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Opinion Article

Competency-based medical education in India: A work in progress

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Change is the rule of nature and resistance is inherent to any change process. The replacement of two decades old traditional curriculum (1997) by the newly reformed competency-based medical education (CBME) in 2019, has led to a turbulent change.[1] This reform in medical education is encountering natural resistance from teachers, students and management. The cause for the resistance could be a generalised apprehension due to the lack of essential training to teachers, proper guidelines to students and support from management. The need of the hour is to allay this apprehension and address the key issues that are hindering the implementation of CBME.

A step in this direction is to follow the example of organisations who have successfully implemented CBME. The key to their success is the efficient way, in which they handled the change process. Heart of the change is in changing people's behaviour and the 'see-feel-change' approach is more appealing than that of 'analysis-think-change.' The emotional component 'feel' plays a pivotal role in changing the attitude and behaviour, making transition process smooth.[2] Hence, active involvement of all the stakeholders during the change process is vital for successful implementation of CBME. In this context, sensitisation of the stakeholders about the benefits and challenges of CBME is crucial in the present Indian scenario.

THE BENEFITS OF CBME

CBME will help today's learners to become better physicians of tomorrow by providing a comprehensive educational experience. Evolutionary educational thinking and new medical program accreditation process in India provided an opportunity to reconsider existing approaches to medical education.[3] Many authors have made an effort to categorise and discuss various advantages of CBME to its beneficiaries.[4]

Benefits to students

Individualised learning facilitated through CBME will ensure that competencies are being met for each stage. Students will receive more personal supervision, mentorship and day-to-day assessment. Increased flexibility may provide additional opportunities for enrichment of knowledge during electives. Students will get equal opportunity of learning and performing the task at their own pace without being compared to other fellow learners avoiding peer pressure in particular. Mastering essential clinical skills will provide an edge by enhancing preparedness for practice. Thus, CBME shifts the emphasis on operational outcome rather than theoretical knowledge.

Benefits to faculty

Faculty will see and feel the paradigm shift in their role while implementing CBME. They will enact as 'guide by the side' rather than 'sage on the stage.' The incorporation of different instructional methods, namely small group discussions, early clinical exposures and linkers allows the teachers to facilitate active learning. Teaching will be based on well-defined learning outcomes; hence, they can focus on specific observable competencies. Thus, teacher centred approach will be properly aligned with student centred teaching without replacing each other.

Benefits to the society

The field of medicine is in a contract with society to serve patients – an ethical, moral and social contract that has to be fulfilled without any bargain or compromise. CBME ensures quality healthcare by creating doctors with specific skills tailored to serve the medical needs of the community. CBME by focusing on non-cognitive variables such as professionalism, communication skills and health advocacy narrows the gap between doctors and patients. Addition of foundation course at the beginning itself, emphasizes the importance of soft skills and empathy toward patients. AETCOM module is the most welcome addition into the new curriculum which facilitates better social behaviour and communication with patients.

CHALLENGES TO BE ADDRESSED

Operationalisation of CBME is a herculean task. Advantages of CBME are many, yet it is not a complete foolproof system. CBME though provides a seamless linkage between all stages of lifelong learning; its implementation poses numerous challenges.[5] These challenges if not addressed properly will have negative implications on students' learning environment. Challenges to various domains are as follows.

Teaching related

CBME necessitates a practical outcome-based approach, which cannot be achieved merely by adding competencies and specific learning objectives. To achieve these competencies, effective teaching methods such as problem-based learning and case-based learning are still missing or partially adopted. However, to meet the demand, further we need to incorporate time tested, best teaching and assessment practices. Integrated approach still appears to be on paper. Core approaches of integration, namely; horizontal, vertical and spiral are far from reality. System based, block wise approach seems to be a better solution to tackle this missing linkage during integration. Most of the institutions are following their own time table as per their convenience, which has undermined the uniform implementation of CBME. There should be some reality check system, probably direct video recording of teaching and assessment, accessible by central council members may rectify the pit falls and discrepancies. Thus, uniform teaching time table and assessment methods across the country may be a single best answer toward successful implementation of CBME.

Assessment related

Assessment is the backbone of any curriculum. Other major lacunae in the proposed CBME are a lack of robust, reliable and valid assessment strategies. The assessment blueprint needs to be designed based on best practices. It should include multiple processes with minimal validity threats.[6] Assessment requires much more objective type settings to reduce subjective bias. Not only the qualitative but quantitative evaluation also has to be incorporated, especially while assessing non-cognitive skills.

Nevertheless, one must remember that expertise, not competence, should be the ultimate goal of CBME. Hence, CBME must represent a medical career that includes lifelong learning and on-going assessment. We can follow the guidelines prescribed in The Milestones framework – a descriptive blueprint for each specialty, to guide curriculum development and assessment practices.[7]

FACULTY DEVELOPMENT PROGRAMS: A MISSING MAJOR LINKAGE

Echoing the words of John Dewey; 'if we teach today's students as we taught yesterday's, we rob them of tomorrow,' we are pointing at importance of faculty development programs (FDP) by policy makers. Faculty play a key role in successful implementation of CBME. FDPs are fundamental to the effective transition of traditional teaching to CBME.[8]

However, there are many questions yet to be resolved especially in Indian scenario; are the faculty well acquainted with CBME? Have they prepared adequately to teach and assess? If not, how, where and when will they be given sufficient training? Is it not essential to train them sufficiently before expecting them to take a plunge into the unfamiliar, vast ocean of CBME? These queries need to be addressed. Although curriculum implementation support programs are being conducted by nodal centres, many of the faculty are still skeptical and unconvinced. Faculty needs much more elaborative FDPs to meet the demands of CBME than just passively attending few days' workshop. Frequent and constant hands-on workshops are required to bring much needed awareness. Moreover, in many of the institutions, medical education unit (MEU) is in its infancy, with untrained junior faculty being the head and members of the MEU which has, in turn, hampered effective delivery of FDPs. Current faculty in India are not well prepared and trained for the CBME task in imparting newer competencies of medical knowledge, clinical skills,

professionalism, evidence-based practice, interdisciplinary teamwork and systems. The implication of these observations is that the MCI urgently needs a nationwide initiative of faculty development in CBME teaching and assessment.

CBME: THE ROAD AHEAD

Despite the broad endorsement of CBME as a core strategy to educate and assess the next generation of physicians, major concern is about reductionist approaches in CBME, lack of good universal timetable and assessments. Granularity of competency-focused curriculum may result in 'missing the forest for the trees.' The concerns and challenges can be categorised as: (i) Those related to practical, administrative and logistical challenges in implementing CBME and (ii) those which are conceptual or theoretical in nature. Inconsistencies in CBME conceptual frameworks and guidelines remain a significant obstacle.[9] The critical insights into the operationalisation of CBME are warranted. Hall *et al*. relate implementation of the practical components of CBME as a sprint, while realising the principles of CBME and changing culture as a marathon denoting sustained effort in the form of frequent program evaluation and continuous FDPs.[10] With all these pros and cons, CBME still stands out as a better approach to meet the needs of patients, providers and other stakeholders in the health-care system. Hope everyone will soon join hands in the smooth and successful transition to CBME, to promote better transparency, accountability, fiscal responsibility and patient safety. CBME should not be viewed as a fixed doctrine, but rather as a set of evolving concepts, principles, tools and approaches that can enable important reforms in medical education that, in turn, enable the best outcomes for patients.[11] In overcoming these challenges, one can use conceptual framework, designed using Mento's[12] step change management process for effective and sustainable implementation of CBME.[12]

CONCLUSION

CBME remains the best possible solution for most of the problems inherent to conventional system of medical education in India. Hence, a systemic collaborative approach and dedicated involvement of all the stakeholders; medical educators, students and policy makers will ensure successful implementation of CBME.

Declaration of patient consent

Patient's consent not required as patients identity is not disclosed or compromised.

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Conflicts of interest

There are no conflicts of interest.

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