

*This textbook is available in Elise's office if you are interested (or she can give you her electronic access code, just ask.)*

**Holmboe et al, Practical Guide to the Evaluation of Clinical Competence, Elsevier, 2<sup>nd</sup> Edition**

## **A Brief History of Assessment**

Through the early 1950s, physicians were assessed in limited ways.<sup>29</sup> Medical knowledge was evaluated with essays and other open-ended question formats that were graded by an instructor. Clinical skill and judgment were tested using an oral examination that often required the student to go to the bedside, gather patient information, and present it along with a diagnostic list and treatment plan to one or more examiners who asked questions. Because these were the only generally accepted methods available, they were applied to most assessment problems even if they were not completely suitable to the task. That may have been acceptable in a time when supervisors had much more control over the health care process and had natural checks of everything learners reported. Over the past decades health care has become too complex to warrant this type of “on-the-fly,” ad hoc approach. For example, lengths of stay in hospitals have dropped dramatically and faculty have multiple competing responsibilities.

From that point to the present, there have been extensive changes in the way assessment is conducted. Methods have proliferated, as have the requirements for their appropriate use. Much progress has been made in the assessment of medical knowledge with a variety of written and computer-based techniques offering reliable and valid results (see [Chapter 6](#)). In the last few decades, considerable gains have been made in defining and enhancing the psychometric qualities of objective structured clinical examinations (OSCEs), particularly related to their use in high-stakes examinations (see [Chapter 5](#)). However, assessment in the context of learners caring for patients in clinical units (i.e., wards, operating theater, ambulatory clinic) has lagged to some degree, especially in the areas of clinical skills, interprofessional teamwork, and quality and safety of care.<sup>24,30</sup>

Equally important, the methods that have been developed to support clinical education often rely on faculty who are inexperienced in their use, do not share common standards or shared mental models of the competencies of importance, and have not been trained to apply them in a consistent fashion. In addition, faculty now experience substantial time pressures, more learner and patient handoffs, higher degrees of comorbidity among hospitalized patients, and increasing personal clinical responsibilities. Perhaps more concerning are recent findings that one of the principal drivers of faculty assessment relates to their own clinical skills, with a number of studies highlighting important deficiencies in practicing physician clinical skills such as medical interviewing, physical examination, and communication skills.<sup>31,32</sup> Finally, many of the faculty are also being asked to assess and judge competencies, such as care coordination, patient safety, and use of information technology, areas in which they themselves were never formally trained. Compounding this state of affairs has been the lack of effective faculty development approaches and models to address these new clinical and educational methods.<sup>33</sup>

