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Assessment for "Fit to Practice" Graduates: OTTAWA-ICME Conference 2018

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It was a good experience to attend OTTAWA-ICME conference held in Abu Dhabi from 10–14 March 2018. My focus to attend this conference primarily was to collect novel ideas for faculty training in assessment with my mind-set for learning drive assessment approach. Assessment was debated from almost all the aspects in various forum from the key note address to plenaries, symposia, panel discussion and multiple free paper sessions. However, what I learnt from OTTAWA-ICME 2018 conference is a unique message of what we have been doing is time-worn assessment measure using multiple-choice question (MCQ), checklists, rubrics and global rating as the standard assessments. In current phase of our assessment practice in a competency-based medical education (CBME) we always talk of competencies, milestones and entrustable professional activities (EPAs). However, controversies arise when we look for measures how we do it and it falls back to nothing but old paradigm of assessment measures. This leads us to say we need a system of global judgement with some different structure, be it a new model of assessment system, programmatic assessment or assessment of competencies observed with equivalence beyond grades and psychometrics. Perhaps we need a new assessment model that addresses indigenous yet global needs of medical education and is defensible, practical and feasible.

We heard that a competency-based assessment (CBA) tool, while psychometrically strong cannot be implemented or will have a narrow focus on aspects of individual competencies without adequate faculty development. EPAs are a novel method of operationalising competencies and milestones set to monitor trainees' progress in terms of professional task delivered with knowledge, skills and attitude. Emphasis in assessment should be given to measures that can help to change behaviour, just not knowledge and enable students to perform. However, before signing out EPAs an expert must look into patient safety measures to declare trainee a competent physician. Professional bodies and the World Health Organization (WHO) have also endorsed a patient safety competencies framework for healthcare professionals to enhance local patient safety training programs (1).

We further heard that health care need and medical education is fast moving towards outcomes and competencies however, including an emphasis on self-directed learning as a basis for life-long learning (2).

To be successful in achieving this transition, assessment strategies need to be changed. This change needs to address the assessment of behavioural skills, the focus on feedback, use of narrative assessment information and more longitudinal assessment and monitoring that support self-directed learning (3). Fill-notes practiced by students on day to day experience becomes a narrative at the end help in self-directed learning. To practice curriculum with wide assessment strategies programmatic assessment a solution was recommended (4). This has been considered to support assessment to be more meaningful towards a change called learning driving assessment approach. Now critically analysing that we moved from a traditionally practiced curriculum based on past premise of what teacher wanted to teach to a new premise of what students are able to do in an outcome based education (OBE) or CBME, are we satisfied? In my frank opinion what has been all talked about, aren't we still practicing a curriculum which until now rely on what students are able to show than what they are able to do or perform specially in undergraduate medical education. Miller's clinical skills pyramid at "does" level of performance is usually not addressed in training as well as in assessment (5).

There is general perception, we like it or not that medical schools and students with increasing numbers across the world are in danger of producing "fit to pass exams' graduates than fit to practice graduates". The medical profession now globally needs an effort to come to a consensus and to adapt a practical approach in creation of competency achieved syllabus that produces undifferentiated tomorrows doctors with generic skills, who are able to perform during the internship. Currently medical university education is selective based on standards and grades in which purpose of assessment is to clearly demonstrate learning outcome and award qualification. However, we need CBA that fits for purpose of practice and an assessment that foster lifelong learning and development. My critique after having heard world renowned experts in medical education is focused on outcome of learning that do not neglect students' ability to perform. We need to address assessment if it is too fragmented or there is misalignment of learning and workplace (6). For a new assessment system first step is to align learning with workplace. The best way to assess students' affective domains is by putting students in a real workplace environment. In preclinical phase of training school should provide workplace environment with role-model iconic-figure tutors, simulated-patients developed through patient mentorship and clinical skills lab with clinical skills sessions and those assessed by Case-based Discussion (CbD). However, adapt to workplace-based assessment that do not rely on tick box cynicism rather than narratives to bring in qualitative assessment complementing quantitative assessment in a well-defined standard setting strategy towards logical decisions on students' performance.

New theory to revolutionise assessment should seriously consider assessment design based on research, validity, reliability, equivalence, multitude of methods, learning impact, longitudinal integration and being meaningful and trust worthy (7). Key principles to follow should be, an assessment that measures learning with multiple tools in which instructions and assessments are well aligned and information collected is aggregated, combined and triangulated to make logical decision. Often an assessment design with multiple assessment tools is simply a quantitative adds-on score of those tools that facilitate assessors to achieve desired pass rate. Complimenting one assessment tool with another in a compensatory standard setting strategy without a decision on their respective weighting based on purpose of individual tool is often a fit to pass-exam design.

Focusing on the CBA at workplace activities of trainees based on learner performance on those activities sounds most appropriate (8). In CBME, EPAs provides a comprehensive

framework to achieve multiple competencies and skills in curriculum (9), however, the process is not only resource intense but it also requires faculty development training in CBA to implement for desired outcome. Another option of programmatic assessment is based upon candidates' summative assessment result triangulated with information collated on students' performance of a formative or continuous assessment process. We assess students in bit and pieces needs to be replaced by holistic assessment approach provided in programatic assessment. This will provide evidences to make important decision on minimal competency achieved by the graduates needed for safe community health care practice.

Aggregated assessment information over periods in a training program may help to triangulate with summative assessment in making logical decision is a good choice in a standard setting strategy particularly for making difficult decision on borderline students. Triangulation in assessment refers to collecting information that determines student's performance on multiple points both in quantitative and qualitative, formative and summative in an assessment system. The process will facilitate committee comprising of experts to make a decision based on a longitudinally delivered new assessment system rather than relying on a quantitative scores based assessment system. A compromise to consider formative assessment for a logically authentic decision based on multiple data points at the end can be a good idea in triangulation of assessment that may ensure to produce fit to practice graduates. However, what an agreed upon assessment system will look like needs further work and guidelines that fulfils the indigenous needs of medical education curriculum and is feasible for a quality assessment system.

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