The Practicalities of Competence Committees

What we've learned so far

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MAC-CBME, Postgraduate Medical Education, McMaster University

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Preamble:

This document is for Program Directors, Chairs of Competence Committees and their committee members, Residency Program Committees and Learners – to use as a resource regarding some of the practicalities / clarifications / things to consider regarding the operations of the Competence Committee. Particularly as we transition to competency based medical education, it is important that the nuances of processes of the competence committee be made transparent to the learners as this will help promote the growth mindset and reduce anxiety.

Sources:

- Competence Chair survey 2019 (Saperson, Acai).
- CBME Retreat discussion of Competence committee chairs, April 2019.
- National CBD Leads annual meeting, May 2019.
- Terms of Reference – suggested guidelines for a Competence committee – Appendix 1
- Process and Procedures in Decision making – suggested guidelines – Appendix 2

Role of the Residency Program Committee (RPC) & the Competence Committee (CC) & ratification

The CC has the authority to make decisions on individual EPA achievement. The CC presents status change recommendations to the RPC. The RPC ratifies these status recommendations.

Notes:

1. The CC's decision re EPA achievement is based on the data that the CC has received. The decision is final and cannot be changed by the RPC. The CC could modify their decision based on additional information.

2. In most cases, the Program Director is a member of the CC, and while for confidentiality reasons may not be able to disclose any details, s/he may be able to alert the CC of other extenuating circumstances that exist for the learner. Sensitive information about the learner should be kept confidential and only provided on a need to know basis.

3. While the RPC cannot change the CC's decision the EPA achievement, they may have additional information which may change the outcome for the learner.

4. The letter to the RPC should clearly state that the stage promotion piece is a recommendation and requires RPC ratification.

Example:

The CC has reviewed a learner's file and makes a decision regarding EPAs of "Failure to Progress". In addition, the CC has recommended that a formal remediation plan be designed.

The Program Director is aware that the learner has been dealing with many personal issues and is making good progress by putting supports in place, etc. The Program Director does not think a remediation plan will be helpful at this point. The RPC decides not to initiate the remediation. This information should be fed back to the CC for review.

Discussion prompts / for consideration:

Are the correct voices at the table or are new voices needed?

Competence Committee's review of EPAs and milestones

The Competence Committee is expected to exercise judgement in making EPA decisions and status recommendations: i.e., they will use the Specialty defined EPAs and the expected number of observations as a **guideline**. The functioning of the CC will be a focus of accreditation (relevant accreditation standards – see Appendix 3). The CC must be able to provide documentation of why they made their decision.

Notes:

1. The CC is not bound to the specific number, context or type of assessments as outlined in the specialty's national assessment strategy. These were developed as guidelines only and will evolve over time.

2. The CC's focus should not necessarily be on the scores, but should look at the learner's progress over time. The CC should pay particular attention to the EPAs deemed as critical to the specialty.

3. The decision should be a holistic view of the learner's performance, considering all sources of data. The CC should review the learner's progression based on the program's programmatic assessment plan.

Example:

A learner who is nearing completion of Transition to Discipline has a couple of 3's, a couple of 4's and one '5', on the entrustment scale, for each of his TTD EPAs but his trajectory shows that he is progressing. The guideline was to receive 6 assessments of 'Achieved' e.g. '5's'. He has a good variety of contextual variables assessed. The learner has received consistent 'Satisfactory' ITARs; items on the ITAR are Very Good / some Outstanding. All comments on the ITAR are very positive. A written test shows that he is at the higher end of a PGY1.

Decision: The CC review the documentation provided and agree that there is sufficient evidence that the learner has met the EPAs. The CC decide, that while he has not met the target, in terms 6 Achieved EPAs that the overall consensus is that he has successfully achieved TTD EPAs and recommend that he be promoted to Foundations.

Discussion prompts / for consideration:

Given that CCs are often more problem-focused in their approach, how might we ensure that our processes adequately support both high- and low-performing residents?

Are there standardized questions for members to guide reflection?

Is there a shared understanding by members?

Role of the Academic Coach on the CC

Academic coaches may be invited to the CC to discuss the learner's progress with the CC. Alternatively, they may be asked to provide a written submission.

Notes:

1. Academic coaches should not be part of the decision making with respect to their own learner(s).

2. In smaller programs where an academic coach might be a CC member, they should recuse themselves from decisions regarding their learner.

Discussion prompts / for consideration:

What, if any, role do academic coaches serve in your program? What factors did you consider when choosing to implement / not implement an academic coaching program?

How do you select your academic coaches? How, if at all, do they interact with your Competence committee?

How well are academic coaches working within your program? Is there anything about your academic coaching system that has worked particularly well? Less well?

Documentation

Documentation will be key for accreditation in order to provide the evidence used by the CC to support their decision making process.

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

The role of the CC is to monitor enhanced learning plans and remediation. While the CC is responsible for monitoring, they are not responsible for developing the plans.

Notes:

The learner's portfolio must be kept up to date.

The CC should notify the RPC, in writing, a summary letter on the learner's progress.

It is very useful to have a standardized form for presenting residents to the committee. (See Appendix 4.)

It is important that the notification be timely, in order that the learner be notified of his / her progress in a meaningful manner. Therefore, it is important for the Program to consider the timing of CC and RPC committee meetings so that ratification and notification can take place quickly.

The learner ultimately needs to be notified on his / her status by the RPC. Decision letters should be sent out once RPC ratification has occurred. If timing of ratification is an issue, the program could send a provisional decision letter, but it should highlight that the decision requires RPC ratification and the outcome may change.

Most programs do not directly share their CC minutes with the RPC.

If CC minutes are kept, they should only report the information that supports the content of the decision letter.

Appendix 1

Competence Committee – Suggested guidelines for Terms of reference

These guidelines have been developed by the CBME Assessment committee at McMaster, in accordance with the Royal College of Physicians and Surgeons of Canada's guidelines. Program can adapt these guidelines and develop their own Terms of reference to fit their own local environment. A template in Word can be found on the CBME website: https://cbmepg.mcmaster.ca/. Refer to Resources – Guide / Templates.

Preamble:

Competence Committees are critical components of Competency Based Medical Education that allow for robust and transparent resident performance review. Their goal is to ensure all residents achieve the requirements of the discipline through synthesis and review of qualitative and quantitative assessment data at each stage of training, and to provide recommendations on future learning activities. This document provides the Postgraduate Dean, Program Director, Clinical Faculty, Competence Committee member, Program Administrator as well as the resident with information on the structure and function of Competence Committees.

Role:

A Competence Committee reviews and makes recommendations to the Program Director and Residency Program Committee related to the progress of residents enrolled in a competency-based residency program, in achieving the national standards established by the discipline.

The Residency Program Committee ratifies resident status recommendations of the Competence Committee. The Residency Program Committee or its sub-committee also sets individual learning plans.

Responsibilities:

The Competence Committee will be responsible for:

- Ensuring that graduates will have demonstrated competence to provide high quality, safe care to patients and maintain standards of the healthcare system.
- Maintaining a shared mental model of what a resident's performance looks like and what is acceptable for competence.
- Monitoring the progress of each resident in demonstrating achievement of the EPAs or independent milestones within each stage of a competency-based residency training program.
- Synthesizing the results from multiple assessments and observations to make recommendations related to:
    - The promotion of residents to the next stage of training.
    - The determination that a resident is failing to progress within the program.
    - The review and approval of individual learning plans developed to address areas for improvement;

- The monitoring the outcome of any learning or improvement plan established for an individual resident. Determining readiness to challenge the Royal College examinations
- The determination of readiness to enter independent practice on completion of the transition to practice stage;

- Maintaining confidentiality and promoting trust. For details regarding access to resident assessments, refer to the policy on Assessment of Learners in Postgraduate Programs.

Advisory to the Residency Program Committee with respect to recommendations regarding system issues identified as a possible reason for residents not progressing as expected.

Composition:

The Competence Committee will be composed of individuals with interest and experience in assessment and medical education relevant to the discipline. The Competence Committee members must be able to interpret multiple sources of qualitative and quantitative observation data to achieve consensus, where possible, in order to make judgments on outcomes.

The size of the Committee should reflect the number of residents in the program with a minimum size of three members for smaller programs. The literature suggests that a group size of five to seven is probably ideal, and no more than eight to 10 is recommended for optimal committee functioning.
Members of the Committee are normally from either the Residency Program Committee or clinical supervisors associated with the program.

The use of an Academic Advisor/Coach to mentor residents in their learning and development is a good idea, but not required. For programs that use this approach these individuals may attend the Competence Committee meeting to summarize resident progress, but are not members of the committee.

Smaller specialty programs may consider a combined competence committee, with membership reflective of the programs.

The Program director and the Residency Program Committee, in conjunction with the chair will be responsible for selecting the competence committee membership.

Conflict of interest should be taken into account for all business of the committee.

Suggested Membership:

1. **Competence Committee Chairperson**: The Competence Committee will ordinarily be chaired by a member of the clinical teaching faculty affiliated with a residency program who has expertise in assessment and knowledge of postgraduate medical education. Ideally the Competence Committee will not be chaired by the Program Director, although in small programs this may not be possible.

2. **Program Director and Assistant Program Director**, if applicable: The Program Director should serve as a Committee member.

3. **Faculty Member Representative(s).**

4. **Resident Representative(s)** - Resident representation is encouraged but not required; some residents may not feel comfortable reviewing their peers. This can be a resident from the Residency Program Committee.

5. **Non-Program representative(s)** - A member that is 'external' to the teaching faculty and has some knowledge of the assessment process in postgraduate medical education can be helpful. This individual may be a program director from another residency program at the University or a faculty member from within the Department or within the Faculty. It also could be another healthcare professional or a public member.

6. **Chair of Remediation / Academic Support Committee** – If applicable, the individual in this role may be a useful member.

7. **Program Administrator (non-voting).**

8. **Reporting:** The Competence Committee will make recommendations to the Program Director and the Residency Program Committee.

9. **Terms of Office:** Members should be appointed by the Program Director to serve a defined term with an appropriate process for renewals.

10. **Meetings:** The Competence Committee will meet at least four times per year, though more frequent meetings may be required particularly for larger programs and to support the transition between stages. Meeting can also be called on an ad hoc basis by the Chair. Meetings may be either virtual, face to face or some combination of the two.

    At minimum, quorum should be set at a simple majority; however, programs may wish to establish a higher quorum for meetings during which stage promotion decisions are being made.

Appendix 2

Competence Committee – Suggested Guidelines for Process and Procedures in Decision Making

These guidelines have been developed by the CBME Assessment committee at McMaster, in accordance with the Royal College of Physicians and Surgeons of Canada's guidelines. Program can adapt these guidelines and develop their own Process and Procedures to fit their own local environment. A template in Word can be found on the CBME website: https://cbmepg.mcmaster.ca/. Refer to Resources – Guide / Templates.

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.

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 Program Committee (RPC).

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 RPC. The RPC 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 Program 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 RPC for ratification.
- Once ratified by the RPC, 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 Program 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.

10. **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:

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

Concepts Relevant to Group Decision Making	Key Aspects Based on the Literature
Member characteristic	• Heterogeneous groups perform better than homogeneous.
Group size	• With defined procedure, large groups tend to outperform small groups. However, in large groups, members may go along with group opinion rather than think their own opinion (social loafing).
Group understading of its work	• A shared mental model is a shared understanding of a group's work that improves group performance. • Group cohesion and insulation are antecedents of groupthink. • Insulated groups consider fewer alternatives and make poorer decisions than uninsulated groups. • Default position at the start of group work strongly influences outcomes. • Perception of group work as an intellective task (correct answer that group members can show others) versus a judgemental task (absence of a correct answer; relies on judgement).
Group leader role	• Group leader or more senior, powerful, or confident members can dominate decision making. • Group leader influences degree to which members will seek and hear new information.
Information-sharing procedures	• More information sharing leads groupd to better decisions. • 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. • 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 one or a few members know (unshared information). Groupd processes can be structured to invite diverse opinions and comments from all members.
Effects of time pressures	• Time pressures lead to lower-quality decisions. • New or unshared information is more likely to emerge with longer discussions.

Table 2

Recommendations for Clinical Competency Committes 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.
	Committees should include new or rotating members, in addition to more experienced members, and nonphysicians to ensure novel perspectives.
Size	Larger committees outperform smaller, as long as all members acquire relevant knowledge and demonstrate commitment.
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, 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 cohesivess, and leads members to feel better about their work.
Sharing written information	Sharing assessment data and written information, rather than just relying on committee member's memory, increases information sharing.
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 the alternatives, including the risks and benefits of different courses of action for a resident.
Group leader soliciting perspectives	Committee chairs can encourage members to share, dicuss, and integrate information rather than prioritizing ready agreement among members.
Group leader encouraging elaboration and exchange	Committee chairs can use elaboration strategies by repeating and summarizing, inquiring about additonal information, and encouraging information exchange.

Appendix 3

CanERA General standards of Accreditation for Residency programs (version 1.1)
Excerpts related to committee structure and organized system of resident assessment.

Requirement 1.2.2
Domain: Program Organization; STANDARD 1

The residency program committee has a clear mandate to manage and evaluate key functions of the residency program.

Indicators of Compliance with Requirement 1.2.2 (relevant to CC):

1.2.2.4: The residency program committee structure includes a competence committee (or equivalent) responsible for reviewing residents' readiness for increasing professional responsibility, promotion and transition to practice.

Requirement 3.4.2
Domain: EDUCATION PROGRAM - STANDARD 3

There is a mechanism in place to engage residents in a regular discussion for review of their performance and progression.

Indicators of compliance for Requirement 3.4.2

3.4.2.1: Residents receive regular, timely, meaningful, in-person feedback on their performance.

3.4.2.2: The program director and / or an appropriate delegate meet(s) regularly with residents to discuss and review their performance and progress.

3.4.2.3: There is appropriate documentation of residents' progress towards attainment of competencies, which is available to the residents in a timely manner.

3.4.2.4: Residents are aware of the processes for assessment and decision around promotion and completion of training.

3.4.2.5: The residency program fosters an environment where formative feedback is actively used by residents to guide their learning.

3.4.2.6 (Exemplary): Residents and teachers have shared responsibility for recording their learning and achievement of competencies and / or objectives for their discipline at each stage of training.

Requirement 3.4.3

There is a well-articulated process for decision-making regarding resident progression, including the decision on satisfactory completion of training.

Indicators for compliance of Requirement 3.4.3

3.4.3.1: The competence committee (or equivalent) regularly reviews residents' readiness for increasing professional responsibility, promotion, and transition to practice, based on demonstrated achievement or expected competencies and / or objectives for each level or stage of training.

3.4.3.2: The competence committee (or equivalent) makes a summative assessment regarding residents' readiness for certification and independent practice as appropriate.

3.4.3.3: The program director provides the respective College with the required summative documents for exam eligibility and for each resident who has successfully completed the residency program.

3.4.3.4 (Exemplary): The competence committee (or equivalent) uses diverse assessment data and learning analytics to make effective decisions on resident progress.

Requirement 3.4.4

The system of assessment allows for timely identification of and support for residents who are not attaining the required competencies as expected.

3.4.4.1: Residents are informed in a timely manner of any concerns regarding their performance and / or progression.

3.4.4.2: Residents who are not attaining the required competencies as expected are provided with the required support and opportunity to improve their performance as appropriate.

3.4.4.3: Any resident requiring formal remediation and / or additional educational experiences, is provided with:

- A documented plan detailing objectives of the formal remediation and their rationale;
- The educational experiences scheduled to allow the resident to achieve these objectives;
- The assessment methods to be employed;
- The potential outcomes and consequences;
- The methods by which a final decision will be made as to whether or not the resident has successfully completed a period of formal remediation;
- The appeal process.

Appendix 4

Competence Committee Report Letter to RPC: Template

Resident: **PGY Level: / Stage:**

Date of Review:

Review: Regular review / Concern has been flagged/ completion of stage / Determine readiness of RC exam / Delay in progression / Acceleration in progression / Re-review

Primary Reviewer:
Secondary Reviewer:

Current status as of last review: Progressing as expected / Inadequate data to determine / Requires EEP / Not progressing as expected / Requires Remediation / Exam Readiness / Failure to progress

Summary of process: *[Example]: Our recommendation was developed via a consensus making process involving the committee members, which included faculty representation from both academic teaching sites (Hamilton Health Sciences and St. Joseph's Hamilton) as well as two elected resident representatives.*

Committee members present at the meeting: *[List members present at that meeting]*

Summary of Findings:

The CC reviewed*: [List the items that are used by your program, check those that are used for the review of this resident].*

[Example]

- Academic Coach Progress report
- Secondary reviewer reporting form
- Program Director meeting summaries
- Additional information as required. Please specify.

EPA Review

Summary of discussion [Example]: the committee agreed that Resident has achieved EPAs 2.4, 2.8, 2.11 and 2.13. After discussion, it was felt that EPA's 2.2, 2.3, 2.5 should be achieved, but the exact timeline for this was not clear. For EPA 2.1, at present this has not been achieved, but the exact timeline for this was not clear.

Additional Program Requirements: *[List any additional program requirements Example: research project, procedures log etc.]*

The CC has recommended the resident status to be: *[List the statuses used by your Competence committee.] Terminology may vary somewhat from program to program. Below is the RCPSC terminology:*

- Progressing as expected
- Not progressing as expected
- Failure to progress

CC Promotion Recommendation:

- Resident should be promoted to the next stage.
- Resident should NOT be promoted to the next stage.
- Regular review at CC on:
- Re-review at CC by:
- Inadequate data to determine status – more data required in order to re-review.

Recommended action:

- Requiring an Enhanced education plan (please provide recommendations and specifics).
- Requiring Remediation (please provide recommendations and specifics).
- Requiring amendment of education plan (please provide recommendations and specifics).
- Resident to book appointment with Program Director
- Resident to book appointment with Academic Support Committee.
- Resident to submit EEP to PD, AC.

Recommendations:

Minor Review RPC or Major Review RPC:

Ratified by RPC Y / N Date:
(The feedback loop should be completed with the RPC notifying CC of ratification.)

Important Links

McMaster CBME website: https://cbmepg.mcmaster.ca/ See Topics / Competence Committees

RCPSC: Competence Committees: Guidelines for the Terms of Reference, General Considerations

RCPSC: Case scenarios

Academic Medicine, Journal of the Association of American Medical Colleges: A national study of longitudinal consistency in ACGME Milestone rating by clinical competence committees. Exploring an aspect of validity in the assessment of residents' competence

Medical Teacher: Twelve tips to maximize the value of a clinical competency committee in postgraduate medical education

Sources:

- Competence Chair survey 2019 (Saperson, Acai).
- CBME Retreat discussion with Competence committee chairs, April 2019.
- National CBD Leads annual meeting, May 2019.
- Terms of Reference – suggested guidelines for a Competence committee – Appendix 1
- Process and Procedures in Decision making – suggested guidelines – Appendix 2