Question: What is your expectation of faculty development for Competency-based Medical Education (CBME)? In both Graduate Medical Education (GME) and Undergraduate Medical Education (UME)?

MG: The idea is that you can send residency program directors from your institution to be trained. Health Resources and Services Administration (HRSA) and American Boards of Pediatrics, Internal Medicine, and Family Practice are sponsoring larger efforts. The Teaching and Learning Center (TLC) is committed to faculty development at the UME level.

Comment: It is a generally held consensus that it is impossible to train an entire medical education faculty in how to use assessment tools to perform evaluations and give appropriate feedback. Should there be a small dedicated group of evaluators?

MG: I am of two minds on this issue. It might be more efficient if we separate the role of coach from the role of “judge,” which might otherwise be conflicted. The students should feel free to try things, expose themselves, and make mistakes in the presence of a coach faculty, who would not also be assessing them – that is the role of the judge. The limitation might be the increased people power this would require. Also, I am concerned that that the assessment faculty person (the judge) may not have enough observation time to offer a substantive assessment.

Question: Thinking in terms of preclinical education, what does a milestone look like? How do you prevent becoming a parser?

MG: I think you shouldn’t feel obligated to teach to all the milestones in the entire curriculum. There will be some that lend themselves to a particular part of the curriculum more than others. This would mean not ascribing a long list of content areas but the student would be asked to demonstrate limited-to-developing knowledge.

Comment: I want to make one point. It may be simply this isn’t part of what you and others are bringing into the system. We need to look at our residents and students and where they should be in their progress. You don’t need a huge study. If you could simply tell them what is expected, that would be transforming.

MG: That’s a good point. There is so much frustration in developing better “forms.” It is not simply the form; it is the person’s ability to complete the form in a meaningful way. Faculty need to be trained on how to go into the room with the student and give an evaluation. That said, some forms make it easier to translate observations into a meaningful assessment. No matter how great an observer you are, it is difficult to translate your observation on to a numerical scale.

Comment: It seems to me that the problem of training faculty already exists but it has been ignored. There is no training given to residents to evaluate medical students either. How does one person’s definition of good relate to another’s? The kind of training we need done is for this present system. It may be more work, but it needs to be done.

MG: Yes, the residents need training in assessment as well. “Frame of reference” and “performance dimension” training, borrowed from industrial psychology, help calibrate observers so they share the same definition of “good.” Although I
would quickly add that “good” is not a good descriptive term as it invites bias. It is easier to achieve a shared mental model of a rich description of actual behaviors. 

*Question:* By the current system our medical students and residents are well above average. While a narrative evaluation may move us to more accurately reflect performance. Would the narratives move us to be a ‘nice guy’? Do we know in terms of some kind of gold standard that the faculty will actually fill out objective assessments?

*MG:* It is too early to say. I can tell you that Bay State Medical School has been doing it more than anyone in their internal medicine residency program. There was more discrimination for sure. The idea is that the expectation is that in the entering class at YSM everyone will make it to graduation, but proceed at a different pace, ultimately meeting the final milestone.

*Comment:* It seems to me that the competency based system is intrinsically YSM. Honors or High Pass is seems at odds with the Yale System.

*MG:* Yes, I completely agree that CBME is very “Yale.” A competency-based system is in line with the Overarching Goals that have been set up for the new curriculum, especially if they were reframed as competencies.

*RB:* Closing remarks

This is a very important conversation at our school. I find it both humbling to realize the size of the task before us as well as reassuring to know that this is being dealt with across all of medical education nationally. YSM should contribute and lead in the national conversation while staying true to what is uniquely Yale.