

Grade Inflation in the Assessment of Clinical Practice

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Abstract

Assessment of performance and achievement in the work place is integral to pre-registration midwifery programmes. The value of hands-on clinical care is so essential to midwifery practice that the professional regulatory body, the Nursing and Midwifery Council (NMC), stated that practice should be graded and contribute to the final award (NMC, 2009). The NMC confirmed the importance of work based learning by stating that a minimum of fifty per cent of a full time course must be situated within the practice environment compared with a minimum of forty per cent in theory (NMC, 2008). Assessment of student performance will be a key component of any programme that has a large work based element (Wilson & Scammell, 2011). The grading of practice in midwifery at this institution contributes to half of the final grade and thus the overall degree classification (NMC, 2009). Assessment in healthcare education is becoming increasingly important for public accountability and safety (Holomboe *et al*, 2010). As educators, we must therefore seek to reassure ourselves, students, professional regulators and the public that the assessment processes we use are valid and reliable.

Keywords: practice, clinical, assessment, grading, midwifery, students

Work based Learning in Midwifery

Work based learning is uppermost in midwifery students' education; they are exposed to the clinical environment from week five of their programme. They undertake twenty-two and a half hours per week working alongside a midwife mentor in a variety of clinical settings, such as delivery suite, community, antenatal and postnatal wards. The importance of being exposed to clinical practice cannot be overestimated. The individual nature of women, their families, their pregnancies and labours cannot be recreated; no person or case will ever be exactly identical. Therefore, the only place to gain this learning is in the workplace, with women (Hager, 2011). Midwifery students participate in patient care, ward routines and are exposed to the culture of the workplace, the reality of the everyday life of the midwife, thus contributing to the community they are becoming a part of (Wenger, 1998; Darra, 2006).

Problem

As a midwifery lecturer, identification of the disparity between grades obtained in clinical and theoretical assessments had been noted. Discussion at exam and scheme boards suggested this was problematic to the higher education institution (HEI). Grade inflation is a challenge for most universities (Weaver *et al*, 2007), with a referral and fail rate for theory to practice being cited as four to one (Hunt *et al*, 2012). The external examiners for the midwifery programme noted a similar picture existed within their own HEI as well as nationally (Hatfield & Lovegrove, 2012). As a midwifery educator, ensuring a student has opportunities to learn, that their workplace assessment is valid, reliable and that they receive constructive feedback, is essential. The purpose of this case study is to explore the issues surrounding grading of clinical practice in relation to grade inflation and suggest potential methods to manage these issues. By reducing subjectivity and bias, we improve the validity and reliability of practice assessments, thus improving the student experience, while ensuring the quality of our courses as well as our graduates.

Grade inflation actually relates to the allocation of a grade higher than the performance warrants (Gray & Donaldson, 2009; Calman *et al*, 2002). It is the inconsistency between the actual performance and the documented grade that creates a problem. Grade inflation is an issue because it affects the reliability and validity of the work based assessment. Students who receive grades that do not reflect their actual performance will have unrealistic perceptions of their

abilities and competence which will affect their ability to develop and improve (Donaldson & Gray, 2012). It could be argued that grade inflation does not truly support work based learning because where there is disparity between the student's actual performance and the grade allocated, it undermines the feedback given to a student. Feedback is where real learning occurs (Norcini & Burch, 2007) and aids the development of clinical practice. However, if the grade and feedback do not reflect each other, the student is unable to benefit from the experience and judgement of the assessor.

Is the disparity between theory and practice grades an issue in itself? Many authors have noted the differences in grade allocation between theoretical and clinical courses (Hunt *et al*, 2012; Seldomridge & Walsh, 2006; Gray & Donaldson, 2009). If criterion-referenced criteria are used for assessments, achieving the normal bell-shaped curve for norm-referencing is not applicable. The assessments are based on individual performance with no comparison to other students or previous assessments (Sadler, 2005), so if all students are graded at an A or top mark then is this not because they all performed to the expected criteria? In reality, we know that there will always be different levels of performances and it is the issue of weak assessments that is the concern, potentially not identifying the student who requires greater support and failing to fail the unsafe student (Duffy, 2003).

It is perceived that clinical mentors are in the best position for clinical teaching (Fisher & Webb, 2008; Darra, 2006), and for assessing the students learning and development (Fitzgerald *et al*, 2010). However, if the issues that cause grade inflation are intertwined with the issues that affect assessment, such as bias and subjectivity (Seldomridge & Walsh, 2006) especially when the assessments are based in the workplace instead of the more controllable classroom setting (Walsh & Seldomridge, 2005; Norcini, 2005), is the clinical mentor really the best person to act as the assessor?

Assessment

Assessment has many facets: establishing baselines, setting standards and judging performance, but assessments are also a method of engaging students in the learning process (Norton, 2009). Assessment also focuses learning and improves motivation (Norcini & Burch, 2007; Shumway & Horden, 2003). Assessment can highlight strengths and weaknesses, but constructive feedback can motivate the student to improve and inform them how to develop their work.

Midwifery is a practical profession that is underpinned by theoretical knowledge (Heaslip & Scammell, 2012; Darra *et al*, 2003). Concerns regarding preparedness for practice at the point of registration (UKCC, 1999; Fitzgerald *et al*, 2012) reinforced the need for teaching and assessment within the workplace as a means of ensuring competent, safe professionals (Flanagan *et al*, 2000). Castledine (2007) stated that students being ill-prepared for practice was possibly a result of assessments not being as accurate as they needed to be. There are many issues related to assessing competence in healthcare education (Heaslip & Scammell, 2012). For the purposes of this study, the importance of workplace assessment to determine competence and fitness to practice is not under question, as it is a requirement of the regulatory body for Nursing & Midwifery (Lovegrove & Hatfield, 2012), but factors affecting this assessment will be considered.

Grading practice

Grading of assessments is the allocation of a number or symbol to measure the quality of the performance (Walsh & Seldomridge, 2006; Sadler, 2005; Walsh & Seldomridge, 2005). It is more than the decision of pass/fail or safe/unsafe; the mentor is required to make a judgement that differentiates between levels of achievement (Heaslip & Scammell, 2012; Bondy, 1983).

Grading of clinical practice was made an essential component of midwifery training by the NMC in 2009 to ensure students were competent in the clinical setting and fit for registration. Allocating a pass or fail to the assessment is enough to indicate competence but grading is about assigning

merit to this aspect of midwifery education. The value of clinical performance needs to be viewed with the same importance applied to theory (Andre, 2000). There was a perception that many HEIs did not recognise the importance of practice and that by allocating academic credit, in the same manner as an academic assessment, it would authenticate this aspect of midwifery education (REF). However, Gray & Donaldson in their 2009 (p. 7) study stated that the 'reliability, validity and effectiveness of grading was yet to be proven' and concerns over the validity and reliability of clinical assessments in general is an issue (Wilson & Scammell, 2011; Smith, 2007).

The development of grading tools that utilised criterion-referenced descriptors were introduced in an attempt to reduce issues associated with reliability (Heaslip & Scammell, 2012). Criteria are descriptions of attitudes, abilities and attributes that allow us to apply a level for making a judgement between differing standards of performance (Sadler, 2005). The use of criteria is thought to allow the student to be assessed on their performance and not compared to colleagues or affected by previous assessments (Sadler, 2005), but even these tools have created debate around their validity and reliability (Lovegrove & Hatfield, 2012). Bondy's (1983) seminal study identified that the criteria gave greater description and clarification, enabling the grade to be interpreted in context of the performance. It was also identified that it resulted in students receiving greater feedback that was more constructive and positive (Bondy, 1983). Explicit descriptors decrease the risk of grade inflation (Weaver *et al*, 2007). Mentors and students appear to value the use of criterion-referenced grading scales, stating it gives a benchmark for future development (Heaslip & Scammell, 2012). Students also believed that it made the assessment less subjective and more legitimate (Bondy, 1983). Grading tools are one component of the assessment process, but it is the mentors and students who use them that are the focus of this case study.

Issues with grading & assessing practice

Students who perform well in the clinical setting can benefit from grading practice (Darra *et al.*, 2003) because their achievements can be rewarded. If their accomplishment in practice is not rewarded, we may be placing them at a disadvantage (Andre, 2000). This implies that practice grades are not inflated but a realistic picture, given the 'typical' midwifery student who tends to perform better clinically than academically. Considering the hands-on nature of midwifery work, is it not right that practice grades are higher to demonstrate competence and ensure high quality patient care? Walsh & Seldomridge (2005) dispute the argument that the hands-on nature of midwifery work is the reason for higher practice grades; they suggest that if theory underpins practice, then should the grades not be similar and thus the notion of hands-on learners did not fully explain the issue of grade inflation (Walsh & Seldomridge, 2005). This seems too simplistic; if we consider the variety of theories on student learning, then many students will prefer and therefore excel in clinical settings, compared with theory settings. Clinical practice may be where their theory becomes applicable, but the ability to write an academically constructed argument to explain this may not be their forte and may result in grade disparity.

The differences in why, how and what is being assessed in theory and practice may be the reason for the variance in grades (Walsh & Seldomridge, 2005). In Seldomridge & Walsh's 2006 study, they identified that mentors believed that students close to qualifying should receive higher grades. Comparatively, a culture of 'giving the benefit of doubt' for new or junior students also exists (Gray & Donaldson, 2009, p). Mentors often have their own views on what needs to be assessed and their personal expectations of student attainment, rather than applying the criteria within the assessment documentation (Parker, 2002).

Donaldson & Gray in 2012 suggested that grading practice improved the learning experience due to the provision of feedback and identification in patterns of performance over time. This suggestion was further supported by Hunt *et al* in 2012, who recognised that where formative feedback was given, grades improved. In theory, formative feedback can be minimal and therefore not allow for improvement and may be the cause of uneven distribution in grades. The supportive and

developmental approach applied to practice assessment should be seen as a positive student centred approach to learning and maybe the HEI should look at the example set in practice.

Regardless of the assessment tool, subjectivity and bias is viewed negatively in relation to workplace assessment. The risk of bias and subjectivity is introduced with the use of an assessor, and relationships between mentor and student can play a pivotal role in the assessment process (Lovegrove & Hatfield, 2012; Seldomridge & Walsh, 2006). Calman *et al* in 2002 identified that the assessor's personality and intimate knowledge of the student affected the assessment process. If a close, almost friendship type of relationship develops between student and mentor, it can affect the mentor's ability to give honest feedback (Seldomridge & Walsh, 2006). The socially situated nature of midwifery work based education also adds to the problem as it becomes difficult to assess people with whom you have developed a relationship. In role modelling their mentor, it makes allocation of a lower grade difficult (Finnerty *et al*, 2006; Watson *et al*, 2002).

Students' personalities and ability to fit in has been cited as having positive and negative impacts on assessment (Smith, 2007; Calman *et al*, 2002). Smith's 2007 study identified the social processes involved in work based assessment, but mentors implied that this did not affect their grading of the student. Yet, students felt that having a university lecturer present at the assessment reduced personal subjectivity affecting the assessment process (Finnerty *et al*, 2006).

Disparity between grades allocated and the feedback given can result in downplaying concerns related to the student's performance (Donaldson & Gray, 2012; Heaslip & Scammell, 2012). Feedback identifying a student's strengths and weaknesses allows them to build upon what is going well and improve on areas of weakness, encouraging growth and development (Heaslip & Scammell, 2012; Hatfield & Lovegrove, 2012). Fitzgerald *et al* (2010) identified inconsistencies with feedback especially in relation to negative feedback. Assessors who are new to their role may find it difficult to give negative feedback and to avoid conflict, give a good grade (Walsh & Seldomridge, 2005). However, it is not just the new assessor that is affected by this (Donaldson & Gray, 2012; Duffy, 2003). Giving difficult feedback is not easy and mentors find assessing and grading difficult and anxiety-inducing (Smith, 2007). However, students appear to accept this if it feels fair, honest and has not come as a complete surprise. If assessment is continuous, mentors should not wait till assessment points to give constructive feedback but should be providing this throughout the placement. This helps to prepare the student for the assessment and also allows the student a chance to improve.

Many mentors identified that effect of leniency (Donaldson & Gray, 2012) on new students and reliance on future assessors to properly assess (Weaver *et al*, 2007). Students quickly identify the variety of assessors; which mentors are stricter, have higher expectations, and which are more lenient. This lack of consistency between assessors (Calman *et al*, 2002) is often referred to as the 'Hawks & Doves' effect (Donaldson & Gray, 2012; Gray & Donaldson, 2009). However, student frustrations can rightly manifest if they are receiving lower grades due to the unpredictable nature of who their assigned mentor is. While all mentors should have high standards we need to ensure that all mentors are assessing against the criteria rather than to their own standards (Parker, 2002).

The exertion of pressure on assessors by the student to allocate a good grade has been identified as an issue (Weaver *et al*, 2007; Walsh & Seldomridge, 2006), with literature citing aggression towards mentors who grade below what the student expects or wants (While, 2004). Support for assessors is essential in cases where this is an issue. Assessment should not be one person's sole responsibility (Holmboe *et al*, 2012). As a social learning environment, many staff will work with or alongside a student and their input should be sought to strengthen the assessment process.

Solutions

Training and support of clinical assessors has long been documented as a necessity to support mentors (Duffy, 2004). Much of the focus in recent years has been on the failing student rather

than grade inflation. Triennial review requirements for mentors, include consideration of assessment issues in relation to validity and reliability of judgements (NMC, 2008). As a midwifery educator, facilitating mentor updates which ensure discussion and debate around these issues could reduce the effects of subjectivity and bias and enhance the validity and reliability of the assessment process.

The inclusion of clinical staff in academic based assessments is also a crucial method for demonstrating and elucidating how criteria grading grids can be used and applied. Clinicians are being encouraged to partake in Vivas, OSCEs and simulation days as part of achieving their mentor sign-off status (NMC, 2008). Educators can use this time to support and develop mentors' assessment skills while enhancing the links between theory and practice.

Triangulation of assessments between lecturer, mentor and student in practice settings has been cited as a means to reduce grade inflation by making the assessment more objective and helpful (Calman *et al*, 2002; Finnerty *et al*, 2006). Finnerty *et al* (2006) also noted greater satisfaction for both students and mentors when lecturers were present. Smith (2007) identified mentors preferred to assess students independently; the mentors in the study likened it to peer review and a core component of their role. It could be questioned that the variety of viewpoints on mentors' ability and preparedness to assess is related to their own motivations for undertaking the mentor role. Mentorship in midwifery is not an optional extra but a fundamental core component of the role. Midwives who do not enjoy or value this aspect of their job may feel that support from the university would remove the responsibility from them or maybe it just reduces the associated anxiety and stress related to grading and assessment.

There are many issues related to tripartite assessment, such as the increasing number of students compared to lectures and distance of hospitals from the university, resulting in expense related to time and travel. The NMC (2008) requires lecturers to be based in practice for twenty per cent of their time; it would be beneficial to use this time for tripartite assessments. To achieve this, an understanding of workloads from the HEI perspective needs to account for this. In fact we have come full circle, the perception and value assigned to clinical practice by HEI needs to be reflected in the support of its academic staff if it is to ensure valid and reliable assessments for its students.

Conclusion

Midwifery is often cited as an art and much of the role is indeterminable. If grading and assessment is fair, valid and reliable, surely this would be the 'holy grail' of defining what it means to be a midwife and what it takes to be a midwife (Darra *et al*, 2003, p. 44). It would also reassure the public, employers and regulatory bodies that newly qualified midwives are fit to practice. Work based learning and assessment may ensure fitness to practice (Flanagan *et al*, 2000) but as educators we also need to ensure the awarding degree is appropriate. As educators in HEI we need to support mentors to feel confident and competent to use the tools provided to assess students if we are to resolve the issue of grade inflation and ensure the appropriate degree classification is awarded.

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