Pass/No-Pass Step 1: Navigating the Changing Path to Medical Education

TO THE EDITOR:

Benjamin N. Schneider, MD, recently highlighted changes likely to accompany the elimination of Step 1 numeric grading.[1] According to Schneider, Step 1 pass/no-pass scoring will likely result in greater emphasis on Step 2 numerical scores.[2] He proposes a new focus on Accreditation Council for Graduate Medical Education (ACGME) Core Competencies in the wake of this revision.[1] We agree that future changes in medical education need to be even more intentional.

Increasingly, medical education exists outside the classroom, as students doubt their curriculum alone will provide the necessary preparation for national examinations.[5] Consequently, the majority turn to commercially available educational resources[3] over traditional didactic lecture attendance.[4] The transition to a Step 1 pass/no-pass format is unlikely to change the self-directed learning behaviors of medical students. What then should medical programs do to regain the participation and confidence of their students? Rather than fight the pervasive use of external resources among students, we believe medical school curricula should (1) be reconstructed to promote rather than disparage self-directed learning, and (2) become more intentionally patient centered.

The Penn State College of Medicine University Park Curriculum attempts to fulfill these goals by replacing the traditional preclinical curriculum with longitudinal outpatient family medicine clinical immersions and small-group class sessions using identified learning objectives. Throughout their first year, students work closely with family physicians twice weekly engaging in longitudinal patient interactions. From these early clinical experiences, students develop defined educational goals. Subsequently, they pursue outside resources to thoroughly investigate select diagnoses encountered among clinic patients before reconvening to share and expand upon their peer's academic explorations. The foundation of this pedagogical framework is early patient interaction that provides context for learning objectives, while fostering communication and clinical reasoning skills expected from budding physicians.[6] Furthermore, these small-group discussions facilitate peer-to-peer teaching opportunities–an activity believed to enhance communication skills and improve learning strategies.[7] Such longitudinal family medicine clinical experiences paired with student-driven, small-group learning serve as an effective transition to clerkships in the second year (vs the third year). Replacing the traditional block format, clerkships are arranged longitudinally throughout the year allowing students to build relationships and maintain continuity of care with several recurring patients. By initiating clerkships a year early, students can use their clinical experiences as a foundation for medical knowledge as they begin United States Medical Licensing Examination (USMLE) preparations in their third year. By fourth year, students have not only fulfilled USMLE requirements, but also have accrued invaluable longitudinal patient-care experiences giving them a more holistic understanding of the multiple medical specialties that exist within our complex health care system.

Medical education is shifting toward self-directed learning, a trend that is likely not going away regardless of recent Step 1 scoring modifications. Instead of striving to retain the traditional curriculum in hopes of improved student engagement, medical schools should utilize their most important educational resource: the patient. Through early longitudinal patient encounters, mastering clinically-based, small-group educational objectives, and promoting self-directed learning, medical schools can best achieve their ultimate goal: cultivating competent, patient-centered, humanistic physicians.

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In Response to Pass/No Pass Step 1: Navigating the Changing Path to Medical Education

TO THE EDITOR:

In Pass/No-Pass Step 1: Navigating the Changing Path to Medical Education,[1] Mr Higgins and Dr Flanagan state that the ultimate goal for medical schools is, "Cultivating competent, patient-centered, humanistic physicians." This goal resonates deeply with me as a medical educator. The authors state that the move to pass/no-pass Step one (S1) grading is unlikely to substantially change self-directed learning behavior and the pervasive use of external resources should be accepted and not fought against. They describe a curricular innovation that incorporates longitudinal clinical experiences early in the educational process and push S1 back until after clinical rotations. I look forward to seeing a future manuscript presenting the outcomes of this curricular innovation.

My concern is that students supplementing their undergraduate medical education (UME) curricula with external,[2] costly[3] commercial resources is not occurring simply because these students don't trust the medical school curricula to prepare them. Students are highly motivated by a successful match and program directors (PDs) have been clear that S1 score was the single most important item used to select who to interview in 2021.[4]

Time in undergraduate medical education is a precious resource. S1 emphasis in residency selection has grown over the last two decades,[5] and with it so have scores and time spent preparing for the exam. In 2000 the national mean score was 215[5] and students reported an average of 319 hours of preparation[6] during their dedicated study period. By 2020 the mean score rose to 234 (NBME)[7] and students reported an average of 490 hours of dedicated study.[8] Passing S1 is by no means easy, but the move to pass/no-pass scoring should free up at least the 171 extra hours that students are now spending, as 215 is still well above the national passing level of 196. I applaud the authors for filling that time with meaningful, early, patient-centered care. How else can we leverage this time to best prepare learners for graduate medical education and future practice?

Unfortunately, Step 2 Clinical Knowledge is already the third most commonly cited factor by PDs in selecting candidates for interviews.[4] I remain concerned that if we as a community of educators cannot identify other meaningful metrics for selecting who to interview, we will simply see that time shifted from S1 study to S2 study. I continue to encourage us as a community of medical educators to define what we care about and how we can objectively assess and communicate those data to partners across the UME-GME divide. Longitudinal patient-centered education may be an excellent way to train the next generation of physicians, but I fear that as long as our interview selection process favors multiple-choice question examinations, that is what our students will dedicate their efforts to mastering.

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