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UNGRADING AND ALTERNATIVE ASSESSMENT IN HIGHER AND HEALTH PROFESSIONS EDUCATION: A NARRATIVE REVIEW WITH REFERENCE TO THE INDIAN CONTEXT

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ABSTRACT
Ungrading challenges the dominance of letter grades, numerical marks and point-based evaluation by decentring grades in favour of feedback, self-assessment and revision. This narrative review examines the theoretical foundations, alternative grading models, empirical evidence and implementation experience of ungrading and related approaches in higher education, with particular reference to health professions education and the Indian context. The review draws on humanistic and critical pedagogy, self-determination theory and the distinction between assessment for and of learning, and describes a spectrum of approaches including specifications grading, contract grading, standards-based grading, pure ungrading and hybrid models. In medical education, pass/fail grading, the most widely adopted form of reduced grading, is consistently associated with better student well-being and lower burnout without adverse effects on licensing examination performance, although programme directors' preferences for tiered grades and the "shadow economy of effort" raise concerns about residency selection. Ungrading aligns philosophically with competency-based medical education (CBME), and programmatic assessment, entrustable professional activities and narrative evaluation offer practical bridges between the two. Important challenges include student anxiety, faculty workload, institutional and credentialing requirements, the maintenance of standards, and the risk of reinforcing inequalities. In India, an examination-centric culture, high-stakes entrance and licensing examinations, large classes and faculty shortages are major barriers, while the CBME curriculum, workplace-based assessment and concern for student well-being create openings for change. A phased, evidence-generating approach to implementation and a research agenda focused on non-Western and resource-constrained settings are proposed.

KEYWORDS: Ungrading; Alternative assessment; Pass/fail grading; Specifications grading; Competency-based medical education; Self-assessment; Student well-being; India

INTRODUCTION
Traditional grading, which is based on marks, letter grades, grade point averages and class rankings, has long reigned over higher education. It is based on industrial era models and it was designed to efficiently sort, rank and credential students. A growing body of evidence suggests, however, that grades may undermine the very purposes of education, namely deep learning, intellectual curiosity, critical thinking and personal growth [1].

Ungrading as a movement and an educational philosophy, questions this hierarchy. It is a method that puts the emphasis on self-evaluation, reflection and revision, instead of focusing on grades, and where the teacher gives detailed feedback instead of grades [2,3]. It is based on research in educational psychology, motivation and assessment and its proponents believe that grades are extrinsically motivating and can lead to a decrease in intrinsic interest, anxiety and unhealthy competition, and can reduce complex intellectual work to a simple quantification [4]. COVID-19 served as a surprising catalyst as institutions shifted to emergency remote instruction, many of which implemented a temporary pass/fail grading policy, which created a significant natural experiment in reduced grading.

There are several reasons why the topic is of importance. Ungrading gives teachers an opportunity to think about the role of assessment in relation to learning. In health professions education, traditional grading is linked to stress, anxiety and competition, an issue that is of great concern as student mental health is already precarious. Ungrading has been touted as an equity practice that has the potential of removing barriers to success for marginalised learners. Assessment needs to change to accommodate a competency-based education and to be able to capture the complex, multidimensional competencies that may not be well captured by conventional grades [5]. Last, but not least, in an education system all over the world, which is getting ready to educate students for an ever-changing world of work, the drawbacks of grading have become more and more obvious.

This review aims to (i) describe the theoretical and philosophical foundations of ungrading; (ii) describe the main alternative grading models; (iii) synthesise evidence on the effects of ungrading and reduced grading, particularly in medical education; (iv) examine the relationship between ungrading and CBME; (v) identify challenges and unintended consequences; and (vi) consider implications and a research agenda for Indian health professions education.

METHODS
This is a narrative review. PubMed/MEDLINE, ERIC, Google Scholar, JSTOR and specialised medical education databases were searched using controlled vocabulary and free-text terms, including ungrading, alternative grading,

specifications grading, contract grading, standards-based grading, pass/fail grading, gradeless learning, narrative evaluation, reduced grading, self-assessment, peer grading, and competency-based education, combined with terms for higher education, medical and health professions education, student outcomes, well-being, motivation, equity and India. Peer-reviewed English-language articles, books and book chapters addressing ungrading, alternative or reduced grading, pass/fail grading in medical or health professions education, self-assessment, or the equity implications of grading in higher education were included, as were empirical studies, theoretical frameworks and implementation reports from diverse settings, including low- and middle-income countries. Literature from 2014 to 2025 was prioritised, with earlier seminal works included. Articles focused exclusively on school (K–12) education, studies not addressing grading or assessment, opinion pieces without empirical or theoretical grounding (unless seminal), conference abstracts without full text, and articles published before 2000 (other than seminal theoretical works) were excluded. Findings were organised thematically and synthesised narratively without formal quality appraisal.

Theoretical foundations

Historical critiques of grading

Criticism of grading is not new. Kohn characterised grades as superficial motivators that undermine creativity, motivation and genuine engagement, arguing that the more artificial inducements are used to motivate people, the more they lose interest in what they are being induced to do [6]. Scholars in higher education have extended these arguments, contending that an emphasis on grades distracts students from learning, encourages them to choose easier tasks, narrows thinking, creates incentives for cheating, reduces the student–teacher relationship to a transaction, and induces anxiety that impairs learning [1,7].

Humanistic and critical pedagogy

Ungrading draws on humanistic educational philosophy. Dewey's progressive education emphasised learning through experience and reflection rather than rote memorisation for examinations [8], while Rogers argued that self-direction and self-assessment within a person-centred climate foster significant learning, personal growth and intrinsic motivation [9]. Both regarded rigid, traditional education as stifling human potential; Dewey emphasised social interaction and experience, whereas Rogers emphasised psychological safety.

Critical pedagogy, associated above all with Freire [10], views education through the lens of power and social justice. In this tradition, ungrading is considered a component of a larger movement that is attempting to resist market pressures on education and to develop more democratic and equitable learning environments. Grades are a currency, embedded in systems that are unfair, as described by Stommel and others [11]; a student in a well resourced area will earn higher grades, not necessarily because they learn more, but because the system is working against students who are not in well-resourced places. Love's abolitionist pedagogy also advocates for the elimination of systems of surveillance and punishment and grading, and for the maintenance of student power in self-evaluation and making mistakes as learning opportunities [12]. In this view, ungrading is about assessing from the bottom up, allowing students to have choice and voice in their learning.

Self-determination theory

Self-determination theory (SDT) provides a robust psychological rationale for ungrading [13]. SDT identifies three basic needs. Autonomy, the need to feel volition in one's actions, is undermined when learning becomes instrumental to external rewards; ungrading restores autonomy by allowing students to direct their learning and evaluation. Competence, the need to feel capable and effective, is often assumed to be supported by grades, yet grades frequently function as controlling rather than informational feedback; well-designed alternative assessment can provide more meaningful information about competence. Relatedness, the need to feel connected to others, can be eroded by the competitive atmosphere that grading creates and enhanced by collaborative, ungraded environments.

Assessment for learning and assessment of learning

A central distinction underpinning ungrading is that between assessment for learning (formative) and assessment of learning (summative). Traditional grading emphasises the summative function of certifying achievement, whereas ungrading prioritises the formative function. Black and Wiliam's seminal review showed that feedback focused on improvement, rather than evaluation, produces substantial learning gains [14]. Ungrading takes this one step further by stripping away the evaluative veneer of grades, which can inhibit students from being able to effectively interact with feedback and self-evaluation.

However, there is no fully developed theory behind ungrading. Much practice is based on implicit, not explicit, research-based theories of learning, as Sorensen-Unruh argues that "the ungrading learning theory we have is not the ungrading learning theory we need" [15]. Ungrading is often touted as a universal solution, but learners are not all alike – some may have been more prepared, some may be more self-regulated, some may have come from different cultural backgrounds, some may be more anxious than others, some may be at a more advanced stage in their careers, some may thrive in an unstructured environment, and others may need scaffolding, deadlines and benchmarks. Ungrading also involves a variety of practices and, as such, can make it difficult to research. Future studies should differentiate between approaches, describe how these work and investigate moderators (e.g. previous success, self-regulation and culture). However, if these sorts of measures are not taken with such rigour, policymakers in medical education may be tempted to view ungrading as ideologically motivated rather than evidence-based.

A spectrum of alternative grading models

Alternative grading encompasses a spectrum of approaches rather than a single method [16]. Table 1 summarises the principal models.

Table 1. Principal alternative grading models

Model	How it works	Reported benefits	Reported challenges
Specifications grading	Detailed specifications define acceptable work; each assessment is marked pass/fail; final grades depend on the bundles of assessments completed; resubmission is permitted	Shifts focus from points to learning; greater ownership; less cheating; transparent grade determination; reduced grading workload; aligns with accreditation	Substantial upfront planning; initial student discomfort; specifications must preserve rigour; students may choose easier bundles
Contract grading	Students agree at the outset what work they will complete for a given grade; labour-based, process-based or mixed contracts	Greater agency and choice; clear expectations; less grade negotiation; focus on effort and engagement	Requires trust; inequity if students choose uninformed; consistency of standards; resistance to non-traditional approaches
Standards-based (mastery) grading	Grades reflect mastery of defined standards rather than accumulated points; multiple opportunities to demonstrate mastery; early failures are discounted	Clarity about strengths and gaps; multiple routes to demonstrate mastery; fosters a growth mindset	Ongoing assessment and feedback workload; difficult to translate into grade point averages; confusing for unfamiliar students and families
Ungrading	Assignments receive narrative feedback only; regular self-evaluation; final grade agreed through student–instructor conversation	Deeper learning; intrinsic motivation; metacognitive development; stronger instructor–student relationships	Discomfort without benchmarks; institutional requirement for final grades; risk of inconsistent standards
Hybrid approaches	Combinations, e.g., specifications with ungraded elements, partial ungrading, token systems for revision, portfolios, student-generated rubrics	Adaptable to local context	Complexity; benefits depend on design

Specifications grading, created by Nilson, is a blend of mastery learning, competency-based education and contract grading [2]. In writing courses, labour-based contracts are a form of contract grading, which pays for the quantity of work rather than the quality [17,18]. Standards-based grading evaluates progress towards clearly defined learning goals [19–21] and is closely related to mastery learning, which is well established in medical education [22]. Pure ungrading removes grades from individual assignments altogether and relies on qualitative feedback and student self-reflection [3,4,23].

Self-assessment and peer assessment

Self-assessment is the mechanism through which ungrading develops students' capacity to judge their own work, identify gaps and direct their learning. It cultivates metacognitive awareness, evaluative judgement, self-regulation [24], professional identity and the capacity for lifelong learning. These attributes are directly relevant to clinical practice: metacognition guards against overconfidence and diagnostic error, and a clinician who can honestly judge whether they are competent to manage a given patient, and seek help when they are not, is essential in settings without immediate supervision, such as understaffed rural health centres.

The accuracy of self-assessment is, however, limited. Weiss and colleagues found only a weak to moderate positive correlation between third-year medical students' self-assessments and their final clerkship grades, significant only for written and verbal skills ($r = 0.39$); students judged their technical and written or verbal skills better than their knowledge base and personal attitudes [25]. The aim of self-assessment within ungrading is therefore not accurate self-grading but the development of evaluative judgement that becomes progressively aligned with professional standards. This requires clear criteria and standards; repeated practice with feedback on self-assessments; exposure to exemplars at different levels of quality; reflection on discrepancies between self- and instructor assessments; and scaffolded development over time. In hierarchical cultures that suppress honest self-evaluation and examination cultures that inflate confidence, self-assessment must be calibrated against external data and protected from punitive use. Nieminen and Tuohilampi showed in a university mathematics course that a summative self-assessment model fostered student agency, with students describing a shift to "finally studying for myself" [26].

Peer assessment, in addition to ungrading, offers other benefits: it provides further perspectives, helps to develop evaluative judgement, alleviates the burden of routine (but not high-stakes) assessment, creates a culture of collaborative learning, and can prepare students for the peer assessment that exists throughout medical practice. Peer assessment has been shown to be a facilitator of learning, especially when it is accompanied by training, clear criteria and faculty supervision [27]. While identified peer assessment can result in more valuable feedback than anonymous assessment [28], this requires a culture of trust, which is often not present in health professions education.

Evidence from medical education

Unique considerations

Medical education poses particular challenges for ungrading. It operates under public accountability, and the consequences of incompetence may be immediate, irreversible and litigable, creating pressure for rigorous, defensible assessment. Standardised licensing examinations, such as the United States Medical Licensing Examination (USMLE), the National Eligibility cum Entrance Test for postgraduate admission (NEET-PG), the Professional and Linguistic Assessments Board test and the proposed National Exit Test (NExT), cannot be ungraded, and students will optimise their learning for them regardless of internal assessment philosophy. Residency selection is a highly competitive bottleneck that rewards differentiation. At the same time, the hidden curriculum is powerfully shaped by assessment: when assessment emphasises self-assessment, peer feedback and reflection, students learn that medicine values self-awareness, teamwork and continuous improvement. Horizontal peer critique and open acknowledgement of limitations nonetheless remain culturally unfamiliar in the hierarchical culture of medicine.

Pass/fail grading and well-being

Pass/fail grading is the most widely implemented form of reduced grading in health professions education, particularly in the preclinical years, and gained momentum after 2010. The change of USMLE Step 1 to pass/fail reporting in 2022 was a pivotal moment that prompted extensive debate [29]. A scoping review of reduced grading reported predominantly positive outcomes, including improved well-being, a more learning-oriented environment, better self-regulation, mastery and less strategic cramming, alongside some negative outcomes, such as poorer study habits, stress arising from uncertainty about standards and future prospects, and reduced effort, with many effects being context-dependent [30].

Evidence for benefits to well-being is consistent [31]. After a change to pass/fail grading in the first two years at the University of Virginia, students reported better well-being on all six subscales of the General Well-Being Schedule and rated the learning environment more favourably [32]. At the Mayo Medical School, students graded pass/fail reported less stress, better mood and greater group cohesion than students in a graded cohort [33]. In a multi-institutional study of seven medical schools, students in curricula with three or more grading tiers had 2.17 times higher odds of burnout and were more likely to have seriously considered dropping out than students in pass/fail curricula [34]. Students in pass/fail systems also report greater satisfaction, more time for extracurricular activities and greater cohesion with classmates [35].

Impacts on motivation are more complex. Students feel more focused on mastering the material and less competitive as per SDT; however, according to some studies, students' effort decreases when there are no longer grade incentives. Students who are motivated from an external source or introjected motivation may not react positively, as may students from cultures emphasizing academic success. In the same way, ungrading has been touted as an equity practice, which will acknowledge improvement and capture strengths that numerical grades might overlook, but its equity impacts are highly dependent on how it is implemented, including the level of faculty attention to their own biases, flexibility in the institution, and culturally inclusive criteria.

Academic outcomes and residency selection

Pass/fail grading does not appear to impair knowledge acquisition. In 96 US medical schools, pass/fail preclinical grading was non-inferior to tiered grading for USMLE Step 1 and Step 2 Clinical Knowledge scores after adjustment for Medical College Admission Test scores [36]. One school observed lower performance in two second-year courses after adopting pass/fail grading, but no differences in USMLE Step 1 scores or residency placement [35].

Concerns centre on residency selection. Surveys have suggested that some programme directors believe pass/fail grading disadvantages applicants [31,37]; in Ontario, 66% of programme directors preferred numeric or letter grading over pass/fail systems [38]. Studies of the quality of residency programmes that students obtained, however, have found no significant difference between pass/fail and tiered cohorts [31]. Programme directors' views on pass/fail clinical clerkships have also been surveyed [39].

A recent crossover study at Aalborg University in Denmark exploited a curriculum reform that switched some examinations from pass/fail to tiered grading and vice versa. Among 7,164 examinations, the failure rate was higher with pass/fail than with tiered grading (3.3% vs 1.97%; $P < .001$), but the difference disappeared when near-failing tiered grades were counted as failures, and final licensing examination grades were unchanged ($P = .47$) [40]. The authors found that pass/fail grading focuses attention from high performance to maintaining standards for low performance students, indicating a potential use to identify and assist underperforming students.

Grading by pass/fail also can have unintended consequences. Warm et al. discussed a "shadow economy of effort", whereby students who are no longer able to compete with their peers on grades invest effort in research, volunteering, and other activities as part of their residency applications, potentially at the expense of clinical excellence, leading to new types of competition and burnout [41]. They concluded that residency selection should be viewed as a complex adaptive system, and that incentives should be given for outcomes, not activities, and that there should be open information flow and continuous monitoring [41].

The critics have three main objections: that the lack of discriminating grades may diminish the incentive for excellence; that less grading does not necessarily lead to better self-assessment; and that a pass/no pass system can lead to delayed

remediation for less prepared students and a cover-up of the more capable. While these concerns do not discount the value of pass/fail grading, they do highlight the importance of additional components to the assessment, including explicit practice in self-assessment, detailed narrative evaluation, and milestone tracking of competence. Overall, the evidence indicates that ungrading is neither a cure-all nor a threat, but a pedagogical decision that is influenced by the quality of implementation, the characteristics of the learners and the context of the institution, and that the ungrading system itself may not be as important as the design of the instruction and the quality of the feedback and faculty development.

Preclinical and clinical phases

The majority of the studies on pass/fail grading have taken place in the preclinical years [32–34]. The evidence of benefit is strongest in this phase, when there is less impact on care, and when implementation could occur without disruption of regulation. Clinical years are a different story: there are well-defined thresholds of competency for patient safety and there is a need to differentiate for residency selection. In this phase, a natural, alternative to grades is workplace-based and entrustment-based assessment, which, however, requires infrastructure which is not available in many institutions.

Ungrading and competency-based medical education

Shared commitments and tensions

The philosophy of ungrading and CBME are similar in nature [5]. Both focus on outcomes rather than time spent, mastery rather than ranking, feedback rather than evaluation, and student agency rather than passive learning, and both call into question the sorting function of education, and a call to action to maximize the number of competent practitioners. In practice, however, these commitments are in conflict with structural realities. In India, the time and hours allowed for the undergraduate (MBBS) programme are defined by the NMC, postings in the clinical departments are made as per a fixed rotation schedule and post-graduation programmes have fixed duration [42]. The seats of undergraduate, postgraduation and super-specialty are based on competition and the toppers are celebrated publicly. Progression still depends on summative university examinations, internal assessment is often reduced to marks, and heavy clinical loads limit structured feedback at the bedside.

India introduced a CBME curriculum for undergraduate medical education in 2019 [42]. Its competency framework, workplace-based assessment, emphasis on attitude, ethics and communication (AETCOM) and self-directed learning all create opportunities for alternative assessment, because these outcomes require observation, documentation and qualitative judgement. Challenges include continued reliance on high-stakes, percentage-based summative examinations; standardised, ranking-based entrance and licensing examinations; faculty trained in traditional assessment, whose efforts in assessment innovation go largely unrewarded; and large student numbers. To date, therefore, CBME has created the language of alternative assessment in India, but not yet its practice.

Programmatic assessment as a bridge

Programmatic assessment, developed by van der Vleuten and colleagues, offers a practical bridge between CBME and ungrading [43]. It optimises formative assessment for learning and summative assessment for decision-making, using different tools for each. Multiple low-stakes assessments provide rich feedback; competence committees make holistic judgements based on a learner's portfolio of clinical observations, examinations, reflective writing, peer feedback and patient evaluations; and high-stakes decisions rest on longitudinal patterns rather than single examinations, which are unreliable because performance varies by day, case and assessor [43]. Separating formative feedback from summative decisions reduces performance anxiety during learning while preserving accountability at key decision points, closely mirroring the principles of ungrading.

Entrustable professional activities as a bridge

Units of professional practice that a learner can be trusted to perform without supervision are called entrustable professional activities (EPAs) (ten Cate [44]). Entrustment is binary (ready or not yet ready); it is based on the observation of multiple people in multiple situations; it is supported by a narrative feedback; it asks the question of whether or not that learner is safe to practise, not whether they are better than another learner. These features are very similar to pass/fail and specifications approaches. In Canada, EPA has been embedded in a national programme of assessment for specialist postgraduate training, and has proven it can work at scale [45]. EPAs thus offer a clinically authentic bridge to ungrading, replacing the question "How much did you score?" with "Can we trust you with a patient?"

Narrative evaluation

Narrative evaluation (detailed written feedback in lieu of grades) can be used for competencies that are irreducibly qualitative, such as clinical reasoning, ethical judgement, communication, empathy under pressure and tolerance of uncertainty, and is consistent with the case-based reasoning traditions of medicine. It takes training for faculty in writing useful feedback, time to write it down, systems to ensure it is done consistently and fairly, and training for students on how to interpret feedback. If poorly done with generic, inconsistent or uninterpreted comments, it can be worse than grading; if well done and if the same faculty member observes a learner repeatedly, it can help the learner understand not only where he or she is, but who he or she is becoming. If these types of narrative evaluation were to be scaled to the massive scale of medical and nursing institutions in India, significant and phased investments in faculty training, digital infrastructure and quality assurance would be needed.

Student perceptions

The students say that ungrading is a way of encouraging real learning; in one study, they said that "success was actually having learned", but some reported feeling stressed by the lack of grading [46]. Students appreciate reduced anxiety and

competition, appreciate detailed feedback and want to learn on their own, but some students are confused with expectations, want traditional grading as a benchmark, and are worried about competitiveness for future opportunities [26,46]. Students who are used to learning for grades are most resistant.

Implementation experience

Alternative grading has been adopted across disciplines. Specifications and mastery-based approaches are used in science and mathematics courses, contract and labour-based grading in writing courses [17,18], portfolio assessment in language and literature courses [47], and project-based assessment in engineering and business. In medicine, the institutional studies at the University of Virginia [32], the Mayo Medical School [33], the seven-school study of Reed and colleagues [34] and the Aalborg crossover study [40] illustrate a recurring theme: alternative grading works best when it is implemented as a structurally complete system rather than as an isolated change.

Experience suggests five requirements for successful implementation (Table 2).

Table 2. Requirements for implementing alternative grading

Requirement	Practical elements
Clear communication	Explicit rationale; detailed specifications, checklists or rubrics for every assessment; transparent pathways to each outcome; regular communication about expectations
Gradual introduction	Pilot in one assignment or module; document and adjust; offer a choice between traditional and alternative approaches; start with enthusiastic early adopters and share results
Student preparation	Orientation to the philosophy of the approach; explicit teaching of self-assessment; annotated exemplars at different levels; low-stakes practice with feedback
Instructor development	Training in qualitative feedback; support for designing specifications and rubrics; communities of practice; administrative support such as smaller pilot classes, protected time and recognition in promotion
Technology support	Learning management systems that track mastery; e-portfolio platforms; digital rubrics; audio and real-time feedback tools; structured self-reflection tools

Challenges and critiques

Students

Reasons for student resistance to the elimination of grades include that they are accustomed to grades and alternative systems require more work to interpret; that expectations are unclear; that students are afraid of being disadvantaged with regard to further study, jobs or residency; that grades give them social validation; and that self-assessment requires time to learn [46]. With changing rules of assessment, students can no longer plan, and opposition should be seen as a sensible reaction to an uncertain situation in a high-stakes setting. The advantages of changing grading practices can only come after a period of initial discomfort and support is necessary to make the transition happen.

Faculty

Perhaps the largest practical challenge is faculty workload. For a class of 150 students, it takes 25 hours to write even 10 minutes of narrative feedback per student, a time few faculty have, especially in publicly funded institutions, where teaching, clinical and administrative demands are high. The development of specifications and rubrics is an investment that has to be made repeatedly and is not usually reflected in the criteria for promotion, which is generally based on research. Grading conversations, continuous support to self-assessment and countering grade inflation or deflation impose additional requirements.

Institutions and standards

Institutions exist in accountability and credentialing ecosystems. Postgraduate admissions may be based on transcript standards and cut-offs and scholarships may be based on GPA or ranking, which may be impacted by dropping grades without an alternative mechanism; student information systems are expensive to change; parents and employers are accustomed to traditional indicators. The practice of maintaining standards without grades poses some challenging questions, however, such as how to guarantee at least the minimum level of competence across multiple dimensions, how to differentiate between an excellent and an adequate performance, how to communicate achievement to outside parties, and how to avoid grade inflation and deflation. The answer is not one, but rather the question needs to be rephrased from sorting students to ensuring all students are competent.

Equity and unintended consequences

Alternative grading cannot simply be transplanted from Western settings. Reduced grading in one domain may shift competition elsewhere [41]; in India, an analogous phenomenon is seen in “dummy schools”, in which senior secondary students forgo school attendance in favour of coaching for entrance examinations, and in the diversion of undergraduate medical students’ attention to coaching for NEET-PG. Ambiguity can increase stress, particularly for students who have spent years calculating the marks needed to clear a cut-off, and for first-generation students whose families equate grades

with security. Alternative assessment can also benefit students who are more skilled in self-assessment and English (since reflection is often in English), have higher levels of cultural capital, have access to devices and internet connection (which have been so evident during the Covid-19 pandemic) and have access to mentorship. The subjective assessment can be used to further reinforce the implicit biases, such as those of students belonging to Scheduled Tribes and Scheduled Castes or women from conservative families, while standardised examinations provide at least an appearance of objectivity. Hence, it is not a question of whether alternative grading is in theory better, but whether institutions are able, willing and able to do so without negatively affecting the most vulnerable students.

The external credential problem

Grades serve as a social currency in the form of negotiable commodities between institutions for admission, employment, scholarships, licensing and international credential evaluation. Thus, institutions implementing ungrading should offer credentials that contain meaning to outside parties, and the interface between internal educational values and credentials must be redesigned, rather than doing away with grades altogether. If class sizes are not reduced, faculty are not trained, and administrative structures are not modernized or incentives to career are not offered to faculty for assessment innovation, alternative assessment can be tokenistic or used as a means of exploiting overloaded faculty.

The Indian context

Barriers

Medical education in India is extremely exam oriented. The students are exposed to NEET-UG for entry to undergraduate program, university exams, NEET-PG for entry to postgraduate program and Foreign Medical Graduate Examination for foreign medical graduates. The 2019 CBME curriculum introduced competency-based outcomes, workplace-based assessment, logbooks, and self-directed learning [42] but was overlaid on the existing examination system and not a replacement for it. Students thus live in two parallel systems, with the examination system prevailing, and with real consequences.

Cultural barriers are the culture of being examination oriented where ranking of the students determines their future; significant investment in medical education and the expectation of a definite return; high power distance in teacher – student relationship which makes it challenging to assess self or peers; high competition for limited numbers of postgraduates; and screening of academic marks by employers. These are not irrational resistances to the system; but rather rational adaptations to it. Structural barriers include having a batch of 100 to 250 or more students, the lack of faculty, regulatory requirements that necessitate specific examination structures, inadequate digital infrastructure, and lack of faculty training in alternative assessment design, narrative feedback and support for self-assessment. These barriers are interdependent and need to be addressed at several levels at the same time.

Opportunities

There are also legitimate opportunities. Competencies can be assessed within the CBME framework as “met” or “not yet met”. Observation and feedback are already used in workplace-based assessment tools like the mini-clinical evaluation exercise and direct observation of procedural skills, instead of grades. Technology-based assessment could be facilitated by investment in digital infrastructure by the government. The shocking rates of depression, anxiety and suicide among medical students in India make it imperative to curb the stress during exams. Finally, there are international shifts towards competency-based and alternative assessment that offer models on which to build.

A phased pathway

Complete de-grading of Indian medical education is not feasible or even desirable in the short-term. A more practicable approach is to establish protected opportunities for alternative assessment within the current system, build up evidence and leverage on successful experiences to drive regulatory reform. A suggested pathway is provided in Table 3.

Table 3. A phased pathway for alternative assessment in Indian health professions education

Level	Recommendations
Policy	NMC guidelines for alternative assessment that maintain standards while reducing grade-related stress; authorised and evaluated pilot programmes; review of licensing examinations for compatibility with competency-based assessment; accreditation standards that recognise alternative assessment
Faculty development	National centres of excellence; mandatory training in alternative assessment design, narrative feedback and supporting self-assessment; workload adjustment and recognition for faculty who innovate
Technology	Digital platforms for portfolios, feedback documentation and self-assessment; Indian-context tools and rubrics; shared repositories of exemplars and specifications
Institutions	Pilots in the foundation course and AETCOM modules; extension to pass/fail grading in preclinical years; specifications grading in clinical rotations; eventual transition to programmatic assessment

Level	Recommendations
Stakeholders and support	Orientation of students, parents, employers and residency programmes; mentorship for self-assessment; feedback workshops; peer assessment training; counselling for transition anxiety

Research agenda

Evidence on ungrading in health professions education, non-Western and resource-constrained settings, and long-term outcomes is limited. Priorities include pilot studies of pass/fail grading in Indian medical colleges; cultural adaptation of self- and peer assessment; evaluation of faculty development; student well-being outcomes; and the cost-effectiveness of alternative compared with traditional assessment. Mixed-methods and longitudinal designs that follow students through and beyond medical school, comparative studies across institutions, participatory action research with students and faculty as co-researchers, and multi-institutional and international collaborations are needed. Research should distinguish between ungrading approaches and examine for whom, when and why they work [15].

LIMITATIONS

This is a narrative rather than a systematic review; study selection did not follow a formal protocol, study quality was not formally appraised, and selection bias cannot be excluded. Only English-language publications were included. Much of the evidence on pass/fail grading is from preclinical training in North American and European medical schools, and some of the evidence on ungrading is in the form of books, essays or web resources rather than empirical studies. Some of the remarks in the Indian context are the result of observation and experience and subject for empirical verification.

CONCLUSION

Ungrading is a continuum of practices ranging from pass/fail grading, to specifications grading, to the elimination of grades, with a shared emphasis on de-centering the grade and on assessment for learning. It is based on various theories of learning and motivation but its own theoretical basis is weak. For medical education, reduced grading has a positive impact on well-being without compromising knowledge acquisition, but there are unintended consequences and the impacts on equity and persistence of external credentialing demands are not well understood and need to be engineered into the system. Competency-based education (CBME) and programmatic assessment offer natural bridges between CBE and ungrading, as do EPAs and narrative evaluation. There are significant cultural, structural and regulatory barriers in India but CBME provides a structural opportunity. The goal is not just to get rid of grades, but to develop assessment systems that in fact support learning, that ensure competence, that promote well-being and prepare graduates for practice, that are phased, that generate evidence and that are contextually appropriate.

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