

EDITORIAL

GRADUATE EVALUATION ... NEED FOR A CHANGE

Muhammad Shamim Anwar

Department of Medicine Ayub Medical College, Abbottabad

After a ward round on a very busy emergency day when I entered my office the ward clerk dropped two huge postal packets wrapped in thick cloth, tightly sewed-up by some master tailor and covered with thick official seals. For a moment I could feel my heart thump inside my chest, my mouth became dry and I had a sticky feel in my throat. These were MBBS *descriptive essay* scripts from the university sent for checking. The bundles were capable of giving a prolapsed disc to a robust young man if he tried to be brave and pick them up. I was therefore not going to try. The accompanying letter said:

"I would be very grateful if you kindly mark the scripts and send the award lists along with the scripts within 10 days of the receipt of the scripts. Kindly ensure that no answer is left un-marked as the frequency of unmarked answer is on the rise. Your co-operation and timely return of the scripts & award list will be regarded a great service to humanity."

I'm sure many of my colleagues are familiar with this scene. All teachers who actually read the scripts (200 to over 400) thoroughly know the misery they have to endure, not because of the time and effort that goes into doing so but because of the realization of how variable (non-uniform) their scoring is from paper to paper and from one sitting to the other. We are going through this pain, our teachers have gone through this pain and the teachers of our teachers have gone through this pain. I wonder why?

Evaluation is as ancient as learning and the two have been and will always be together. Evaluation of students is one of the primary job of all teachers in a medical college. It should be fair, time saving and goal oriented. At the end of an evaluation both the student and teacher should know that justice was done.

The current evaluation (especially the theory evaluation) needs drastic review and change. The evaluation of students and clinicians has advanced and the evaluation process has been evaluated by colleagues again and again to come up with the best. We can not continue with the existing system if we mean to create graduates at par with the rest of the world. Over the past ten years, medical colleges, postgraduate training programs, and licensing and registration bodies throughout the world have made

new efforts to provide accurate, reliable, and timely assessments of the competence of trainees and practicing physicians.^{1,2,3}

It is important to identify the goals of evaluation of medical students and doctors. The first goal of assessment should be to increase the capabilities of the learner. We know that assessments (or examinations) drive student behavior. Our students are very capable if given the correct motivation and guidance. If the evaluation is dynamic the students will definitely bring up their standards and will stay motivated to learn today and in the future. The second goal should be to protect the public by identifying incompetent students. The current system is very poor at achieving this goal. One of the main problem is direct influence or pressure on examiners ... Examiner-Bullying ... by members of the community to deliver favorable evaluation results. We are seeing the growing number of incompetent and extremely dangerous physicians given responsibility for caring for a very poor and needy patient population. Objective evaluation, computer and group evaluation will significantly reduce examiner bullying and hopefully protect the public from incompetent physicians. The third goal should be to provide a basis for preparing and choosing applicants for advanced training. The current evaluation is not fulfilling the last objective as well because it is not in harmony with the majority of postgraduate evaluation methodologies.

Methods of evaluation vary. There is no single perfect and flawless method of evaluation but almost all other modalities are better than our current written examination method. A number of factors have to be considered to decide the most appropriate method of evaluation. These include reliability (the degree to which the measurement is accurate and reproducible), validity (measures what it claims to measure), its effects on future practice and learning, acceptability to learners and teachers, and costs (affordable)⁴. The various techniques involved include written examinations (of various types), assessment by supervising clinicians (including oral examinations), clinical simulations and multi-source assessments⁵. The use of multiple observations and several different assessment methods over time will compensate for flaws in individual evaluation methodology.

It is already late but it is never too late to change for the better. A change is in order for the

sake of fairness to all. The change has to be towards a properly designed objective evaluation. Multiple-choice questions are commonly used for assessment because they can cover a wider area of the curriculum, can be administered in a relatively short period, and can be checked by a computer. These factors make the administration of the examination to large numbers of trainees straightforward and more importantly standardized.⁶ This is in the interest of the student who would like to understand the subject instead of memorizing and cramming up large material in a foreign language. The written examinations have to change to a better variety of context rich objective papers e.g. extended matching type. Questions with rich descriptions of the clinical context invite the more complex cognitive processes that are characteristic of clinical practice.⁷ Manual checking has to be replaced by computer checking for the purpose of fairness and more importantly to ease off pressure of influential people over examiners. The faculty of Khyber Medical University and the faculties of other medical colleges and

universities throughout the country have to put their heads together and come up with better learning and evaluation strategies for today and for the future.

REFERENCES

1. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002;287:226-235.
2. Batalden P, Leach D, Swing S, Dreyfus H, Dreyfus S. General competencies and accreditation in graduate medical education. *Health Aff (Millwood)* 2002;21:103-111.
3. Leung WC. Competency based medical training: review. *BMJ* 2002;325:693-696.
4. Van Der Vleuten CPM. The assessment of professional competence: developments, research and practical implications. *Adv Health Sci Educ* 1996;1:41-67.
5. Epstein RM. Assessment in Medical Education. *NEJM* 2007;356:387-396.
6. Case S, Swanson D. Constructing written test questions for the basic and clinical sciences. 3rd ed. Philadelphia: National Board of Medical Examiners, 2000.
7. Schuwirth LW, Verheggen MM, van der Vleuten CP, Boshuizen HP, Dinant GJ. Do short cases elicit different thinking processes than factual knowledge questions do? *Med Educ* 2001;35:348-356.

Address for Correspondence: Prof. Dr. M. Shamim Anwar, Head Department of Medicine, Ayub Medical College, Abbottabad, Pakistan.