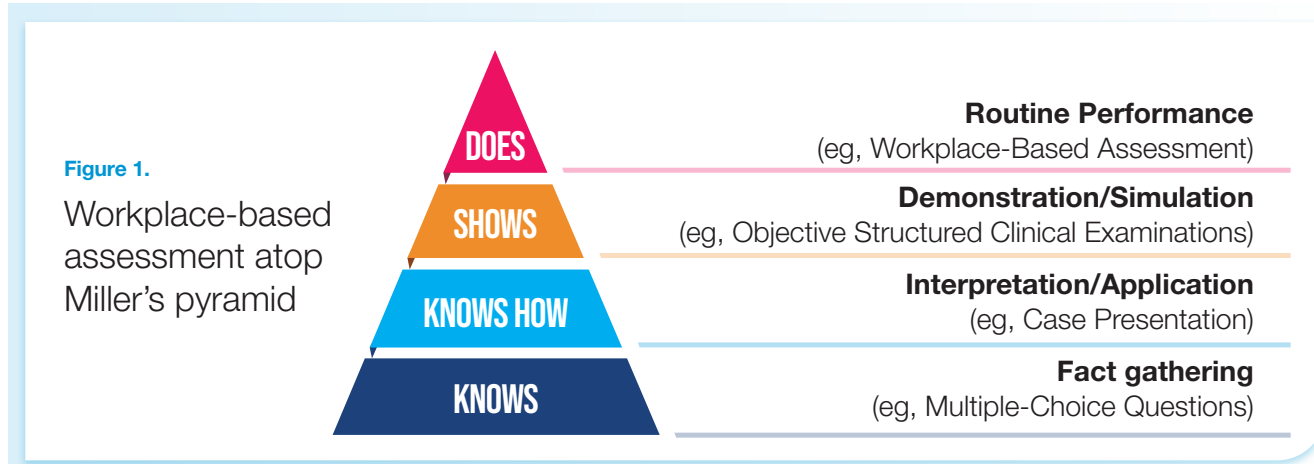


What are WBAs? Modern medical education curricula emphasize individualized teaching through frequent feedback on directly observed behaviors.¹ Workplace-based assessments (WBAs) are practical tools to deliver useful feedback based on specific educational outcomes. Integrating WBAs into clinical teaching elevates the assessment of clinical skills to the highest tier of Miller's Pyramid (Figure 1), wherein students demonstrate competencies in situ.²



Why are WBAs gaining traction? Competency-based medical education (CBME) refers to the intentional teaching and assessment of predefined learning outcomes, or competencies. WBAs are used within a system of evaluation types to help determine whether learners have achieved those outcomes.

Courses or programs employing CBME use qualitative attainment of specific skills as grounds for progression to the next level of training. This stands in contrast with traditional quantitative thresholds (eg, a minimum number of weeks on a rotation or a minimum percentage correct on standardized exams). WBAs do not compare students to one another in a norm-based fashion. Instead, learners are assessed against an expected standard with ratings defined by behavioral anchors.

What are the drawbacks to WBAs? Educators may already feel overwhelmed by growing demands for clinical productivity and reduced personal time. As institutions design and implement their own WBAs, these tools must enhance the efficiency and quality of existing methods of faculty feedback to students. Reliably determining a student's competence with a particular skill may require multiple WBAs by several evaluators.

Although frequent and multisource feedback is correlated with improved learner performance, the actual impact of WBAs on clinical performance is unclear.³ Questions regarding the validity of WBAs have arisen given the link between clinical competence and contextual, qualitative interpretations.⁴

Educational leaders requesting frequent WBAs may have to realign faculty incentives and strategic priorities to acquire enough data to support competency-based decisions regarding learner advancement.

WBAs often use entrustment scales, such as the Ottawa and Chen scales, to represent how much supervision a learner required to complete a task.⁵ This approach may be unfamiliar to educators and require dedicated faculty development to ensure meaningful data is gleaned.

Conclusion: Frontline educators will be impacted by variations in mission, population, setting, and focus of their institutions. CBME and WBAs aim to deliver more equitable, constructive, and accurate assessments of learners. The interplay between faculty, learners, and the clinical learning environment all determine the quality of physician that emerges from a training program. WBAs that promote a growth mindset within that microsystem will become mainstays of programmatic success.

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