3

Competency-Based Education as Another Step in Purposefulness

Lessons Learned from Medical Education's Fifteen Years of Additional Experience with Professional Development and Formation Goals

The preceding chapter provided a purposefulness framework to guide a law school in realizing the four PD&F goals of helping each student to understand and internalize

- Ownership of continuous professional development toward excellence at the major competencies that clients, employers, and the legal system need;
- a deep responsibility and service orientation to others, especially the client;
- a client-centered, problem-solving approach and good judgment that ground the student's responsibility and service to the client; and
- well-being practices.

This chapter explores what legal education can learn from medical education's much more extensive experience in giving purposeful attention to the four PD&F goals. Even if a law school declines to go "all in" on competency-based education, medical education's experience provides insight into purposefulness to foster student growth on these foundational goals.

3.1 MEDICAL EDUCATION'S MOVE TOWARD DEFINING CORE COMPETENCIES AND STAGES OF DEVELOPMENT ON EACH COMPETENCY

Drs. Robert Englander and Eric Holmboe and other medical educators observe that throughout most of the twentieth century, education in the health professions and the delivery of health care services prioritized the technical expertise of the health professional and the health professions educator. Education focused on (1) a certain number of exposure hours of credit (called a "tea-steeping" model, with the student akin to a tea bag submerged in a cup

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of hot water for the right amount of time) and (2) academic outcomes like multiple-choice tests and licensing exams addressing technical knowledge. The student's education did not address what the licensed graduate can actually do to meet patient needs. Curricula were organized by discipline or subject and faculty-produced lessons delivered in a one-size-fits-all package of "goods" to passive learners. Little attention was paid to the learner experience.[1]

In the 1980s and 1990s, concerning signs of problems in the quality and safety of health care percolated through the health care system. By the late 1990s, the medical education community realized that it was not sufficiently preparing students to meet the challenges of a dynamic and changing health care system.[2] Medical educators came to understand that the narrow emphasis on medical knowledge and cognitive skills was inadequate to meet patient and population needs.[3] The earlier approach of "if you are really smart cognitively, you'll be fine" was not sufficient.[4] Medical educators realized the central importance of a much broader framework of patient-centered care – one that recognizes that cognitive technical skills are necessary but not sufficient to meet patient and health care system needs.[5]

By 2000, the pendulum had swung toward stronger emphasis on patient-centered care in the delivery and improvement of health care services and stronger emphasis on learner-centered and learner-driven medical education that focuses on the student's demonstration of the full range of competencies that a graduate needs to provide patient-centered care.[6] Medical educators adopted competency-based medical education (CBME) to guide this change. CBME is defined as "an outcomes-based approach to the design, implementation, assessment, and evaluation of medical education programs, using an organizing framework of competencies. A competency describes a key set of abilities required for someone to do their job."[7]

[1] *See* Eric Holmboe & Robert Englander, *What Can the Legal Profession Learn from the Medical Profession About Next Steps?* 14 Univ. St. Thomas L. J. 345, 346–48 (2018); Robert Englander, Eric Holmboe et al., *Coproducing Health Professions Education: A Prerequisite to Coproducing Health Care Services*, 95 Acad. Med. 1006, 1007 (2020).

[2] *See* Holmboe & Englander, *supra* note 1.

[3] *Id.* at 347.

[4] *Id.*

[5] *Id.*

[6] Englander & Holmboe, *supra* note 1 at 1008.

[7] Celeste Eno, Milestone Guidebook for Residents and Fellows 2 (2020) [hereinafter Milestone Guidebook].

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3.2 LESSONS LEARNED IN MOVING TOWARD COMPETENCY-BASED MEDICAL EDUCATION (CBME)

In a multistage process drawing on scholarship from education theory and medical education, fifty-nine members on an international CBME expert panel identified five core components to CBME.[8] The panel presented its vision of the five core components of CBME in a table reproduced here in Table 10.

Of the five core components in Table 10, the expert panel envisioned "Outcome Competencies" and "Sequenced Progressively" as the *central* core components guiding competency-based medical education.[9]

As Table 10 shows, medical educators started by identifying the needs of patients and the health care system. Only then could they define the critical competencies flowing from those needs that each student should develop and demonstrate.[10] With the critical competencies identified, medical educators could take the next step of sequencing the competencies, and their developmental markers, progressively.[11]

Medical educators use the term "Milestones" to describe narrative models of how student development of a core competency moves through stages toward a level of competency necessary for a licensed physician to serve clients adequately.[12] The Milestones on a specific competency provide a "shared mental model" of professional development starting as a student and progressing to competent practitioner and, beyond, to mastery.[13] A Milestone model defines a logical learning trajectory of professional development. It also highlights and makes transparent significant points in student development using a narrative that describes demonstrated student behavior at each stage.[14] Milestones can be used for formative and summative assessment as well as program assessment. If faculty and staff adopt a Milestone model for a particular competency, they also are building consensus on what competent performance looks like and thus will

[8] Elaine Van Melle et al., *A Core Components Framework for Evaluating Implementation of Competency-Based Medical Education Programs*, 94 ACAD. MED. (No. 7, July 2019) at 1002–09.

[9] *Id.*

[10] Holmboe & Englander, *supra* note 1 at 347.

[11] Holmboe and Englander note: "The next stage of evolution in the thinking of the medical education community, after defining the core competencies, was to develop a model of how the learner should proceed through a series of developmental stages in each competency. The resultant strategy was to adjust curriculum and assessment to facilitate that developmental progression." *Id.* at 350.

[12] *Id.*

[13] L. Edgar et al., *Milestones 2.0: A Step Forward*, 10 J. GRAD. MED. EDUC. 367–69 (No. 3 2018).

[14] *Id.*

TABLE 10 *The five core components of competency-based medical education*[15]

Competency-based medical education is an approach to preparing physicians for practice that is fundamentally organized around competencies derived from an analysis of patient and societal needs

CORE COMPONENTS				
OUTCOME COMPETENCIES: Competencies required for practice are *clearly articulated.*	**SEQUENCED PROGRESSIVELY: Competencies and their developmental markers are *sequenced* progressively.**	**TAILORED LEARNING EXPERIENCES: Learning experiences *facilitate* the developmental acquisition of competencies.**	**COMPETENCY-FOCUSED INSTRUCTION: Teaching practices *promote* the developmental acquisition of competencies.**	**PROGRAMMATIC ASSESSMENT: Assessment practices *support & document* the developmental acquisition of competencies.**
PRACTICE: What the core component should look like in practice				
Required outcome competencies are based on a profile of graduate and/or practice-based abilities.	Competencies are organized in a way that leads to a logical developmental sequence across the continuum of medical education or practice.	Learning takes place in settings that model practice, is flexible enough to accommodate variation in individual learner needs, and is self-directed.	Teaching is individualized to the learner, based on abilities required to progress to the next stage of learning.	Learner progression is based on a systematic approach to decision-making including standards, data collection, interpretation, observation, and feedback.
PRINCIPLE: How the core component is supposed to work in practice				
Specification of learning outcomes promotes focus and accountability.	A sequential path supports the development of expertise.	Learning through real-life experiences facilitates membership into the practice community and development of competencies.	Development of competencies is stimulated when learners are supported to learn at their own pace and stage.	Programmatic assessment systems allow for valid and reliable decision-making.

[15] *Id.*

foster inter-rater reliability of assessments. Because Milestones describe what a trajectory should look like, learners can track their own progress toward becoming competent at a particular competency and programs can recognize students who are advancing well or in need of extra help.[16] Overall, each Milestone reflects the Dreyfus and Dreyfus model of development from novice to expert shown in Figure 3.

Table 11 reproduces an application of the Dreyfus model developed by the Accreditation Council for Graduate Medical Education (ACGME) to define the stages of development for patient-centered, evidence-based, and informed practice. (The reader should note that this goal or competency is similar to the third PD&F goal that we advance in this book for lawyers: a client-centered problem-solving approach and good judgment that ground each student's responsibility and service to the client.)

The ACGME developed a Milestone Model for Reflective Practice and Commitment to Personal Growth that is useful for legal education to emulate in modeling stage development with respect to PD&F Goal 1 – ownership of continuous professional development toward excellence at the major

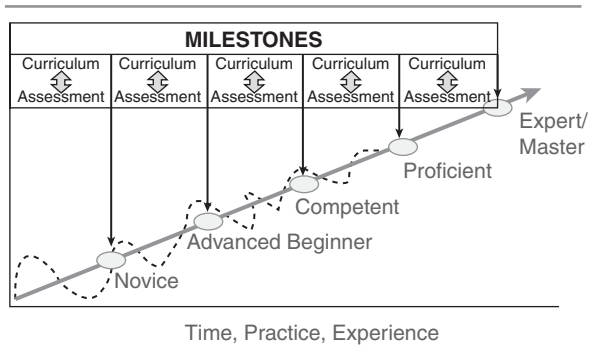

FIGURE 3 The Accreditation Council for Graduate Medical Education Milestones reflect the Dreyfus and Dreyfus model of development from novice to expert for each competency (such as the lawyer competencies shown in Figure 1). Law firms commonly call these "benchmarks."[17]

[16] Holmboe and Englander, *supra* note 1 at 350.

[17] P. Batalden et al., *General Competencies and Accreditation in Graduate Medical Education.*, 21 HEALTH AFF. (Millwood) 103–11 (No. 5, 2002); originally published in H. L. DREYFUS & S. E. DREYFUS, MIND OVER MACHINE: THE POWER OF HUMAN INTUITION AND EXPERTISE IN THE ERA OF THE COMPUTER (1986). Figure adapted with permission from E. Holmboe, ACGME.

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TABLE 11 *ACGME harmonized milestone on evidence-based and informed practice*[18]

Stage	Characteristics of stage
1 Novice	Demonstrates how to access and use available evidence and incorporate patient preferences and values to take care of a routine patient.
2 Advanced beginner	Articulates clinical questions and elicits patient preferences and values to guide evidence-based care
3 Competent	Locates and applies the best available evidence, integrated with patient preference, to the care of complex patients
4 Proficient	Critically appraises and applies evidence even in the face of uncertainty and conflicting evidence to guide care tailored to the individual patient
5 Expert	Coaches others to critically appraise and apply evidence for complex patients and/or participates in the development of guidelines.

competencies that clients, employers, and the legal system need.[19] Similarly, the ACGME's Milestone Model on Patient-Centered Communication can be emulated with respect to PD&F Goal 2 – a deep responsibility and service orientation to others, especially the client.[20]

The Milestone and Dreyfus models contemplate that learners take ownership over their own continuous professional development to later stages on each of the competencies needed.[21] (This matches up squarely with the first PD&F goal.) Learners in a competency-based education system "must be active agents co-guiding both the curricular experiences and assessment activities."[22] What does it mean for students to be active agents in their own learning and assessment? "Learners must learn to be self-directed in seeking assessment and feedback."[23] Ideally, learners should

1. Be introduced to the overall competency-based education curriculum at the beginning and engaged in dialogue about the overall program on an ongoing basis;

[18] Arthur Ollendorff et al., *Harmonizing the Practice-Based Learning and Improvement Milestones*, https://www.acgme.org/Portals/0/PDFs/Milestones/HarmonizingPBLI.pdf?ver=2018-12-06-140314-100

[19] *See id.*

[20] Laura Morrison, *Harmonizing Interpersonal and Communication Skills: Assessment Through Harmonized Milestones* (2018), www.acgme.org/Portals/0/PDFs/Milestones/HarmonizingICS.pdf?ver=2018-12-06-140701-773.

[21] *See* Holmboe and Englander, *supra* note 1, at 350.

[22] *See* MILESTONE GUIDEBOOK, *supra* note 7, at 15.

[23] *Id.* at 16

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2. actively seek out assessment and feedback on an ongoing basis;
3. proactively do self-assessment with feedback from external sources and reflect on both;
4. direct and perform some of their own assessments, such as seeking out direct observation of the learner by an experienced professional and creating portfolios of evidence regarding specific competencies; and
5. develop personal learning plans that are revisited and revised at least twice a year.[24]

With respect to the third core component of CBME outlined in Table 10 (tailoring learning experiences that model practice to accommodate variation in individual learner needs) and the fourth component of CBME (promoting student development by individualizing teaching based on the abilities required to progress to the next level), Table 12 explains the major differences between traditional medical education and CBME.

The change from traditional medical education to CBME began in 2000, and it is still a work in progress. Implementation has been slow, especially in

TABLE 12 *A comparison of traditional versus competency-based medical education*[25]

Variable	Traditional Education Model	CBME
Driving force for curriculum	Knowledge acquisition	Knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchal	Non-hierarchical
Responsibility of content	Teacher	Teacher and learner
Goal of educational encounter	Knowledge and skill acquisition	Knowledge and skill application
Type of assessment tool	Single assessment measure (e.g., test)	Multiple assessment measures (e.g., direct observation)
Assessment tool	Proxy	Authentic (mimics real profession)
Setting for evaluation	Removed	In clinical and professional settings
Timing of assessment	Emphasis on summative	Emphasis on formative
Program completion	Fixed time	Variable time

[24] *Id.*
[25] *Id.* at 2.

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primary-degree schools that remain steeped in tradition and equate curriculum with exposure hours.[26] CBME is a major shift in thinking, and faculty members have lacked a shared mental model of developmental stages and standards regarding many outcomes.[27] Two decades since the shift began, medical education remains in the midst of transformation.[28]

3.3 APPLYING LESSONS LEARNED FROM CBME TO LEGAL EDUCATION

Legal education has begun its journey toward competency-based legal education (CBLE). ABA accreditation standards were revised in 2014, and by 2020, nearly all law schools in response had published learning outcomes as a first step toward CBLE. Further requirements are likely to follow. It is realistic to anticipate that the ABA as an accreditor, along with the regional accreditors for the universities with law schools, eventually will compel law schools to take the next steps beyond mere adoption of learning outcomes. If medical education's experience is any guide, legal education's movement toward CBLE will be gradual over several decades.

The good news for legal education is that the core conceptual features of a sound model of competency-based legal education are already at hand, thanks to medical education's path breaking. The structure and logic of medical education's competency-based model, depicted in Table 10 and Figure 3 earlier, are directly applicable to CBLE. Table 10's five core CBME components and Figure 3's emphasis on "Outcome Competencies" that are "Sequenced Progressively" in CBME translate easily to legal education. A competency-based legal education inspired by and modeled on CBME is depicted in Table 13 and Figure 4.

Developing a law school curriculum that employs "Outcome Competencies" that are "Sequenced Progressively" as contemplated in Table 13 and Figure 4 requires identification of the needs of clients and the legal system and then, in turn, specification of the core-competency learning outcomes that each student must develop and demonstrate to meet these needs. Work to that end is underway in legal education. The Foundational

[26] Englander & Holmboe, *supra* note 1, at 1008.

[27] Eric Holmboe et al., *Mastery Learning, Milestones, and Entrustable Professional Activities, in* Comprehensive Healthcare Simulation: Mastery Learning in Health Professions Education 311, 314, 324 (W. McGaghie et al., eds., 2020).

[28] Holmboe & Englander, *supra* note 1, at 345–46.

TABLE 13 *The five core components of competency-based legal education*[29]

Competency-based legal education is an approach to preparing lawyers for practice that is fundamentally organized around competencies derived from an analysis of client and societal needs

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[29] Adapted from Table 10 *supra*.

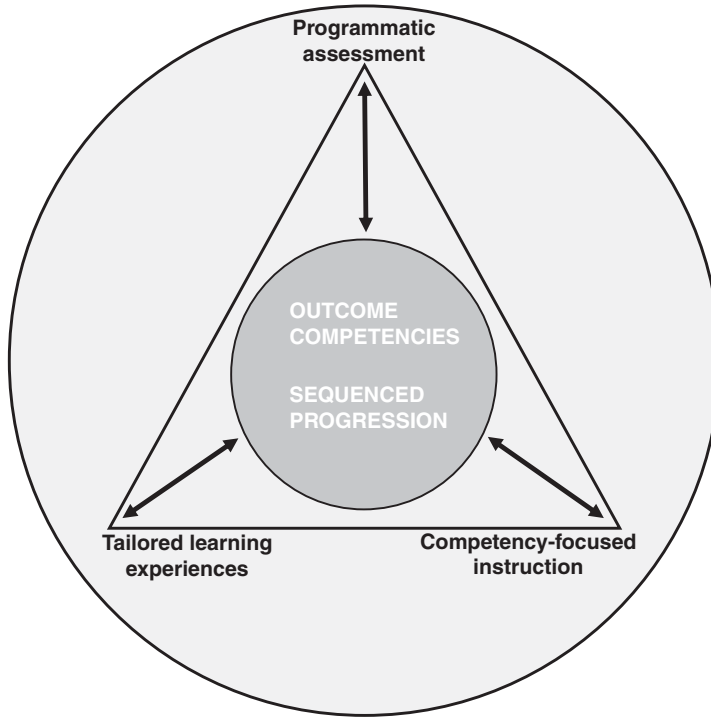

FIGURE 4 Competency-based legal education's two central core components informing the three other components in local CBLE programs[30]

Competencies Model in Figure 1 in Chapter 1 is a synthesis of the best available empirical data on the competencies that clients and legal employers need. And Figure 2 in Chapter 2 illustrates the kind of sequencing models that working groups established by the Holloran Center are devising.

In the next chapter, we will discuss ten key principles to guide legal educators who are interested in fostering student growth toward the four PD&F goals. Those principles are drawn from the five Carnegie Foundation for the Advancement of Teaching studies of higher education for the professions, CBME, scholarship on higher education generally, and moral psychology. One key take-away from CBME to carry forward into the

[30] Adapted from Elaine Van Melle et al., *A Core Components Framework for Evaluating Implementation of Competency-Based Medical Education Programs* 94 ACAD. MED. 1002 (2019).

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TABLE 14 *The purpose and function of Milestones for the four PD&F goals*[31]

Constituency or Stakeholder	Purpose/Function
Law students	• Provide a descriptive roadmap to foster development toward later stages (new entrant students don't know what they don't know and need to be shown later stages). • Increase transparency of performance requirements • Encourage informed self-assessment and self-directed learning • Facilitate better feedback to the student • Guide personal action plans for improvement
Law schools, faculty, and staff	• Provide a meaningful framework/shared mental model of student development • Guide curriculum and assessment tool development • Provide more explicit expectations of students • Support better systems of assessment • Enhance opportunity for early identification of underperformers so as to support early intervention
ABA accreditation and the public	• Accreditation – enable continuous monitoring of programs and lengthening of site visit cycles • Public accountability – report at an aggregated national level on competency outcomes • Community of practice for evaluation and research, with a focus on continuous improvement

next chapter is that Milestone Models for PD&F goals have substantial benefits for all the major stakeholders in legal education. Table 14 outlines these benefits.

[31] Adapted from MILESTONES GUIDEBOOK, *supra* note 7, at 7.

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