

Reducing the total duration of training while still producing well-trained cardiologists should be our future goal (7).

**ACKNOWLEDGMENT** We thank Dr. Chittur Sivaram for his guidance and critical review during the preparation of this manuscript.

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# RESPONSE: Are We Ready for Competency-Based Cardiology Training?

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Within the evolving framework of competency-based medical education, cardiology has unique opportunities to develop and evaluate innovative methods of training. The American Board of Internal Medicine (ABIM)/American College of Cardiology Pilot is an initial step in this direction. Dr. Asad presents the perspective of 2 fellow participants in this program. This perspective is critical in evaluating outcomes and implications for this or any innovation in training.

There is much interest nationally in identifying ways to decrease the cost and intimidating amount of time required for medical training. Given our comfort as a field in adapting to emerging evidence, cardiology is well positioned to innovate in evidence-based medical education. We do, however, need to ensure that we approach this in a thoughtful, deliberate manner. Dr. Asad describes advantages for fellows with an early career focus. He concludes that an early focus did not lead to gaps in core internal medicine (IM) knowledge. This is also the conclusion of the IM and cardiology program directors who participated in the Pilot. Acting responsibly, we must then ask whether an early focus results in lost opportunity for expertise in noncardiology areas of IM. If so, is this

important for fellows' long-term career goals and ultimately for their patients' care?

The primary tools used for identification of gaps in trainee knowledge and for determination of competency for independent practice are imperfect and not standardized. Determining how to best make these assessments and then, in turn, how to implement them across institutions is a major challenge moving forward in competency-based cardiology training (CBCT). In fact, it leads to more questions. How do we determine the amount of knowledge or skill that is appropriate for each individual trainee? Are the necessary amounts the same in all areas for internists compared with general cardiologists and electrophysiologists? Are they the same for future physician scientists compared with pure clinicians? Some of the skills in which these different physician phenotypes need to be competent to practice independently vary, implying that the paths to acquire these skills should vary as well. Currently, we address this by adding time to training, but is this the most effective and efficient method to accommodate different learning needs? We know from experience that, even for trainees pursuing the same career goals, the amount of experience required to obtain competency is

not the same. Can we then develop a truly flexible system that allows trainees to progress as their individual knowledge and skill dictates? These are important questions that cardiology has the potential to answer.

There are many stakeholders involved in decisions ahead of us as we continue to develop CBCT, including residency and fellowship programs,

accrediting bodies, hospitals, government, trainees, and the public. There are implications of cost and resources to all of these stakeholders, but most importantly, our patients. As cardiology grows in complexity, it is imperative that we determine how to utilize our resources as effectively as possible. We must embrace and invest in CBCT and lead in the innovation of medical education.