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Title:

Changing the Focus of Medical Undergraduate Assessment: Safety and Best Practice as Criteria

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Submission

Changing the Focus of Medical Undergraduate Assessment: Safety and Best Practice as Criteria

Assessment of medical students is fraught with difficulties. How do we say this student is fit to practice, even if in a supervised capacity. How do we set the standards? Currently, there are several methods in common use, namely, multiple choice questions (MCQ) and variants thereof, objective structured clinical examinations (OSCE), observed clinical cases or long case, portfolio systems with assignments and so on. These methods tend to focus on components of competence such as knowledge, or skills and fail to give an overall picture of performance, though some extrapolations can be made. Even when attempts are made to use criteria for assessment, they need to have some norm referencing against to set an acceptable pass level. It is hard to say under those circumstances, that a student who achieves just above the pass mark is fit to practice as opposed to one who achieves just below. By the time medical students get to their final years, they have cost a lot to train, and in New Zealand have committed substantial personal funds or accrued debt, so a failure mark, needs to be backed by good evidence of the soundness of the assessment process. Most of those involved in medical education will be able to recall students who seemed unsafe, but who were able to scrape through the examination system, and those who seemed OK, who struggled with exams, reflecting academic rather than professional capability. Also many will be able to cite instances of capable practitioners who have lacked judgement, and so committing errors. The assessment process drives learning and thus commits medical students to cram vast amounts of knowledge for examination purposes, which they forget most of shortly afterwards. Lifelong learning skills, an ability to recognise limits, ability to practice as part of a team, ethical standards are some of the attributes aimed for in new doctors but not usually assessed. Some schools, not in New Zealand, use either simulated patients or standardised patients (looking at the whole encounter unlike the OSCE which tests an identified component skill), as part of the assessment process, which gives examiners a chance to assess the performance of student as a whole. These patients can also be a powerful learning tool, providing formative as well as summative feedback. However, there is still the difficulty of setting an appropriate pass mark. How much of each component of the clinical encounter does the student need to get right to pass? And on how many patients?

At the Department of General Practice, Dunedin School of Medicine, we are trialing a system which focuses on the achievement of **safety** and **best practice** outcomes in a clinical encounter. We have set up a simulated clinic, using trained professional actors from a company with long experience in working with the medical school in providing simulated patients, where we control the inputs, with clear and detailed scenarios. The students are warned that they must achieve safety and best practice. However they are allowed to use any resource they wish during the consultation. The consultations are designed by experienced general practitioners to test a variety of safety issues. We have defined a safety issue as one in which the patient comes to serious harm, or the student has left themselves open to a complaint to a professional body. Best practice is defined as the application of evidence based medicine which is appropriate for that particular patient

in that particular context. Criteria are developed for each patient encounter.

This has proven a powerful educational tool as well as allowing for a complete overlap of formative and summative assessment. The students are focussed on professional performance, they need to be aware of their limits, they have to use resources effectively, and the standards they measure up to are those of the profession as a whole, and the public.

This method offers the opportunity to assess a student's level of performance, by comparing use of resources, including time and other team members, to achieve the two criteria, their knowledge of their limits, and if assessed over periods of time, a change in performance level, which we would term capability, i.e. an ability to adapt and learn. Use of these clinics in a formative way allows for identification of learning needs, and (self) testing using the more traditional component of competence assessment methods will allow both staff and students to identify areas to work on.

This innovation is in line with the moves towards authentic learning in professional education.

At the workshop, we wish to discuss and gain feedback on

- The theoretical basis of this process

- Practical aspects of constructing the clinics-details provided of current methods

- Methodology for benchmarking student performance against peers, postgraduate trainees and practising family doctors