EDITORIAL
MEDICAL EDUCATION-WHERE DO WE STAND?

We were taught in a traditional curriculum. Learner was not an active participant in determining a learning plan. Stress was on Content-Knowledge acquisition. Path of learning was from teacher to student as the content was decided by teacher. Learning was in class rooms and not with reference to actual life situations. It was non-contextual. Teaching was discipline based and student was a passive recipient of knowledge. Typical assessment tool was single subjective measure: viva-voce, Long essay questions or Multiple-choice questions. Assessment tool was in-vitro in artificial conditions as short case, long case. Setting of evaluation was removed from real site of job. No direct observation was made, and no formative feedback was provided. Evaluation was norm referenced. Emphasis was on summative evaluation. There was a fixed time for the components of the curriculum to be learnt.

Program evaluation focused on matters of process (e.g., ''Are there objectives for every rotation?'' or ''Is there a teacher evaluation form?''). Most learners successfully completed their training by meeting time, process, and curricular requirements.

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Now the move is towards Constructivist model where Learner is an active participant in determining a learning plan. Stress is on Outcome-Knowledge acquisition. Educational strategy is Learner centered. Path of learning is Non-hierarchical. Responsibility for content is shared by the student and teacher.

Learning is with reference to actual problems faced by professionals and thus contextual. Learning by students is active. Boundaries of disciplines are no more barriers and integrated curricula are being developed. Multiple objective measures for assessment ("evaluation portfolio") are being used. Assessment tool is in vivo. Work place based assessment like Mini clinical examination, Direct observation of procedural skills (DOPS), Case based discussions, and Acute care assessment tool are being utilized. Setting of evaluation is the work place. Direct observation, with formative feedback is in place. Evaluation is criterion referenced. Emphasis is on formative feedback. In contrast, competency-based training is based on the successful demonstration of the application of the specific knowledge, skills, and attitudes that are required for the practice of medicine.

In support of Competency Based Medical Education, accreditation requirements have become Increasingly focused on outcomes. For instance, ACGME accredited Internal Medicine programs must now demonstrate evidence of data-driven improvements to the training program by using resident performance data, or outcomes, as a basis for improvement, and use external measures to verify both the learner's and the program's performance (ACGME 2009b).

Similarly, all Royal College of Physicians and Surgeons of Canada programs require demonstration of both traditional time-based rotations and specialty-specific competencies (Accreditation Committee 2006).

At the level of the individual stakeholder, the transition to a competency-based training model can represent a dramatic redefinition of professional identity.

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