Why competency-based medical education is a value proposition

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Timothy M. Smith
Contributing News Writer

Competency-based medical education (CBME) has earned an esteemed place in physician training for how it reduces variability in learner outcomes by embracing a multiplicity of pathways to competency development. But it also often comes up against the perception that it is resource intensive.

But is that perception accurate? And even if it is, does that mean competency-based medical education isn’t worth the added investment?

Kimberly Lomis, MD, vice president of undergraduate medical education innovations at the AMA, posits answers to these questions and others surrounding competency-based medical education in a post on the International Clinician Educators blog.

Why educators and learners love it

“Defining value is a matter of perspective,” wrote Dr. Lomis. “If we consider medical education’s purpose of generating the workforce needed to serve patients and populations, CBME offers enhanced standardization of the product of training and more deliberate assurance of each individual’s readiness for specific duties, while simultaneously elevating unique strengths of individuals.”

Residency programs, for example, should be particularly fond of competency-based medical education, Dr. Lomis wrote, because it enables them to expect more consistency in their residents’ performance, along with fewer supervisory burdens, better patient outcomes and even improved well-being.

Meanwhile, medical students enjoy clearer expectations, and the frequent formative feedback they get helps dispel the myth of the perfect student while also promoting their individual strengths and
opportunities for growth.

“Importantly, CBME empowers learners with greater agency in their own development, fostering master adaptive learners better positioned to grow throughout their careers,” Dr. Lomis wrote.

What’s holding it back

To be sure, generating this kind of value requires investment.

“Implementation with fidelity demands a reorientation that can seem overwhelming and is commonly cited as a severe limitation to the concept of CBME,” Dr. Lomis wrote. “Our community must continue to advocate for greater overall investment in medical education, as only an estimated 2% of total health care expenditures globally are devoted to training. But we rarely discuss what current resource investments could be reduced or redeployed to support CBME.”

Those investments reflect a bias toward content delivery over assessment and feedback. In some of her earlier work on the subject, Dr. Lomis found that investment in the pre-clerkship phase of medical school was greater than investment in the clerkship and final phases combined.

“And resources devoted to education are even scarcer as careers advance,” she noted.

A different distribution is needed

When setting budgets, it’s easy to get caught up in competing priorities, yet there is a touchstone that administrators should always fall back on.

“The prime perspective on value should be that of patients and populations,” Dr. Lomis wrote. “Lack of trainee preparedness for escalating responsibilities generates costs to patients and health systems that are often hidden in our discussions of educational investment. Health systems can be shortsighted in valuing clinical productivity over time devoted to educational roles or to physicians’ continuing development.”

Given what today’s medical students are up against, this is a particularly opportune time to revisit the value of competency-based medical education.

“Consideration of the current realities of practice, acknowledging the impact of exploding information and evolving technologies,” Dr. Lomis wrote, “may reveal creative opportunities to redesign for sustainable value.”