

Quality: assurance or standards?

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Public and professional concern for issues of safety and quality in clinical practice has moved the focus of attention from participation in programs of Continuing Medical Education (CME) or Continuing Professional Development (CPD) to measures of competence or performance in practice. The debate about quality has reached an important position: it is no longer a matter of demonstrating involvement in 'Quality Assurance' activities or the definition of 'Standards', but rather one of recognizing the necessity of developing approaches that contribute sig-

nificantly to the 'Assurance of Quality and Standards'. This report describes an activity designed to progress this topic through discussion and clarification of the key issues that need to be addressed in assessing the performance of practitioners in their clinical settings.

Key words: Quality assurance, competence, performance assessment, recertification

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Introduction

A recent Editorial in the *Bulletin of the Kuwait Institute for Medical Specialization* asked the important question: "Should the countries of the Arabian Gulf Region introduce systems of recertification in the various medical specialties?"¹ Acknowledging the need to identify and remediate those few practitioners whose performance may be below a generally acceptable level, it was argued that such measures "would go a long way in setting and maintaining professional standards, in fostering learning throughout a lifetime of practice as knowledge and technology continue to grow, and in improving patient care."¹ This approach and concern for the process of recertification is increasingly seen in health professional disciplines in all regions of the world. In particular, the concern for the ways in which the level of performance of clinicians in their own practice settings can be measured raises personal and professional issues related to Quality Assurance and Continuing Medical Education that are truly international in their nature, and continue to be hotly debated in numerous international forums.²

In July 2001 an invited group of thirty-eight medical educators from around the world, each with expertise and interest in the assessment of performance in clinical practice, met for one week near Sheffield in England under the sponsorship of the 10th Cambridge Conference. The principal outcomes of their deliberations are contained in ten articles³⁻¹² published in *Medical Education* in October 2002. The important principles and clarification of issues contained in these articles provide a useful framework for considering approaches that may assure governments, professional colleagues and the public at large that any individual clinician is indeed performing at an acceptable level.

The Cambridge Conference was able to focus on an agreed list of topics that were derived and prioritized by the participants from a close investigation of the key features of the assessment of performance in clinical practice, including detailed reviews of existing certification, recertification and accreditation processes and the international literature on related issues. Groups of participants then spent three or four days on each topic with regular reporting and plenary sessions to gain overall coordination and consensus on each issue. Drafting and finalization of the articles then proceeded for six months or more following the Conference, resulting in the acceptance and publication of the ten articles.

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Report

Discussion of the issues of quality and safety in clinical practice go far beyond the definitions of terms such as 'competence' and 'performance'. Certainly an understanding of the distinction between these terms in a medical education context is important, but far more important are "the implications of the distinctions between the two areas for the purpose of assessing doctors in practice".³ The distinction between competence and performance has particular relevance for identifying methods of assessment. Those methods which can measure what a practitioner actually does in professional practice when dealing with the problems of patients (i.e. the clinical performance) may be quite different from the methods needed to assess what doctors are capable of doing in controlled representations of professional practice as possible predictors of future practice (i.e. clinical competence). As is clearly true at all levels of professional learning, amongst other variables the context of practice, including the nature of professional teams and systems, impacts dramatically on the outcomes and quality of patient care.⁴

Any investigation into the assessment of clinical performance in practice settings shows very readily that clinical performance is an extremely varied and idiosyncratic construct, and therefore although a vast array of performance components and tasks may be identifiable⁵, the matching of appropriate assessment methods^{4,6} is a complex and difficult process. Practitioners, employers and consumers will obviously need to accept that some form of performance assessment is actually necessary as a personal and professional responsibility⁷ no matter what range of contexts and systems are involved.⁴ To achieve this, assessment approaches will need to be seen as being fair and defensible⁸⁻¹⁰ and clearly relevant to the defined purposes of assessment and the nature of the clinical performance. Such is the complexity and huge range of potential combinations of factors involved that any single approach to assessment or single method of assessment would be extremely limited in its application. What is necessary is an understanding of principles and guidelines that allow for their application in any well-defined setting.

Further, acceptance of any model of learning and practice that builds upon and further advances the notion of CME/CPD will require an understanding of distinctions between formative and summative assessment approaches.¹¹ Gathering information and providing feedback that is largely qualitative and designed to assist in the improvement of an individual practitioner's performance is a vastly different activity from gathering ratings or largely quantitative information which demonstrates characteristics of practice which are then used for judgmental or legislated summative purposes. Any approach that is designed to provide comparative data against other practices, standards or requirements will also require individual practitioners to accept the need to have a realistic insight into their own performance¹² and accept the need for remediation whenever indicated. A conflict will arise whenever the purposes or intentions of an approach, and thus the outcomes, are used for differing purposes. A basic starting position requires the clear and accepted definition of the purposes of assessment, and the intended use of the outcomes or judgments made as a result of the assessment.

An approach recommended for consideration is one that links "performance and assessment to ensure that ongoing learning and continuing competence are, in reality, connected".¹¹ It needs the practitioner to be able to identify and accept those aspects of clinical practice that are not only adequate and acceptable to himself or herself but also in line with acceptable professional standards. Assessment, as an educational process, allows a clinician opportunity to compare characteristics of actual practice with some ideal or desired practice, whether defined by the individual, by the profession or by some external registration or accreditation authority. Assessment also validates good practice when there is consistency between what the individual does and what is expected of him or her. Any perceived discrepancy between performance and requirements should initiate further consideration and reflection.

As clinicians are involved in such a vast range and variety of tasks and components, assessment through any single approach is unlikely to be able to reflect an overall level of performance. Typically, the notion of case

or content specificity indicates that one will do better at some tasks, in some domains, in some contexts, with some patients than on other occasions. Performance levels are not static over time or content, and individual practitioners will have differing perceptions of both what standards they apply to their own performance and what standards are expected of them. Critical errors may occur, but most practitioners with adequate insight should be aware of their own weaknesses and deficiencies before such unacceptable events occur. Setting personal standards too high or too low could have unwelcome consequences either in the standard of care provided to patients or the perception of the practitioner's own performance and need for remediation. Accepting too low a standard obviously puts patients at risk, whereas recognizing too large a discrepancy from an expected standard may block effective remediation through appearing to be unrealistic and thus be denied.¹³

An important area to consider in discussing the issues of quality and standards is therefore the ability of the individual practitioner to assess the level of their own performance across a range of tasks over extended periods of time and to set the impressions gained against realistic standards and requirements. Single incident or task measures are not sufficiently robust to rely upon, nor is the averaging of various differing performances. From a technical viewpoint, assessment must be sufficient to gain an adequate and accurate perception⁸ so that some generalization of behavior is possible, i.e. the assessment measures must be both valid and reliable.

Summative assessments undertaken to allow judgments on standards of practice, such as examinations, take a snapshot of performance across a range of tasks at a particular point in time. Practice audits collect data about single conditions or a small group of conditions, and being largely qualitative measures do not easily allow summative comparisons to be made. Formative assessment allows for more frequent feedback on tasks and components, but is designed to assist in ongoing development and extension of skills rather than comparison with existing standards. Combining several assessment approaches to provide data for the compilation of a portfolio provides increased flexibility in

interpreting the appropriateness of practice, but requires coverage of the domains of patient care, personal development and context management.⁶ Further, portfolios have become more acceptable in offering greater opportunities to identify effective learning activities for formative purposes than in contributing to global judgments of performance for summative purposes.

Whatever approach to assessment of clinical practice is taken, the purpose and intended outcome of that process must be very clear and agreed upon by the individual practitioner.⁹ Assessors from the same or related disciplines will often be required. These assessors will make judgments on the basis of a sample of performance that is observed or documented, and are key components of any practice performance assessment program that is used for certification, recertification or accreditation purposes.⁹ Of particular importance is the need to use assessors who are appropriately selected and trained and who are acceptable to the clinician. Fair and defensible programs for performance assessment must also use an acceptable and valid sampling of behavior, and be as free of potential bias and error as is possible.⁸

Discussion

Although there has been a recent shift in attention away from the structure and delivery of CME/CPD programs, they remain at the core of ongoing maintenance and development of clinical knowledge and skills. What is clear is that, in themselves, participation in such programs is not likely to meet the increasing legislative and employment requirements that favor clear indicators of professional and personal performance which will allow practitioners to continue to practice. From both summative and formative aspects of the assessment of performance in realistic practice contexts, CME/CPD programs are a necessary complement to the assessment processes and allow practitioners to check personal perceptions and insight. To a large extent these programs will also allow practitioners to validate standards against professional colleagues and legislative requirements.

The assessment of clinical performance is a very complex and difficult process that needs to be set within individual practice settings

and the broader team and system contexts that are also extremely varied and difficult to define.⁴ To accept the pressures and challenges of future registration and reaccreditation requirements, clinicians need to understand the advantages and disadvantages of a wide range of assessment approaches, methods and tools. They need to develop ways of demonstrating the quality of their clinical performance that are realistic, valid and reliable, and will be acceptable to legislative and employment authorities.

The 10th Cambridge Conference provides some useful guidelines to practitioners in its recent publications.³⁻¹² The medical educators involved in the conference had a common aim: to provide the best evidence on the complex issues investigated and to provide practical guidance that would apply to all clinicians, no matter their discipline, level of expertise or practice setting. A closer investigation of all the issues covered in these articles is highly recommended.

References

1. Bandaranayake R. Recertification: Is it about time? *Bull Kuwait Inst Med Spec* 2002;1:51-2.
2. Paget NS. Competence to practise: Whose responsibility? *Bull Kuwait Inst Med Spec* 2002;1:40-2.
3. Rethans J-J, Norcini JJ, Baron-Maldonado M, Blackmore D, Jolly BC, LaDuca T, et al. The relationship between competence and performance: implications for assessing practice performance. *Med Educ* 2002;36:901-9.
4. Farmer EA, Beard JD, Dauphinee WD, LaDuca T, Mann KV. Assessing the performance of doctors in teams and systems. *Med Educ* 2002;36:942-8.
5. Hays RB, Davies HA, Beard JD, Caldon LJM, Farmer EA, Finucane PM, et al. Selecting performance assessment methods for experienced physicians. *Med Educ* 2002;36:910-7.
6. Wilkinson TJ, Challis M, Hobma SO, Newble DI, Parboosingh JT, Sibbald GR, et al. The use of portfolios for assessment of the competence and performance of doctors in practice. *Med Educ* 2002;36:918-24.
7. Finucane PM, Barron SR, Davies HA, Handfield-Jones RS, Kaigas TM. Towards and acceptance of performance assessment. *Med Educ* 2002;36:959-64.
8. Schuwirth LWT, Southgate LH, Page GG, Paget NS, Lescop JM, Lew SR, et al. When enough is enough: a conceptual basis for fair and defensible practice performance assessment. *Med Educ* 2002;36:925-30.
9. Lew SR, Page GG, Schuwirth LWT, Baron-Maldonado M, Lescop JM, Paget NS, et al. Procedures for establishing defensible programmes for assessing practice performance. *Med Educ* 2002;36:936-41.
10. Melnick DE, Asch DA, Blackmore DE, Klass DJ, Norcini JJ. Conceptual challenges in tailoring physician performance assessment to individual practice. *Med Educ* 2002;36:931-5.
11. Handfield-Jones RS, Mann KV, Challis ME, Hobma SO, Klass DJ, McManus IC, et al. Linking assessment to learning: a new route to quality assurance in medical practice. *Med Educ* 2002;36:949-58.
12. Hays RB, Jolly BC, Caldon LJM, McCrorie P, McAvoy PA, McManus IC, et al. Is insight important? Measuring capacity to change performance. *Med Educ* 2002;36:965-71.
13. Fox RD, Bennett NL. Continuing medical education: learning and change: implications for continuing medical education. *Br Med J* 1998;316:466-8.