# Workshop Report from the BASHH SAS conference, Keele 2017

# Finding the silver lining in work-place based assessments, Saturday 9th September 2017 (One Hour)

## Background

Workplace based assessments (WBPA) such as Mini-CEX and DOPS were introduced as a panacea for many of the issues with postgraduate education at the time. Initially proposed by John Norcini (Norcini, Blank et al. 1995, Norcini, Blank et al. 2003), they looked like an excellent approach to climb Miller’s Pyramid (Miller 1990), improving the validity of the assessments. However, the assessments themselves and the manner of their introduction led to considerable unintended consequences.

42 participants attended one of two one hour workshops that explored some of the negative aspects of WBPA and how these might be mitigated by active and early management of trainee’s expectations (ground rules). This document provides a summary of the outputs of the workshops.

## Negative aspects of WBPA (identified over two workshops, no particular ordering)

* Trainees tend to “binge”, leaving all their assessments until very late in their attachments, when suddenly they have many to do
* Retrospective requests for assessments are loaded with ethical, professionalism and role-modelling challenges, and tend to have little utility [[1]](#footnote-1)
* Workload
  + Time pressures
    - The assessments and observations take time to complete
    - The opportunistic nature of the assessments makes planning difficult
    - Unless there are dedicated teaching clinics, this is not taken into account for clinic workload, there is usually no protected time for WBPA
    - With funding cuts and changes in job plans, there is less time available
  + Paperwork
    - The paperwork involved/different forms etc can be onerous
    - There can be large numbers of assessments to complete.
  + Setting
    - The clinical environment may not be appropriate in terms of space and facilities and working practises and policies.
* The assessments can have effects on patients
  + Patient embarrassment with more than one person present
  + Issues around consent – patients need to give consent to help the trainee learn, and we need to be aware that this consent remains fluid (GMC 2008)
  + Patient assumptions need to be carefully managed – It is good for patients to know that all doctors have ongoing learning and assessment, it may be detrimental if the patient assumes that this is a doctor in difficulty.
* The trainee may change style whilst being observed
  + Intentionally (eg to appear more empathic, or to use fewer closed questions)
  + To try and conform to this assessor’s particular teaching agenda[[2]](#footnote-2)
  + Unintendedly (because of the anxiety of being assessed)
* The usefulness of the assessment, particularly as a developmental tool, depends on the relationship between the assessor and the trainee.
  + This can be challenging to form in one-off assessments
  + It can be negatively affected by giving negative feedback or low marks
  + Situations where the trainee is an expert in other fields can be particularly challenging
* Paperwork
  + Sometimes the forms do not appear to adequately cover the task in hand (Poor Validity)
  + Sometimes the assessment forms do not correlate with the suggested learning material or course objectives (Poor constructive alignment (after Biggs 1996))
  + The tick-box nature of many of the assessments demeans those aspects of the task which are difficult to quantify in this way (the McNamara fallacy)
  + Some of the mark descriptors seem arbitrary (eg what is the difference when inserting a speculum between adequate, good or excellent?)
  + Descriptors of good measures of competence may cease to be good measures when they become targets (Goodheart’s Law)
* Feedback given
  + There is poor consistency of marks between different assessors
  + The qualitative feedback given is often non-specific and so unhelpful (“needs more practice”, “getting there”, “good”)
  + Poorly framed feedback can have highly detrimental effects on trainee confidence, morale and ongoing learning.
  + Assessors may be Hawks or Doves, and may have reputations as such. Subject experts can be more stringent as we all feel that our own topic or sub-topic is most important.
* Electronic forms predispose to a delay in completion as a ticket needs to be raised and then answered.
* The philosophy behind the assessment can be unclear
  + There is some lack of clarity as to the balance between formative (for learning) and summative (for a final assessment) responsibilities of the assessments
  + The role of the assessor using the tool may be Teaching, Observing or Assessing at different times or with different trainees, or sometimes in combination
* There is a perceived lack of standardisation between assessors
  + Hawks and doves
  + Those who take the process more formally and those who don’t
* Culture
  + Tick box culture
    - Individual assessments are often seen as a tick box exercise, with little need for true reflection
    - The whole process is often seen as ticking boxes, and having little purpose behind it
    - There may be ”mutual cynicism” about the process between assessor and trainee
  + The wider medical culture, morale and work pressures are likely to have an effect on the rigour of activities which are not directly related to patient care and patient safety
* There are conflicting responsibilities and areas of focus (“discourses”):
  + Trainer focus (the trainer as the expert who makes summative assessments)
  + Learner focus (the aim is to help the learner develop)
  + Patient focus (best possible care for this patient)
  + Service focus (get through the clinic without delays etc)
* Trainees can come in with poor prior experiences and inappropriate expectations (too high, *or*, more commonly, too low)
* Biggs, J. (1996). "Enhancing teaching through constructive alignment." Higher Education **32**: 17.
* GMC (2008). Consent : patients and doctors making decisions together. London, General Medical Council.
* Miller, G. E. (1990). "The assessment of clinical skills/competence/performance." Acad Med **65**(9 Suppl): S63-67.
* Norcini, J. J., L. L. Blank, G. K. Arnold and H. R. Kimball (1995). "The mini-CEX (clinical evaluation exercise): a preliminary investigation." Ann Intern Med **123**(10): 795-799.
* Norcini, J. J., L. L. Blank, F. D. Duffy and G. S. Fortna (2003). "The mini-CEX: a method for assessing clinical skills." Ann Intern Med **138**(6): 476-481.

Dear Alex (new trainee),

Welcome to the clinic. So that we are clear, right from the start, I am always very happy to complete Mini-CEX and DOPS for you, but only in the following circumstances:

* The patients involved should know the purpose of the assessment, and they must know that they can decline to be involved at any time. Most of our patients are happy to participate in the ongoing development of their doctors.
* Timing and spacing
  + The assessments should be run spread throughout the training time, at regular intervals. Please don’t leave lots of assessments until the end of the attachment, there is a good chance that we will not have the capacity to do them, and this might delay your progression. Make sure you factor in any leave that your or your assessors have planned.
  + Assessments must be requested in a timely manner *[See first footnote on page 1, perhaps assessments will only be done if requested prospectively, some participants were more liberal about recent retrospective]*
  + To make the assessments useful, we will need to commit some brief but protected time to discuss the feedback face to face, this must happen within *[X time]* of the observation *[perhaps before the end of the day, or before the end of the session, or within a week…]*
* Inappropriate requests
  + The assessments should be on topics that are relevant and appropriate to the curriculum, to the patients and to the assessor’s areas of expertise
  + Probity is important, so please don’t ever ask an assessor to complete an assessment unless they have personally observed you. To ask them to do so is to ask them to lie about an assessment of clinical competence for patient safety, which could never be acceptable.
  + Please don’t ask to be signed off as competent when you suspect that you are not ready.
* Assessments are for improvement
  + In this department, we believe that everyone can benefit from feedback, regardless of their level, so the feedback that we give will be honest and well intentioned. We will try and point out the things you do really well, and also the things that we think should change.
  + Therefore, please expect to get some “negative” feedback, highlighting things that need to be improved. Please be prepared to accept and reflect on it.
  + Please understand that having an assessment may not always result in you being signed off as competent (but you should leave with a plan of how to get there)
  + Similarly, please expect that you may require more than the minimum number of assessments, and plan accordingly.
  + Be clear on what feedback you would particularly like from each assessment – you may wish to focus on areas of improvement suggested in previous assessments. This allows the assessor to tailor the feedback that they give to you, ensuring that it is as useful as possible.

Additionally, to get the most out of these assessments during your time with us, I would recommend the following

* Good time keeping, please arrive early enough before clinic to be ready to go at the starting time, please be prepared to stay until the clinic is finished, sometimes a little later if we need to feed back from an assessment
* Please come appropriately prepared for workplace-based assessments, including reading any pre-assessment paperwork, reading around the relevant subjects including guidelines
* Many assessors will find it useful if you could print a copy of the assessment out before the observation, so that they have something to work from whilst observing you.
* In this department, we are focused on your (and our own) ongoing learning and development, you should have a willingness to focus on your learning needs, share expectations. Please be honest about gaps in your knowledge and skills and accept that this process should find them and help fill them
* We work in multidisciplinary teams, with allocation of expertise across the professions, so please aim to actively participate in teamwork
* Reflection and reflective practice is central to the role of any clinician, wbpa provides an excellent trigger for reflection
* An initial meeting with your educational supervisor or principle trainer should help identify the areas where you should focus (your learning objectives or PDP), a target number of assessments throughout an agreed time-frame and relevant learning opportunities. You should arrange follow up meetings with them to review your progress.

This is a great placement for your learning and development, I really look forward to working with you.

Dr SAS

1. There was debate about what threshold was acceptable for retrospective assessments from none at all to one week for a simple procedural skill that was directly observed. There was agreement that any longer than this would be inappropriate, and an interesting parallel was drawn with writing patient notes retrospectively. [↑](#footnote-ref-1)
2. This was a particular issue for trainers who gave closed, fixed “you should do it my way” style feedback [↑](#footnote-ref-2)