Key findings from the Becoming Certified Initiative identified the need to:

- Assess additional skills and competencies important to the specialty.
- Create an assessment that is more relevant to practice and with the flexibility to adapt to changes in practice.
- Provide a format that can assess the aspects of emergency medicine practice that are not easily replaced by artificial intelligence
- Provide candidates with a meaningful assessment experience. The current format of the virtual Oral Certification Exam (OCE) cannot adequately grow in size or structure to meet these needs; however, the specialty believes that an exam beyond medical knowledge is still needed.

The Oral Examination Assesses Different Content

The oral examination measures elements that are not measured on a written examination. Specifically, the ABEM OCE measures knowledge, skills and abilities (KSAs) that are not measured on the Qualifying Exam (QE) as well as unique factors such as:

- Thoughtfulness (situations requiring reflective thought; conditions that solicit empathy).
- Structured Decision-Making (decision trees; deductive reasoning).
- Restraint (situations requiring contemplative thought; conditions that do not warrant an aggressive approach; conditions that solicit empathy).
- Complex Reasoning (high complex, deductive thought required, often merges diagnosis and management).
- Rarities (not “meat and potatoes” cases, varied topics such as OB/GYN, rheumatology, ophthalmology, hematology).
- Cognitive Diagnoses (problem solving involving complex questions and situations requiring multiple diagnostic steps).

That the QE and OCE measure different competencies and content was confirmed by a study published by Gorgas D. et al, that showed the Pearson’s correlation coefficient between QE and OCE performance was 0.33 (Acad Emerg Med. 2023 Jul 29. doi: 10.1111/acem.14780). This suggests that although there is moderate correlation (probably due to a shared core content), there is sufficient difference in performance to prohibit claims of redundancy for the OCE.

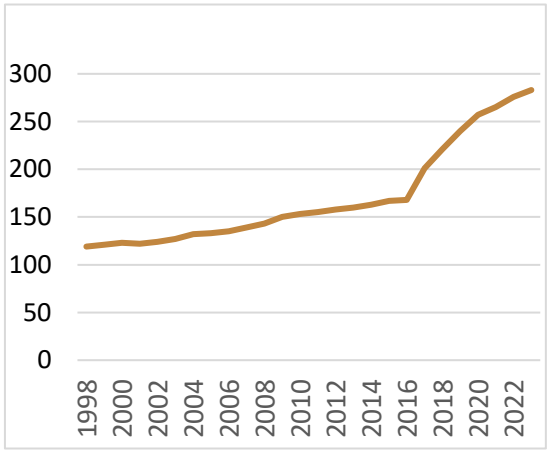
Emergency Medicine Landscape

Growth in Residency Programs and Residents

Categorical EM residency programs grew from 1998 to 2023 (Figure 1). In 1998, there were 119 categorical EM residency programs. Growth was steady until the Single Accreditation System (SAS) was approved in 2015. Categorical EM programs grew 19.6% from 2016 to 2017. Since 2017, yearly growth in residency programs has ranged between 2.5% to 10%. In 2023, there were 283 programs reported of which 47 were formerly AOA-approved programs (17%). While the SAS contributed to residency program growth, it was not the only contributor. New programs were also being added at a high rate.

Since 1998, the number of enrolled EM residents has also grown (Figure 2). Between 1998 and 2016, the growth in the number of residents ranged from 1% to 7% with an overall pattern of growth of 3-4% per year. Between 2016 and 2019, the number of residents grew 9%, 11%, and 7% respectively primarily due to the SAS. Since that time, the growth in the number of enrolled residents has returned to a pattern of a 4-5% increase per year. In 2023, there were 9,459 residents; in 2016, the number was 6,084. In seven years, the number of residents had grown 55%.

Figure 1: Number of Categorical EM Programs (1998-2023)



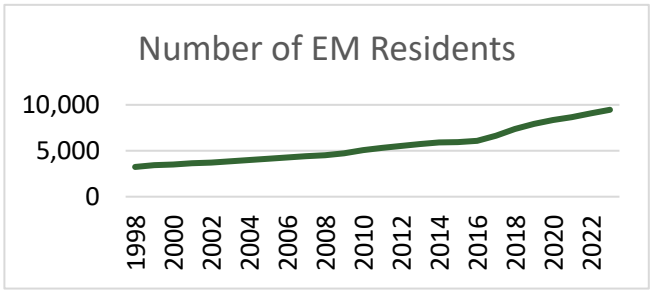


Figure 2: Number of EM Residents (1998-2022)

The majority of these residents (approximately 98%) apply to become ABEM certified. This reinforces the importance for ABEM to continue to maintain high standards for board certification in EM. ABEM embraces its responsibility to provide assessments that are relevant to clinical practice. ABEM also recognizes that its assessments will likely need to evolve to address the key areas identified. ABEM embarked on the Becoming Certified Initiative to improve and enhance its assessments by learning more about what the specialty values for the future of EM.