Clinician's Commentary on Dawes et al.¹

Physiotherapists typically have no great love of paperwork—the literal kind or its electronic equivalents. In this respect they are likely similar to most other health professionals. Paperwork can include patient records (“charting”) or other records about accountability, such as institutional workload statistics or billing forms; when a physiotherapist is a clinical educator (CE), student evaluation forms are added to the paperwork to-do list. The most common complaint about paperwork is that it takes too much time, but that complaint, stated thus, is incomplete: we typically don’t begrudge time spent when it brings value. Implicitly, the full complaint is that something takes too much time if the time seems excessive relative to the value of the *process* or the *product*.

Dawes and colleagues¹ compared the Australian-developed Assessment of Physiotherapy Practice (APP) to the US-developed Physical Therapy Clinical Performance Instrument (PT-CPI) in assessments of students’ clinical performance. In answering their first two research questions, they demonstrate that use of the APP is feasible and acceptable for both CEs and students. The authors’ framing of feasibility and acceptability is explicitly about value for time spent. Their findings also demonstrate impressive time savings: CEs’ average time to complete the APP was less than one-third of their completion time for the PT-CPI. The difference cannot be attributed to the number of criteria, as the APP has 20 while the PT-CPI has 24, several of which are commonly not rated.^{1–3} Nor is a 5-point ordinal scale any faster to mark, theoretically, than a visual analogue scale. I see three possible reasons for one instrument to be faster to complete than another: first, the perceived relevance and clarity of the criteria; second, the perceived ease of judging student performance against expectations, based on the content of the criteria and on the rating system; and, third, expectations related to narrative comments. The APP has no expectation for narrative comments, whereas the PT-CPI invites comments on all 24 criteria as well as summative comments at both mid-term and final evaluations.

The value of assessment as a *process* is for the people directly involved in it. CEs reflect on whether they have been giving students appropriate opportunities to gain skills and demonstrate competence, while students learn from feedback calibrated against standardized expectations. Dawes and colleagues¹ report that both CEs and students found APP’s performance indicators more useful than those of PT-CPI for feedback on performance. The concept of mid-term and final assessment in student placements has parallels in reassessments during client care and at discharge. Part of the value of client reassessment as a process is that it leads physiotherapists to reflect on all aspects of a client’s function in which progress was expected or desired, thereby refining goal setting for that client and for similar clients in their future practice.

Dawes and colleagues’ third research question is about the value of assessment in creating a *product*.¹ The authors examined whether the standard for entry to the profession is maintained independent of the instrument used; the product here is an indicator of each student’s competence relative to the entry-level competence standard, used by the university programme as part of progress toward graduation. They conclude that the

standard was indeed maintained. The unavoidable limitation, however, is that each CE was simultaneously rating students on both instruments and may therefore, to avoid cognitive dissonance, have cross-checked that the two instruments converged on the same conclusion. This would be a natural thing for an intelligent person to do, much as one might use ratings on criteria within each instrument to converge on global ratings. Dawes and colleagues also acknowledge the limitations inherent in their small sample size. As is the case when tracking rare adverse events that everyone tries to prevent in patients, one would need a large sample followed longitudinally to evaluate the prognostic value of the rare instances when students fail placements based on CEs’ assessments.

Assessment is stressful. Davies and colleagues have reported stress arising from a sense of responsibility among CEs compounded by self-doubt about their own teaching or evaluation skills;⁴ Dudek and colleagues found that medical educators experience stress when they must substantiate their decision to fail a student;⁵ and Bogo and colleagues have described tension among social-work students’ supervisors between the professional ethic of fostering student learning and the requirement to play a gatekeeping role for the university programme.⁶ Some of the stresses associated with documenting patient care may be similar: Harman and colleagues documented examples of physiotherapists who did not wish to use functional outcomes or document client goals because they doubted their own ability to do so successfully.⁷ Physiotherapists are often advocates for their clients, and charting non-improvement creates cognitive dissonance when we feel we are making a difference. In such situations, reassessment has negative value as a *process* because of the stress it creates; whether it has value as *product* cannot always be perceived by the assessor or by the person being assessed, and may only be measurable at a programme level.

Dawes and colleagues have impressively demonstrated how to thoroughly review an instrument’s psychometric properties and then systematically examine results from a carefully designed trial about feasibility and acceptability.¹ In applying their results, others should note that the aim is never to reduce assessment time to zero; rather, the goal should be to acknowledge the stress involved in assessments and ensure good value for the time spent.

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