

Medical Education 2.0

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It's usually not long after beginning clinical practice that we run into a problem for which we are not prepared. Human nature being what it is, such an encounter usually leads to our reflecting on our training, and how (as we start to heat up) we seemed to spend so much scheduled time on clinical problems that aren't particularly important—despite what the objectives say. And we start to reflect on how much better (now we're really starting to feel aggrieved) the program could have been designed, and what on earth was the Resident Education Committee thinking, anyway? It is clear that those people (now our blood pressure is rising) are out of touch, and a snippy email to the Program Director would be entirely appropriate.

Well—you could go ahead and send the email, but it's likely the Program Director is aware of your concerns, and is already thinking quite a bit further ahead. You may not have been aware of this, but over the past five years there has been a substantial re-examination of medical training in Canada. The first part of this re-examination, the Future of Medical Education in Canada MD Project, ran from 2007 to 2010 and resulted in a report published in 2010.¹ This report made recommendations for enhancing undergraduate medical education to produce the kinds of physicians we will need for the future, and was the first serious, wide-ranging assessment of medical education in Canada since the Flexner Report in 1910.² Yes, 100 years later. The second part, the Future of Medical Education in Canada Postgraduate Project, was funded by Health Canada and ran from 2010 to March 2012. It resulted in a report which appeared earlier this year³ and contained recommendations aimed not only at ensuring that we produce the kinds of physicians we will need in the future but also at strengthening the role of medical educators and leaders.

The first report, about the MD Project, contained 10 general recommendations and five “enabling” recommendations; the second contained 10 recommendations based on four guiding principles. Not uncommonly, such reports

and their recommendations can be fairly remote from reality, but these reports, for the most part, are not. Those responsible for the reports seemed to get it.

There were some shared thoughts in each report, and I was struck particularly by the recommendation in each report related to competency-based training programs. The recommendation for postgraduate training was to “develop, implement, and evaluate competency-based, learner-focused education.” At first, I was not confident that I understood what was meant by the terms “competency-based” and “competence,” even though these are part of CanMEDS⁴—so I read a little more.⁵ It's common sense, really: “competence” refers to the range of abilities a person has to do a job in a specific context. If someone is competent, they have the required abilities to do a specified job. “Competency” is an observable (hence, measurable) ability that puts together knowledge, skills, values, and attitudes, and is a component of a health professional's progress towards competence. In order to be a competent practitioner, that person must have multiple competencies.

This is where it gets interesting from the perspective of medical training. “Competency-based medical education,” a currently hot concept, takes the focus away from subjects, resources, and time, and puts it squarely on the trainee. In describing the rationale for competency-based medical education, key proponents list four principles: focusing on outcomes, emphasizing abilities, de-emphasizing time-based training, and promoting greater learner-centredness.⁵ Putting these more simply, this form of medical education would ensure that all graduates are competent in all of the essential areas (no more passing semi-competent trainees on down the line because it's the easiest thing to do). It would ensure that the emphasis of training was not necessarily on knowledge, but on translating knowledge into actions. It would

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mean that a trainee would have to attain competence regardless of how long it took; and it would mean that a trainee would be as responsible as his or her mentors for becoming competent. This sounds ideal in theory; an obvious concern, however, would be accommodating trainees who require more than the length of a rotation to acquire all competencies. Logistics would likely be challenging, and a strategy to allow time flexibility has not yet been developed.⁶ An additional concern is that requiring trainees to acquire a series of competencies in order to be declared “competent” might indicate to them that clinical excellence is not the goal—they would simply have to be able to show that they can complete an activity.⁵ If medical education is going to be changed, it should not only result in uniformly competent graduates, but it should also catalyze the quest for excellence.

In reading these reports, however, I was struck by a curious thing: the reports focused heavily on the process of producing competent physicians, but said little if anything about keeping them competent. As we all know, the MOC Program of the Royal College of Physicians and Surgeons of Canada⁷ and the MAINPRO Program of the College of Family Physicians of Canada⁸ were established to support and document lifelong learning activities of graduate physicians, and do an excellent job in these roles. If we are to “ensure the right mix, distribution, and number of physicians to meet societal needs,”³ we must be confident that those physicians have the skills to remain current and competent. Perhaps the implication in the reports was that among the competencies acquired during training would be the ability to stay current; if so, this should have been explicitly stated.

In this issue of the *Journal*, Doug Wilson comments that current undergraduate and postgraduate curricula do not result in graduates having enough knowledge of clinical genetics to provide adequate counselling of patients.⁹ The result is that consent obtained for prenatal diagnosis procedures, for example, is not “informed” consent; but there are insufficient numbers of reproductive geneticists to provide appropriate counselling for all who need it. True

competency-based medical education would provide the relevant contemporary knowledge for all graduates. But medical knowledge, and particularly in medical genetics, is expanding rapidly, and that expansion is likely to accelerate. Would competent graduates keep their knowledge current?

Therein is our challenge: to raise the bar in medical education, so that all graduates are not only entirely competent from the outset but also equipped and enabled to remain entirely competent throughout their professional lives. This is a big challenge and a worthy goal—do we have the dedication to see it through?

REFERENCES

1. The Association of Faculties of Medicine of Canada. The future of medical education in Canada: a collective vision for MD education. Ottawa, ON: The Association; 2010. Available at: http://www.afmc.ca/future-of-medical-education-in-canada/medical-doctor-project/pdf/collective_vision.pdf. Accessed September 9, 2012.
2. Flexner A. Medical education in the United States and Canada. A report to the Carnegie Foundation for the Advancement of Teaching. Bulletin no. 4. New York: Carnegie Foundation; 1910.
3. The Association of Faculties of Medicine of Canada. A collective vision for postgraduate medical education in Canada. Ottawa, ON: The Association; 2012. Available at: http://www.afmc.ca/future-of-medical-education-in-canada/postgraduate-project/pdf/FMEC_PG_Final-Report_EN.pdf. Accessed September 9, 2012.
4. Frank JR, ed. The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better Care. Ottawa: Royal College of Physicians and Surgeons of Canada; 2005.
5. Frank JR, Snell LS, ten Cate O, Holmboe ES, Carraccio C, Swing SR, et al. Competency-based medical education: theory to practice. *Med Teach* 2010;32:638–45.
6. Iobst WF, Sherbino J, ten Cate O, Richardson DL, Dath D, Swing SR, et al. Competency-based medical education in postgraduate medical education. *Med Teach* 2010;32:651–6.
7. Royal College of Physicians and Surgeons of Canada. Maintenance of Certification. Available at: <http://www.royalcollege.ca/portal/page/portal/rc/members/moc>. Accessed September 10, 2012.
8. College of Family Physicians of Canada. Introduction to MAINPRO (Maintenance of Proficiency). Available at: <http://www.cfpc.ca/MAINPRO>. Accessed September 10, 2012.
9. Wilson RD. Reproductive genetics and the obstetrics and gynaecology clinician. *J Obstet Gynaecol Can* 2012;34(11):1023–4.