Acceptability of workplace based assessments in clinical setting

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Current trends in medical education are moving rapidly away from traditional marks-based examination towards the assessment gathering evidence of clinical competence and professional behavior on a daily basis in the workplace. Congruently, in the clinical setting workplace-based assessments (WPBA) have been developed to assess workplace-based learning programs[1].
Work place-based assessment is the assessment of a trainee's professional skills and attitude and should provide evidence of appropriate everyday clinical competences. It has the advantage of high content validity through assessing actual performance in the workplace. Workplace-based assessments should be promoted as an integral part of curriculum design and educational planning in post-graduate and super speciality departments, in which teaching, learning, assessment and feedback can be closely integrated[2]. WPBA will be an excellent potential source of information for educational supervision and feedback, geared towards providing evidence of satisfactory progress and achievement as well as identifying areas needing further development and discussing and agreeing means of addressing them. Post graduate should generally be judged against the standard that they are expected to have reached by the end of their current stage of training.

WPBA tools are practical and valuable as they can drive learning by facilitating regular one to one training time and allowing opportunities for concomitant feedback and identification of learning needs along with demonstrable evidence of engagement and progression in learning and training. However, since its inception in trainee assessment, WPBA has experienced significant problems in all specialties owing to a number of issues including rushed implementation, inadequate training, unrealistic expectations and a lack of clear purpose.[3] The existing structure and format has subsequently often been seen as a 'tick-box exercise' rather than a genuinely meaningful educational opportunity[3].

The role of WPBA and its popularity in medical education has arisen from the fact that competency is prized and evidence of this competency is sought using Miller's pyramid. In the Miller‟s framework for assessing clinical competence, workplace- based methods of assessment target the highest level of the pyramid and collect information about doctors' performance in their everyday practice. Direct Observation of Procedural Skills (DOPS), Mini-Clinical Evaluation Exercise (mini- CEX) and Case-based discussion (CbD) are some of the most commonly used methods of workplace - based assessments.

Using different assessment tools is thought to allow an overall valid assessment of a post-graduate and enhance learning.[1] The acknowledgment that increasing the number of WPBA tools improves both the reliability of the assessment and may serve to aid the trainee in their practice is a reasonable supposition.[2] The very fact that multiple different methods of assessments and sources of feedback are sought is based on the understanding that multiple types of assessment help to inform a more reliable result. It also helps to triangulate feedback sources. Perhaps many different modes of assessment points to the complex nature of the environment under assessment and that no single approach is perfect.

The reliability and validity of WPBA is often debated but it is also argued that, since most WPBA tools involve many encounters with a number of assessors spread over a period of time,

their reliability may be considered acceptable with six to eight encounters per tool per year.[3] However, there are significant feasibility issues relating to achieving this frequency of encounters. The consequential validity of WPBA is much debated in the literature; it has been suggested that the dynamic nature of clinical work is poorly served by the quantitative performance data and psychometric focus inherent in WPBA.[4] Several concerns arise about the PG manipulating the assessment process, such as altering their behaviour depending on their assessor and regarding the WPBA as a mini high-stakes examination, thereby putting pressure on the assessor to award a 'pass'.[5]. Undoubtedly, in assessments where the assessor knows the situation is formative, there tends to be a higher quality of feedback and appraisal of the task performed than in a summative situation. In addition, the trainee's reflection is constructive and astute when part of a collaborative discussion with a trainer. The most useful assessment occurs when the trainer has observed the trainee over a prolonged period and has assessed the skill or task before with the trainee.

The acceptability and utility of WPBA hinges on the sensitization of assessors and trainees, the cultivation of an educational learning environment and the training of assessors in providing constructive feedback. These are all adjustable dynamics that can be improved with deliberate effort in the correct educational pathway. The WPBA provides us with an opportunity to not only tell what the trainees have learnt but it also tells us the quality of their learning and this could be generalizable to any specialties.

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