Postgraduate Medical Education

Competence Committee: PROCESS AND PROCEDURES IN DECISION MAKING

Suggested Guidelines

Preamble:

This document outlines a set of guiding principles, processes and procedures, which programs can use as a resource as they transition to Competence by Design. Programs can adapt this material to their unique contexts provided they promote the principles of CBD, as outlined in this document.

Principles

The roles, responsibilities and activities of a Competence Committee are guided by the following principles.

1. The Competence Committee is a subcommittee of the Residency Training Committee (RTC).

2. Committee members should have a shared mental model of the purpose and nature of the group's work and be committed to performance goals. The competence committee allows for an informed group decision-making process, where patterns of performance can be collated to reveal a broad picture of a resident's progression toward competence.

3. The Competence Committee has authority to make decisions on individual EPA achievement. The Competence Committee presents status change determinations as recommendations to the RTC. The RTC ratifies these status recommendations.

4. Committee work is guided by the national specialty competency framework, including specialty-specific milestones and EPAs by stage, as established by the specialty committee as well as the relevant university and Royal College assessment policies.

5. The Competence Committee is expected to exercise judgment in making EPA decisions and status recommendations: i.e., they will use Specialty defined EPAs and the expected number of observations as a guideline, but they are not bound to a specific number, context or type of assessments. The key is that the committee must feel it has adequate information on the EPAs to make holistic judgments on the progress of the resident. The wisdom of the Competence Committee is considered the gold standard for EPA decisions and resident status recommendations.

6. In addition to utilizing milestones and EPAs, Committee discussions will be based on all of the assessment tools and relevant evidence from the program.

7. All committee discussions are strictly confidential and only shared on a professional need-to-know basis. This principle is equivalent to patient confidentiality in clinical medicine.

8. Committee decisions must be based on the evidence available in the resident's Portfolio at the time of the committee meeting. Individual committee member experience can only be introduced with appropriate documentation within the Portfolio. Committee members must make every attempt to avoid the introduction of hearsay into the deliberations. Discussions are informed only by the evidence available in the Portfolio.

9. The functioning of the Competence Committee, including its decision-making processes, will be a focus of accreditation surveys in the future.

10. Individual residents, or their Academic Advisor/Coach (for programs that implement this approach), may be invited to discuss their progress with the members of the Competence Committee.

11. Committee work must be timely in order to ensure fairness and appropriate sequencing of training experiences.

12. Competence Committees operate with a growth mindset. This means that Committee work is done in a spirit of supporting each resident to achieve their own individual progression of competence.

13. Competence Committees have a responsibility to make decisions in the spirit of protecting patients from harm, including weighing a residents' progress in terms of what they can safely be entrusted to perform with indirect supervision. Some Committee discussions must be shared to provide focused support and guidance for residents. This principle is equivalent to patient handover in clinical medicine.

14. Competence Committees, on an exceptional basis, have the option to identify residents who are eligible for an accelerated learning pathway provided that all requirements are met.

15. Competence Committees, on an exceptional basis and after due process, have the responsibility to identify residents who have met the predefined category of *failure to progress*.

16. Competence Committee decisions/recommendations and their associated rationales must be documented within the resident's Portfolio.

Competence Committee Process and Procedures

1. **Agenda Development**: Residents are selected for the agenda of a planned Competence Committee meeting by the Chair of the Committee, the Program Director or their delegate. This must occur in advance of the Committee meeting to provide reviewers adequate time to prepare for the meeting.

2. **Frequency**: Every resident in the program must be discussed a minimum of twice per year. However, greater frequency of monitoring is desirable.

3. **Quorum:** There should be at least 50% attendance from the members of the Competence Committee to achieve quorum, with an absolute minimum of 3 clinical supervisors for smaller Committees. The program director (or 'delegate' in large programs) should be present for all discussions.

4. **Selection:** Residents may be selected for Competence Committee review based on any one of the following criteria:

    - Regularly timed review;
    - A concern has been flagged on one or more completed assessments;
    - Completion of stage requirements and eligible for promotion or completion of training;
    - Requirement to determine readiness for the Royal College exam;
    - Where there appears to be a significant delay in the resident's progress or academic performance; or
    - Where there appears to be a significant acceleration in the resident's progress.

5. **Primary Reviewer**: Each resident scheduled for review at a Competence Committee meeting is assigned to a designated primary reviewer. The primary reviewer is responsible for completing a detailed review of the progress of the assigned resident(s) based on evidence from completed observations and other assessments or reflections included within the Portfolio. The primary

reviewer considers the resident's recent progress, identifies patterns of performance from the observations, including numerical data and comments, as well as any other valid sources of data (e.g. in-training OSCE performance). At the meeting, the primary reviewer provides a succinct synthesis and impression of the trainee's progress to the other Competence Committee members. A written summary is helpful. After discussion, the primary reviewer proposes a formal motion on that trainee's status going forward.

6. **Secondary reviewer**s: All other committee members are responsible for reviewing all trainees on the agenda as secondary reviewers. All secondary reviewers are required to come prepared to discuss all trainees' progress.

7. **Recommended Committee Procedures**:

- The Chair welcomes members and orients all present to the agenda and the decisions to be made.
- The Chair reminds members regarding the confidentiality of the proceedings.
- The Chair asks members to declare any conflicts of interest. Conflict of interest should be taken into account, for example members that may be involved in future fellowship selection or job opportunities for the resident may potentially have a conflict and wish to excuse themselves from the discussion.
- Each trainee is considered in turn, with the primary reviewer presenting their synthesis, displaying relevant reports from the Portfolio, and sharing important quotes from any observational comments about the trainee. The primary reviewers are encouraged to have a written summary to share with competence committee members. The primary reviewer concludes by proposing a *status* for the trainee going forward in the program.
- If seconded by another committee member, all members are invited to discuss the motion.
- The Chair will call a vote on the proposed recommendation of the primary reviewer.
- If the recommendation of the primary reviewer is not seconded or the motion does not achieve a majority of votes, the Chair will then request another motion regarding the trainee.
- This will continue until a majority of Competence Committee members supports a status motion. It is recommended that the decision be unanimous, particularly if there are small numbers of people on the committee. However, when consensus is not achievable, there must be a minimum of 75% agreement for those in attendance. If 75% (i.e., < 100% is achieved), the case should be flagged for discussion at the Residency Training Committee. The rationale for the recommendation must be documented in the resident's Portfolio.
- Status recommendations can only be deferred if additional information is required. However, this deferred recommendation must be revisited within 4 weeks.
- A status recommendation is recorded in the trainee's Portfolio and is communicated to the RTC for ratification.
- Once ratified by the RTC, a status decision is communicated to the trainee and recorded in the committee's archives.
- Competence Committees should flag EPAs or Milestones which are inconsistently met at a defined stage for a cohort of residents to the Program Director. The Program Director, in turn, and

in conjunction with the Residency Training Committee, should alert the Specialty Committee for a discussion of the appropriateness and expected time of completion of those EPAs.

8. **Post Competence Committee meetings:** As soon as possible after the committee decision, the Program Director, Academic Advisor/Coach, or other appropriate delegate will discuss the decision of the Competence Committee with the trainee. Changes to the trainee's learning plan, assessments, or rotation schedule will be developed with the resident and implemented as soon as feasible, if applicable.

9. **Appeal Process:** There must be an appeal mechanism in place for the situation where a resident does not agree with the decision of the Competence Committee. Please refer to the PGME guide on assessment.

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Status Recommendations: Competence committee members will discuss the status recommendation and vote on the resident's official status in the program. (i.e., progressing as expected, not progressing as expected, progress is accelerated, failure to progress or inactive) and any resident action required (i.e., monitor, modify or promote).

Resident Status	Resident Action	PG Dean Approval/Awareness
Progressing as Expected	Monitor Resident	Not Required
	Modify Learning Plan Suggested focus on EPA observations or RTE	Not Required
	Promote Resident to next stage (2, 3, 4)	Not Required
	Promote Resident to Exam Eligible	Awareness
	Promote Resident to RC Certification Eligible	Required
Not Progressing as Expected	Modify Learning Plan Additional Focus on EPA observations or RTE	Not Required
	Formal Remediation	Required
Progress is Accelerated	Modify Learning Plan Modify Required EPA observations or RTE	Awareness
	Promote Resident to next stage (2, 3, 4)	Awareness
	Promote Resident to Exam Eligible	Awareness
	Promote Resident to RC Certification Eligible	Required
Failure to Progress	Modify Learning Plan Additional focus on EPA observations or RTE	Awareness
	Formal Remediation	Required
	Withdraw Training	Required
Inactive	Monitor Resident (i.e. expected return - parental leave, sick leave, etc.)	Required
	Withdraw Training	Required

Considerations:

There are also two significant issues in competence committee work: groupthink and group cognitive errors and bias. The website Mindtools has a useful definition for groupthink: Group think is a phenomenon that occurs when the desire for group consensus overrides people's common sense desire to present alternatives, critique a position, or express an unpopular opinion." Here, the desire for group cohesion effectively drives out good decision-making and problem solving." (See Mindtools: https://www.mindtools.com/pages/article/newLDR_82.htm) Risks for groupthink are the presence of a strong, dominating leader, high levels of group cohesion, and the group experiencing or feeling strong pressure from others to make a good decision. It is not hard to see how this can happen in competence committees. Below are symptoms of groupthink adapted from Mindtools.

Symptoms of Groupthink:

1. Rationalization: This is when team members convince themselves that despite evidence to the contrary, the decision or alternative being presented is the best one. "Those other people don't agree with us because they haven't researched the problem as extensively as we have or know the resident as well as we do."

2. Peer Pressure: When a team member expresses an opposing opinion, or questions the rationale behind a decision, the rest of the team members work together to pressure or penalize that person into compliance.
"Well if you really feel that we're making a mistake about this resident you can always leave the CC."

3. Complacency: After a few successes, the group begins to feel like any decision they make is the right one because there is no disagreement from any source. "Our track record speaks for itself. We have never misjudged a resident's progress and development."

4. Moral High Ground: Each member of the group views him or herself as moral. The combination of moral minds is therefore thought not to be likely to make a poor or immoral decision. When morality is used as a basis for decision-making, the pressure to conform is even greater because no individual wants to be perceived as immoral. "We all know what is right and wrong in medicine, and this is definitely the right thing to do with this resident."

5. Stereotyping: As the group members become more uniform in their views, they begin to see outsiders as possessing a different and inferior set of morals and characteristics from themselves. These perceived negative characteristics are then used to discredit the opposition. "Nurses will find any excuse to complain about residents, even when the facts are clear they are wrong about a resident."

6. Censorship: Members censor their opinions in order to conform. "If everyone else agrees then my thoughts to the contrary must be wrong." Information that is gathered is censored so that it also conforms to, or supports the chosen decision or alternative. "Don't listen to that nonsense; they don't have a clue about what is really going on."

7. Illusion of Unanimity; Because no one speaks out, everyone in the group feels the group's decision is unanimous. This is what feeds the groupthink and causes it to spiral out of control. "I see we all agree on this resident so the decision not to place the resident on remediation is final.

Rater bias and error is common even in groups. This table from Dickey[1] and colleagues provides a list of possible rating errors and bias in groups.

Bias	Definition	Example
Anchoring	Holding on to an initial observation or opinion and not acknowledging changes.	A poor patient history and physical examination performance by someone in TTD may ‘‘anchor’’ in an attending’s mind and result in assigning an assessment that is too low later in residency.
Availability	Giving preference to data that are more recent or more memorable.	In a CC meeting, an attending may give more weight to his or her own observations of a resident than to observations of attendings from other rotations.
Bandwagon	Believing things because others do.	Faculty member mentions an insignificant mishap by a resident, and other members join in and mention other minor mishaps that would not have been described otherwise.
Confirmation	Focusing on data that confirm an opinion and overlooking evidence that refutes it.	Faculty member with a negative opinion of a resident recalls a single instance of prescribing error and neglects the 99% of prescriptions written correctly.
Groupthink	Judgment influenced by overreliance on consensus.	CC members may choose not to challenge a stage determination in order to preserve group camaraderie. Some committee members, such as senior faculty or the program director, may exert undue influence over other committee members.
Overconfidence	Having greater faith in one’s ability to make a judgment than is justified.	CC members may have too little data to determine a recommendation, yet feel comfortable making a decision.

Selection	Relying on partial information that is not truly random or representative.	A faculty member may meet the program director by chance in the hallway and describe a resident's minor breach of professionalism. Had he or she not met the program director, the story might not have been relayed. Now the program director may place too much emphasis on the event during CC discussions.
Visceral	Judgment influenced by emotions rather than objective data.	A "favored" or personally attractive resident may receive higher assessment than another resident for a similar performance.

TTD: Transition to Discipline
CC: Competence Committee

1. Dickey CC, Thomas C, Feroze U, Nakshabandi F, Cannon B. Cognitive Demands and Bias: Challenges Facing Competency Committees. J Grad Med Educ. 2017 Apr;9(2):162-164.

TABLE 1
Group Decision Making: Aspects of Groups That Influence Their Outcomes

Concept Relevant to Group Decision Making	Key Aspects Based on the Literature
Member characteristics	• Heterogeneous groups perform better than homogeneous.[27]
Group size	• With defined procedures, large groups tend to outperform small groups.[21,27] However, in large groups, members may go along with group opinion rather than think their own opinion (social loafing).[34]
Group understanding of its work	• A shared mental model is a shared understanding of a group's work that improves group performance.[35] • Group cohesion and insulation are antecedents of groupthink.[36] • Insulated groups consider fewer alternatives and make poorer decisions than uninsulated groups.[37] • Default position at the start of group work strongly influences outcomes.[22] • Perception of group work as an intellective task (correct answer that group members can show others) versus a judgmental task (absence of a correct answer; relies on judgment).[38]
Group leader role	• Group leader or more senior, powerful, or confident members can dominate decision making.[5] • Group leader influences degree to which members will seek and hear new information.[39]
Information-sharing procedures	• More information sharing leads groups to better decisions.[18] • Information sharing enhanced with structured discussion process that invites elaboration. • Sharing written information versus just relying on group member memory increases chances of information being incorporated into group decisions.[40] • Social pressure is minimized through structured voting and acknowledgement of diverse opinions.[5] • Information that all group members know (shared information) carries more weight than information that only 1 or a few members know (unshared information). Group processes can be structured to invite diverse opinions and comments from all members.[5,41]
Effects of time pressures	• Time pressures lead to lower-quality decisions.[22,42] • New or unshared information is more likely to emerge with longer discussions.[22]

TABLE 2
Recommendations for Clinical Competency Committees Based on Study Findings and Literature on Group Decision Making

Topic	Recommendation for Clinical Competency Committees
Group Composition	
Membership	Committees should include members selected or assigned to represent disparate opinions.[41,62,63]
	Committees should include new or rotating members, in addition to more experienced members, and nonphysicians, to ensure novel perspectives.[64]
Size	Larger committees outperform smaller, as long as all members acquire relevant knowledge and demonstrate commitment.[15,24,27]
Group Process	
Group understanding of its work	Committee members should have a shared mental model of the purpose and nature of the group's work and be committed to performance goals;[38,53,65] members also need a shared understanding of resident performance expectations based on milestones.
Information sharing	Sharing more information and sharing unique information that is not known to other committee members improves the group's knowledge, increases cohesiveness, and leads members to feel better about their work.[19,66]
Sharing written information	Sharing assessment data and written information, rather than just relying on committee members' memory, increases information sharing.[40]
Structuring discussions	Structured group discussions (versus unstructured) facilitate information sharing that increases the likelihood of relevant information becoming available to group members. Structure can entail soliciting multiple perspectives, members' speaking in a predetermined order, and weighing of alternatives, including the risks and benefits of different courses of action for a resident.[19,41]
Group leader soliciting perspectives	Committee chairs can encourage members to share, discuss, and integrate information rather than prioritizing ready agreement among members.[46]
Group leader encouraging elaboration and exchange	Committee chairs can use elaboration strategies by repeating and summarizing, inquiring about additional information, and encouraging information exchange.[46,67]