Dear Medical Education Committee -

We are pleased that an MEC subcommittee including Adam Weinstein, Surachai Supattapone, Dean Madden and Hal Manning among others conducted a detailed review of the competency document submitted to the MEC in March, and suggested substantive document revisions which have now been accepted by the curriculum redesign leadership.

We think this vigorous conversation has led to a document the MEC will agree is high quality, and something we can bring to a vote on Tuesday. Please review it again. Below we have described some of the steps leading to this document, and related considerations.

Sincerely,
Sarah Johansen, MD
Chair, Medical Education Committee

Tim Lahey, MD MMSc
Project Leader, Curriculum Redesign

1. History of the Geisel Institutional Competency Revision Document

This document is the product of extensive review and revision not only by approximately 16 sub-committees of the curriculum redesign group involving well over 100 faculty and student participants but also of the MEC itself on multiple occasions. Steps in the process include:

a. Redesign subgroup drafts competencies based on the following (spring 2013)
   - existing Geisel competencies
   - competencies at other institutions using competency based approach
   - ACGME competencies
   - consultation with thought leaders in the field

b. Redesign subgroups each edit individual competencies (spring/summer 2013)

c. Multiple rounds of redesign review and revision of competencies by all redesign groups (summer 2013)

d. AAMC competency guidance published (August 2013; see below for more info)

e. MEC review of competencies and suggestions for multiple revisions in two meetings plus email revisions (fall/winter 2013)

f. Revisions to competencies by redesign leadership in response to MEC and AAMC (January/February 2014)

g. Advanced review of revised document by MEC (February 2014)

h. Discussion of document and decision to vote in March in MEC meeting (March 2014)

i. Additional edits to competency document suggested after the meeting by students and faculty (March 2014)

j. MEC subcommittee collates revisions (March/April 2014)

k. Revised competency document returned to redesign leadership and the sub-subcommittee led by Glenda Shoop that guided the document through the original 16 committees (April 2014)

l. Approval of revised competencies by redesign leadership and sub-committee

We think you will agree this has been a robust and collaborative process which has led to a high quality document that captures the key priorities in physician training in 2014 and beyond.

2. AAMC Competency Guidance
As mentioned above, in August 2013 authors from the AAMC published the attached paper by Englander et al. entitled "Toward a Common Taxonomy of Competency Domains..." It describes eight categories of competencies, including in the domains "Knowledge for Practice," "Systems-Based Practice" and "Practice-Based Learning and Improvement." We were delighted to find that the pre-existing draft Geisel competencies parallel this document closely, but in a fashion that capitalizes on our institutional strengths, and invite you to confirm this impression.

3. Balancing Outstanding Teaching about Foundational Sciences with Distinctive Emphasis on Population Health

One question that arose during correspondence about competencies that followed the March meeting was whether the number and language of competencies devoted to "Medical Science" are sufficiently balanced with those in "Population Health" or "Evaluation and Improvement in Medicine." This is a nuanced question that touches on how competency-based education works, and one that needs a three-part answer. Bear with us:

(a) How well should we teach "Medical Science?" During this time of change, rumors swirl about rather metastatically to the effect that teaching our students about population health will lead to a "dumbing down" of the medical sciences. Please help us squelch this invidious rumor. There is vehement unanimity at all levels that we must teach the medical sciences in a robust, scholarly, in-depth, and sophisticated fashion. Our graduates must be the kind of sophisticated and critical thinkers the medical field and we as patients need. We are training MD's, not PA's. Far from "dumbing down" the medical sciences, our #1 goal is to teach those topics more effectively using more evidence-based teaching approaches. Put simply, our goal is to teach the medical sciences more effectively because we think they are so important.

(b) Institutional competencies describe the breadth not depth of our teaching in a topic. Neither the number of competencies in a given topic domain nor the number of words in each competency are the major determinants of depth of teaching in that domain. This is a key concept in competency-based education. Depth of teaching in a topic, by contrast, is determined by how many course objectives are mapped to a given competency, and how many session objectives meet each course objective. Unavoidably and appropriately, the domain "Medical Science" is covered in greater depth than topics like "Population Health." This asymmetry of depth, driven by the comparable vastness of "Medical Science" and its continuing centrality to physician-hood, cannot be adequately captured in a document like this.

To give you a sense of how course objectives, by contrast, DO shape depth of teaching, we have already preliminarily mapped 619 draft course objectives to this competency document. Fully 329 of them map to the "Medical Science" domain whereas 41 map to "Evaluation and Innovation in Medicine." These estimates give you a sense that "Medical Science" will be addressed in many multiples greater depth than other topics in a fashion that is completely independent of the number of competencies.

As a guide, I encourage you to compare the number and depth of competencies in "Medical Science" and "Population Health" and other competencies domains in the draft Geisel competency document to those in the Englander et al. document from the AAMC. They are similar, but ours retains institutional distinctiveness. Similarly if you would like to compare this draft with our existing competencies I think you will see a similar parallelism, but with improvements in the new version.

That said, we are pleased that this latest iteration of the competency document includes a new "Medical Science" competency drafted by Dr. Supattapone (below), along with multiple other helpful edits to the competencies in that section, while a few of the "Population Health" and "Evaluation & Innovation in Medicine" competencies were redacted for the sake of clarity.

New competency statement: "Use interdisciplinary basic science knowledge to appraise novel mechanisms of disease, and propose and assess diagnostic strategies, and treatments"

(c) Providing detail about new stuff. There is one last reason why the level of detail in "Population Health" competency domain is slightly greater than, for instance, "Medical Science." That is that the "Population Health" stuff is newer. We have been teaching the "Medical Science" competency at Geisel for a long time. We know what that is - it's vast, but it is more of a known quantity. By contrast, in the curriculum redesign we are hoping to improve the depth of teaching in population health and systems improvement material because those topics are less traditional in medical school curricula and yet incredibly important to modern clinical practice and to making an impact in healthcare. Because of this newness, we (and the AAMC) thought it would be appropriate to be transparent and clear and thus provide a bit more detail.