

EDITORIAL

## Assessment and appraisal: much ado about something

Assessment and appraisal of those in specialist training are currently subjects of prolonged debate in the United Kingdom. Many of those responsible for education and training in anaesthesia believe that they have been asked to take on a new responsibility for which they feel ill prepared. There is therefore a growing demand for new courses and explicit guidance on how to conduct assessment and appraisal, either to assist those who believe themselves to be floundering or to offer reassurance to others that they are acting correctly.

Many of the anxieties surrounding assessment and appraisal must be attributed to the lack of consistent terminology in texts on medical education, indeed the words are sometimes used interchangeably. Further confusion arises from the subdivision into summative, formative, educational and developmental assessment, and there is conflict over whether one defined activity can inform the outcome of another. A useful and practical distinction is between those processes which purport to predict future performance and those which mould education in the present [1]. The former are summative; passing or failing an examination, or the decision to award a certificate marking the completion of specialist training; the latter focus on personal and professional development.

All disciplines in the arts and sciences are guilty of appropriating common words and modifying the dictionary definitions for their own specific use. Post-graduate medical education is no exception and it is not surprising that assessment and appraisal have now acquired different meanings in this particular context. Similarly the noun competence, first given modified meaning in education as a specific skill [2], has now acquired a broader definition in the field of medical education [3]. Even education and training are terms used synonymously, though training is a

learning process for repetitive skills and uniform performance whereas education develops an acknowledgement and understanding of complexity and uncertainty [4].

Assessment and appraisal are not new. The medieval craft guilds from which the Medical Royal Colleges developed had systems to manage the transitions from apprentice to journeyman and from journeyman to master. Assessing the performance of trainees is integral to any training system. In the United Kingdom the goal of most in specialist training is appointment to a consultant post, the only grade deemed capable of taking independent responsibility in specialist practice in the National Health Service. Before 1996, appointment to a consultant post followed successful passage through three distinct training grades. Initial entry to the most junior grade, and subsequent movement between grades, were dependent on competitive processes. As trainees still provided an essential contribution to clinical service the quality of those appointed was subject to the laws of supply and demand as well as judgment on their intrinsic merits. Candidates for appointment were supported by confidential references from referees of the candidates' own choosing: references were expected to be as supportive as possible consistent with honesty and protection of the public. Examinations played an essential part in the assessment of training but could only test knowledge of the clinical and academic base of the specialty and provide a snapshot view of professional behaviour and clinical judgment.

In the early 1990s, the Government of the United Kingdom became concerned that the systems for the recognition of specialist training might not comply with European Community law. A Working Group was set up under the chairmanship of Sir Kenneth Calman, Chief Medical Officer (England) at that time, to advise on the authorities competent to approve specialist training and so facilitate mutual recognition of specialist qualifications within the European Community [5].

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The Working Group also recommended changes to specialist training which in some specialties lacked a well-defined curriculum and had become too long. The reformed system of specialist training was introduced in 1996 and has become known by the convenient shorthand term, 'Calman Training'.

The reformed specialist training merged two of the three training grades and required a defined curriculum for each specialty. Assessment and appraisal were built into a structured, planned and managed system. For the more senior of the two training grades the Departments of Health in the United Kingdom issued comprehensive and detailed guidance on the management of training [6]. Assessment for this grade became 'competence based' and took place in the working environment, with central review of the documentation at least once a year. Satisfactory review was essential to progress to the next stage of training and to mark the completion of training. The system of assessment was to be broadbased, explicit and open, and appeal mechanisms against decisions were put in place.

There were four cogent reasons why assessment needed to become structured and properly documented. The first was to reassure the public. Recent unfortunate events have caused widespread concern over the performance and behaviour of doctors [7,8]. The public rightly demands that if the term specialist is awarded those charged with the responsibility for education and training have satisfied themselves that the new member of the elite has consistently demonstrated the skills and behaviour necessary for independent practice.

The second reason was to defend and justify decisions made as to whether trainees should progress to the next stage, can be deemed to have completed training satisfactorily, require remedial training or should be removed from the training programme. Structured assessment provides documented evidence on which decisions have been made: the decisions are then open to independent appeal and review. Natural justice demands that decisions which can have profound effects on trainees' careers and livelihoods can be challenged. If those in independent practice show evidence of poor performance then licensing authorities may wish to backtrack through training records to ensure that assessment processes are sound.

The third reason was to assist trainees, who believe their learning is enhanced if progress is made explicit and their strengths and weaknesses are discussed: they know where they stand. The fourth was to assist trainers, who find that their satisfaction is increased if there are formal opportunities to discuss trainees' progress on a regular basis. If good educational structure is in place time is saved.

The system of postgraduate medical education in the United Kingdom is complex but a simple overview would be that postgraduate deans, who have responsibility to both a university and the administration of the National Health Service, manage the process to standards set by the Medical Royal Colleges. Postgraduate deans are therefore closely involved in assessment for trainees of all grades. Discussions with trainees on deans' visits to hospitals reveal that good educational programmes are often described but there is a lack of overt process for setting out an educational plan based on an individual trainee's needs. This plan should be drawn up by trainer and trainee at the start of a post, placement or module, and will describe the learning opportunities, the extent to which increasing responsibility for patient management will be developed, and the nature and timing of the assessments which will be carried out.

There is particular merit in setting aside specific undisturbed time for formal assessments which are preceded by a brief period for reflection by both trainer and trainee on what will be discussed. The need for documentation has already been emphasized. Written records should be kept of the key points raised and the conclusions reached should be agreed by both parties. Failure to achieve mutual agreement will be rare, but if it occurs the underlying reasons should be explored.

In postgraduate medical education the apprenticeship model is still valued. There will be daily discussions about patients, principles and procedures. These 'professional conversations' [4] will inevitably include less formal assessments in the form of feedback on progress. Unfortunately feedback on deficiencies, even though given constructively, is more common than praise for tasks performed well. The comment 'I suppose I must be doing OK as no one has told me off' is still common from trainees. There

are few who do not benefit from praise and encouragement when this is deserved, and the reassurance that progress is satisfactory, even if not outstanding, should be explicit.

Trainers and trainees often ask what should be assessed. The 'competence revolution' requires that assessment should be 'competence based' [2]. Patients expect that doctors who treat them have demonstrated possession of the necessary clinical skills. However, the proper practice of medicine demands much more than a correct sequence of individual skills or competences. It requires clinical reasoning and clinical judgment; an understanding of medical ethics, research methods and clinical audit; a capacity for self evaluation and self criticism, and an ability to work in teams. It requires the ability to communicate with patients whose individuality and autonomy are respected.

There is a natural tendency to devote more time to those aspects of practice that are most easily assessed. It is easier to assess a trainee's ability to insert a pulmonary artery catheter than to assess the equally important ability to interpret the measurements obtained and act appropriately. As long as assessment is regarded as something new there will be a temptation to fall back on to 'tick list' assessment which offers false reassurance to trainers and the general public [9]. Trainees must also be made aware that their professional behaviour will be assessed. Complaints from patients and their relatives relate to problems in doctors' behaviour as often as to doubts over their clinical abilities. Two recent publications from the General Medical Council of the United Kingdom provide guidance on ethical behaviour and professional practice [10,11].

Assessment is not new and my personal view is that most consultants have been assessing the clinical skills and professional behaviour of their trainees well. What was introduced in 1996 was a firm structure involving detailed documentation, the sharing of assessments with trainees in an open manner and the right of appeal. Concerns expressed by consultants over the new system fall into three main categories: the need to keep written records, the difficulties of discussing unsatisfactory progress with trainees and fears of the legal repercussions of an adverse assessment. Analogies with clinical practice may be helpful in allaying these concerns. The need to keep detailed

clinical records is accepted and equivalent documentation on assessment is now required. All consultants have experience in breaking bad news to patients and though the task is neither pleasant nor easy, it is an accepted responsibility of medical practice. There is an equivalent obligation to discuss problems in training in an open and constructive manner. If patients are becoming more litigious then it is not surprising that trainees are becoming more litigious as they believe both their income and integrity may be threatened by an adverse assessment.

The best defence against litigation by patients and trainees is considered and unbiased professional judgment supported by documented evidence. 'No papers, no problems' is no longer an option and licensing authorities will be auditing the records of training, both as a check on process and to review training if those accredited subsequently show lapses in performance.

Education and medicine are morally charged activities. They operate to the fundamental ethical imperatives to do no harm and to respect the autonomy of the patient and of the learner [12]. Patients perceive their doctors as powerful: trainees perceive their consultants as powerful in three areas: as teachers, as employers and as gatekeepers controlling entry into and exclusion from a professional club. In clinical practice, doctors are required to consider patients 'as partners' with whom information is shared and a similar approach is now expected in postgraduate medical education.

Anxiety over assessment is needless. Clear and concise guidance on assessment and appraisal is available [13]. Medicine and education share the same ethical foundations and accepted practice in the former can now be adopted in the latter. Assessment is as old as medicine: it is the introduction of an underlying structure which is new.

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