Received: 1 March 2022 | Revised: 11 March 2022 | Accepted: 12 March 2022
DOI: 10.1111/medu.14802

Patient involvement in assessment: How useful is it?

Bunmi S. Malau-Aduli

College of Medicine and Dentistry, James Cook University, Townsville, Queensland, Australia

Correspondence
Bunmi S. Malau-Aduli, College of Medicine and Dentistry, James Cook University, Townsville, Queensland, Australia.
Email: bunmi.malauaduli@jcu.edu.au

A scoping review published in this issue of *Medical Education* by Khalife et al. highlights the benefits of involving patients in assessing postgraduate medical learners.[1] The authors set the scene by stating that the authentic patient voice is still merely a whisper in contemporary competency-based assessment in medical education despite the global movement towards greater patient partnership in defining a holistic medical learners' competence for 21st century health care. They postulate that patients can be effective assessors given the high correlations among themselves in rating the humanistic attributes of residents in professional behaviours, advocacy and communication skills and the lower correlations with clinicians who prioritise medical knowledge. The authors argue that there is a misalignment between the perspectives of patients and clinicians and that the extent to which unique insights from patients are taken up in postgraduate medical education may be dependent on the readiness of assessment systems, particularly the readiness of clinicians, to partner with patients as assessors.

Authentic patient voice is still merely a whisper in contemporary competency-based assessment in medical education.

Although clinicians, as the central actors in assessment systems, have expressed uncertainty and concerns regarding ability, expertise and potential bias of patients in assessment,[2] studies have shown that clinicians themselves are not totally free of bias in their judgement.[3] As such, Khalife et al.[1] reignite the debate about the usefulness of patient involvement in assessment within medical education. In this commentary, I will further contrast and compare the decision making of patients (standardised or real) with the processes employed by clinically trained examiners in an effort to help elucidate the usefulness of the patient's voice in competency-based assessment and guide future research in this area.

Clinicians, as the central actors in assessment systems, have expressed uncertainty and concerns regarding ability, expertise and potential bias of patients in assessment.

Clinical performance assessment is a complex cognitive task that requires processing and assimilation of initial impressions with a proactive detection and selection of relevant performance elements that can burden working memory.[4] Objective Structured Clinical Examinations (OSCEs) are commonly used for this purpose to remove the priority of patient care and to enable the evaluation of students using consistently presented scenarios.[5] Our recent study[6] confirms that medical schools are still keen to retain OSCEs, despite COVID related restrictions, due to their ability to enforce rigour and standardisation in the assessment process. In this context, assessor judgements are guided by prescribed expectations and scoring criteria, provided by

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2022 The Authors. *Medical Education* published by Association for the Study of Medical Education and John Wiley & Sons Ltd.

assessment academics, outlined on the OSCE sheet. The judgements offered are not 'objective', however, as my colleagues and I have noted that the process of making judgements about student performance involves combining analytical and affective elements with an intuitive drive to rate candidates against a personal construct of a 'prototypical intern'.[7] In making such a comparison, the specific, time-limited, and pre-scripted nature of OSCE encounters may require assessors to adapt their expectations of learner performance to take into account situational constraints. In a follow-up study,[8] we explored OSCE assessors' perceptions of the 'prototypical' construct by applying a theoretical framework (Cultural Historical Activity Theory [CHAT]) that enabled examination of the complexity inherent in making assessment decisions. Interestingly, we found that clinical assessors make judgements that combine, to a varying extent, two interacting sets of roles and experiences that have different origins: The academic construct, achievement of expected graduate learning outcomes, and the clinical workplace construct, the ability to successfully and safely work within professional settings. If a goal is to evaluate professional expectations such as rapport-building and patient safety, which emphasise person-centred care, it makes sense to involve the patient in the decision-making process. However, there may be important differences in the cognitive processes standardised patients (SPs) use in OSCE settings relative to those utilised by real patients in the workplace-based assessment (WBA) setting.

If a goal is to evaluate professional expectations such as rapport-building and patient safety, which emphasise person-centred care, it makes sense to involve the patient in the decision-making process.

Although SPs have been known to provide sound judgements on professional skills such as empathy and communication skills,[9,10] they do so through the lens of a list of medically enculturated checklists provided by faculty members with a focus on achieving standardisation, rather than prioritising the SPs' authentic opinions.[11] As a consequence, other researchers have suggested that real patients outside the educational environment provide more valuable feedback that better prepares medical students for clinical practice.[12] In fact, an exploration of the potential role of patients in assessment has revealed a disconnect between the views of real patients and medically enculturated examiners, with patients being able to better identify deficiencies in students' communication skills.[13] Interestingly, this study has generated a lot of interest among the medical student body, who endorsed the involvement of patients in assessment but identified crucial areas of consideration, such as it being imperative for cultural factors to be considered if the data are to be used summatively.[14] Based on anecdotal observation, these authors reported that the ratings they received from patients were less favourable when compared to peers from more extroverted cultures. In further consideration of relevant perspectives, Harris et al. challenged the non-involvement of student opinions by pointing out that further research is needed to explicate the subtle differences in patients', examiners', and students' viewpoints[15]; patients were deemed critical stakeholders in clinical assessments if we are to optimise preparative training for patients and aid an equitable implementation of patient involvement.

The medical student body endorsed the involvement of patients in assessment but identified crucial areas of consideration.

Juxtaposing these findings with those of Khalife et al.[1] unveils a field of enquiry that will elucidate a pathway to identifying best practices for involving real patients in OSCE and WBA competency-based assessments. Greater understanding of the socio-cultural perspectives, cognitive processes and sources of bias of all key stakeholders will feed into innovations that effectively increase assessment authenticity with the added potential to appropriately drive learning, professional development and clinical practice. Involving a diverse patient population in competency-based assessment will provide a more authentic representation of the diverse society in which medical trainees will work.

Greater understanding of the socio-cultural perspectives, cognitive processes and sources of bias of all key stakeholders will feed into innovations that effectively increase assessment authenticity.

ORCID

Bunmi S. Malau-Aduli https://orcid.org/0000-0001-6054-8498

REFERENCES

1. Khalife R, Gupta M, Gonsalves C, et al. Patient involvement in assessment of postgraduate medical learners: A scoping review. *Medical Education*. Published online. January 4, 2022;56(6):602-613. doi:10.1111/medu.14726
2. Moreau K, Eady K, Jabbour M. Patient involvement in resident assessment within the Competence by Design context: a mixed-methods study. *Can Med Educ J*. 2019;10(1):e84-e102. doi:10.36834/cmej.56881
3. Yeates P, Moreau M, Eva K. Are examiners' judgments in OSCE-style assessments influenced by contrast effects? *Acad Med*. 2015;90(7):975-980. doi:10.1097/ACM.0000000000000650
4. Tavares W, Eva KW. Exploring the impact of mental workload on rater-based assessments. *Advances in Health Sciences Education*. 2013;18(2):291-303. doi:10.1007/s10459-012-9370-3
5. Reid H, Gormley GJ, Dornan T, Johnston JL. Harnessing insights from an activity system—OSCEs past and present expanding future assessments. *Med Teac*. 2021;43(1):44-49. doi:10.1080/0142159X.2020.1795100
6. Malau-Aduli BS, Jones K, Saad S, Richmond C. Has the OSCE met its final demise? Rebalancing clinical assessment approaches in the peri-pandemic world. *Front Med*. 2022;9:825502. doi:10.3389/fmed.2022.825502
7. Malau-Aduli BS, Hays RB, DSouza K, et al. Examiners decision-making processes in observation-based clinical examinations. *Med Educ*. 2021;55(3):344-353. doi:10.1111/medu.14357
8. Malau-Aduli BS, Hays RB, D'Souza K, et al. “Could you work in my team?”: Exploring how professional clinical role expectations influence decision-making of assessors during exit-level medical school OSCE. *Front Med*, Forthcoming. 2022;
9. Snow R, Crocker J, Talbot K, Moore J, Salisbury H. Does hearing the patient perspective improve consultation skills in examinations? An exploratory randomized controlled trial in medical undergraduate education. *Med Teach*. 2016;38(12):1229-1235. doi:10.1080/0142159X.2016.1210109
10. Prediger S, Harendza S. Perspective matters: assessment of medical students' communication and interpersonal skills by simulated patients from the internal and external patient perspective. *GMS J Med Educ*. 2021;38(4):Doc82. doi:10.3205/zma001478
11. Gordon J, Markham P, Lipworth W, Kerridge I, Little M. The dual nature of medical enculturation in postgraduate medical training and practice. *Med Educ*. 2012;46(9):894-902. doi:10.1111/j.1365-2923.2012.04301.x
12. Bleakley A. Embracing ambiguity: curriculum design and activity theory. *Med Teach*. 2020;43(1):14-18. doi:10.1080/0142159X.2020.1795099
13. Moult A, McKinley R, Yeates P. Understanding patient involvement in judging students communication skills in OSCEs. *Med Teach*. 2021;43(9):1070-1078. doi:10.1080/0142159X.2021.1915467
14. Wook Park C, Ahmed SES, Chua CU, Olubodun OR, Radford DJ. Response to: Understanding patient involvement in judging students communication skills in OSCEs. *Med Teach*. 2021;1-10. doi:10.1080/0142159X.2021.1993163
15. Harris W, Skuse K, Craig C. Understanding patient involvement in judging students communication skills in OSCEs: a medical student perspective. *Med Teach*. 2021. doi:10.1080/0142159X.2021.1996552

How to cite this article: Malau-Aduli BS. Patient involvement in assessment: How useful is it? *Med Educ*. 2022;56(6): 590-592. doi:10.1111/medu.14802

DOI: 10.1111/medu.14788

On identity, agency and (sub)culture

Christopher J. Watling

Department of Oncology, Department of Clinical Neurological Sciences, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada

Correspondence
Christopher J. Watling, Department of Oncology, Department of Clinical Neurological Sciences, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada.
Email: chris.watling@schulich.uwo.ca

Several years ago, I was presenting at a small research meeting. The audience was mostly PhD-trained research scientists, reflecting the diversity of disciplinary backgrounds that so enriches the field of health professions education. In introducing myself, I used the same simple identifier I'd been using for the previous twenty-odd years: ‘I'm a neurologist’. As if that were entirely self-explanatory. An astute ethnographer colleague approached me afterward and asked, ‘Why do you always introduce yourself that way?’ I had to admit I'd never given it any thought (I am, after all, a neurologist). But her question made me reflect on how strongly embedded that identity had become, how readily I invoked it and how it might sometimes serve as a shield rather than as a bridge.

Identity and culture matter a great deal in medical education and practice. The training of doctors is a process of enculturation and ‘tacit socialization’.[1] Instilling a sense of identity as a medical professional is, in fact, an explicit goal of many medical education programmes. Social identity approaches suggest that group membership influences an individual's self-concept and that group norms tend