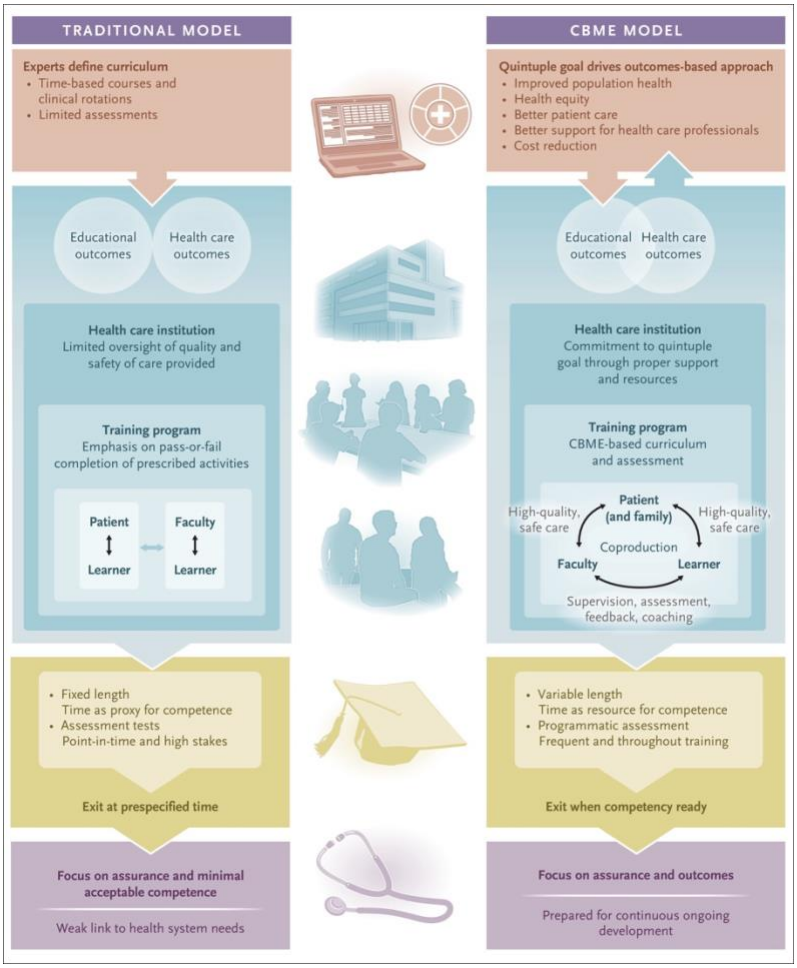
Competency Based Medical Education - Challenges and Opportunities Aug. 17, 2025

Dear Residents,

The NEJM published the second of its planned articles in a series dedicated to medical education. This second article focuses on competency-based medical education (CBME). Currently we train you in a time-fixed (3 years for most of you) paradigm and we hope that along this 3-year journey, relying on an immersion model, that you would have sufficiently mastered the six core competencies (patient care/procedural skills, medical knowledge, professionalism, communication, system-based practice and practice based learning and improvement) required to enter unsupervised clinical practice. Yet, a model that immerses you, but keeps faculty at an arm's length, can never fully provide assurance that all six will be achieved by the time you graduate. Some specialties have case logs to ensure that you've seen/managed X number of Y things. In Internal Medicine, we do not have such specific requirements. We depend instead on a combination of diverse clinical experiences, progressive responsibility and the (imperfect) assessment of your skills by your supervising faculty. The advent of the EHR and the need to review ever-increasing data for your patients has taken us away from the bedside and consequently diminished the ability of faculty to directly observe you, losing opportunities for formative feedback and accurate assessments. Most assessments are now inferential, listening to your presentations and reviewing your written work.

The authors add other inspirational elements to your education: namely, the quintuple goal of improved population health, health equity, better patient health care, better support for health care professionals, and reduced health care costs. That's a tall order but does nudge us to consider a major redesign of medical education. The CBME model uses time as a resource rather than as a proxy for fixed length of training - but that does immediately raise the logistic difficulties involved in the traditional sequence of medical education. The uniform June30/July 1 switch would be thrown off to accommodate those who graduate early and those who need additional time for readiness for independent practice. It's a vexing situation but it should not in itself stop us from reimagining a different future.



Beyond the issue of time-variable vs time-fixed training, the CBME model is based on direct observation of trainees with immediate formative feedback, rather than the high-stakes end-of-rotation summative feedback. It also requires much more faculty time and engagement. Faculty find themselves boxed in by their own productivity requirements and hospitals by their own efficiency models. Accordingly, the actualization of such models would require broad buy-in from all stakeholders. The article outlines some of the key shifts that will be required to fully achieve this.

One model of CBME involves the creation of entrustable professional activities (EPAs) - these are often "synthetic" or, in other words, combine elements of one or more discrete core competencies. An example may help. Think of the discrete activities you perform - admitting a patient, managing a complication, discharging a patient, resuscitating a patient, performing a procedure. All these involve parts of more than one of the six core competencies - patient care, medical knowledge, communication, understanding the "system" etc. You will notice that the evaluations that faculty complete are designed to assess these "observation units" that cross many core competencies. By carefully defining these EPAs using shared mental models, we get one-step closer to fulfilling the principles of CBME.

Many of you have expressed an interest in medical education. We have a dedicated medical education track and several faculty who possess both a background in the principles or medical education and the desire to use these skills. One approach to scale-up their efforts could involve developing resident peer educators who are uniquely positioned to provide the sort of just-in-time observation and feedback that can close the current gaps we face in fully implementing CBME. Much of this is already occurring. Residents supervise and teach others, but they themselves feel the pressure of time and opportunity and the need to "divide and conquer" rather than work closely in pairs. The equipoise between having enough patients to gain broad experience and not too many to slow down to teach and learn continues to elude us.

Our university has undergone immense clinical growth, the faculty has more than doubled, the residency has grown, replete with new combined programs and specialized tracks. This has posed both a challenge and an opportunity. Our team of program leadership, our core faculty, specialty education coordinators and our program coordinators are together rising to the new challenge of ensuring that each one of you completes the training program without gaps in knowledge and skills. This will be a shared effort, and your engagement will be vital in our success in achieving this goal. We are lucky to have such a rich learning environment, but that should not lead to a passive approach to your learning. It doesn't happen all by itself. Yes, the immersion is invaluable, but without a CBME framework, we won't know what has been missed.

Thank you for your dedication on three fronts: your commitment to providing safe and effective care to your patients, your efforts to teach others, and your motivation for continuous self-improvement. I consider myself very luck to be surrounded by the excellence you represent.

Best regards,

Dino Kazi