Australian Medical Council Limited

Conducting assessment in a changing environment

Workshop Session 1: Current state of assessment in Australian and New Zealand Medical Training

2:00pm – 4:00pm AEDT, Tuesday 30 March 2021

Contents

Acknowledgement of Country



The Australian Medical Council (AMC) acknowledges the Aboriginal and Torres Strait Islander Peoples as the original Australians, and the Māori People as the original Peoples of New Zealand.

We pay respect to these Peoples, the traditional custodians of all the lands on which workshop participants will be based and, recognise their ongoing connection to the land, water and sky.

We recognise the Elders of all these Nations both past, present and emerging, and honour them as the traditional custodians of knowledge for these lands

Purpose of this booklet

This booklet sets out the key speakers, program, focus activities and background reading for the Session 1 of the AMC's Assessment Workshop series. Participants are encouraged to read this booklet as a means of guiding them in how the workshop session will be structured and to maximise opportunities for engagement during the session.

Prior to Attending Session 1

☑ Register for workshop sessions

☑ Read this booklet

☑ Visit the Virtual Attendee Hub to see all your workshop sessions, access resources, and watch any previous recordings

☑ Get ready to engage in online discussions on 30 March 2021 from 2.00 – 4.00 pm AEDT

Workshop platform

To access the workshop sessions please visit the **workshop site**

- Click the "Virtual Attendee Hub" button
- You will need to verify your access and will receive a code on the mobile and email you used to register
- Enter the code to continue to the hub
- On the hub, you can see your schedule and sessions. Click join session to participate.
- Any issues? Email us using the AMC contact details below

Etiquette

Participants are asked to please observe the following during the workshop sessions -

- During presentations and whole of workshop sessions:
    - Use the Q&A function to ask questions - the Q&A button can be found to the right of the workshop live stream
- During the Breakout sessions
    - Microphones muted unless you are speaking
    - Camera to remain on if possible
    - Participants to identify themselves on screen by first and last name and organisation
    - Use the raise hand function to ask a question or comment
    - Use the zoom chat function to make comments
    - We recommend gallery view so you can see everyone in your group

AMC contact

Karen Rocca
Email: accreditation@amc.org.au

Overview of workshop sessions

Building on earlier AMC workshops on moving to online examinations (2020), and programmatic assessment (2017), this workshop aims to provide education providers with opportunities to engage in effective change to their assessment programs. The workshop will provide opportunities to explore the need for change and some of the barriers, highlight some common challenges experienced in meeting current AMC standards in assessment, balancing program based assessment with other methods, share good practice examples of assessment programs, and implementation considerations.

The workshop sessions will support education providers to:

- develop outcomes based training programs, where those outcomes describe the specialists the community wants
- consider assessment approaches for specialty registration and the value proposition for these
- design programs of assessment that balance workplace-based assessments with other methods, are aligned to the training program, and are accessible, relevant and sustainable.
- manage change to current assessments to achieve aligned programs of assessment that use methods fit for purpose
- identify needs for ongoing AMC support in assessment – possible future masterclass workshops

Session 1 objectives

The aim of *Session 1: current state of assessment* provides an opportunity to sharing learning and experiences. It is intended to encourage reflection on the value proposition for assessment in medical training and what assessment is aiming to achieve – what is the point of assessment/why do it?

The workshop will highlight the common issues identified by AMC accreditation processes in relation to specialty medical training and Specialist International Medical Graduates and share a trainee perspective and international perspective on the current challenges and opportunities.

Experiences in assessment in the context of the 2020 COVID-19 pandemic provide an opportunity to consider how the disruption can result in rapidly progressive and positive change to college assessment and participants will be invited to share their learning as well as the challenges and opportunities they see ahead.

This session will:

- Share learning about common issues in assessment identified through AMC accreditation processes
- Share perspectives on the current state of assessment, including issues and challenges
- Consider opportunities for improvements and innovations in specialty training assessment practice that arise from the COVID19 pandemic context and experience in 2020

Conducting assessment in a changing environment

In 2020 our world changed. The global COVID-19 pandemic has affected us in ways that are yet to be fully understood and has likely permanently changed how health professions practice, health professional education is conducted, and the assessment of health professional students and trainees.

This first in a series of four workshop sessions acknowledges the disruption that the global pandemic caused to longstanding assessment practices in specialty medical training contexts, and the opportunities arising from necessary changes to these practices in 2020. Some of these changes were innovative for the education providers implementing them, some were challenging at the scale required, and some were constrained by technology failure. All required 'new thinking', agility and resilience of individuals and organizations. In this workshop Jane Cannon, Head of Operations, Education Directorate, General Medical Council, will provide insights about the experiences and opportunities of the COVID-19 pandemic for assessment in the UK context. Dr Hashim Abdeen, Chair, AMA Doctors in Training will explore the trainee experience of assessment in Australian and New Zealand specialty training more broadly and the issues brought into sharp relief in 2020. Dr Lindy Roberts, Chair of the AMC Progress Reports Subcommittee will present insights regarding assessment in specialty medical training in Australia and New Zealand from the AMC perspective.

In breakout sessions participants will be challenged to consider fundamental questions relating to assessment in specialty medical training, the diversity of the participant group allowing multiple stakeholder perspectives in the conversation. Underpinning this discussion is a resource pack presenting current thinking and evidence for 'best practice' in assessment. The nature of 'best practice' is not static – a changing environment - and all participants are encouraged to reflect on the current state of assessment in their particular context, as well as common themes that may arise in discussion.

By considering 'where we are', what opportunities for positive change have come from disruption, and what 'good' looks like in assessment, a path forward to 'better' is explored in the subsequent sessions.

Workshop Program

2:00pm	**Workshop Opens**
2:00	**Welcome and Opening Address** *Professor Kate Leslie AO*, President, Australian Medical Council
2:10	**Workshop overview from the session Chair** *Dr Lindy Roberts AM, Chair, AMC Progress Reports Sub Committee. Deputy Chair, AMC Specialist Education Accreditation Committee*
2:15	**Presentations**
	AMC insights regarding assessment in specialty medical training *Dr Lindy Roberts AM* Reflections from the UK: changes in specialist medical training assessments in response to the COVID-19 pandemic *Ms Jane Cannon, Head of Operations, Education Directorate, General Medical Council* The trainee experience of assessment *Dr Hashim Abdeen, Chair, AMA Council of Doctors in Training*
2:55	**Break**
3:00	**Group activity - Where are we now? Where could we go?**
	Participants will break into groups to work though the following questions: • What are we trying to achieve with our current assessment processes? • What is working for us? • What are we struggling with? • What does 'good' look like? Then, coming back together, the summarised key points from the group work will be presented to the workshop. *Background reading is available on page 13-18 of this booklet*
3:40	**Presenter Q & A**
	Reflecting on the questions asked by participants during their presentations earlier in the session, the three presenters will answer some questions and provide thoughts on points raised in the group activity.
3:55	**Session wrap-up and next steps**
4:00pm	**Workshop closes**

Presenters

Dr Lindy Roberts AM

Chair, AMC Progress Reports Sub Committee. Deputy Chair, AMC Specialist Education Accreditation Committee

Dr Lindy Roberts is a Specialist Anaesthetist and Specialist Pain Medicine Physician at Sir Charles Gairdner Hospital in Western Australia. She was President of the Australian and New Zealand College of Anaesthetists from 2012 to 2014. Since 2016, she has been an ANZCA Director of Professional Affairs (education).

In 2019, Dr Roberts was appointed chair of the AMC Progress Reports Sub Committee. She was recently appointed deputy chair of the Specialist Education Accreditation Committee, having been a member from 2014 to 2017 and since 2019. Dr Roberts is an experienced AMC assessor.

Ms Jane Cannon

Head of Operations, Education Directorate, General Medical Council

Jane Cannon joined the Education and Standards directorate of the General Medical Council in 2014 and is currently Head of Approvals. Prior to this she spent 5 years as Head of Quality at the Joint Royal College of Physicians Training Board. In her current role Ms Cannon's main focus is to ensure that UK training meets the needs of the UK population and health workforce. She also leads a cross-directorate program of work to address the ethnic attainment gap in medical education.

Dr Hashim Abdeen

Chair, AMA Council of Doctors in Training

Dr Hashim Abdeen is a Rheumatology and General Medicine Advanced Trainee and is the current Chair of the Federal AMA Council of Doctors in Training (CDT) & Deputy Chair of the Binational RACP College Trainees' Committee (CTC). Dr Abdeen is a member of the AMC's Intern Training Framework Review Working Party.

About the AMC

What does the AMC do

The Australian Medical Council has a broad remit:

Appointed as the accreditation authority for the medical profession in Australia and provides accreditation services for New Zealand

Accredits over 128 primary and specialist medical programs

Oversees medical training in 40 educational providers in Australia and New Zealand

Uses accreditation as a quality assurance tool for state-based authorities that set standards for medical internships and embeds quality improvement tools to facilitate reflection and improved practice

Sets and assesses standards for IMG workplace based providers and pre-employment clinical structured interview providers

Conducts IMG assessments in the Standard Pathway (AMC examinations) 2500 MCQ; 2300 Clinical

Works internationally and in partnership with other accreditation, testing and standard setting bodies.

Click on the play icon to hear the Philip Pigou, AMC Chief Executive Officer, provide an overview of the AMC's current activities.

AMC Accreditation, Standards and Monitoring

The AMC is the accreditation authority for the medical profession under the Health Practitioner Regulation National Law as in force in each state and territory (the National Law). Under the National Law, an *accreditation standard*, for a health profession, means a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practice the profession in Australia.

The AMC develops accreditation standards for all phases of medical training and education. The standards follow similar structure and formatting but are customised to the requirements of the stage of training and education. The Medical Board of Australia approves accreditation standards for the medical profession. The accreditation standards and the AMC's accreditation processes are also relied upon by the Medical Council of New Zealand in relation to primary medical qualifications, specialist medical training, continuing professional development and the assessment of specialist international medical graduates.

The AMC uses accreditation standards to assess medical programs for accreditation and for subsequent monitoring of accredited programs and providers. The accreditation standards can be found on the **AMC website**.

Accreditation conditions and monitoring

Following an AMC accreditation assessment of an education providers programs, the AMC will provide a series of commendations, quality improvement recommendations, and conditions on the accreditation. The AMC sets conditions when a program and provider substantially meet the accreditation standards but do not fully meet the all the requirements. Conditions are intended to lead to the program meeting the standard in 'a reasonable time[1]'.

Once the AMC has accredited programs and their providers, under the *Health Practitioner Regulation National Law* it must monitor the program and provider to ensure that they continue to meet the accreditation standards.

- Principal mechanisms are structured progress reports, comprehensive reports and full accredited assessments every ten years.
- Providers are also expected to report at any time on matters that may affect accreditation status of their programs.
- Progress reports enable the AMC to monitor accredited education providers and their programs between formal accreditation assessments as required by the National Law.
- When a progress report is submitted, AMC staff will seek commentary on a report from an experienced AMC assessor and reviewer.
- The report and commentary, with a summary of the AMC's response to the providers' previous progress reports are then considered through AMC committee processes.

[1] Section 48 Health Practitioner Regulation National Law

Assessment Standards at the AMC

Assessment is one of the areas of focus in the prevocational, primary medical program and specialist medical program accreditation standards.

Key Concepts

The key concepts underpinning AMC standards on assessment for medical programs across the continuum are:

- **Assessment approach**
  The assessment program is aligned with learning outcomes, with requirements clearly documented and easily accessible to staff, supervisors and students/trainees/interns.
- **Assessment methods**
  The program contains methods that are fit for purpose, has a blueprint to guide assessment through each stage and uses validated methods of standard setting.
- **Assessment feedback**
  The provider/program facilitates regular feedback to students/trainees/interns to guide their learning, gives feedback to supervisors on assessment performance and has processes for underperforming students/trainees/interns and implementing remediation.
- **Assessment quality**
  The provider regularly reviews its program of assessment to ensure the validity and reliability and scope of its practices, processes and standards is consistent across teaching sites.

The standards for specialist medical colleges also includes standards for the assessment of Specialist International Medical Graduates:

- **Assessment framework**
  The process for assessment of specialist international medical graduates is documented, accessible and designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.
- **Assessment methods**
  The methods of assessment are fit for purpose and uses validated methods of standard setting.
- **Assessment decision**
  Assessment decisions are made in line with requirements of the assessment pathway, and any additional requirements are clearly documented.
- **Communication with specialist international medical graduate applicants**
  Mechanisms are in place to inform applicants of the relevant policies and processes, of any proposed changes to policies and processes, and outcomes at various stages of the process.

AMC Assessment of International Medical Graduates

The AMC has been responsible for setting and delivering examinations for the registration of International Medical Graduates in Australia since 1986. From July 2010, the examination, leading to general registration for international medical graduates has been conducted under the provision of the Health Practitioners Regulation National Law Act 2009. The AMC assessment for general registration involves two components:

- a knowledge test in the form of a computer adaptive test of multi-choice questions; and
- an Objective Structured Clinical Exam, or a
- Workplace Based Assessment program.

The Clinical Exam has been run at the AMC's Melbourne-based National Test Centre, which also hosted exams for a number of medical specialist colleges. However, in response to travel restrictions during the COVID-19 pandemic, the face-to-face format has been translated into an online exam using the existing blueprint. The Zoom-based platform and remote marking capability is also available colleges that use the test centre.

Further information about the AMC's exams for International Medical Graduates can be found on the AMC website

Research and Innovation

The AMC is committed to research and innovation to ensure its methods of assessment and key approaches are leading practice. The development of the AMC Assessment Strategy is drawing upon evidence in the medical education literature regarding known strengths and weaknesses in assessment. Both current and future projects are focussing on multi-modal assessment that can be delivered in more flexible ways with the affordances of new technology and the experience of longitudinal programs of assessment with feedback and directed learning. The health and cultural safety of Aboriginal and Torres Strait Islander and Maori people is a priority in the AMC Assessment Strategy.

Background reading and resources

Session 1: Conducting assessment in a changing environment

The Covid 19 pandemic has had a significant impact on education and assessment in Australia and around the world. Although the disruptions in Australia and New Zealand may have been less than many other places in the world, most organisations in medical education have had to adapt their processes. It is fair to say that these many examples of Plan B solutions have met various degrees of success. With the arrival of vaccinations and good hopes for an end to the disruptions in the near future the question what the 'new normal' will look like and how to prepare for it are both relevant and timely. Our viewpoint is that the 'new normal' will not likely be the same as the 'old normal' and, more importantly, that it **should not** be the same as the old normal. Amongst other things, Covid 19 has shown that the old normal was likely to be too vulnerable for disruption and not in keeping with the advances in the relevant literature.

Therefore, with Covid 19 as an unexpected 'catalyst' for improvement and change of current assessment processes, it may be wise to consider some of the robust evidence in the medical education literature about strengths and weaknesses around assessment. The most important of these are discussed in this document. Every subsection makes reference to literature. Each reference is only one example of that literature, and each subsection could be supported by many references.

– the issue of adequate sampling

Every assessment is in fact a small sample out of the whole domain of relevant questions, stations, assignments that could have been used. Even a 200 item multiple-choice examination is only an 'n' of 200 out of the domain of at least tens of thousands of relevant possible questions. Like in research, the smaller the study sample, the lower the generalisability of the results to the population at large, and the less the likelihood of reaching any statistical significance. Sampling does not only relate to the number of items in an assessment but also to the number of examiners, stations and even the number of occasions at which the exam took place. An exam that takes place for one day only is likely to be a more limited sample than assessment on a more longitudinal basis. As in clinical medicine, poor use of a diagnostic procedure or inadequate sampling is not only likely to produce false negatives – candidates failing who are actually sufficiently competent – but also to engender false positives - candidates passing who are actually not sufficiently competent. So, any exam that is based on a limited number of cases, includes judgements from a limited number of examiners or involves observations from limited sources on limited occasions, is likely to produce a significant number of false positive and false negative results[2]

– the issue of domain specificity

Unfortunately, all components of competence suffer from domain (aka content) specificity. This means that performance on one case, station or assignment is a poor predictor of how the same candidate would perform on any other relevant case, station or assignment. This is a counterintuitive concept. We often think that if we have observed a candidate in one situation, we can reliably draw inferences from this and make generalised judgements as to whether the candidate is a competent doctor or not. Unfortunately, this is not the case and is a very robust finding in the literature. The explanation for the phenomenon of domain specificity is quite complex

[2] - Swanson DB. A measurement framework for performance-based tests. In: Hart I, Harden R, eds. Further developments in Assessing Clinical Competence. Montreal: Can-Heal publications 1987:13 - 45.

- Swanson DB, Norcini JJ. Factors influencing reproducibility of tests using standardized patients. *Teaching and Learning in Medicine* 1989;1(3):158-66.

- Norcini JJ, Swanson DB. Factors influencing testing time requirements for measurements using written simulations. *Teaching and Learning in Medicine* 1989;1(2): 85-91.

and centres on the capacity of seemingly different cases to connect to the same underlying principle or competence[3]. This has ramifications for generalised judgements about a candidate based on one single observation or case. A candidate who performs poorly on one case and fails an assessment, might have done perfectly on all other given cases, but also a candidate who performs well on a certain given case might have performed very poorly on all other given cases.

- The difference between assessment format and assessment content

Although it is customary in assessment practice to be primarily focused on the format of an assessment, it is actually the content that determines the validity. Counterintuitively, when the same content is being asked of a candidate, the format is relatively unimportant. This has even been demonstrated when comparing an actual, practical OSCE with a written test on physical examination skills[4]. This is probably the most counterintuitive finding and such comparative studies are relatively rare in the literature, but there are myriads of publication comparing different item formats – typically open-ended with multiple-choice– in the medical education literature. In a nutshell, they almost unanimously show that competence does not generalise well across contents but extremely well across formats. So, two multiple-choice items asking different things do not correlate well, and the same holds for two open-ended questions or essays, but a multiple-choice question and an open-ended question asking for the same (applied) knowledge aspect correlate very highly. Therefore, careful item or clinical station writing, thorough review, and post-test psychometric analysis with moderation, contribute more to the validity of an assessment than specific scoring rules, complicated formats and weighting or the way in which numerical scores of different assessments are combined.

– the issue of validity

A central problem in all assessment is the fact that we are trying to assess something that we cannot observe directly. Where, for example, a patient's weight can be both measured but also gauged by observation, every aspect of competence has to be inferred from what is observable. This is a bit like taking a blood pressure. Blood pressure cannot be observed directly, and it has to be inferred from reading a sphygmomanometer whilst gradually lowering the pressure in the cuff auscultating the brachial artery. So, in order to assure that the blood pressure measurement is valid we have to be certain that the measurement is based on a correct procedure, in other words that the observations made by the clinician (from the sphygmomanometer) are correctly translated into numbers. It is also important that sufficient blood pressure measurements are taken to ensure that the findings are reproducible and that the findings correspond with other measures around cardiovascular health (such as pulse, auscultation, jugular venous pressure, et cetera)[5]. Validity in assessment follows a similar pattern; procedures have to be in place to ensure that the observation of performances correctly translate into scores, that the scores are based on a sufficiently large sample to ensure that they are reproducible/generalisable and that the findings correspond with other measures of assessment so that a complete image of a candidate's competence can be validly made[6].

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[3] - Eva KW, Neville AJ, Norman GR. Exploring the etiology of content specificity: Factors influencing analogic transfer and problem solving. *Academic Medicine* 1998;73(10):s1-5.

[4] - Van der Vleuten CPM, Van Luyk SJ, Beckers HJM. A written test as an alternative to performance testing. *Medical Education* 1988;22:97-107.

[5] - Llabre MM, Ironson GH, Spitzer SB, Gellman MD, Weidler DJ, Schneiderman N. How Many Blood Pressure Measurements are Enough? An Application of Generalizability Theory to the Study of Blood Pressure Reliability. *Psychophysiology* 1988;25(1):97-106.

[6] - Kane MT. Validation. In: Brennan RL, ed. Educational Measurement. Westport: ACE/Praeger 2006:17 - 64.

- Reliability

In its classical sense reliability purely indicates the reproducibility of outcomes of an assessment. This means, in its strictest interpretation, that if a candidate obtains a certain score – let's say 58% – he or she should obtain the same score if he or she were tested again with a similar test of similar difficulty. The slightly less strict interpretation is the expectation that the candidate's position in the rank order from best performing to most poorly performing would be the same, i.e. if they were the fourth best performing candidate on the assessment they would be expected to also be the fourth best performing candidate on a similar assessment. This second interpretation is most often used, for example in the rather famous Cronbach's alpha[7].

This straightforward approach to reliability as reproducibility has long been the only one. However, when assessment started to include human judgement more prominently, and with the increased awareness that competence is not something that can only be expressed in scores but also in narratives, other approaches to reliability have since gained importance. One such approach is based on the concept of saturation of information[8]. Although this concept is derived from qualitative research it is also something that is well-known to almost any practising clinician. When conducting a diagnostic workup, there is always a moment at which the clinician decides that no further diagnostic information is needed, because the diagnosis or the preferred management can be determined with sufficient certainty. This too is a saturation of information principle and can be applied in the same way to assessment.

- The role of feedback

There is overwhelming support in the literature that providing constructive and meaningful feedback leads to more rapid development of expertise and, eventually, to higher levels of expertise.[9] Unfortunately, many educational contexts in medicine do not have a culture of providing constructive and meaningful feedback and of 'closing the loop'[10]. It is clear that this can be seen as a missed opportunity because where there are systems of identifying registrars who are struggling and giving them access to feedback and remediation opportunities they are considerably more likely to perform well. For example, on the fellowship examinations[11] . The incorporation of feedback cycles, focusing on strengths but also weaknesses in combination with opportunities to practice and improve the weaknesses or to retain the strengths with repeated observation, is often called 'deliberate practice'[7].

- The role of the supervisor or assessor

Whereas in written or computerised assessment, validity can be built into the assessment through careful test production, this is not the case with workplace based assessment. In workplace based assessment, the quality of the assessor – their ability to translate what they observe into a

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7 - Clauser BE, Margolis MJ, Swanson DB. Issues of validity and reliability for assessments in medical education. In: Holmboe ES, Hawkins RE, eds. Practical Guide to the Evaluation of Clinical Competence. 1st ed. Philadelphia: Mosby/Elsevier 2008:10 –23.

8 - Driessen E, Van der Vleuten CPM, Schuwirth LWT, Van Tartwijk J, Vermunt J. The use of qualitative research criteria for portfolio assessment as an alternative to reliability evaluation: a case study. *Medical Education* 2005;39(2):214-20.

9 - Ericsson KA, Charness N. Expert performance. *American Psychologist* 1994;49(8):725-47.
- Ericsson KA. An expert-performance perspective of research on medical expertise: the study of clinical performance. *Medical Education* 2007;41:1124-30. doi: 10.1111/j.1365-2923.2007.02946.x

10 - Watling C, Driessen E, Van der Vleuten CPM, Vanstone M, Lingard L. Beyond individualism: professional culture and its influence on feedback. *Medical Education* 2013;47(6):585-94.

11 - Prentice S, Benson J, Schuwirth L, Kirkpatrick El. A meta-analysis and qualitative analysis of flagging and exam performance in general practice training. *AUSTRALIAN JOURNAL OF PRIMARY HEALTH* 2019;25(3):XLIII-XLIII.

meaningful result or score – **is essential** for validity. Untrained assessors will not be able to produce high-quality assessment results. Structured rubrics may mitigate this negative effect of lack of training of assessors[12], but only to a small extent[13]. An important implication of this is that a comprehensive 'picture' of a registrar's or candidate's competence can only be obtained when multiple stakeholders are involved. Each stakeholder has expertise to see certain aspects but may be blind to others. For instance, a scrub nurse may not be a good person to ask about a surgeon's interaction with patients, but may know a great deal about their sensitivities and respect for tissue, and they have far more experience with a range of surgeons. This is the reason why instruments such a multisource feedback are a valuable addition to the range of instruments in an assessment program.

Another development that has demonstrated its usefulness in supporting the assessor in making valid decisions is the use of so-called entrustable professional activities (EPAs)[14]. The biggest advantage of EPAs is that they employ a language which is more intuitive to most clinical supervisors. This is certainly not trivial. One could argue that by asking supervisors to use judgements they have more experience with, instead of using more 'educational' language, they are actually put in a more 'expert' position. Good EPAs lead to demonstrably positive effects on the quality/validity of workplace based assessment[15]

- The difference between plan B and real improvement through innovation

If we see education also from the perspective of a business, it is worthwhile to make a distinction between the organisation's value proposition and the organisation's processes. As a result of the covert 19 pandemic, many educational organisations – including Australian colleges – have focused on adapting their current processes to an online-only context. In the short term, this has created some breathing space. There is another significant benefit from this application of the proverbial plan B, namely that it has 'loosened the existing processes sufficiently to enable true innovation. The medical education literature is now being populated with publications that describe experiences with moving processes online and lessons that can be drawn from that.[16] In addition, there are publications emerging which advocate for educational organisations to consider more revolutionary changes to their business.[17] There is now a unique opportunity to align educational processes with the imperatives of competency-based education, to extend the assessment tool box from a purely measurement orientation to one that also includes human judgement and due process, and finally, to smooth and the transition between the various phases of the education continuum from the first day of the undergraduate curriculum to the a final day of continuing medical education. Another reason to consider these fundamental changes exists because of the fundamental changes in the learners' affordances. Especially through ICT, learners now have

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12 - Govaerts MJB, Schuwirth LWT, Van der Vleuten CPM, Muijtjens AMMl. Workplace-Based Assessment: Effects of Rater Expertise. *Advances in health sciences education* 2011;16(2):151-65.

13 - Berendonk C, Stalmeijer RE, Schuwirth LWT. Expertise in performance assessment: assessors' perspectives. *Advances in Health Sciences Education* 2013;18(4):559-71.

14 - Ten Cate Th J. Entrustability of professional activities and competency-based training. *Medical Education* 2005;39:1176-7. doi: 10.1111/j.1365-2929.2005.02341.x

15 - Valentine N, Wignes J, Benson J, Clota S, Schuwirth LW. Entrustable professional activities for workplace assessment of general practice trainees. Medical Journal of Australia. 2019 May;210(8):354-9.

- Weller JM, Misur M, Nicolson S, Morris J, Ure S, Crossley J, Jolly B. Can I leave the theatre? A key to more reliable workplace-based assessment. British journal of anaesthesia. 2014 Jun 1;112(6):1083-91.

16 Daniels VJ, Pugh D. Twelve tips for developing an OSCE that measures what you want. Medical teacher 2018;40(12):1208-13.

17 Hauer KE, Lockspeiser TM, Chen HC. The COVID-19 Pandemic as an Imperative to Advance Medical Student Assessment: 3 Areas for Change. Academic Medicine 2020

affordances that did not exist in the past[18]; not in the least the continual availability of information everywhere through the Internet. Educational programs that do not sufficiently adapt to these fundamental changes and keep on thinking in terms of tweaking existing processes rather than a fundamental reorientation of their value proposition, run the risk of making themselves vulnerable. So, for organisations whose role is to ensure quality of health professions workforce in a country it is an important consideration whether they want to exert this role purely from a gatekeeper perspective or from the perspective of promoting of quality of all learners. The former typically leads to testing, whereas the latter would lead to a more longitudinal assessment program intertwined with feedback and educational activities.

In summary, for any redesign of assessment, especially within an academic/scientific context, there is consolidated evidence in the medical education literature from which appropriate strategies can be drawn. Unfortunately, a lot of that evidence is not in complete alignment with current practice and tradition. Approaches we believe to be valid and reliable have repeatedly been demonstrated to be all but valid and reliable. It is not an easy task to change assessment approaches in an existing organisation[19], but given the pandemic, the vulnerabilities of the existing (business) models and the rapid improvements and innovations across the globe, there is a real need and opportunity for a fundamental redesign of assessment practices.

[18] Friedman LW, Friedman HH. The new media technologies: Overview and research framework. Available at SSRN 1116771 2008

[19] - Harrison CJ, Könings KD, Schuwirth LW, Wass V, van der Vleuten CP. Changing the culture of assessment: the dominance of the summative assessment paradigm. BMC medical education. 2017 Dec;17(1):1-4.

Competence-based medical education - AMC consultation paper

In medical education as in other health professions, the terms ‘competency’, ‘competency based training’ and ‘competency frameworks’ are increasingly used but have not been clearly defined.

This paper reviews the use of competency-based training in education, and proposes a revised framework for the adoption of competency-based approaches within health professional education. It will articulate and extend the Australian Medical Council’s (AMC) understanding of the terms ‘competence’, ‘competency’ and ‘competency-based training’, building to an outline of an AMC framework that will guide the AMC’s accreditation of medical programs across the continuum from undergraduate to continuing education, and the assessment of International Medical Graduates (IMGs) for eligibility for general registration and entry into the workforce.

Health professional education is inextricably linked to professional practice within the health care system. An increasing interest in competency-based approaches in the health professions is driven by a number of emerging challenges to health care delivery internationally and domestically. The central concept underpinning the AMC framework is that overall competence is dependent on the development of discrete competencies but also on the development of tacit knowledge and that overall competence is dependent on the stage of training, the context and varies over a professional’s working life. This paper proposes that the approach to competency-based training as used in the Australian Vocational Education and Training (VET) sector is not always suitable for application in all areas of medical education and training.

The paper can be found on the AMC website **here**.

Next Steps

Overview of **Session 2 – Tuesday 20 April, 2:00pm – 4.00pm AEST**:

The focus of the Assessment Workshop Session 2 is on the case for change – what does good practice look like in contemporary medical training assessment? What are the opportunities, issues and risks associated with change?

Session 2 Presenters:

- Professor Lambert Schuwirth, Professor of Medical Education, Director Prideaux Research Centre
- Mr Chris Mirner, Assistant Director for Postgraduate Training, Royal College of General Practitioners

Pre-session Activities

- Visit the workshop website regularly in between sessions for news updates and any additional resources
- Look out for your workbook for session 2

Please note other key dates of sessions in this online workshop series are:

- **Session 3: A pathway for change**
  Tuesday 18 May 2:00pm AEST
  Looking at case studies, this session will focus on managing change, and barriers and enablers for change

- **Session 4: Next Steps – where to from here**
  Tuesday 8 June 2:00pm AEST
  This session will focus on moving towards effective change in assessment programs, and opportunities for collaboration.

Appendix 1: Assessment Workshop Planning Group

Planning Group Members

Name	Role
Associate Professor Jenepher Martin	Chair, Workshop Planning Group Member, AMC's Progress Reports Sub Committee Medical Education Research, Eastern Health Clinical School, Faculty of Medicine Nursing and Health Sciences, Monash University
Professor Julian Archer	Executive General Manager for Education, Royal Australasian College of Surgeons
Dr Ainsley Goodman	Member, AMC's Progress Reports Sub Committee Education Committee, Medical Council of New Zealand
Dr Julie Gustavs	Manager of Education Development and Projects, AMC
Professor Brian Jolly	Conjoint Professor of Medical Education, School of Medicine & Public Health, College of Health, Medicine and Wellbeing, University of Newcastle and Adjunct Professor, School of Rural Medicine, University of New England
Mr Carl Matheson	Director of Assessments and Innovation, AMC
Dr Will Milford	Deputy Chair, Progress Reports Sub Committee
Emeritus Professor David Prideaux	AMC Director Chair, AMC Assessment Committee
Ms Karen Rocca	Manager, Accreditation Projects and Process Development, AMC
Professor Lambert Schuwirth	Professor of Medical Education, Director Prideaux Research Centre
Associate Professor Andrew Singer AM	AMC Director Chair, AMC Prevocational Standards Accreditation Committee Member, AMC Specialist Education Accreditation Committee and Progress Reports Sub Committee Principal Medical Adviser, Australian Government Department of Health Associate Professor in Emergency Medicine, Australian National University Medical School Senior Specialist in Emergency Medicine, Canberra Health Services
Professor Stephen Tobin	Member, AMC's Progress Reports Sub Committee Associate Dean and Professor of Clinical Education, Western Sydney University
Ms Theanne Walters AM	Deputy Chief Executive Officer, AMC
Ms Kirsty White	Director, Accreditation and Standards, AMC