source).

Each question directly tests 1 of these key features, and each challenges the candidate to apply his or her knowledge in making clinical decisions.

DEVELOPING KEY FEATURES PROBLEMS

The first section of this article highlighted the rationale, nature and main advantages of the key features approach. The sections that follow outline a practical guide to the steps involved in developing KFPs, which build upon the guidelines for writing KFPs presented by Page and Bordage.¹

Assembling problem-writing groups

Both face validity and content validity require the use of problem writers whose backgrounds and clinical expertise are pertinent to the context of the examination. In Australia, for example, the RACGP employs general practitioners from diverse metropolitan, rural and remote practices across the country, who work in small guided groups to create draft KFPs for use in part of the fellowship examination.⁸ This ensures that the problems written are well grounded in practice and experience and represent a wide range of real-life Australian general practice contexts. Using the writing process outlined below, problems are written so that they do not represent mere abstractions or generalisations from textbooks.⁹ This is an important step in supporting the content validity of the format and applicability to real-life practice, as perceived by the candidate group.¹⁰

Selecting a problem, defining its key features

First, problem writers are asked to select a clinical problem (e.g. diarrhoea), usually selected from a blueprint for a key features examination. They are asked to think of several instances (real cases) of the problem in practice. Relative to these cases, they are then asked to address the most important question they face as a problem writer: 'What are the essential steps in the resolution of this problem?'⁷ This fundamental question prepares writers to concentrate on only the most critical decisions within each case – the problem's key features. It is essential to differentiate between decisions or steps that are appropriate, but not critical, and those that *must* be present. Coming to grips with this distinction is the

single biggest issue for novice writers. This step usually requires discussion amongst a small group or panel of writers to clarify which steps are critical and achieve consensus. Secondary considerations which can guide the identification of a problem's key features involve asking problem writers to also identify the elements or steps most likely to result in errors by candidates at particular levels of training (e.g. graduating medical students), and to identify the difficult aspects of the identification and management of the problem in clinical practice.

Key features are unique for each clinical problem, and may pertain to any component of the work-up and management of a case; for example, in initial data gathering and diagnostic steps, in longterm management, or in prevention of complications. Key features focus on clinical decisions (e.g. 'include depression in a differential diagnosis') or clinical actions (e.g. 'elicit risk factors', 'order a mammogram') where the clinical action is an expression of a clinical decision. Figure 2 illustrates typical decisions or actions tested in KFPs.

- Elicit history or reasons for patient request
- Interpret symptoms
- Seek critical physical findings
- Interpret physical findings
- Make a diagnosis or differential
- Order investigations to confirm or deny differential diagnoses
- Specify management goals or decisions
- Prescribe drugs
- Specify follow-up

Figure 2 Critical clinical decisions or actions tested in KFPs.

A final component of a key feature is a qualifier that may reflect such issues as the urgency of a decision (e.g. 'What *initial* action...?'), or a decision-making priority (e.g. 'What are the *most important*...?'). Figure 3 presents some common qualifiers.

- Immediate
- Initial
- Longterm
- Definitive
- Urgent
- Most important
- Most likely
- Must not miss

Figure 3 Common qualifiers in key features.

It is important to note that key features may pertain to a broad range of clinical decisions in addition to the biomedical. Key features problems can be constructed to assess ethical, medico-legal, population, preventive and organisational decisions, and in a range of health care settings. This flexibility is a useful attribute of KFP formats in contrast to the more limited multiple-choice and extended matching approaches.

Following their discussion of key features, the problem writers select 1 case for development into a problem scenario and related questions. The clinical scenario for the problem usually begins by stating a patient's age, gender and setting for the encounter. If the key features for that problem focus on the diagnostic component of the problem, the case scenario is often brief (e.g. patient demographics, presenting complaint and limited clinical information). Where the KFP focuses on the management of the problem, the case scenario is typically longer and includes laboratory and diagnostic information. The KFP format is flexible in that additional clinical information can be inserted between questions. This sequential format enables the problem to be followed longitudinally. This attribute allows writers to produce realistic scenarios that evolve over time as required. In this respect, the format is similar to the flexibility found in other sequential formats, such as the modified essay question. Figure 4 gives some examples of the kinds of clinical scenarios that lend themselves to the KFP approach.

- A reason for attendance (e.g. chest pain, check-up, follow-up)
- A request (e.g. sick note, preventive care)
- Symptoms (e.g. cough)
- Signs (e.g. abdominal tenderness)
- Results (e.g. biochemistry, imaging, haematology, audiology, ECG, spirometry)
- Photographs (e.g. clinical signs, rashes)
- Complications of therapy or management

Figure 4 Typical elements in KFP clinical scenarios.

Writing the questions

With the key features defined and the case scenario written, the next step in KFP development is to write the questions that test those key features. Most KFPs consist of a case scenario, typically followed by 2 or 3 questions, each question testing 1 or more key

features. The questions request that candidates record their clinical decisions, which, depending upon the problem's key features, can relate to data gathering (e.g. 'What investigations would you order at this consultation?'), diagnosis ('What are the most likely differential diagnoses?'), management ('What are your longterm management steps?'), etc. Most questions have several answers, which comprise the critical steps in resolving this specific problem. The number of answers may vary from 1 to 10; typically there are 3 to 5.

Selecting question formats

Two question formats are used in KFPs. These are the write-in (WI) format, where candidates supply their responses in very short note form (e.g. they write in 'insulin-dependent diabetes', or 'prescribe penicillin'), and the short menu (SM) format, where candidates select responses from a list of prepared options. The length of the options list varies and may contain up to 25 items. To reduce guessing effects, the list must contain all correct responses plus common misconceptions or likely mistakes. In practice, to reduce cueing, this requires at least 4 or 5 incorrect options for each correct item.

Write-in questions must be marked by hand, whereas SM questions may be marked by computer. The WI question is strictly limited to very short notes or single words, in contrast to the modified essay or short answer question formats, thereby reducing marking time to the minimum. While the feasibility of WI questions could be a problem, data from the Medical Council of Canada and the RACGP suggest that WI formats are more effective in identifying weaker candidates and are more discriminating.¹¹ In addition, it is often harder to write sequential questions purely in SM formats because of backward cueing of candidates to correct answers. Therefore, most KFPs continue to contain both formats.

Specifying the number of required answers

Each question must contain an instruction that stipulates the number of responses to select or supply. Common instructions are:

- write, in note form only, one (1)...
- select up to 'x'...
- select 'x'...
- select as many as are appropriate, and
- select none if none are indicated.

PREPARING SCORING KEYS

The scoring key for a question consists of the list of correct and incorrect responses, and scores to be assigned to each response.

Some scoring keys can contain only a single required response, such as the scoring key for question 1 of the diarrhoea problem shown in Fig. 1 (Fig. 5).

Score	Response	Synonyms
1	Dehydration	Hypovolaemia fluid loss fluid depletion
0	Listing more than 3 items	

Figure 5 Scoring key for question 1 of the diarrhoea problem shown in Fig. 1.

To emphasise that candidates must not give more than the required number of responses to a question, a forfeit is applied if this occurs. In Fig. 5, up to 3 answers were specified. A candidate who provides say, 4 answers, will receive no marks for the question.

Other scoring keys contain several responses clustered on the basis of logical considerations regarding the correct clinical actions to be taken. A simple scoring key for question 3 of the diarrhoea problem is shown in Fig. 6.

This scoring key illustrates a partial credit system of scoring, where a weight is assigned to each response – in this case the same weight of 1 mark to each response.

Score	Correct responses
1 each	# 3 Enteric precautions # 8 Notify Public Health Authority # 11 Stool cultures # 13 Temporary absence from work
0	# 5 Give immune serum globulin to patients at longterm care facility # 12 Strict isolation of patient <i>or</i> Selecting more than 4 items

Figure 6 Scoring key for question 3 of the diarrhoea problem shown in Fig. 1.

Specifying different scores for responses allows for the instances where problem writers regard some correct answers as more important clinically than others. Starting with a default option of each correct answer scoring equally, (e.g. 1 point), more important answers may be weighted more highly (e.g. be awarded 2 or even 3 points). Simple weighting systems are preferable, as more complex systems do not improve reliability. Similarly, negative marking is not used because it does not contribute to reliability and may discriminate between students simply on the basis of their risk-taking behaviour.¹² However, an especially important answer can be specified as 'must be present'. In this case a penalty is applied such as 'no marks for the question if answer not present'. Similarly, a dangerous or negligent response (e.g. unnecessary invasive investigation, unnecessary or harmful treatment) may result in the candidate forfeiting the marks for the question involved, no matter what other responses the candidate makes to that question. Items 5 and 12 in the scoring key shown in Fig. 6 are examples of such actions. Such a penalty, if applied, results in the forfeit of marks only for the relevant question within a KFP. In most cases, where a problem consists of 2 or 3 questions, this penalty results in the forfeit of half or a third of the total marks for that problem. Whether or not such an approach is used depends on the views of the examining body and possibly partly on the stakes associated with the examination.

Total examination scores are simply the sum of the scores on each problem. Problem scores are the sum of the scores on the questions within the problem. Each problem is given the same weight in the calculation of the total mark. This can be easily achieved by transforming problem scores into a percentage.

VALIDATION AND REFERENCES

With questions and answer keys defined, the next step is their validation. Validation entails piloting the problem with discussion, review and editing by colleagues new to the problem, and confirmation of the correctness of answers through reference to suitable literature. Markers particularly appreciate evidence from the literature if questions test a new or rapidly developing area. This process is cited as enjoyable and challenging by writers, and the lively debate and sharing of clinical practice contributes to writers' own continuing education.

COMPUTERISED PRESENTATION OF KFP FORMATS

Presenting KFP in a computerised format offers 2 immediate benefits: ease of presentation of high quality pictorial material such as photographs and imaging, and a mechanism to prevent backward cueing if additional clinical information is given between questions. However, this approach requires additional resources.

QUALITY ASSURANCE ISSUES IN ITEM DEVELOPMENT

Problems that perform well can be maintained in an item bank where the performance of a problem in each examination in which it is used may be recorded. Similarly, question writers may receive feedback on the performance of a problem, and may be involved in review of their problems after use. Candidate feedback is another important source of quality assurance.

STANDARD SETTING OF KFP FORMATS

The issues of standard setting for high stakes KFP examinations are comparable to those in other written tests. The Medical Council of Canada uses the modified Angoff method while the RACGP currently employs a new approach, the Angoff at question level (AQL) method. These methods require multiple judges and are based on the concept of the borderline candidate as presented by Norcini in a previous article in the series *the Metric of Medical Education*.¹³

CONCLUSION

Writing key features problems is challenging and enjoyable. Following the steps in this guide will help ensure that KFP examination papers possess high levels of face and content validity and demonstrate levels of test score reliability that are acceptable for making decisions about individual candidates' clinical decision-making ability.

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