

learning to be competent...  
getting to be a good doctor...  
making sure...

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Concurrent Plenary Session, AFMC, CFPC

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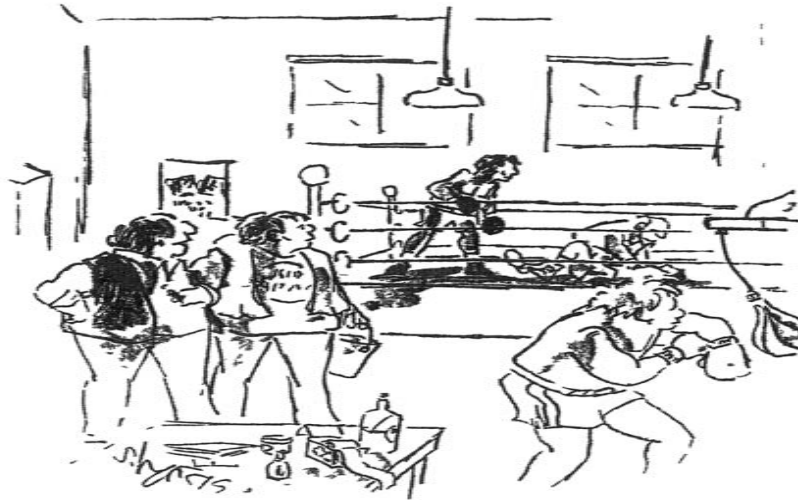
# Objectives

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- ❑ Some distinctions; *competence, competencies, and performance*
  - ❑ Incorporating patient/public input into working definition of *competence in practice...a new perspective!*
  - ❑ Learning *competencies* is necessary, but not sufficient, to reach *competence in practice*
  - ❑ Introducing a practical formula to ensure *competence in practice* (CanMeds+)
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“He looks very promising—but lets see how he does on the written test”

(New Yorker Magazine)



*“He looks very promising—but let’s see how he does on the written test.”*

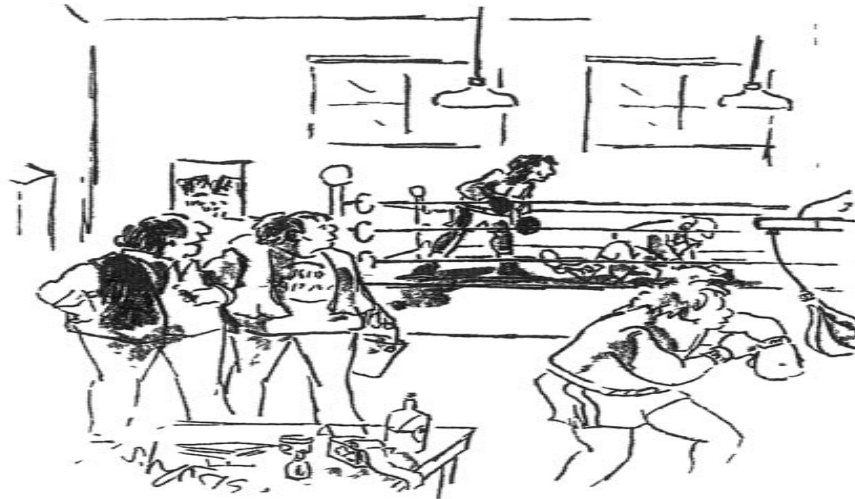
# Definitions; Competencies, Competence and Performance

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- ❑ Linguistic distinctions are important
  - ❑ *Common language* ...what does it mean to be “competent”?
  - ❑ *Educational language* ...what does it mean to be competent?
  - ❑ Where performance fits into the picture
  - ❑ What is “performatance”?
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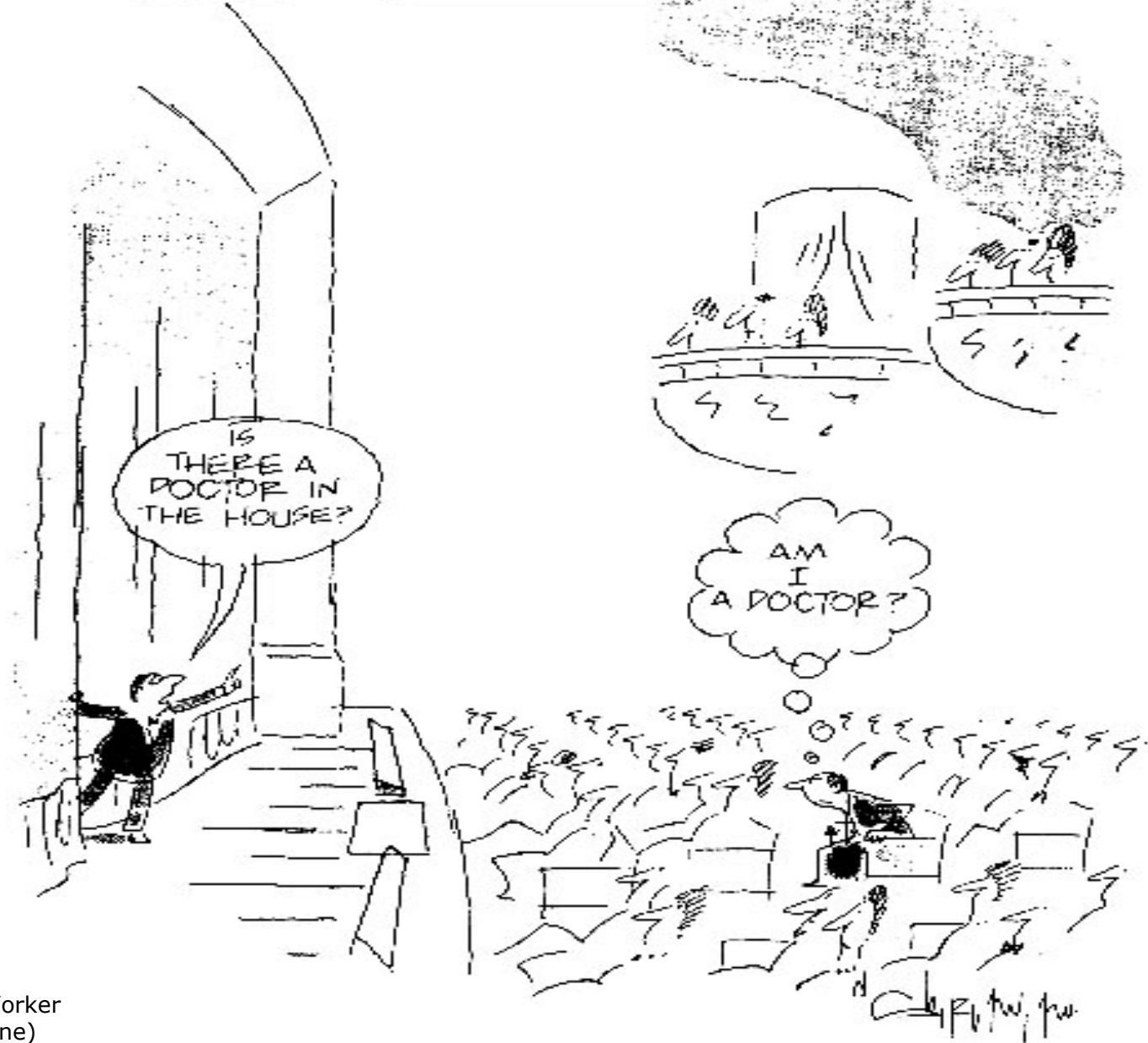
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*“He looks very promising—but let’s see how he does on the written test.”*

MOMENT OF TRUTH



(New Yorker Magazine)

# Objective 2

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- A paradigm shift; how public expectations affect the manner in which the profession “implements’ competence.
  - Aspect of social accountability
  - Return to EFPO roots
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# Transforming medical culture

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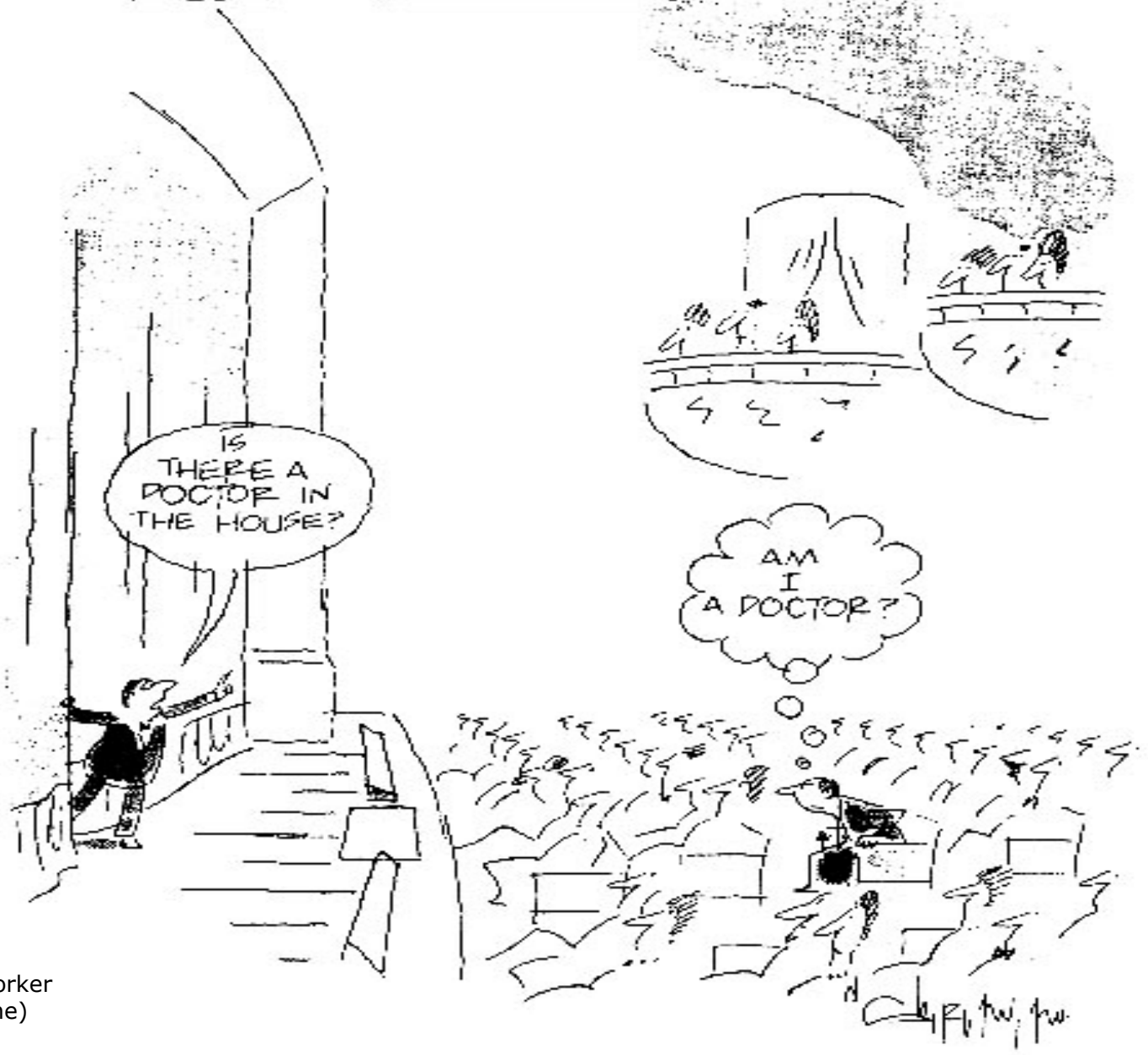
- ❑ Public expectation drives professional behaviour
  - ❑ Patients expect “results”
  - ❑ Public expects “good outcomes” (eg safety and teamwork)
  - ❑ New level of “accountability”
  - ❑ The concept “trust me I’m a doctor” is replaced by “show me that I can trust you!”
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# This is a big change

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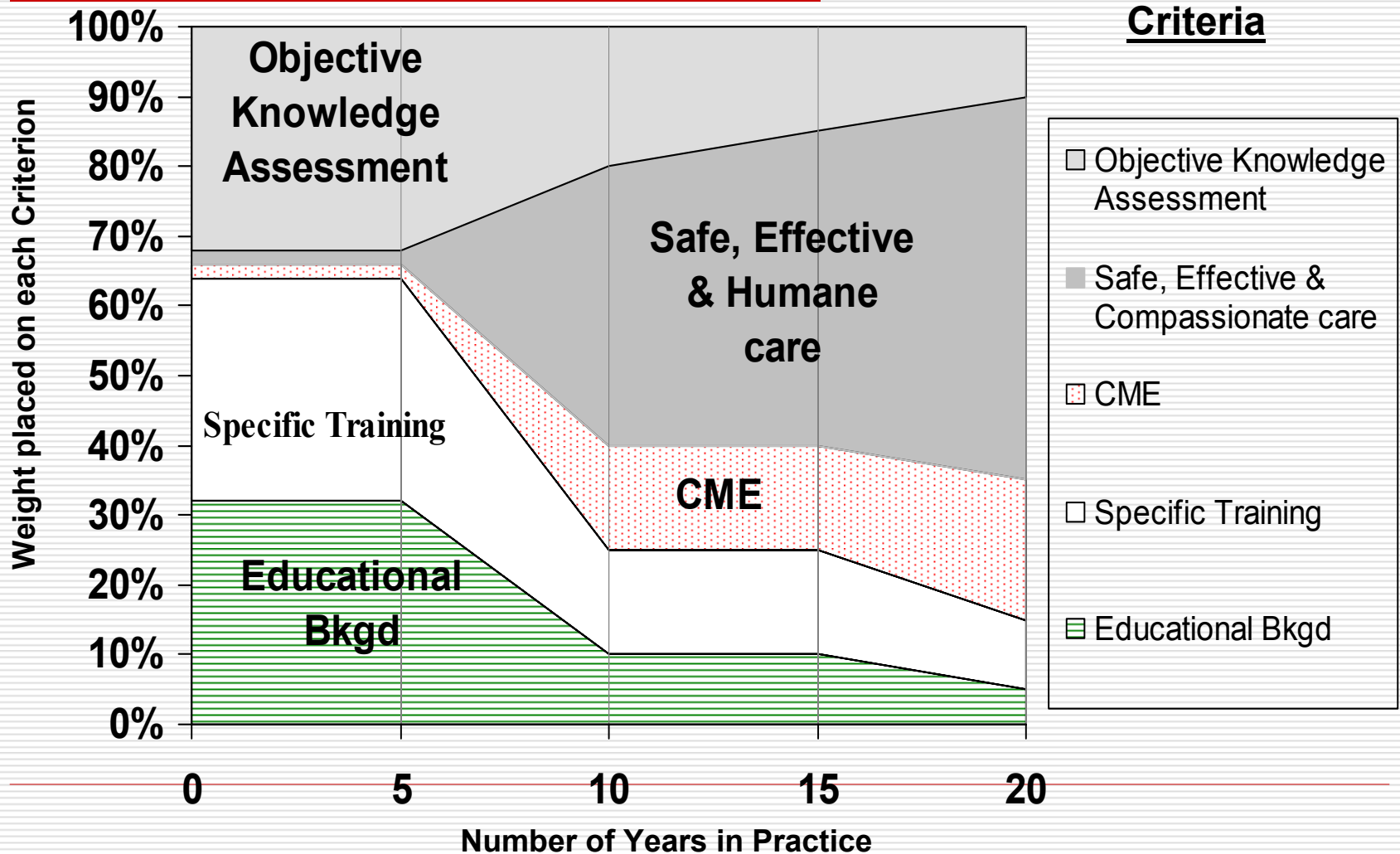
- 20<sup>th</sup> Century era of Professional “autonomy” in defining what a good doctor is (ideals of competence-knowledge skills). These are the attributes (defined by the profession) that are predicted to get good results in practice
  - This concept is being challenged
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MOMENT OF TRUTH



(New Yorker Magazine)

# Sources of evidence of competence and change in availability and relative value of evidence over time



# The changing face of competence

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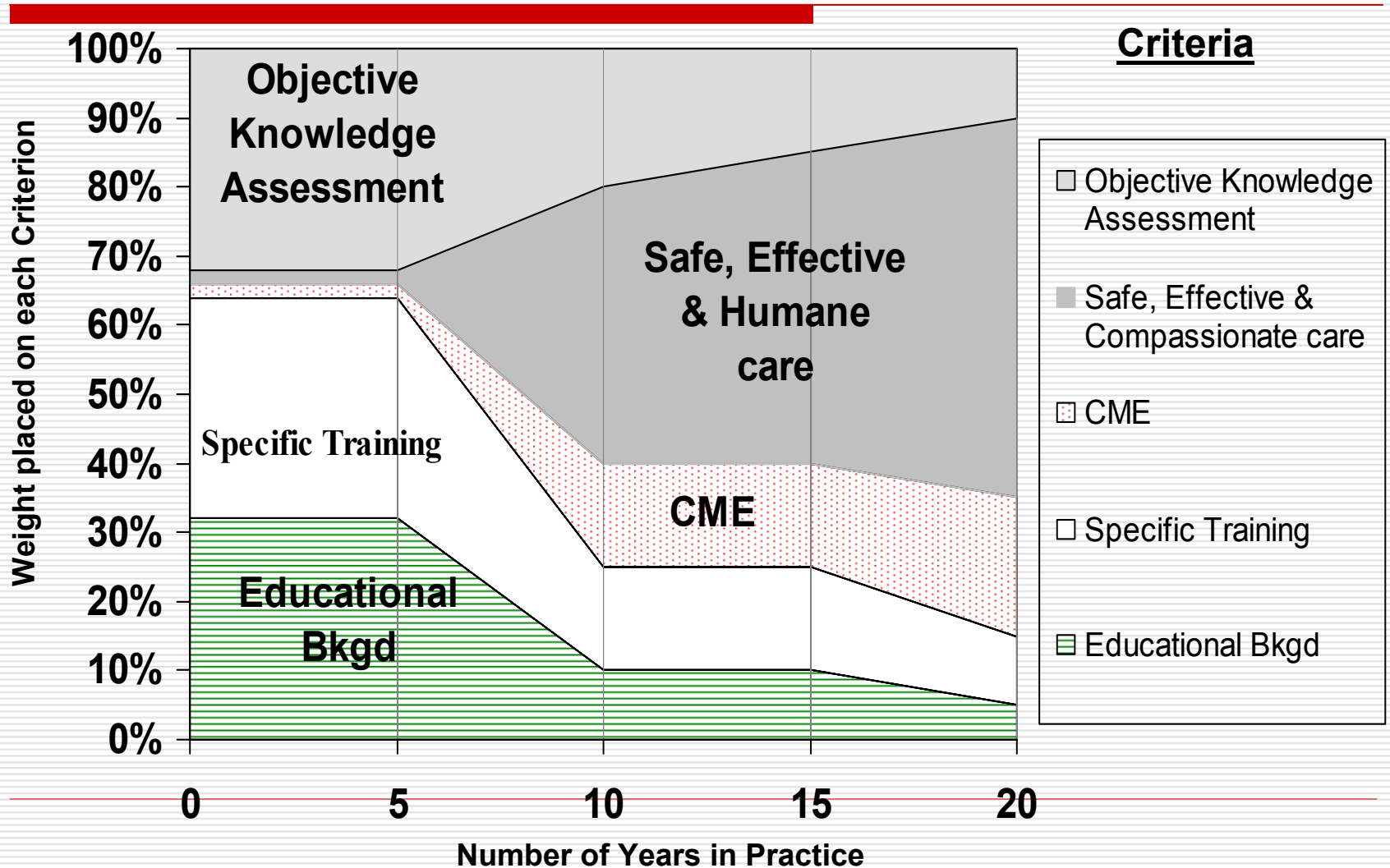
- Early in continuum...in the absence of direct evidence from practice, and in the absence of “a practice” “competencies” loom large
  - Later, perception of competence is a function of quality of performance measured directly, grounded in “a practice”
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# Weakness in connecting action to result

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- We are still at an early stage of understanding the relationship between clinical processes and observable clinical outcomes.
  - Even in practice, the “attribution” of competence needs to be tentative
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# Sources of evidence of competence and change in relative value of evidence over time



# Among School Children

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**O chestnut-tree great rooted blossomer,  
Are you the leaf, the blossom or the bole?  
O body swayed to music, O brightening glance,  
How can we know the dancer from the dance?**

**W. B. Yeats ( poet and school inspector!)**

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# Objective 3: Do competencies add up to competence?

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- ❑ Question valid through the continuum
  - ❑ Where does competence reside?
    - Competence as a set of attributes vs
    - Competence as a set of roles vs
    - Competence as a relationship between abilities in a person and tasks needing to be done; competence needs an object!
    - The whole is greater than the sum of its parts
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# Objective 4

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- Constructing a *situational* curriculum
    - Move beyond restrictive dependence on attributional competencies
    - Adopt “situational” view of competence: competence is a relational property
    - A statement of competence requires defining characteristics of both individual and situations; there is more variance in the situations than in the doctors
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# To speak of individual competence

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- ❑ Requires understanding of the situation...competent at what?
  - ❑ the determination of success depends upon the actual scope of practice.
  - ❑ For curriculum and assessment, the important variables are *the situations that challenge the learner*
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# Challenges of situational approach

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- ❑ The only elements of “the situation” we have delineated so far are variations on “the disease that has the patient”
  - ❑ But Osler said, more important to “define the patient who has the disease” and also....
  - ❑ Define the “persons, problems and places” (the situations”) that constitute practice
  - ❑ *A ‘practice’ in medicine is defined as a series of encounters between a doctor (and partners), with patients (and families) who have problems in particular places*
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# Challenges of situational approach

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- So far, we have spent most of our time wrestling narrowly with the diseases that patients have, and the “competencies’ needed to deal with them
  - Now need to move to define models of practice which incorporate the other elements, *patients with problems in places* to specify what competence means
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# How can we construct competence in the absence of “a practice”?

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- Need to paint broad scenarios or practice models (relatively undifferentiated)
    - Base the models on epidemiology of situations
    - Examples...Step 3 of USMLE, Rand Corporation Studies of practice..
  - Base curriculum and assessment on these models
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# Hopeful signs

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- Emphasis in practice related activities to categories like “chronic illness”, “behavioural problems”, “acute reversible problems”
  - Recognition of the “team” requirements in practice
  - So far little penetration into curricula at medical school or PG levels....need some activism!!
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# The changing view of assessment

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- Admiring the doctor at work....

What's wrong with this picture?



# The changing locus of assessment and competence

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- Admiring the doctor at work



- Admiring the work of the doctor, including the nurses and patient's perspective

