What does the College Want From Us Now?

Peeking Behind the Curtain of Competency-Based Medical Education

Glenn Regehr, PhD
Centre for Health Education Scholarship

Disclaimer

For the year of my sabbatical (and the subsequent year), I was acting as a consultant to Jason Frank in his leadership role for the Competency by Design program

However, I am NOT speaking on behalf of the RCPSC or Jason Frank in this talk and have no obligations to them

All opinions expressed in this talk are my own

Rationale for CBD movement

- What problem is it supposed to solve?
  - The "outcomes" argument (Eric Holmboe)
    - Second lowest ranked health care system in developed world
    - Surely we can do better than that
  - The "process" argument (Brian Hodges / Jason Frank)
    - Educational experiences are not sufficiently planned
    - The tea steeping model of education (Hodges)
    - Learning by Brownian motion (Frank)

The “real” problems

- Program director gripe list:

The “real” problems

- Program director gripe list:
  - The RCPSC
    - Demands for effective documentation of educational processes

The “real” problems

- Program director gripe list:
  - The struggling resident
    - Find out too late
    - No clear understanding of problem
    - No faculty willing to document a problem

The “real” problems

- Program director gripe list:
  - Resident rotation assignment decisions
    - No good data to make decisions based on educational need
    - No structures to support meaningful reflection about decisions
    - Devolves to administrative decisions based on clinical need

The “real” problems

- Faculty preceptor gripe list:

The “real” problems

- Faculty preceptor gripe list:
  - Meaningless assessment forms
    - 1-5 scales based on CanMeds roles
    - “We found that the six ACGME competencies (which came into being as a result of a complex political process) do not directly correspond to anything that has been empirically measured among trainees. Thus, we concluded that, while the competencies provide a necessary framework for organizing assessments of trainees, it does not appear possible to ‘measure the competencies’ as naturally occurring psychological constructs.”

Stephen Lurie

The “real” problems

- Faculty preceptor gripe list:
  - High stakes assessment moments
    - Single end of rotation moment to document opinion
      - “Honest” assessment can affect trainee’s career’
      - Documenting difficulties an indictment of resident not a learning prescription
    - Not what they signed up for
      - I wanted to be a mentor for bright, enthusiastic learners not act as a “gatekeeper” for the university

The “real” problems

- Faculty preceptor gripe list:
  - No faith in system for support of honest documentation
    - Strong perception that giving a low assessment results in a heavy administrative burden for the preceptor
    - Unclear definitions of “evidence” (how would you prove it)
    - Unclear whose problem this becomes (no clear remediation paths)
    - Concern about own time / reputation (anticipation of appeals / reprisals)
    - Perceived lack of university support (whose side is administration on)

The “real” problems

- Resident gripe list:

The “real” problems

- Resident gripe list:
  - Random rotations (no sense of building)
  - Unclear expectations (what will get me the knife)
  - Not much meaningful feedback (“read more”)

The CBME solution

- Find ways to foreground educational mandate
  (rather than clinical and/or administrative mandate)
  - Support clear sense of developmental trajectory
    (milestones)
  - Support collection of useful data for decisions and feedback
    (timely, massive, meaningful)
  - Support reflective, proactive educational decisions being made by right people
    (competence committees NOT preceptors)

Milestones

WARNING:

This is definitely NOT what I hear being talked about at the College

More what I think we SHOULD be talking about

Milestones

- Not a list of things a graduating resident should do
  - Should not devolve to a “Disneyland passbook”
- Rather a developmental trajectory
  - How do you know when a resident is ready to take the knife
  - What makes a good junior vs a good senior resident (and how do you know when someone is ready to take that step)
  - What are the “threshold concepts” of surgical practice

Meaningful data

- ITER documentation is incompatible with the way clinical faculty naturally assess residents
  - Scales organized conceptually around dimensions and level of competence on each dimension
    - Eg CanMEDS roles
  - Attendings' constructions organized practically around level of independence and trustworthiness

“Naturalistic” assessment

- Does this person make my life easier or harder?
- Is this someone I trust:
  - To manage patients
  - To handle emergent situations
  - To know when she is over her head
  - To get help when she is over her head
  - To give me an “accurate” picture of the situation

“Construct aligned scales”

- Align evaluation tools with these conceptualizations
  - Items based on tasks and/or procedures
  - Scale based on level of supervision required

(Crossley et al, Med Ed, 2011)

For example (the Northwestern implementation)

- For every procedure resident participates in:
  - Description of resident participation
    - Show and tell
    - Active help
    - Passive help
    - Supervision only

For example (the Northwestern implementation)

- For every procedure resident participates in:
  - Description of resident participation
  - Assessment of case difficulty
    - In easiest one-third of cases
    - Average
    - In hardest one-third of cases

For example (the Northwestern implementation)

- For every procedure resident participates in:
  - Description of resident participation
  - Assessment of case difficulty
  - Verbal recording of other thoughts
    - Additional details of what happened
    - What the resident might do differently next time to gain more extensive trust

For example (the Northwestern implementation)

- Implemented using cell phone technology
  - Resident indicates case participated in
  - Links to database that texts link to preceptor
  - Preceptor hits two radio buttons and records a note

George BC, Teitelbaum EN, Meyerson SL, Schuller MC, DaRosa DA, Petrusa ER, Petito LC, Fryer JP. Reliability, validity, and feasibility of the Zwisch scale for the assessment of intraoperative performance. J Surg Educ. 2014 Nov-Dec;71(6):e90-6

Frequent, rapid, meaningful assessment

- Not a big burden
  - Fits with faculty experience and easy to document
  - No one assessment feels “high stakes”
- Generates big(ish) data about resident
  - Many cases, multiple preceptors
- Generates big(ish) data about faculty
  - Many cases, multiple residents

Reflective proactive decisions

- Competence committees
  - Interpret data together
  - Brainstorm about individual residents (and faculty)
  - Notice curricular gaps

  - Take the decision making (gatekeeping) out of the hands of the preceptors
    - Let them be the mentors they deserve to be

CBME in practice

- What does this look like as a complete curriculum?
  - The RCPSC doesn't know
    - No one has ever done it in med ed ("Building the plane as we fly it")
    - It is an approach, not a practice (won't look the same everywhere)
  - So there is opportunity
    - For frustration (just a new administrative problem to solve)
    - For innovation (possible mechanism for solving perennial problems)

Centre for Health Education Scholarship

Faculty of Medicine, University of British Columbia

glenn.regehr@ubc.ca