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COMPETENCY BASED MEDICAL EDUCATION (CBME) – A CHALLENGE IN INDIA

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Competency Based Medical Education (CBME) has been implemented Pan-India from the academic year 2019-20. The goal of the new curriculum is to have a competent ethical Indian Medical graduate who will acknowledge the social obligations for the health rights of all citizens and work efficiently to achieve it. The CBME document has been meticulously made with new additions of Foundation course, AETCOM (Module), Self Directed Learning, Electives, Early Clinical Exposure, Extra Curricular Activities and sports, & Exit examination other than subject wise competencies. Progressive complexity of predetermined core or noncore competencies in different domains along with proficiency table is specified in this document. It has the freedom of formation of curriculum at the institute and assessment at university level. The features of Competency Based Medical Education are that it is outcome based with behavior, skill and knowledge application. CBME has multiple authentic assessment tools. It has shared responsibility between student and teacher with variable time of completion. In India, Medical Council of India has adopted a hybrid approach of Competency Based Medical Education as different phases are time dependent. To achieve a specific competency, specific period has been given and at the end of every phase summative examination is scheduled. There is no freedom for students to finish the phase early or late which is the distinctiveness of CBME. Early clinical exposure, electives was really much needed in curricula and will be of advantage to curriculum.

The emphasis of Competency Based Medical Education is imparting a perfect blend of precise experiences at workplace to acquire the skills with right attitude by the medical graduate. There is a gap between practice & medical education which can be filled by having competent graduates. Uniform education and shared responsibility between teacher and student to complete the goal of CBME are few of the assumptions. The problem is with implementation of these assumptions in the Indian scenario. Just merely copying global concepts of curricula in medical education may not be able to outline the medical practice in India. Similar to financial extremity; we are at different extremes of medical practices catering to poor and rich, accessible and non accessible areas; also in medical education well established institutes and peripheral institutes, government and private institutes & so on. Because of these, challenges faced by different institutes vary. Very few institutes which have fair and righteous work culture are actually competent for implementations of CBME, the remaining need to improve soon.

Hence, I would like to reflect upon the challenges

What happened?

CBME is now present as gazette and implemented pan India without preparation of administrators, institute infrastructure, faculties and students in academic year 2019.

So what?

The challenges which we are facing are at different levels of implementation.

1. **Regulating bodies:** CBME was a long pending document. Most of the training conducted was with PROPOSED document. Hence, uncertainty of implementation for year 2019 had percolated. The CBME was implemented with very short notices to administrators and institutes with ambiguity. In the process of implementation, various documents were released at different point of time which further added to confusion. As faculty development, revised basic & AETCOM workshops were conducted but only faculties interested in medical education mainly attended it. This workshop should have been mandatory to all faculties before implementation of CBME. Quality assurance assessment will also remain a big issue as yet there are no guidelines to follow. Acquisition of competencies does not mean assurance of competence of the Indian Medical Graduate in community.

2. **Administrators:** This are again at two different levels viz universities and institutes.

    a. **University level**–CBME does give domain and subject wise competencies along with proficiency table. There are additions of few subject wise competencies. High order cognitive components like professionalism, leadership, critical thinking, empathy, problem solving etc of CBME requires a thought process and internalization. Delayed guidelines to universities with flexibility of formation of curriculum and assessment methods were major challenges to them. Due to which it was difficult to design in detail. Assessment plays major roles especially work place based assessment methods. Formative assessment is characteristic of CBME but most of the assessments still favor summative assessment. The university rules like higher marks out of two assessors or grace marks can be a hurdle for actual possession of competence of Indian Medical Graduate. It has been observed that in recent past students are getting high marks but their proportionate knowledge in respect to these marks is debatable.

    b. **Institute level** – CBME focuses more on small group teaching. Widespread deficiency of trained staff is perhaps what every institute must be facing. The tendency of most appointing authorities is to hire minimum staff as per Medical Council of India requirement. In addition to this; there was hike in seats of undergraduate students in nearly every institute leading to very low student teacher ratio. This has raised major concerns of accommodation in the same infrastructure of these students for various activities. Simulation and computer laboratories which are mandatory are further a huge financial burden for infrastructural development. Country like India where abundant patients are available; do we actually require a skill lab is again arguable. Unluckily other than handful of institutes; in India most of the administrators have favoritism which further gives unfair distribution of work, independent of capabilities or competence of faculty.

3. **Faculties:** Availability of trained and competent faculties is disputable. They themselves are confused with new changing terminologies; facing conceptual issues of various components of CBME. Most of the faculties are implementing CBME without training which is worrisome.

In most institutes multiple courses are running along with medical curriculum. Faculties are busy with other responsibilities like administrative, research etc. This is creating massive time crunch leading to unavailability of faculties to oversee few components like extracurricular activities, sports etc. Other factor is lot of flexibility for formation of curriculum at institute level as per their logistics. No standard role model for CBME curriculum exists. Most of the faculties are puzzled with Competency Based Medical Education as they were used to traditional curriculum. There is paradigm shift of teaching learning and assessment methods. Faculties are not empowered for the same. Last but not the least is the attitude of the faculties. Do we actually have enough role models for the students with right attitude who will give right experiences to students to develop attitudinal changes which we are hoping for? There were teachers who shaped the great doctors with their passion and nature. It is high time that every one of us needs to reflect; are we doing our best for student's development or working only for our own personal goals. With this I fear that CBME may remain just on paper or like old wine in new bottle.

4. **Students:** compared to global scenarios our students are very young and accustomed to teacher centered approach from their childhood. Their goals are what they need to know for summative assessment. For them competencies, objectives and learning outcomes are one and the same. What matters to them is am I going to pass with this? They are trained for objective assessment and now with subjective assessment along with formative assessment they are mystified.

The challenges of process of implementation varied as per leaders of institute. Institutes with Dean as medical education technology supporters have encouraged the whole process. There were common challenges too which we have faced in different degree. Curriculum implementation support program was carried out for faculties. During this program short notices were given for specific learning objectives & time table formation of phase 1. Faculties had to work on war front for the same. During this process they hardly got time to think about all the technical aspects of timetable formation like intra or inter phase overlapping of SLO, redundancy of objectives, thought process of teaching learning methods, clarity of concepts or availability of staff for foundation course activities etc. At the start of the academic year, logbooks or new journals were not printed as faculties were overburdened with many aspects simultaneously. Foundation course is innovative concept for overall development of the students. Duration of it for achieving the skills is short whereas for sensitizing it is long. If objective is to sensitize then two to three weeks are adequate. August being in rainy season is not the right time for outdoor sports. As it is done now; most students are sensitized to this concept but you can hardly see any difference in short term outcomes among previous & this batch. AETCOM module is very elaborative module with goal of shaping the students as clinician, leader, communicator and lifelong learner who will function appropriately, ethically and effectively. AETCOM module and few topics of foundation course like doctor patient relationship, communication skills, leadership etc has got similarities and overlaps; and that actually looses the interest of the students. The biggest challenge is what they are learning and what is happening around them may keep them baffled. Attitudinal changes have a lot of confounding factors like their own personality, environmental factors like experiences, way of feedback received etc. Some students also tend to give manipulative feedback. Factors like to whom the feedback is given, depends on position of teacher or how much marks that teacher usually gives or when it depends closeness with period of summative examination

matters a lot for true feedback. Our students are not trained for reflections and written feedback. If we keep this for grading it is possible to get them over a sale counter like the projects in the school or coaching classes for entrance examinations.

CBME emphasizes practice in simulated environments as powerful learning tool. Students practicing in safe environment may ultimately lack preparedness of individual practice in community. Acquiring skills need not mean acquiring competence. It may be highly relevant in scarcity of patients outside India. Due to abundant patients' observation guides, clinical encounters can be used as dominant learning tools. Early clinical exposure can be considered as obligatory change to traditional curriculum. A fantastic linker if used properly for knowledge application, correlation, critical thinking & analysis. Electives in CBME will provide students to choose what they really wish to only if they are given impartial opportunity by institutional administrators. But this gives them a good chance to understand their likings and carve their future career path. Self directed learner is best learner. In CBME formative assessment and work place based assessments have major role. Regular periodic examinations along with evaluation of day to day activities are required. Our teachers as well as students are not used to work place based assessments. Universities have freedom of assessment patterns. More credentials are still given to summative examination. Rules of assessment in universities like taking best of two assessors marks or grace marks need to be reconsidered as we have been seeing high marks in proportion to knowledge & skills of the students in the last decade. Assessment drives learning and students tend to learn more from summative assessments as that is aligned with their primary objectives. For them feedback and examination marks are criteria for the competencies. There is more objectivity ie tick boxes of done /not done and documentation in CBME. Checklists are integral part of assessments. It is proven that even assessment by detailed checklist done by same examiner at different time and by different examiners shows variability. In practice you cannot apply the same checklist in every patient. There is no fixed single approach to every patient even of the same disease. This depends on how doctor thinks and judges his patient for his thinking. Competence depends a lot on this. Hence, some amount of professional judgments can be part of assessment.

The best part of whole process is improved interactions of professionals at all levels viz institute, regional, state & national. We are trained to work collaboratively in crisis as most of us are understaffed with lot of burden. Most of the regional institute's faculties joined their hands to form SLO. There was lot of collaboration, interactions among us during the process of implementation.

What next?

Whole heartedly try to implement the program as best possible. Next five years will be maximum challenges we have to face. Every next batch can be modified as per institute set up as we have flexibility. Extensive training workshops are required for both revised basic course with AETCOM & CISP. Target for this can be all faculties till 31st December 2020. This really requires fast approvals of workshops from regulatory bodies. Quality assurance with internal & external validation especially with regulatory bodies is essential. Increase in staff proportion is desperately required rather must. Teaching learning methods should be blended to maximum which can cater to all type of students. Optimum amalgamation of different teaching learning & assessment methods is requisite. Exposure to Indian & global scenarios can be done by exchange programs. Activities should not be measured only in numbers like publications, rather quality assessment is must otherwise it will not serve the

purpose. Universities should modify their assessment methods giving more importance to formative assessment. What we are assessing in assessments should undergo Blueprinting, pre-validation & post validation at institute &even at university level. Rules of assessment should be aligned with quality of assessment. Leaders & stakeholders should be identified and appropriate person should be given responsibility impartially by administrators. Regular non bias feedback from all cadres to administrators, regulators should be taken in to consideration. Head of the department of pre & para-clinical branches must be clinical person. Faculty empowerment program like workshops on blueprinting, teaching learning & assessment methods should be conducted as per need. Train students for writing reflections, giving and receiving feedback. Last but not the least, we should conduct ethical research which will prove its benefits or loss and review it. Short & long term goals achieved or not achieved? Question yourself: CBME or modified version of traditional curriculum, which one is more beneficial? Achieving goals of CBME & its success in India is a very big challenge. Competence or incompetence of Indian Medical Graduates of CBME will be proven with the passage of time itself.