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EDITORIAL

The Fuzzy World of Objectivity, Subjectivity, and Trustworthiness in Health Professional Education

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De Groot (1961) [1] defined objectivity as “judgement without interference or even potential interference of personal opinions, preference, modes of observation, views, interests or sentiments” (p.342).

Objectively assessing performance in health professions education cannot be separated from the assessor’s beliefs and experiences which has shaped his/her perception of the observed performance. Every observation includes aspects that arise from the object that the observer is observing and the observer’s way of observing, understanding and preferences. In medical education it is even more complex. We have the patient, the student, the assessor and the complex work environment. Each has its own reality about the encounter. In addition, the context of practice and the case specificity creates problems when predicting and generalizing the judgement about the competency of a student or a health professional.

The observation of performance on a particular problem or in a particular situation is only weakly predictive of the same individual’s performance on a different problem or in a different situation [2]. In the field of education, psychometricians are looking to the statistical validity and reliability of tests and the generated scores in order to justify pass/fail decisions, standard setting procedures, etc. and label the decisions as “objective ‘or’ free from personal bias”.

In fact, even large-scale MCQs are not objective. Every test question is produced by experts and represents a value judgement when selecting the correct answer. All standard setting procedures are based on collective personal judgements through Angoff’s, Ebel, or compromise methods. The famous cut-off marks for passing an exam set to 60%

or 50% are not based on any objective criteria. They are frequently based on organizational culture and historical practice.

So, we have to accept that objectivity in health professions education is based on subjective experts’ judgements over observed situations, over a period of time, and by multiple experts in the field of practice. In medical diagnosis, experts use pattern recognition in coming up with an initial diagnosis. This is of course also a subjective judgement. Its meaning increases with the number of judgements, diversity of the events, and expertise of the professional. The same applies to education.

The practical application of the value of collective, subjective, documented evaluation is represented in “multiple source feedback” and the use of portfolios, and in providing timely constructive feedback. In medicine and all health professions the issue of trust, entrustability and entrustable professional activities [3] is the ultimate goal of the relation between the patient, society, and the professional. The important question to be asked is “Can I trust him/her to take care of me or my child?” The trust is not based on scores, but it based on the interaction which took place between the caregiver and receiver of care. It is believing that the person who is trusted does what is needed during a specific situation.

So, is all this objective or rather subjective? Definitely, subjectivity as described here is not a sin.

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