

Module 1 – Chapter 4

Medical Humanities, Professionalism, Communication, & Competency

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Medical Humanities

Medical Humanities represents an interdisciplinary field of Humanities (literature, philosophy, ethics, history and religion), social science (anthropology, cultural studies, psychology, sociology), and the arts (literature, theater, film, and visual arts) and their application to medical education and practice. The Humanities and arts provide insight into the human condition, suffering, personhood, our responsibility to each other, and offer a historical perspective on medical practice. Attention to literature and the arts help to develop and nurture skills of observation, analysis, empathy, and self-reflection -- skills that are essential for humane medical care. The social sciences help doctors to understand how bioscience and medicine take place within cultural and social contexts and how culture interacts with the individual experience of illness and the way medicine is practiced.

Humanist, the word, is derived from the 15th century Italian term **umanista**, meaning a teacher or scholar of Classical Greek and Latin literature and ethical philosophy. The **umanista** subjects of study include: grammar, rhetoric, poetry, moral philosophy, and history. The humanist is trained to speak well and write. First, he/she masters grammatically the language, and secondly attains eloquence or rhetoric.

Humanism deals with human concerns, dignity, rationality and capability. It ethically endorses human rights. It comprises a body of literary knowledge and linguistic skill. There are three philosophical categories of humanism. First, **religious** humanism promotes the traditional social role of religion. Second, **secular** humanism regards all forms of religion to be superseded. Third, a moderate approach to Humanism is its recognition as a **life stance**. All three categories reject deference to supernatural beliefs. They seek truth through reason. They endorse the scientific method via the best **humanly** observable evidence, and refrain from considering the issue of immortality. Their goal is to make life better for all living humans and to promote concern for the welfare of others and to the planet, thereby focusing on doing good, living well, and leaving planet earth a better place for future generations. In sum,

Humanism denotes a life stance which upholds ethics, justice and scientific reason and rejects pseudoscience, superstition and supernaturalism.

In 1877, Humanities was used for the first time in America, to describe **Felix Adler**, who was a rationalist intellectual, popular lecturer, religious leader and social reformer. He founded the **Ethical Culture** movement, a term that is presently used interchangeably with **Ethical Humanism**. The **American Humanist Association** was organized in 1941. The **International Humanist and Ethical Union (IHEU)** represents more than 40 countries as the world union. In 2002, the IHEU adopted the Amsterdam Declaration which is the official defining statement of World Humanism.

Educational Humanism, which dominates U.S. school systems, holds that educational development of human intellect is based on what makes humans "most truly human". In the U.S., there should be more emphasis placed on the Humanities, thereby better preparing potential future doctors to tackle sundry ethical and medical issues that involve patients and society as a whole. **Medical Humanities** deals with physician concerns, dignity, rationality, capability, ethics, literary knowledge and linguistic skill. It should be more emphasized in the core medical curriculum.

Healing Authority

The "**healing authority**" of physicians is based on scientific medical knowledge and expertise, and it dates back to the Oath of Hippocrates. The Oath demands "ethical" integrity on the part of physicians. The Oath enjoins the physician healer to a duty and service that is beneficent, in the best interests of the patient, coupled with a declaration of respect for human life under all circumstances. The physician is enjoined from taking advantage of or exploiting the patient-physician relationship, including any sexual relationship. Thus, the physician avoids discrimination, preserves confidentiality, is truthful, altruistic, suppresses self-interests for the welfare of others, refers and consults with colleagues when needed, adheres to medical lifelong learning, maintains a high level of the patient-physician relationship, and sanctions and censures incompetent physicians. Physicians use the healing authority to act as an intermediary between the patient and a body of knowledge, which generally is not possessed by the patient or society. The physician's healing authority, which is based on expert medical scientific knowledge, benefits the patients but renders them vulnerable to its potential abuse.

Physician Professionalism

Physician professionalism is generally regarded as a separate and distinct concept from the physician healing authority. Healing authority imposes duties, while professionalism generally denotes standards. Physician professionalism is an ideal

toward which “healers” must always strive. The basic principles of physician professionalism emphasize factual knowledge, procedural competence, and technical advances as well as the humanistic qualities of professionalism. Physician professionalism stemmed from the societal creation of the concept of professions in the guilds of the Middle Ages. It represents a dynamic covenant between society and the medical profession, which is constantly evolving to meet the changing societal medical needs, e.g. H1N1, AIDS, diabetes, obesity, patient safety, medical errors, access to care and health care for the uninsured.

The physician’s ability or authority to practice is granted through state licensure. The state acts in the best interest of society and the patient. Physician professionalism is influenced by both environmental and personal factors, including physician well-being. If the physician fails to meet the needs and expectations of society, the privileges granted can be suspended or taken away altogether by the State Medical Licensing Board. Medical societies and associations at all levels, including hospital medical staff organizations, have also developed programs to meet societal needs, interface with government and corporations, aid in self-regulating and self-disciplining and serve the vital function of preserving the integrity of the medical profession.

Therefore, the basis for the trust in the patient-physician relationship is physician professionalism. Trust is at the heart of the physician-patient relationship and the core of the medical profession. It is predicated on the integrity of both the individual physician and the profession as a whole. Physicians earn patient trust by their conduct, behavior, personal beliefs, values, attitudes and ideas when interacting with patients and society. Physician professionalism denotes a core set of values, which represent the sum total of education from childhood to postgraduate medical training and serve as the infrastructure for the trust that is absolutely necessary to the patient-physician relationship. The goal of the patient-physician relationship is healing. The physician always acts in the best interest of the sick patient who is vulnerable and in constant need for reassurance.

Physician Competence: Guide to Good Medical Practice – USA¹

On September 26, 2008, following two years of Summit Meetings involving 34 organizations, the National Alliance for Physician Competency (NAPC), sponsored by the Federation of State Medical Boards (FSMB), published the “**Guide to Good Medical Practice – USA**”. This publication presents for the first time an excellent and comprehensive set of “guidelines” for practicing physicians in the United States. The Guide states that “... competence means being qualified in the specific range of skill, knowledge, and ability to perform in a defined role.” And, “... a good physician will strive to demonstrate substantial adherence to these competencies.”

Physician competence is the quality of being competent, the adequacy and possession of required skill, knowledge, qualification, or capacity to practice as a licensed health care professional. At law, competence of a board-certified physician expert witness denotes legal capacity or qualification based on meeting certain minimum requirements of age, soundness of mind, citizenship, scientific training, expertise and certification by a nationally recognized certifying organization as “board certified” specialist in a particular medical or surgical specialty.

In 2008, Turchin et al² reported on the Effect of Board Certification on Antihypertensive Treatment Intensification in Patients with Diabetes Mellitus. The study “analyzed a quantitative relationship between the length of time since the last board certification and quality of care”. It was retrospective involving 8,127 diabetic patients treated for hypertension by 301 internists at primary care clinics to determine “treatment intensification” if BP is too high at time of visit. Better care (optimal hypertension control) by internists who were board certified less than a year was only 26.7%, and that dropped to 6.7% for those who were board certified over 30 years.

What is physician competence?

Physician competence is **NOT** merely cognitive expertise that is, the ability to answer knowledge questions on a secure exam. Competence is a “personal ability,” and competency is “a complex set of behaviors built on the components of knowledge, skills, attitudes . . .”³. Competency represents a behavioral construct comprised of discreet capabilities that can presumably be measured against some objective set of predetermined criteria. The term “competency” is not synonymous with “learning objectives”. Competencies differ from learning objectives in that they describe a terminal performance whereas learning objectives describe the desired intent or outcome of the instruction.

With respect to Specialty Board Certification, Physician competencies are groups of skills, behaviors, or knowledge that are identified as performance standards for a particular specialty. Competencies of Board Certified specialists are applied to the particular specialty rather than the individual physician. They are typically validated by other similarly board certified specialists who are performing the competency at least at an acceptable level, legally referred to as the standard of care for that particular specialty. There are two types of competencies: (1) knowledge or (2) skill/behavior. A “knowledge competency” can be measured by an objective test or question. A Skill/Behavior must be demonstrated or observed.⁴

Medical educators consider competency in terms of observable performance. Competency judgments are made upon direct observation of the learner’s performance, and not upon *how* a learner understands a concept or a skill. The goal of competency

based education is the development of a competent practitioner. Another goal of the competency-based medical education movement is increased specificity. Competencies may be used to standardize the instruction across medical schools, residency training programs and post-graduate medical education.

Competency-Based Medical Education

During the nineteenth century, numerous for-profit proprietary medical schools offered medical education to all individuals who could pay the required tuition. Consequently, incompetent physicians were graduated. Concerns over competence in medicine were first voiced in the late nineteenth century at a time when the system of American medical education was in the midst of an identity crisis⁵. During the last one hundred years no fewer than twenty-four blue-ribbon commissions have issued reports calling for the reform of medical education⁶.

The physician competency concerns triggered a denouncement by the U.S. Congress and an in-depth study of medical schools by the Carnegie foundation. The resulting Flexner report of 1910 detailed the inadequacies of medical schools and called for a variety of structural remedies designed to improve the competence of medical school graduates⁷. During the next few years all proprietary medical schools were closed and the proposed quality standards were adopted by virtually all institutions.

In the 1970s the fields of pediatrics⁸ and reproductive biology⁹ considered a new approach to medical education that was organized by competencies instead of traditional disciplines¹⁰. During this period, Carraccio described the definition of **competence** as a “personal ability” and **competency** as the “complex set of behaviors built on the components of knowledge, skills, [and] attitudes. . .”¹¹.

In 1999, the problem of physician competence again confronted the American public through a landmark report entitled “To Err is Human: Building a Safer Healthcare System”, issued by the Institute of Medicine (IOM), an organization that “serves as an advisor to the nation to improve health.”¹². The IOM reported that 98,000 deaths may occur annually due to errors associated with physicians and the healthcare system¹³.

The reported types of medical errors included:

1. **Diagnostic Errors:** Error or delay in diagnosis; Failure to employ indicated tests; Use of outmoded tests or therapy; and Failure to act on results of monitoring or testing.
2. **Treatment Errors:** Error in the performance of an operation, procedure, or test; Error in administering the treatment; Error in the dose or method of using a drug; Avoidable delay in treatment or in responding to an abnormal test; Inappropriate (not indicated) care.

- 3. Preventive Errors:** Failure to provide prophylactic treatment; Inadequate monitoring or follow-up of treatment.
- 4. Other Errors:** Failure of communication; Equipment failure; Other system failure.

In 2003, the IOM released another monograph “Health Professions Education: A Bridge to Quality”¹⁴ that labeled the current medical education system “inadequate” and called for a restructuring of clinical education, by developing and maintaining a set of core competencies to include delivering patient-centered care, working as part of interdisciplinary teams, practicing evidence-based medicine, focusing on quality improvement and using information technology.

Accreditation Council for Graduate Medical Education

The notion of competency-based medical education was largely cloistered within specific medical specialty disciplines until 2002 when the Accreditation Council for Graduate Medical Education¹⁵ embarked on an ambitious new plan to only accredit graduate medical education (i.e., residency training) programs that had assessed and confirmed resident competency in six identified areas, including:

1. patient care;
2. medical knowledge;
3. practice-based learning and improvement;
4. interpersonal and communication skills;
5. professionalism, and
6. systems-based practice.

The outcomes project initiated by the ACGME has become the popular touchstone for most conversations regarding competency based medical education during the twenty-first century. This move by the ACGME might be viewed as a preemptive self-regulation measure during a time when physician educators were exquisitely sensitive to the idea of external regulation and surveillance.

The ACGME provides an Online Instructional Toolkit entitled, “Teaching From a Competency Perspective: An Instructional Toolbox for Graduate Medical Education”. It “describes and illustrates the principles and practices of competency-based education when specifically applied to the teaching and learning activities for the ACGME General Competencies.” The Toolkit is available at: <http://www.acgme.org/outcome/instrmod/instrModHome.asp>

The ACGME provides additional resources:

*Education Resources for Medical Professionalism, Practice-Based Learning, and Interpersonal and Communication Skills. <http://www.acgme.org/outcome/implement/impHome.asp>






*ACGME Toolkit of Assessment Methods:

- 2000_ACGME&ABMS_ <http://www.acgme.org/Outcome/assess/Toolbox.pdf>
- 2004_ http://www.acgme.org/outcome/implement/Profm_resource.pdf
- 2005_ http://www.acgme.org/outcome/implement/complete_PBLIBooklet.pdf
- 2005_ <http://www.acgme.org/outcome/implement/interperComSkills.pdf>
- 2008_ <http://www.acgme.org/outcome/>

The ACGME also provides Power Point Slides and Facilitator Manuals:

“Educating Physicians for the 21st Century,” is a series of five PowerPoint presentations with a Facilitator’s Manual. It is a new educational resource from the Research and Education Department. The Facilitator’s Manual contains speaker notes and discussion questions to help Program Directors give these presentations during faculty meetings or educational retreats.

[Educating Physicians for the 21st Century - Introduction \(web-based learning module\)](#)

Module 1 - Introduction to Competency-Based Resident Education (PowerPoint)	Facilitator's Manual 
Module 2 - Practical Implementation of the Competencies (PowerPoint)	Facilitator's Manual 
Module 3 - Developing an Assessment System (PowerPoint)	Facilitator's Manual 
	Facilitator's Manual 
Module 4 - Developing a Competency-based Curriculum (PowerPoint)	Curriculum Template (MS Word)
Coming Soon (Not available yet in December 2009):	
Module 5 - Educational Quality Improvement (PowerPoint)	Facilitator's Manual 

Competency-Based Medical Education in Other Countries

The United States has not been alone in the push towards competency-based medical education. Medical education authorities in Canada¹⁶ have recently developed a Canadian-centric CanMEDS framework of essential physician competencies that include several physician “roles”: Medical Expert, Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional.

In the United Kingdom the General Medical Council issued a recommendation entitled *Tomorrow’s Doctors: Recommendations on Undergraduate Medical Education*¹⁷ that list

no less than one hundred and eight curricular outcomes (i.e., competencies). Likewise, Scottish medical schools have adopted the Scottish Doctor learning outcomes which include clinical skills, practical procedures, patient investigation, patient management, communication, health promotion and disease prevention, medical informatics, basic/social and clinical sciences and underlying principles, attitudes/ethical understanding and legal responsibilities, decision making skills, and clinical reasoning and judgment, the role of the doctor within the health service, and personal development¹⁸. Not surprisingly, these various competency frameworks share much in common and may be reciprocally cross-mapped with relative ease.

There are also international educational standards-development entities. In the medical education domain, the MedBiquitous organization has established a Competency Working Group to develop an open standard that would facilitate the creation and free exchange of competency definitions between medical schools, specialty societies, and other interested parties¹⁹.

Assessment of Competency in Medical School

The first assessment of competence begins in medical school using medical school courses. This type of assessment relies heavily on **multiple-choice examinations** and practical exams to evaluate student knowledge. The courses are supplemented by **global clinical ratings** in which faculty rate medical students on a variety of measures such as medical knowledge, patient care ability, professionalism, technical skills, interpersonal skills, and problem-solving ability. These global ratings are assigned at the end of each clinical rotation. In addition, several disciplines conduct an oral exam in which students are required to undergo a faculty-led interrogation regarding a standardized clinical case. In some cases students are required to participate in an **objective structured clinical exam** (OSCE) which requires the student to rotate through a series of ten to fifteen minute stations that focus on a discreet clinical skill (e.g., chest radiograph interpretation, interview of a depressed standardized patient). At some schools the OSCE approach is used to assess the entire class as a requirement for graduation.

The second major type of physician assessment is government-mandated licensure assessment conducted by the **National Board of Medical Examiners** (National Board of Medical Examiners, 2007). The NBME delivers a series of three mandatory exams, the **United States Medical Licensure Exams** (USMLE). The USMLE Step I is comprised of a two-day multiple choice examination that evaluates the learner's knowledge of the basic sciences; this exam takes place during the summer period that immediately follows the second year of medical school. The USMLE Step II-Basic Sciences is another two-day multiple choice exam that evaluates the student's ability to apply integrated basic science knowledge to patient diagnosis and management. The

USMLE Step II-Clinical Skills exam evaluates student clinical ability to conduct a comprehensive history and physical exam on a series of standardized patients. This exam occurs during the transition period during the third and fourth year. Finally, the USMLE Step III consists of a series of computer-based virtual patients that require the learner to assess, diagnose, and manage a digital patient; this exam occurs near the end of the intern year.

Foreign practicing physicians and recent medical school graduates must also take the USMLE Steps one through three, a process organized by the Education Commission for Foreign Medical Graduates.

Competency of Residents

Systems-based competency emerged from ACGME deliberations as one of six core errors that residency training programs must address.²⁰ They define systems-based practice as the resident's ability to "demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value." This new systems-based competency requirement was not clearly understood by many resident program directors when it was first presented to them as a requirement for program accreditation. To ensure that residents are competent as individual practitioners and competent within a system of healthcare providers, educators must provide ample opportunities for the resident to realize the complexities of healthcare systems and inculcate specific behaviors that will illustrate that the resident can function competently within such a system.

Competency of Practicing Physicians - Maintenance of Certification

The formal assessment of practicing physicians has garnered increased attention during the last several years. Clearly, medical knowledge is expanding at a terrific pace and the knowledge learned during medical school alone is simply insufficient to practice effective medicine. The traditional approach to re-certification of practicing physicians relied on programs of self-study and self-evaluation. It was relatively uncommon for practicing physicians to undergo a formal high-stakes assessment similar to that used with medical students and residents. However, this has changed with the increased social pressures and concerns regarding physician accountability and quality of care. The new paradigm has been labeled "maintenance of certification" and entails formal assessment of competence.

Maintenance of certification, which is discussed below, is under the aegis of medical specialty boards who individually select a competency assessment approach that will be most suitable for their particular specialty. Most specialty boards assess maintenance of certification through computer-based written exams although a few offer oral exams (Norcini, 1999).²¹

Core Competency of a Medical Specialty²²

“The core body of knowledge that defines an area of medical specialization is referred to as the core competencies for that specialty. Core competencies are developed through detailed review of the medical literature and are formatted using a psychometric taxonomy such as [Bloom's Taxonomy](#)²³.”

According to a 2004 report by Brennan and co-authors,²⁴ authors of “To Err is Human”, “The Institute of Medicine's reports and discussions on quality of medical care have focused on a systems-based approach to quality improvement. The authors noted that,

- “Patient safety is enhanced when problem-solving uses readily accessed habits of behavior, the same behavior necessary to achieve board certification”,
- “... Certification and maintenance of certification are highly valued by the public.”
- “... A physician's current certification status should be among the evidence-based measures used in the quality movement.”

Legal Claim to being a “Board Certified” Professional

- The United States Supreme Court addressed the issue concerning the utilization of professional credentials awarded by private organizations. In the decision *Peel v. Attorney Registration and Disciplinary Committee of Illinois*, 110 S.Ct. 2281 (1990)²⁵ the court suggested that a claim of certification is truthful and not misleading if:
 1. The claim itself is true.
 2. The basis on which certification was awarded are factual and verifiable.
 3. The certification in question is available to all professionals in the field who meet relevant, objective and consistently applying standards.
 4. The certification claim does not suggest any greater degree of professional qualification than reasonably may be inferred from an evaluation of the certification program's requirements.”

Specialty Board Certification, Credentialing & Physician Performance

In 2008, Kocher et al²⁶ reported an article entitled, “Orthopedic board certification and physician performance: an analysis of medical malpractice, hospital disciplinary action, and state medical board disciplinary action rates.” They stated:

- “Specialty board certification status has become the de facto standard of competency by which the profession and the public recognize physician specialists. However, the relationship between orthopedic board certification and physician performance has not been established. ... There was no significant difference between BC and NBC surgeons in medical malpractice claim proportions ... or in hospital disciplinary action proportions. ... There was a significantly higher proportion of state medical board disciplinary action for NBC surgeons.”

In 2009, Freed et al²⁷ reported on the relationship between board certification and credentialing policies for surgeons and nonsurgical subspecialists in nonchildren’s hospitals. The authors concluded that “Most hospitals do not consistently use board certification to ensure physician competence at their institutions.”

In 2009, Dunham, Singer & Freed²⁸ reported their findings in a pilot study on the use of board certification in ambulatory surgery center credentialing. They noted that,

- “Specialty board certification is one metric for measuring physician competence.”
- “Nevertheless, our results indicate that almost half of multispecialty ASCs are not using this measure of physician competence issued by specialty boards as part of their privileging process.”

In 2009, Freed, Dunham and Singer²⁹ characterized the role of board certification in general surgeon, surgical specialist, and nonsurgical subspecialist credentialing and contracting policies of health plans. They concluded that “Most health plans did not use specialty board certification to assess surgeon and nonsurgical subspecialist competence.”

What Should A Physician Do To Maintain Competency?

In 2004, Madewell³⁰, at the University of Texas M. D. Anderson Cancer Center, answered the question by reporting on “Lifelong learning and the maintenance of certification.”

The author stated that,

- “Lifelong learning is defined as a continuation of medical education with an ongoing process of professional development along with self-assessment, which enables physicians to maintain the requisite knowledge, skills, and professional standards.”
- “The challenge will be the maintenance of specialty certification and its components and competencies, along with the attainment of knowledge and the skills necessary in our unique practices for quality patient care in the evolving health care environment.”

CME Activities: Key to Improving Physician Knowledge

In 2009, Bordage et al³¹ reported that “Physicians are continuously engaging in continuing medical education (CME) activities.” “... The results from the majority of the studies (79%) showed that CME activities were associated with improvements in physician knowledge.

Gender Differences in Physician Competence

Malpractice claims may reflect on physician competency. Taragin et al³² reported on the association of physician demographic characteristics with increased rate of medical malpractice claims. “Male physicians were three times as likely to be in the high-claims group as female physicians, even after adjusting for other demographic variables.” “No association was evident between claims rate and a physician's site of training or type of degree.”

Physician Specialty and Malpractice Rates

According to Taragin et al³³, “Physician specialty has been consistently associated with different malpractice claim rates, with neurosurgery, orthopedics, and obstetrics and gynecology having the highest rates.” “These results were unchanged after controlling for physician age, degree, site of training, certification status, and severity of patient injury. “This suggests that the variation in malpractice rates results from factors other than a meaningful difference in physician performance.”

Physicians Disciplined by State Medical Board

In 1998, Morrison and Wickersham³⁴ reported a list of the factors in cases of unprofessional medical conduct.

- “The most frequent causes for discipline were negligence or incompetence (34%), abuse of alcohol or other drugs (14%), inappropriate prescribing practices (11%), inappropriate contact with patients (10%), and fraud (9%).”
- “In the regression model with additional matching criteria, disciplinary action was negatively associated with specialty board certification ...and positively associated with being in practice more than 20 years.

Medical Schools and Residency Programs

In 2000, Weycker and Jensen³⁵ reported on “...whether a physician's future claims of medical malpractice are predictable from information on the physician's recent claims history, training credentials, practice characteristics, and demographics.” “Physicians trained at lower ranked medical schools or who went through lower-ranked residency programs faced higher odds of developing adverse malpractice records, even after controlling for their previous litigation record.”

Role of Legal Medicine and Medical Ethics

Legal medicine and medical ethics education has become an integral part of teaching medical students and is being incorporated in the core curriculum in medical schools. In an article “On Professionalism”, published in BULLETIN, of the Oklahoma County Medical Society, January 2009, entitled, “Legal Medicine Education and Board Certification”, Sanbar³⁶ wrote the following about educating physicians in Legal Medicine and Ethics:

- “An integral part of the professional life of every physician is dealing with the legal aspect of medical practice. Education and knowledge of legal medicine serves to enhance the physician's expertise in the law of medicine thereby providing better and safer professional care to patients.”
- *Legal Medicine Seminars, Conferences, Lectures, Publications, Mock Trials and Board Certification* are all excellent methods for physicians to cultivate and enhance their professionalism, improve their patient care and safety, diminish their professional risk, and be knowledgeable about the law of medicine through continuing legal medicine education.

The ABMS Task Force on Competence (1998) and the Maintenance of Certification (MOC) Program

In March, 1998, the ABMS Task Force on Competence, which formed the Maintenance of Certification (MOC) program, proposed that:

- All 24 board started MOC as of 2008 with full implementation by 2016; and
- Replaced the single, secure exam for recertification.

The ABMS/MOC has the following four parts:

1. Professional Standing;
2. Lifelong learning and self-assessment;
3. Cognitive expertise (secure exam); and
4. Practice performance assessment.

This new MOC program of the ABMS represents a dramatic shift from how graduate medical education, initial certification in the medical specialties, and recertification in the medical specialties are being conducted. The article by Batmangelich and Adamowski updates how specialty boards are implementing the four components.³⁷

Presently, there is no evidence that links participation in MOC to improved physician performance and patients outcomes. In 2008, Sheldon Horowitz, M.D.,³⁸ who is the ABMS executive for MOC stated in his published article in Neurology that:

- “linkages of participation in MOC to improved physician performance and patients outcomes are not yet available”;
- “all four parts of MOC are essential, but Part 4 (practice performance assessment) is the heart and soul of the program as it involves looking directly at patient care and patient outcomes”. In other words, the ABMS is placing less importance on cognitive capacity via a secure exam.
- “As MOC establishes links to other programs, such as maintenance of licensure, pay-for-performance, and recognition programs, diplomats with non time-limited certificates will be more likely to participate in MOC.”
- “ABMS also is working with the Federation of State Medical Boards so that participation in MOC may eventually fulfill some new, more stringent requirements for renewing a state medical license.”

Therefore, in determining physician competence, there is a dramatic and discernable shift away from merely measuring cognitive expertise via a secure exam, which ABMS had traditionally relied on. The physician’s performance assessment “... is the heart and soul of the program as it involves looking directly at patient care and patient outcomes,” according to the ABMS.

Initiatives by Federation of State Medical Boards – MOC/MOL

The FSMB has been more expansive in its approach by focusing on two initiatives – namely, Maintenance of Certification and Maintenance of Licensure (MOC/MOL). It appointed a special committee on MOL, which proposed the following standards for demonstrated competency:

- Participation in an ongoing process of reflective self-evaluation, self assessment, and practice assessment including learning modules, CME, etc.;
- Demonstration of medical knowledge through a secure exam at least once every 10 years;
- Accountability for performance on practice thru 360 evaluations, patient satisfaction surveys and collection and analysis of practice data.

The National Alliance for Physician Competency (NAPC)

Sponsored by the Federation of State Medical Boards (FSMB), the Physician Alliance for Physician Competency (PAPC) - now renamed the National Alliance for Physician Competency (NAPC), was created in 2005. Between 2006 and 2008, groups of leaders from a wide spectrum of professional medical organizations met in challenging and engaging Summit Meetings to develop a “Good Medical Practice” document for the US Healthcare Community. The Summit participants represented a wide range of experience and practice - including academia, regulatory agencies, payers, the public sector, providers, and professional organizations (34 different organizations in total) including:

1. [The Association of American Medical Colleges](#)
2. [AARP](#)
3. [Accreditation Council for Continuing Medical Education](#)
4. [Accreditation Council for Graduate Medical Education](#)
5. [American Board of Internal Medicine Foundation](#)
6. [American Board of Medical Specialties](#)
7. [American Medical Association](#)
8. [American Osteopathic Association](#)
9. [American Osteopathic Board of Emergency Medicine](#)
10. [Association of American Medical Colleges](#)
11. [Association for Hospital Medical Education](#)
12. [Blue Cross/Blue Shield Association](#)
13. [Christiana Care](#)
14. [Council of Medical Specialty Societies](#)
15. [Crozer-Keystone Health System](#)
16. [Educational Commission for Foreign Medical Graduates](#)

17. [The Federation of State Medical Boards](#)
18. [Iowa Board of Medical Examiners](#)
19. [Michigan Board of Medicine](#)
20. [National Board of Medical Examiners](#)
21. [National Board of Osteopathic Medical Examiners](#)
22. [Oregon Board of Medical Examiners](#)
23. [The Robert Wood Johnson Foundation](#)
24. [Texas A&M Health Science Center](#)

The primary question underlying all these Summits was:

How does the healthcare community determine, measure, and assure the public concerning physician competence over the entire career of the physician?

On September 26, 2008, the National Alliance for Physician Competency published Version 1.0, of the **Guide to Good Medical Practice – USA**³⁹.

“This document describes desirable characteristics of competent physicians licensed to practice medicine in the United States.” The document provides the following six domains of competency. The detailed publication materials are readily available Online.

“Domains of Competency – The key principles of the competency categories are:

1. Good physicians care for patients.
2. Good physicians maintain knowledge and skills.
3. Good physicians actively learn from their practices.
4. Good physicians exhibit excellent interpersonal and communication skills.
5. Good physicians exhibit commitment to the ethical and professional standards of the medical profession.
6. Good physicians practice effectively in systems of healthcare.

EXAMPLES OF APPLYING THE COMPETENCIES

The content of the following chapters provides examples of behaviors that exemplify each general competency.

1. Patient Care
2. Medical Knowledge and Skills
3. Practice-based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professional Behavior

6. Systems-based Practice”

The document noted that these competencies are interdependent; many behaviors can be categorized in several competencies. Remarkably there is no specific discussion or mention of board certification and recertification in the Guide to Good Medical Practice - USA.

Quoting the **Guide to Good Medical Practice – USA**, “The various entities responsible for educating physicians, accrediting institutions, privileging/credentialing, certifying, and licensing physicians currently have no common language or framework for fulfilling their responsibilities in a consistent, coordinated manner. *A Guide to Good Medical Practice – USA* is explicitly intended for the first time to provide common language and a common framework for those organizations. It is further hoped that this document will support the development of a common view of professional responsibility among individual physicians.

Caution from the **Guide to Good Medical Practice–USA**, “*Minority opinions captured during development of GMP-USA*: Some NAPC participants believe *GMP-USA* should be framed as aspirational for individual physicians and that it should not be used by the entities responsible for accreditation, licensure, and/or certification. Acceptance by the physician community is perceived to be less likely if *GMP-USA* is associated with regulation. Some NAPC participants also expressed concerns that articulating a comprehensive view of physician competence would have the unintended consequence of supporting malpractice litigants and attorneys.”

Acknowledgement

The author wishes to respectfully thank Associate Dean of Medical Education and Associate Professor of Medicine, Christopher S. Candler, M.D., of the University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, for being kind and gracious to provide some of the references and materials in this chapter.

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