

Competence Is a Habit

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CONCERNS ABOUT PATIENT SAFETY, GEOGRAPHIC variations in patient care unrelated to medical science, and poor “customer service” for patients have called into question the competence of physicians and the health care systems in which they work.¹⁻²² Many physicians are unhappy in practice, some feeling that their education has not prepared them to lead complex delivery systems; others, that their values are in conflict with their daily work.²³⁻²⁶

The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) have developed initiatives designed to improve graduate medical education by using educational outcome assessments as an accreditation tool (ACGME) and to strengthen the education of residents and practicing physicians by using assessments that demonstrate achievement of certain competencies (ABMS). Both organizations have agreed on 6 general competencies that frame and to some extent define the substance of medicine independent of specialty and delivery model. The 6 competencies are patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.²⁷ These competencies and attempts to assess them contribute to the medical profession's attempt to regulate itself.

Epstein and Hundert²⁸ contribute substantially to the discussion about the definition and assessment of physician competence. They require “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served.” This is the language of enlightened humanists and is refreshing.

Skill acquisition is a developmental process. Although insights may occur suddenly, competence develops over time and is nurtured by reflection on experiences. To use the language of Epstein and Hundert, it is a habit. A model of knowledge and skill acquisition that is simple, elegant, and relevant for medicine has been developed.^{29,30} The named stages of novice, advanced beginner, competent, proficient, expert,

and more recently, master add depth and breadth to conversations about competence and offer alternatives that reflect the developmental nature of competence. Coupled with the 6 general competencies, this model moves closer to the reality of how physicians learn. For each of the 6 competencies, there are rules that must be learned (novice, advanced beginner), and these rules must be applied in increasingly complex contexts (competent, proficient, expert, and master). Just as there are many levels of skill, so also there are many levels of lack of skill. For instance, gifted communicators may not know the rules necessary for clinical care, while rule-bound individuals may be incapable of functioning in the ambiguous situations that characterize much of medical practice. Residency education should systematically foster development from advanced beginner to competent. Correctly conducted, such development forms individuals into physicians who have the habit of competence. This area is of great interest to the ACGME, the 7800 residency programs in the United States,²⁷ and the 100 000 residents whose formation is being nurtured (or not) in these programs.

To be competent, residents must be involved enough to be accountable. In the Dreyfus model,²⁹ moving from advanced beginner to competent means less detachment and greater immersion in particular contexts. Medical schools, residency programs, and serious lifelong learners can benefit from understanding the Dreyfus model. Although life is not condensable, models can help with understanding life. Ideally, medical students progress from novice to advanced beginners; residents, from advanced beginners to competent. Dreyfus³⁰ characterizes this progress as moving from rule-based behaviors to context-based behaviors. As residents encounter particular patients and attempt to apply the correct rules, they are forced to select a perspective. Not all the details of a particular case are equally significant; some are more relevant than others. Learners select which details are relevant and in doing so select a perspective from which to view the case. “At this stage [competent], the result depends on the perspective adopted by the learner; the learner feels responsible for his or her choice.”

Two paths become apparent when a mistake is made. The first involves detachment and the creation of new rules that

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will prevent that mistake from recurring. The learner returns to the clinical arena with an ever-heavier rule book. That response, according to Dreyfus, arrests development in a cycle between advanced beginner and competent and back again. The second path, which leads up to and beyond competent, requires a more complete engagement of all human faculties. Involvement, not detachment, leads to accountability. Dreyfus suggests that it is necessary to feel bad to become competent. Somehow, feeling bad about mistakes and good about correct decisions provides the needed intimacy with context that leads to actually learning about the context and not just the rules. This path eventually leads to and reinforces accurate pattern recognition. It is not uncommon for good clinicians to recognize a disease within a few seconds or minutes and then to spend the next few minutes confirming or denying that initial impression. Rules become subliminal and are integrated with intuition. Tacit knowledge, knowledge that is accurate but hard to explain, emerges.

Epstein and Hundert also provide interesting insight about assessment. If competence is a developmental process and incorporates all 6 competencies, how can physicians assure society and themselves that a given individual is competent enough to practice unsupervised? What tests can assess a habit? The authors review current assessment methods as well as several newer and more comprehensive approaches to assessment. A comprehensive view of competence implies that multiple types of assessment are conducted over time to discern development. Measuring a habit implies measuring more than knowing the right answer: it implies assessing the 6 competencies by clinical decisions and actions that demonstrate harmonized skill sets over time. The product of such assessment is not as much a grade as a learning plan. The cycle of action, assessment, and modified action is familiar because it is the way physicians improve patient care and their own learning.

This enlightened approach of Epstein and Hundert does, however, imply a certain trust that gross and dangerous incompetence is detected and that those who are incompetent are removed from further consideration. The authors acknowledge the need to remove "those few trainees who are not expected to overcome their deficiencies." This dilemma is longstanding—should energies be spent on detecting and removing incompetent physicians or on across-the-board improvement? Professionalism demands an assessment system that does both. The power of peer assessment, gently introduced at the novice-advanced beginner stage and built in as an expectation through competent to proficient, expert, and master stages, offers the benefit of professional self-regulation and accountability. There is no other way.

Good medical schools facilitate the student's progress from novice to advanced beginner, good residency programs facilitate the resident's progress from advanced beginner to competent, and good lifelong learning relationships facilitate further development through the master level. What types of relationships are needed to foster accountability

among the individuals in these programs? Humans are designed for learning. Physicians need to have the integrity, motivation, and capacity to discern good learning and good health care but should be restless until they get it right. Epstein and Hundert have provided an important reminder that competence is a habit that engages all human faculties. By extension, the competence of the profession must engage all physicians. It is a professional habit.

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