PERSONAL VIEW PAPER

TITLE: Illusions of specificity in power-laden clinical performance assessment

SHORT TITLE: Power in assessment

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Illusions of specificity in power-laden clinical performance assessment

The practice of observation-based assessment is synonymous with clinical performance assessment methods employed on many academic programmes which lead to health professional qualifications. Typically health professional students undertake apprenticeship-type practice placements during which time they are assessed by a supervising clinical educator, i.e. a clinician who has undertaken the facilitation and assessment of a student’s clinical performance while continuing with their primary service role. Clinical performance is determined through the achievement of learning outcomes identified on clinical performance assessment tools, or through tick-box or global rating scales in which students’ observed performance is matched against pre-set learning outcomes. These high-stakes assessments yield grades that are critical to students’ progression and entry into their chosen profession.

In this paper, we critically question the centrality of observation-based assessment of practice, probing the assumptions underpinning its use. We outline the highly performative nature of clinical performance assessment and argue that the tenet upon which observation-based assessment is constructed does not pay sufficient attention to issues of power in the student-assessor relationship. To date critiques of the clinical performance assessment model have largely focussed on the psychometric properties of assessment instruments used and the interrater reliability of assessors (Govaerts et al. 2013). We argue that insufficient attention has been given to the influence of student-assessor power relations on the process and judgements associated with observation-based assessment. Furthermore, we illustrate using a Foucauldian framework how students’ performances are fundamentally aligned with their estimations of what their clinical educators want of them rather than an actual calculation of what is required in a particular clinical setting.
According to Foucault (Foucault 1995), hierarchical control is subtle but pervasive and is enacted in three main ways. These features of control include “hierarchical observation”, “normative judgement” and the “technology of the examination”. All three features are evident within observation-based assessment in the health professions. Hierarchical observation - the observation of one by another - can significantly influence the behaviour of the student ensuring that they remain compliant with the perceived expectations of the observer, i.e. the assessor. Being subject to this ‘calculated gaze’ (Foucault 1995) influences behaviour more significantly than more explicit forms of control. In this context the student’s ‘performance’ becomes an act; a form of dressage so to speak, displaying compliance with the routines and practices associated with ‘being’ a competent physiotherapist, doctor, nurse. The assessment does not necessarily shed light on the underlying thought processes underpinning the action.

Foucault’s second concept that of normative judgement, is evident in the observation-based process. Whilst the assessor has access to an assessment instrument with defined descriptors or indicators of performance, suggesting a form of criterion-referenced assessment is being employed, in reality judgements are normatively referenced, based on comparison with similar students or practicing professionals. In that context ‘being’ a physiotherapist, nurse or doctor equates to replicating and complying with others’ practices. Therefore while the assessment instruments provide the ‘illusion of specificity’ in terms of the application of criteria, one cannot remove the assessment process from the normative judging that underpins control. Use of complex grading rubrics may give the impression that set criteria are being objectively applied by assessors but this ignores the likelihood that assessors are also using subjective criteria based on implicit normative expectations grounded in experience.
The third dimension outlined by Foucault refers to the ‘technology of the examination’ (Foucault 1995). This is the culmination of the previous two dimensions where hierarchical observation combined with normative judgement is employed to examine the student. The examination constitutes a formalised process, a ritual of power “that makes it possible to qualify, to classify and to punish” (Foucault 1995). Foucault referred to this when he described the organisation of hospitals in the 18th century as “examining machines”, and likewise the examination processes conducted in schools as “sites of perpetual examination” (Foucault 1995). Similarly the health professional student is a “case” subjected to constant scrutiny by the assessor, which in itself becomes a further exercise of power. Additionally, documented evidence pertaining to the student’s performance exposes them to ongoing measurement and analysis by their assessors and comparison to their peers, further empowering assessors throughout the process.

Evidence provides support for Foucault’s concepts. For example, it has been shown that assessor’s decision-making is often intuitive rather than objective. Assessors use implicit definitions of effective behaviours based on what they estimate to be desirable aspects of performance (Govaerts, Van de Wiel, Schuwirth, Van der Vleuten and Muijtjens 2013). Assessor intuition is not only derived from examiners’ idiosyncratic experiences but also from the implicit, taken for granted norms and beliefs associated with their membership of particular professional groupings or institutions. In other words assessor intuition is not just an individual attribute but is also socially constructed through participation in professional communities. For example a recent study which examined how clinicians become teachers (Cantillon et al. 2016) found that performing as a clinical teacher requires a continuing negotiation of teacher identity and practice in relation to regimes of competence within
clinical teams, teaching hospitals and medical schools. A critical feature of regimes of competence within clinical communities was “looking the part”. Student health professionals strive to talk, act and perform in a manner conducive with the dominant regime of competence within their clinical teams and institutions.

Foucault’s concepts allow us to interrogate the role that observation-based assessment may be playing in maintaining the status and prestige of the health professions. Assessors act as gatekeepers to membership of professions and as such observation-based assessment is a technology whereby supervisors and clinical teachers not only measure performance against predetermined learning outcomes, but also exercise considerable power in terms of defining a learner’s conformity with the norms, beliefs and practices of a particular professional group. If, as we have argued here, the assessment of health professional students in the workplace is not as objective as the assessment tools would lead us to believe, it is perhaps understandable that students undergoing observation-based assessments come to see them as exercises in impression management. Our concern is that students ‘perform’ for assessors regardless of the specificity of the assessment instrument used to mediate the process in a ‘give them what they are looking for’ approach. Observation-based assessment can be portrayed as a legitimate form of assessment of a student’s readiness and competence to practice, mapped out to meet national accreditation requirements. Alternatively, from a Foucauldian perspective, observation-based assessment is also a form of disciplinary control where compliant students are expected to ‘act’ in a manner congruent with the perceived beliefs and assumptions of the assessor. Is clinical competence therefore essentially about ‘looking the part’ rather than meeting the prescribed learning outcomes?
We believe that this poses several questions and reasons for re-examining clinical performance assessment methods, particularly where it is solely relied upon to determine students’ readiness for practice. For example, is the observation and assessment of student performance a form of boundary maintenance designed to maintain the status quo and filter out candidates who do not ‘fit in’? What therefore are the implications for the development and standards within the health professions? Moreover, if this is the case, then the value, time and effort afforded to the development of assessment tools and grading rubrics needs to be re-evaluated. We also need to consider the act of observing clinical performance from the student perspective. Does an assessment process based on observation exert too much pressure on the learner because of this scrutiny thus hindering a student’s development as a professional? Alternatively, is it a game of impression management played out by the student in order to comply with the imagined expectations of assessors?

In spite of the enduring apprenticeship model of practice-based education among the health professions, we suggest that the assessment process involved in determining the readiness to practice of health care professional students requires a fresh perspective, in particular regarding the roles of the student and their assessors. We recommend a means of quantifying the impact of power in this setting. Furthermore we advocate a review of the role and input of the health professional educationalist (a facilitator of learning and also a qualified clinician employed for the sole purpose of facilitating practice based learning) and clinician in the assessment process, perhaps leaving the facilitation of learning to the clinician and the assessment of performance to the trained educationalist? Such a system would preserve highlighted attributes of the apprenticeship model while affording transparency to the assessment process. Further collaborative dialogue among health education providers is necessary to consider and explore these recommendations.
References

