

Sacred or self-evident? The constitutional process and milestones 2.0.

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Abstract

In 1787, the founders of the United States crafted the Constitution for a fledgling democracy. In the same way, the Accreditation Council of Graduate Medical Education (ACGME) convened a group of educators to design milestones 2.0—the criteria of residency training for internal medicine in the United States. Like the constitution, these milestones are a foundational document. They define the supported, graduated path towards independent practice, incorporating competency-based educational principles such as Entrustable Professional Activities (EPAs).

Keywords: Milestones, Internal medicine, Constitutional convention.

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Introduction

On June 21st, 1776, Thomas Jefferson asked Benjamin Franklin to review the most recent draft of the declaration of independence. According to the legend, Franklin made only one subtle change that had resounding implications. Jefferson had written, “We hold these truths to be sacred and undeniable.” With a heavy hand, Franklin crossed out the line and wrote, “We hold these truths to be self-evident.” In doing so, he re-oriented the country away from the assertions of religion, and embraced the enlightenment philosophers of David Hume and John Locke. It was a subtle shift, but one that placed our political system in the realm of reason rather than sectarian faith [1]. The gritty work of nation building had begun.

Literature Review

Milestones 2.0

Cardiac After the war, in the summer of 1787, a diverse assemblage of Southern planters, New England puritans, and Mid-Atlantic merchants met in Philadelphia to craft the constitution. Debates raged. Franklin wanted a unicameral legislature, but others debated how best to represent small and large states fairly. Hamilton felt that the President should be appointed for life. Franklin believed that power should not be so concentrated. He advocated for a ruling committee rather than a single President. Slaves were counted as 3/5th a person—an obscene compromise between Southern landowners and the Northern abolitionists. There was conflict, deliberation, and finally, a document that has stood the test of time for more than 200 years.

In the same way, albeit with much lower stakes, the internal medicine milestones 2.0 team gathered several times. We were a diverse group of thirty-six educators-program directors, DIOs, residents, and public representatives. We came from small and large residency programs from across the country, representing a diversity of ethnic groups, and evenly balanced genders. There were two different groups who crafted the milestones and then a third gave feedback and criticism. While our task was not nation

building, we were challenged to craft a foundational document. This was our constitutional convention to answer the question, “When is a doctor ready to be a doctor?”

There were uncanny parallels between the constitutional convention and our own milestones 2.0 work. Certain of us were big-picture types, with an uncanny understanding of physician growth to autonomy. Others of us were wordsmiths who loved to clean up split infinitives and dangling participles. We experienced bursts of creativity and spun our wheels in the mud. Differing perspectives clashed. How should we weigh needs of program directors, faculty in the trenches, learners, and patients? We debated vigorously, critiqued with kindness, and built trust. The work got done.

Discussion

The very idea of “milestones” represents a sea change in education. The Likert scales we previously used had no anchors to actual skills or knowledge. Was a 7 that much better than a 6? Could you graduate if you only had 5’s? Some attendings routinely gave 7’s no matter who the resident was. Everyone was above average. In this environment, we had difficulty giving formative feedback, suggesting corrective action, and placing residents on remediation plans. Milestones 1.0, crafted in 2015, shed light on these deficiencies, moved us forward, and gave us a good framework for evaluation.

Milestones have been around for a long time—at least since the late 1960’s when Frankenburg and Dodds developed the denver developmental scale. They understood that children progressed through a series of fine motor, gross motor, language, and social skills. At twelve months of age, a child might be able to stand alone, speak a single word, put a block in a cup, and wave bye-bye. While there was some variability in a child’s progression, the assessment helped identify those children who needed extra support or diagnostic intervention [2]. As we apply the milestones to physician development, a trainee may have strengths in professionalism and communication, but need guidance with fund of knowledge. The Milestones help identify those needs. The challenge is how we implement them. Even

a perfect constitution gets corrupted by imperfect politicians. The milestones can turn into another empty Likert scale without faculty training or conscientious implementation.

How can the challenges of a Competency-Based Medical Education (CBME) model be met in a way that is meaningful to our residents? One option is the idea of Entrustable Professional Activities (EPAs) which incorporates all elements of competency into a specific activity, such as performing annual wellness examinations or the care of a patient with chronic illness [3-5]. Both activities require each of the six core competencies but it may be difficult to determine why a learner is not yet able to complete it successfully. Will milestones 3.0 and EPAs be the solution? Will a new method of evaluation be developed? Milestones and EPAs are beginning to lead fundamental change in CBME which function a bit like amendments to the constitution.

Another challenge to the milestones in the United States is bridging the undergraduate and graduate divide. As it stands now, citizens in Undergraduate Medical Education (UME) must undergo an intense, complex system to immigrate into the country of Graduate Medical Education (GME) [4,5]. In an ideal world, this transition would focus on the professional fit of the learner and match them with the strengths and patient populations of the GME institution. UME institutions need to provide a reliable learner handoff so that the GME training program could continue to develop a learner's strengths and weaknesses. For priorities in patient care and the benefit of learners, assessment of readiness for the start of residency is essential. This process is marred by cross-current incentives for the UME institution to obtain the best match as well as limited resources for GME programs to sift through large number of applicants with imperfect information. We have a UME-to-GME transition system that is in need of reform. We must continue to evaluate options to better integrate the systems and consider opportunities for milestones that bridge the gap between our UME and GME institutions.

Conclusion

In his final speech before Congress, an 81-year-old Benjamin Franklin rose before the constitutional convention to address

his colleagues. They had survived a war together and grinded through the sausage-making of a new constitution. He said, "I cannot help expressing a wish that every member of the convention who may still have objections to it, would with me, doubt a little of his own infallibility, and to make manifest our unanimity, put his name to this instrument" [6]. History has shown how our Constitution is far from infallible. Our own milestones 2.0 will not be perfect, but they represent the best of what we have right now. No doubt, milestones 2.0 will reveal further opportunities for growth that our constitutional convention did not foresee. As Ben Franklin said, "I should have no objection to go over the same life from its beginning to the end; requesting only the advantage authors have, of correcting in a second edition the faults of the first" [6]. Time will tell how long milestones 2.0 will last. And yet, this is our foundational document, our constitution, to define when a doctor is ready to be a doctor.

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