# Competence to practise: Whose responsibility?

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As health practitioners around the world face a more knowledgeable patient population and increased public and political pressure to demonstrate that the highest possible quality of patient care and health outcomes is being provided, issues of resources, time and responsibility to meet these challenges are being debated. This report highlights some of these concerns and refers to an international forum that typifies the current focus on these issues and the shift in emphasis that needs to be addressed at several levels within each health system.

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## Introduction

Trends in medical education are increasingly recognized as being international in nature, and it is not surprising that issues that relate to standards of clinical practice in medical and other health fields are also seen to be of an international nature. Proceedings of the Conference *Credentialing Physician Specialists: A World Perspective*[1] amply demonstrate this. This conference was held in Chicago in June 2000 and was jointly sponsored by The American Board of Medical Specialties and The Royal College of Physicians and Surgeons of Canada. It attracted wide representation from various regions of the world, and through presentations, discussions and workshops tackled many of the issues that relate to the initial credentialing of doctors and those procedures and processes that may assist in the provision of high quality clinical practice thereafter.

In this report three aspects of the current situation will be explored:

1. Is there sufficient understanding of the role of medical education in the maintenance and enhancement of clinical practice?
2. Is the maintenance and enhancement of practice standards a professional responsibility?
3. Is the maintenance and enhancement of practice standards a personal responsibility?

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## Is there sufficient understanding of the role of medical education in the maintenance and enhancement of clinical practice?

Two types of terminology are commonly used to indicate ongoing participation by health professionals in activities related to their clinical practice. Regarded by some now as perhaps a more traditional term, Continuing Medical Education (CME) has been variously defined to include or exclude specific types of educational activities, but is no longer seen in the very traditional way as being based on attendance at meetings, lectures and workshops. For various reasons, many related to a limiting interpretation of CME in defined contexts, Continuing Professional Development (CPD) has become increasingly used to indicate the full range of educational options open to clinicians to improve and enhance their clinical knowledge, skills and professional behaviour. In essence the intention and application of the two terms is the same, that is they are intended to indicate that there are a range of possible strategies available to practitioners to help them resolve their educational needs identified through contacts with patients and peers.

In these times of evidence-based medicine there has been an increased demand for best-evidence medical education as well. Proven

and accepted basic principles of lifelong learning within clinical practice contexts would include the well-established principles summarised below by Abrahamson et al. in their article "Continuing medical education for life":[2]

CME planning and program development should be based on needs assessment, including outcomes data.

- The goals of CME should include the development of skills necessary for lifelong learning, the exercise of clinical reasoning, an understanding of the decision making process, and specific content acquisition.
- The multiple goals of CME should be reinforced by the appropriate choice of learning methods.
- Incorporation of new instructional technologies for CME should be based on their intrinsic strengths as learning tools after thorough evaluation.
- Faculty development is important within CME and should include exposure to new learning methods (theory and application), enabling faculty to translate their content expertise into formats more appropriate to learners' needs.
- Educational activities should be supportive of and coordinated with the transition to evidence-based medicine.
- Professional and, whenever possible, interdisciplinary interaction should be given priority in CME programming.
- Outcomes-based measures of CME effectiveness and research should be introduced into the determinants of physicians' practice behaviours.

The first major systematic review of continuing medical education strategies by Davis et al. in 1995 stimulated considerable interest in both effective educational interventions and the types of change that these may produce.[3] Much more systematic research is now being completed in these areas. Allery, Owen and Robling have identified a vast range of reasons for clinicians changing their clinical practice. These they have classified into twelve main categories suggesting that educational strategies need to be multifaceted.[4] A great deal of other evidence is now available on the factors that influence the process of change and learning in clinical practice. Fox and colleagues have clearly demonstrated the characteristics that will influence the adoption on innovation and provide useful insight into the reasons that multiple learning resources may often be necessary.[5]

**Is the maintenance and enhancement of practice standards a professional responsibility?**

In the sense that the professional organizations that represent various professional groups have a role in the definition and assessment of standards of practice, the answer to this question must clearly be "Yes!". The concern, as far as the public and legislative authorities are concerned, is that health professionals remain competent to practise once they have received their initial and specialist qualifications and licence to practise. But competence is not an easily-defined generic ability as it is highly context dependent and does not lend itself easily to traditional forms of clinical assessment.[6] Defensible practice assessments must include: (a) defined standards of acceptable performance; (b) defined standards for acceptable data gathering procedures, largely related to sampling of behaviours and outcomes; and (c) a progressive system of data gathering that provides sufficient data to enable a valid and reliable judgment of practice performance to be made.

Around the world, Medical Colleges, Registration Boards, Medical Councils and other delegated Boards and Institutes such as the Kuwait Institute for Medical Specialization have accepted responsibility for assisting the educational procedures and processes that will support the provision of the highest standards of clinical practice and patient care. This is largely through supporting participation in and recognition of CME/CPD and quality assurance activities for practitioners, and where legislated authority has been given to the organization in ensuring that minimal levels of involvement and quality data gathering are adhered to as a condition for continuing practice.

Quality management has thus become related to the CME/CPD thrust. Wilson defines quality management as a term which embraces a range of functions and activities, including quality assurance, quality improvement, utilisation review and risk management.[7] Quality assurance, he maintains, refers to clinical performance related to explicit policies and standards, including interventions to correct deficiencies.

## Is the maintenance and enhancement of practice standards a personal responsibility?

The individual practitioner fits into the modern approach to high quality standards of patient care by accepting the educational philosophy that underpins effective CME/CPD. To do this there must be an acceptance of the need to recognize and address areas of practice that are highlighted by individual patient contacts as being those in which up-to-date knowledge and skill are critical. There must also be a willingness to understand the contribution of quality assurance and quality management to these processes. Qualifications and licence to practise only signal the beginning of a lifelong learning responsibility, as it is the activities undertaken after that which will indicate to other professionals and the public that the practitioner is competent to continue in practice.

## Conclusion

The trend has been international. The shift in emphasis from qualifications to practice to the demonstration of continuing competence to practice has been swift. Each individual practitioner must have a realistic perception of the ever-changing nature of his or her clinical practice and must accept the personal and professional responsibility that competence to practise implies. CME and CPD activities will only be effective if they relate to the real educational needs of the individual within a well defined and understood practice profile and are followed up by adequate monitoring of the quality of care and patient outcomes that result from the clinical care provided.

## References

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