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Competency-based Advancement: Risky Business

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The Accreditation Council for Graduate Medical Education Outcomes Project has successfully initiated a shift in focus on residency education from process measures to educational outcomes. The next phase of this transformation is the development of clear milestones to mark incremental steps toward competency. The development of these milestones for internal medicine is an important and challenging task that has been undertaken by a group of educators and residents facilitated by the American Board of Internal Medicine. Representatives from multiple key stakeholder groups are participating in this initiative, including, but not limited to, the Alliance for Academic Internal Medicine, the Association of Program Directors in Internal Medicine, the Society of General Internal Medicine, and the American College of Physicians. This project will advance our understanding of the incremental achievement of competency in the many areas of professional development and inform the even more difficult next task of developing reliable tools to assess a resident's progress toward competency.[1]

If successful, this initiative will vastly improve current methods of evaluating residency programs and individual practitioners. With milestones and assessment tools in place, the Accreditation Council for Graduate Medical Education will measure the success of residency programs by the growth of their residents, rather than by the program's ability to conform to process rules.[2] Likewise, with milestones and assessment tools in place, the American Board of Internal Medicine will certify individual practitioners with confidence that they have achieved competency not just in medical knowledge, the only area currently objectively assessed, but in the 5 remaining core competencies. We, the authors, fully support both of these objectives.

We believe there will be significant benefits to individual residents and program directors. Residents will be empowered with a clear set of expectations that will allow monitoring of their own progress, as well as establishing and pursuing personal learning goals. Program directors will be able to monitor residents' progress, identify those who are not reaching goals on schedule, and plan timely remediation.

Competency-based assessment also will allow identification of residents who are progressing more rapidly than expected.[3,4] We believe the choices we make about these "advanced" residents are critical and carry inherent risks that have not received sufficient attention. Some have suggested that once measurable competency is achieved, it makes sense for the resident to leave the core program and move on to the next step of their career, whether that is fellowship or practice. Advancement would be based not on the passage of an arbitrary period of time—3 years in the case of internal medicine—but on the achievement of competency.[5] Though this concept is initially compelling, we urge caution in moving training in this direction.[6] This approach ignores important realities that, if unaddressed,

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could have significant deleterious consequences to all physicians-in-training.

RESIDENCY AS A DELICATE LEARNING COMMUNITY

We are concerned that the "one-resident-at-a-time" focus of competency-based training ignores the reality that a residency program is a delicate ecosystem where residents depend heavily on their peers for growth and learning. This supportive social learning community struggles, advances, and grows together, and mutually fosters the individual transition from student to physician for each member of the group. The high standards of the residency program, and of the profession, are embodied by the top residents in the program. Their example inspires and cultivates the growth of all residents in the program. In addition to sharing their knowledge in team-based conferences such as morning report and noon conference, these elite residents are role models for the embodiment of professionalism, the delivery of patient care, the effectiveness of interpersonal skills, and the importance of practice-based learning. Removal of the best peer role models, those residents who will be deemed competent earliest and encouraged by a system of competency-based advancement to leave the core residency early, will substantially reduce the educational environment for all residents.

Allowing residents to become single-mindedly focused on their individual competency and advancement encourages them to lose sight of their responsibility to the rest of the learning community. When we recite the Hippocratic Oath, we promise "to consider dear to me . . . him who taught me this art; to look upon his children as my own brothers, to teach them this art."[6] The Accreditation Council for Graduate Medical Education declares that one of the central tenets of professionalism is that "residents are expected to demonstrate accountability to patients, society and the profession."[7] Yet the hidden curricular message of "early graduation based on competency" is that residents should prioritize self-gain above their obligations to their peers, a lesson contradictory to both the profession's and the Accreditation Council for Graduate Medical Education's central tenets. We cannot allow residency education to be reduced to a linear gauntlet of learning stations made up of patient experiences and faculty evaluators that residents run through at different speeds until crossing the finish line. Rather, a residency program is a complex, supportive group dynamic where the interactions of the group create the moments of critical socialization and reflection that foster the many intangibles in the development of the physician. Our system of training must instill in our best residents a deep sense of dedication to their colleagues and to the good of the many before the good of the few. Commitment of the residents to each other, and to the profession, distinguishes great residency programs.

PERSPECTIVES VIEWPOINTS

- Development of residency education competency milestones for internal medicine has been undertaken by ABIM and key stakeholders such as AAIM, APDIM, SGIM, and ACP.
- Residents will be empowered with a clear set of expectations, and program directors will be able to monitor residents' progress, identify those who are not reaching goals on schedule, and plan timely remediation.
- However, advancement based not on time but on the achievement of competency ignores important realities that could have significant deleterious consequences.

HONEST ACCOUNTABILITY FOR THAT WHICH IS MEASURABLE, AND THAT WHICH IS NOT

Many of the beliefs that underpin competency-based advancement assume that we are able to accurately measure the acquisition of all important competencies. Yet the development of adequate and reliable assessment tools for even the most basic competencies is in the earliest of stages. We believe the central educational experience of residency is a dedicated learner and a dedicated teacher at a patient's bedside. Direct observation by the master teacher is the cornerstone of evaluation in this setting and leans equally on measurable components of competency and subjective judgments by the observer. Even under the best of circumstances, we believe many of the most crucial attributes that residents must acquire to become fully competent independent practitioners will prove especially difficult, if not impossible, to measure. Examples include judgment under uncertainty, clinical intuition, pattern recognition, recognition of diagnostic thinking errors, anticipatory thinking, well-practiced rapid response actions, calm self-assurance, calm under pressure, decisiveness, leadership, and the ability to mentor. Yet a system that enables early graduation hinges on objective criteria, and we fear that a process that focuses only on the measurable will lose sight of these less measurable, but no less critical, attributes that are often among the last to mature.

INTEGRITY OF TEACHING SERVICES

Although we seek to strike a balance between service and learning, Osler's educational environment is made

possible only by providing service in the care of patients. Residency programs have been entrusted with establishing teaching services to meet this end, and this commitment to staffing a residency service is fixed: Because patient needs are constant, the service cannot be sometimes staffed and sometimes not. The current model of training enables a program director to assess resources to ensure staffing of the medical service that is central to the residents' educational needs, as well as the patients' clinical needs. The proposal for early graduation based on competence would transform a fixed system into a fluid system, with intermittent periods of non-staffing proportional to the volume of residents who leave the program early.

Educating the physician requires emotional engagement that is only accomplished when residents develop authentic personal accountability for their patients; a system that teaches that accountability is contingent on available residents detracts from this message. Teaching services must be constructed such that the implicit message is to encourage residents' sense of ownership of their patients, as well as allowing for incremental autonomy up to and including complete independence. Only on services where residents are consistently present and engaged with all other members of the health care team can the necessary levels of responsibility, accountability, and autonomy be maintained. Once a system has been fully calibrated and staffed to function without residents, residents begin to assume the mentality of visitors rather than full participants.

An alternative to variable staffing on core teaching services would be to maintain full staffing on these services at all times to ensure their integrity by moving remaining residents from elective to core experiences to compensate for residents who have advanced early. This would sacrifice educational balance for the remaining residents, denying them career-defining clinical elective experiences or research opportunities. The good of the many residents and the learning environment of the program would be sacrificed for the benefit of the few.

THE PITFALLS OF EARLY TRANSITION TO FELLOWSHIP: ACCOUNTABILITY TO ALL SUBSPECIALTIES AND TO FAIRNESS IN CAREER DECISION-MAKING

Competency-based advancement will allow some residents to begin fellowship after only 2 years of core internal medicine training. We acknowledge that well-established milestones and assessment tools may allow identification of a small number of residents who achieve competency after only 2 years. Practically, however, this determination could not be made until well into the second postgraduate year, certainly no more than 6 months before the proposed advancement to fellowship would occur. The current fellowship application and selection process requires applicants to interview 14 to 18 months before their fellowship begins and fills all slots more than 1 year in advance. Competency-based advancement to fellowship after 2 years is not compatible with this application/selection paradigm, unless fellowship programs would be willing to interview and select applicants during their second postgraduate year without any assurance that they would be ready to advance at the end of their second postgraduate year.

Allowing early transition to fellowship may have additional unintended consequences. Residents considering competitive subspecialty careers will quickly learn that their best chance to enter fellowship is to pursue early advancement and to focus elective and research experiences (eg, cardiology or gastroenterology) to the exclusion of exploring less-competitive generalist or subspecialty careers. This will lead to premature career decision closure. Further, because of the timing and logistics of creating a match, it is likely that accelerated residents will only be able to move into fellowships at their "home" institution. This will quickly disadvantage community hospital programs that do not have the spectrum of fellowships.

Finally, the consequences would be dire for residents selected for early advancement who suddenly had to cancel all of their plans because they did not achieve competency. Likewise, the fellowship would have to deal with an unfilled position very late in the process. Realizing this, core residency programs might feel pressure to pass on less-than-competent residents to the next level of training simply because plans had been made. This would not be in the best interests of either the candidate or the fellowship.

CONCLUSIONS

We applaud and support the movement to competency-based education based on developmental milestones and reliable methods of assessment. We believe that graduate medical education programs should be judged on the quality of their educational outcomes, and that individual practitioners should be certified on the basis of achievement of broad-based competency in their discipline.

At the same time we urge caution regarding implementation of a system of advancement that encourages residents to leave core training and move on to the next step as soon as minimum competency is established. We believe such a system will:

- disrupt the delicate learning community of residency programs;
- encourage residents to consider their own interests to the exclusion of those of their colleagues;

- reduce core residency programs to the pursuit of adequacy rather than excellence; and
- threaten the integrity of teaching services as they currently exist.

We believe the academic internal medicine community can encourage individualized learning so that residents are always pushing themselves beyond their comfort zone, always increasing their knowledge and skills. Residency programs and program directors should not be satisfied with achieving adequacy for all residents. There is always more to learn and always a higher level to aspire to, even after the agreed on minimum bar has been cleared. Indeed, the American Board of Internal Medicine's focus on ongoing competency through the maintenance of the certification process emphasizes that there is no end point to competence. A premature closure to residency training would seem to send a contradictory message to our future physicians. Time spent in the core program after the achievement of minimum competency is time well spent in pursuit of excellence, not time wasted.

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