Published Online: 2025 July 7 **Letter**

A Critical Foucauldian Perspective on Competency-Based Medical Education and Entrustable Professional Activities

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Received: 25 March, 2025; **Revised:** 22 April, 2025; **Accepted:** 11 June, 2025

Keywords: Competency-Based Medical Education, Entrustable Professional Activities, Critical Discourse Analysis, Foucauldian Perspective

Dear Editor,

I am writing to offer a critical perspective on two dominant frameworks in contemporary medical education: Competency-based medical education (CBME) and entrustable professional activities (EPAs). As these approaches increasingly shape medical training worldwide, there is an urgent need for a critical examination of their underlying assumptions and power dynamics. This letter presents a five-step Foucauldian critical discourse analysis (1) of these frameworks, revealing how they function not merely as neutral pedagogical tools but as discursive formations embedded within complex power relations that shape legitimate medical knowledge, professional identity formation, and authority distribution.

The Discursive Nature of Educational Frameworks

Medical education frameworks represent more than methodological innovations; they establish what Foucault would term "regimes of truth" about professional competence (2). The CBME and EPAs have emerged as dominant discourses that define what counts as legitimate medical knowledge, who is qualified to teach and assess, and what constitutes a competent practitioner. These frameworks establish "rules of tolerability" that delimit boundaries between acceptable and unacceptable practices while concealing their own historical contingency and political dimensions (2).

The power/knowledge nexus operates prominently through these systems (2). The CBME and EPAs establish what knowledge is valued, how it should be assessed, and who has the authority to judge competence. Through workplace-based assessments, competency committees, and entrustment decisions, these frameworks institute surveillance mechanisms that continuously monitor trainees against standardized benchmarks. This creates what Foucault termed a "disciplinary apparatus" that shapes professional conduct and identity through normalization processes rather than overt coercion (2).

According to BEME Guide No. 66, within this disciplinary framework, corrective feedback is most effective when it acknowledges the emotional experiences of learners during the learning process. By fostering a two-way conversation between the instructor and the learner, it motivates the learner to engage more deeply in future learning and can result in enhanced clinical performance (3).

Historical Emergence and Power Relations

The CBME emerged within specific historical conditions, responding to perceived inadequacies in time-based models (4). This shift toward outcomes-based education and increased accountability was driven by concerns for patient safety, demands for standardization, and calls for educational accountability. The discourse constructs medical education as an engineerable process designed to produce predetermined outcomes — a significant departure from earlier apprenticeship models. By articulating specific competencies for meeting

How to Cite: Moradi S. A Critical Foucauldian Perspective on Competency-Based Medical Education and Entrustable Professional Activities. J Med Edu. 2025; 24 (1): e161444. https://doi.org/10.5812/jme-161444.

healthcare needs, CBME establishes new truth regimes about what constitutes adequate training.

The EPAs subsequently developed to bridge gaps between atomistic competencies and integrated clinical practice. Introduced by Ten Cate et al., this framework shifted focus from isolated skills to whether trainees could be "entrusted" with activities integrating multiple competencies (5). From a critical perspective, this represents a discursive strategy reconciling competing demands for standardization and contextual complexity, while introducing new power mechanisms through entrustment decisions.

Both frameworks establish knowledge hierarchies that privilege certain competencies while potentially marginalizing others. The CBME positions specific stakeholders — typically regulatory authorities, educational institutions, and senior educators — as legitimate definers of competence, often limiting patient and community involvement despite rhetorical emphasis on inclusivity. Similarly, EPAs introduce a politics of entrustment where decisions about supervision levels represent significant power exercises, extending assessment beyond technical competence to character judgments.

Subject Positions and Identity Formation

These frameworks construct specific subject positions for participants in medical education. Faculty simultaneously occupy roles as coaches, assessors, and gatekeepers, navigating potentially conflicting responsibilities. Trainees are constructed as self-directed learners engaged in continuous self-assessment and improvement — aligning with neoliberal discourses emphasizing individual responsibility and self-monitoring. This represents what Foucault termed "technologies of the self", where trainees internalize professional norms and engage in self-regulation (2).

Patients occupy complex positions as beneficiaries of improved training, partners in education, and objects through which competence is demonstrated. Despite patient-centered rhetoric, patients typically remain objects rather than subjects of educational processes, with limited agency in determining what constitutes competent care. These subject positions reveal how power operates not merely through coercion but through identity formation — shaping how individuals understand themselves as medical educators, trainees, and patients. The ideal CBME trainee demonstrates self-direction and responsiveness to feedback, while the ideal EPA trainee exhibits trustworthiness and appropriate help-seeking behavior. These constructions encourage particular forms of self-presentation aligned with institutional expectations.

Discursive Tensions and Contradictions

Significant tensions permeate these frameworks. General practice knowledge occupies a "discursively fragile position" relative to specialized knowledge, revealing underlying hierarchies despite inclusive rhetoric. Tensions between standardization and individualization remain unresolved, as frameworks simultaneously emphasize uniform competencies and personalized learning pathways. The EPAs attempt to resolve these tensions through entrustment (6), but introduce new contradictions between objective assessment and subjective judgment.

Implementation disparities further reveal contradictions between discourse and practice. Faculty development for CBME is often delivered in an "ad hoc manner instead of being a deliberately sequenced program matched to data-informed individual needs". This highlights gaps between rhetorical commitments and institutional realities, where resource constraints and competing priorities undermine full implementation.

Implications for Medical Education

This analysis encourages attentiveness to the power effects and resistance possibilities within these frameworks. Medical educators should recognize these frameworks as historically constructed and adapt implementation to local contexts, remaining alert to their normalizing tendencies. Educators can approach implementation more reflexively. Faculty development should incorporate critical perspectives that help educators navigate tensions between developmental and evaluative roles. By understanding how these frameworks shape professional identities, faculty can support trainees in meeting requirements while preserving space for authentic development beyond standardized competencies.

For researchers and policymakers, this analysis highlights the importance of examining how frameworks privilege certain stakeholders in defining competence. Greater involvement of diverse perspectives — including patients, communities, and trainees themselves — could help address power imbalances in competency definition and assessment.

Conclusion and Call to Action

Medical education frameworks are never politically neutral; they shape professional formation through power relations that deserve critical examination. As medical education continues to evolve, I urge journal

readers to: (1) Approach CBME and EPA frameworks with critical awareness of their power effects; (2) create spaces for alternative discourses emphasizing tacit knowledge and professional wisdom; (3) involve diverse stakeholders in defining and assessing competence; (4) support trainees in navigating assessment demands while preserving authentic learning; and (5) research implementation through critical lenses that examine power dynamics.

By engaging with these frameworks through a Foucauldian perspective, medical educators can implement them more thoughtfully, remaining attentive to both their benefits and limitations. Rather than accepting these approaches as inevitable educational truths, we should recognize them as particular historical constructions that reflect specific values and priorities — and remain open to alternative visions of medical education that might better serve diverse communities and healthcare needs.

Footnotes

Authors' Contribution: S. M. was responsible for all stages of preparing this article.

Conflict of Interests Statement: The author declare no conflict of interests.

Funding/Support: The author declared no funding for the study.

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