Continuing 
Competence in the 
Health Professions 

Judy Grossman 

Key Words: certification • licensure • policy making 

The health professions are confronted with external pressures to assure the public of the continuing competence of health care providers and internal pressures for self-regulation. This article describes the forces driving continuing competence, the difficulty defining the scope of professional competencies for experienced practitioners, the difficulty creating valid measures to evaluate continuing competence, and the need for shared responsibility and collaboration among regulatory boards, professional associations, and specialty certification programs. The article presents findings from the Study of Professions, which was based on literature review, document review, and telephone interviews with key informants from 13 regulated health professions.

Across professions, there is agreement, in principle, that the public should be assured of the continuing competence of health care providers. However, there are considerable differences in the philosophical and practical issues regarding what constitutes continuing competence, how it should be measured, and who should be responsible. Health professions also differ in strategic planning for continuing competency programs and their commitment to proactive solutions to maintain high standards for experienced practitioners.

The concern about the ability of health professionals to provide competent and ethical services throughout their careers is an outgrowth of changes in the health care industry that demand public accountability and quality assurance. External pressures exist to regulate the professions and protect the consumer. The professions are also internally motivated to set standards, regulate themselves, and maintain autonomy in an increasingly competitive health care environment. Each practitioner must balance professional standards with marketplace demands for high-quality, cost-effective services.

The requirements for continuing professional competence in areas of specialty practice and board certification are more readily accepted than are mandates that require all health care providers to demonstrate continuing competence. The goal of continuing competence for all practitioners is much more complex and controversial, as demonstrated in the discussion that follows.

Policy analysts, practitioners, and other stakeholders must address four fundamental questions as they develop goals and objectives related to continuing competence: (a) What are the forces that have contributed to the heightened focus on continuing competence in the professions? (b) What is the purpose of continuing competence evaluation? (c) Who is responsible for the assurance that each practitioner continues to practice competently and ethically? (d) What are the actions being taken to assure consumers, insurers, employers, and colleagues that health care providers remain competent?

These questions were addressed in A Study of Professions conducted by MAGI Educational Services, Inc., under contract to the American Occupational Therapy Association (Grossman, 1997). The methods included extensive literature and document review and telephone interviews with a sample of 42 key informants representing the leadership of 13 regulated health professions, including chiropractic, dentistry, dietetics, nursing, occupational therapy, optometry, pharmacy, physical therapy, podiatry, psychology, speech-language pathology and audiology, social work, and veterinary medicine. Multiple interviews were conducted to include a variety of stakeholders from professional associations, umbrella organizations of state regulatory boards, and
voluntary credentialing organizations for specialty and board certification. Continuing competence was one of the areas examined across all professions.

What Are the Forces Driving Continuing Competence in the Health Professions?

Each regulated health profession is unique, but they share similar challenges and concerns about continuing competence. This burgeoning interest in the assurance of competence stems from a number of developments. One of the foremost is a report by the Taskforce on Health Care Workforce Regulation (1995) of the Pew Health Professions Commission that specifically recommended that “states should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals” (p. 25). Continuing competence was identified as one of the challenges faced by state legislatures in the 21st century. The Citizen Advocacy Center (CAC) has also taken issue with the position that licensure is for life. Before the Pew report, the CAC (1995) issued a policy report recommending that licensing systems and certification systems reassess their responsibilities for assuring the continuing competence of health care professionals.

Licensure and certification are examples of credentialing, the process of collecting and verifying information on a practitioner's training and experience (Guarino, 1995). State licensure boards are responsible for entry-to-practice standards and periodic renewal of the professional's license on the basis of payment of a fee and, in some instances, evidence of continuing education and adherence to a code of ethics. State practice acts reflect the minimal standards of competence necessary to protect the public. In contrast to a statutory or regulatory requirement, certification is a voluntary program that confers recognition of clinical excellence. Specialty credentials are granted to practitioners who voluntarily meet additional requirements beyond the minimum competencies required for licensure, thus ensuring that they meet the highest standards in an area of specialization. Mandated periodic review of the practitioner’s continuing competence may include reexamination, continuing education, peer review, or self-assessment.

Initially, board certification programs in medicine concentrated on initial certification and readiness for practice. During the past 25 years, the focus has included recertification because of the tremendous expansion in knowledge and pressures to improve patient care and protect the public. Currently, 23 of the 24 medical boards recognized by the American Board of Medical Specialties have time-limited certificates from 7 years to 10 years to verify that physicians maintain standards of clinical excellence (Norcini, 1994). There is consensus that “passing an exam after a residency does not ensure competence in perpetuity” (Wilson, 1993, p. 1348).

Specialty and board certification programs are more likely to include a system of recertification for continuing competence than are state regulatory boards for a number of reasons. First, higher standards may be needed to protect consumers when safety is an issue on the basis of increased knowledge and technical demands made of the practitioner. Second, it is easier to evaluate continuing competence in an area of specialization with a more defined scope of practice than to evaluate generic competence, which covers the entire scope of professional practice. Third, the decision to seek advanced credentials is voluntary. In some professions, specialty credentials are associated with economic reward and greater prestige, but in less developed professions, this is not yet the case, and there is concern that managed care will encourage specialty certification as an assurance of quality control.

A second driving force for continuing competence is the regulatory system and collective action in some states regarding standards of performance. For example, the Regents of the State of New York sponsored a conference entitled Continuing Professional Competence in a Changing World to support its new initiative that “the public will be served by qualified, ethical professionals who remain current with best practice in their fields and reflect the diversity of New York State” (McGovern et al., 1997, p. 5). Two strategic goals are mandated professional development and periodic review of competence. Another example of regulatory action is that, in some professions, state boards are reviewing continuing education mandates for license renewal and questioning the validity and relevance of this approach.

Managed care is another driving force for continuing professional competence because of the focus on high-quality care at low cost. Insurers and employers are beginning to evaluate a person's qualifications and performance through verification of credentials, patient satisfaction surveys, and patient outcome data. Credentialing and privileging are systematic methods to assure the practitioner’s ability to provide quality care (Rustia & Bartek, 1997). Ultimately, consumers and managed care organizations want to know that they are receiving value for their money. In this consumer-driven and litigious society, the assurance of continuing competence of health professionals is becoming a certainty.

Employers must share responsibility for continuing professional competence by promoting excellence and upholding standards of care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) includes professional development activities and staff competence as one of the requirements for accreditation (Schmidt, 1995). The JCAHO mandated that all staff members will be competent in the knowledge and skills required to perform their job responsibly and safely. Institutionally based staff development and evaluation activities are becoming more systematic; for example, specialty certification and other professional development activities may be built into the
The American Journal of Occupational Therapy

career-laddering program. The nursing profession has the Magnet Hospital Recognition Award for Excellence in Nursing Services, given by the American Nurses Credentialing Center, to recognize the collective efforts of a department in a particular institution to set high-quality standards and achieve positive patient outcomes.

In addition to external forces exerting pressure to assure continuing competence, the professions are internally motivated to be proactive and develop mechanisms to demonstrate that practitioners continue to meet the professional standards established by their peers. This motivation is driven by the belief that only the professionals within a field are capable of accurately assessing the competence of their peers. Professional organizations have historically taken the role of policing themselves on the basis of the premise that they are best qualified to set standards for competence within their own discipline (Cork, 1992).

The challenge is for the professions to maintain autonomy by becoming proactive in the movement to ensure continuing competence. In medicine, there has been a shift from self-regulation to increased accountability to the public and managed care organizations: "If medicine abdicates its responsibility to impose credible standards on itself, our place will be taken by very interested, but less knowledgeable, others" (Wilson, 1993, p. 1348). Unlike physicians, nonphysician providers are experiencing more autonomy as they expand their role in primary and preventive health care and disease management. Reform efforts are giving greater responsibility to nonphysician providers to perform services that may overlap with medical practice acts (Safriet, 1994). These health professionals must also balance public accountability and self-regulation (Bauer, 1994; McGuire, 1993).

What Is the Purpose of Continuing Competence Evaluation?

The issues surrounding continuing professional competence are very complex because competence is multidimensional and the evaluation of competence involves inferences about performance. Competence is based on a person's knowledge, skills, and clinical judgment and the demands of the practice environment. The hallmark of a profession is specialized knowledge, and the explosion in information and technology is a persistent factor in the drive to assure the public that practitioners remain competent.

The lack of responsibility to keep informed is one cause for incompetence, but incompetence can also be due to chemical impairment, emotional or physical disability that impairs functioning, and unethical behavior. Although the need to maintain competence through continued learning remains the focus of professional development activities, ethical issues have surfaced as a primary concern, and the Interprofessional Workgroup on Health Professions Regulation has identified discipline and ethics as the focus of interest for future meetings (Grossman, 1997).

Defining and evaluating competence is not an easy task. To plan and implement a continuing competency system, policymakers and planners can be guided by the following questions.

Should the professions evaluate elements of practice across all settings and roles, or should the evaluation of continuing competence be specific to a person's current practice? Because of advances in knowledge and technology, health care providers have become more focused in their daily practice. The trend is for the practitioner's scope of practice to become more narrow as he or she strives for clinical excellence in the workplace. Competence is defined as professional encounters, and each encounter involves a context, a patient, and the reason for the intervention (Kane, 1992; Norcini, 1994). It is not possible to evaluate the practitioner's ability to handle every professional encounter, including knowledge, judgment, skills, professional behaviors, and ethical standards. Therefore, it may be necessary to define continuing competence more specifically, to evaluate a sample of behaviors, and then to extrapolate to the practice environment.

For entry to practice, all licensed professionals must complete an accredited educational program and pass a national examination, state examination, or both that assess general knowledge. After a practitioner begins to narrow his or her practice, there are no standardized educational programs or, in most professions, uniform standards and quality control for specialty and board certification. A fundamental issue is whether candidates should be tested on general knowledge and held to the same standards as candidates for entry-to-practice credentials. There is evidence that experienced physicians score lower on general knowledge than do new graduates who take the entry-to-practice examination. McGaghie (1993), and the standards for passing may have to be lowered if entry-level examinations are used as a measure of continuing competence. Attempts to evaluate general knowledge after a practitioner gains experience may not be valid, and practitioners strongly resist them.

Some leaders suggest that it may be more relevant and accurate to measure a person's competence by setting, role, or disease category rather than to measure general knowledge (C. Lewis, personal communication, 1997). Defining competence by the practice environment may be more feasible, although this approach has obvious shortcomings. Such an approach approximates specialty and board certification programs, which are easier to design because of the limited scope of practice.

Should recertification be mandatory or voluntary, and should failure to meet continuing competence standards result in punitive action or remediation? If recertification or relicensure is mandatory, there is an obligation to take disciplinary action—to decertify or revoke one's license—or to require additional training for practitioners who do not meet standards.

Historically, regulatory agencies have functioned reac—

Downloaded From: http://ajot.aota.org/ on 11/09/2018 Terms of Use: http://AOTA.org/terms
tively by taking disciplinary action when practitioners do not meet ethical and practice standards. A proactive approach is to promote good practice and offer remediation through feedback, correction, and counseling when practitioners do not meet recertification standards or mandates for licensure renewal. An important consideration is that remediation programs are costly because they require additional resources such as staff, budget, and collaborative partnerships with educators, employers, and professional associations.

A related issue is whether the status of one's credentials should be confidential or public information. Both medicine and dentistry must comply with federal requirements to provide information to the National Practitioners Data Bank. The chiropractic profession has made its disciplinary data bank accessible to the public since 1995. There appears to be growing support to make individual practitioner data accessible to the public (Grossman, 1997).

**Should there be multiple options to measure continuing competence, and are all options comparable and valid?** The lack of validated methods to evaluate professional competence is one of the major constraints preventing the professions from developing continuing competency systems. Currently, the most widely accepted mechanism to demonstrate professional competence is participation in continuing education activities, but the literature suggests that this does not guarantee competence throughout a person's career (e.g., Davis, Thomson, Oxman, & Haynes, 1995; Umble & Cervero, 1996). With some exceptions, the licensee must only demonstrate that he or she has attended the course; there is no assessment of performance. There is no requirement or mechanism to determine whether the information is relevant to the practitioner's specific work responsibilities or whether the information has been understood. Finally, within any profession, there is great variability in state requirements for licensure renewal. Some professions, such as chiropractic and pharmacy, have been aggressive in their attempts to get almost all states to mandate continuing education, whereas other professions, such as occupational therapy and physical therapy, have no mandated continuing education requirements in many of their jurisdictions (Grossman, 1997).

As stated previously, there are limitations to the range of professional encounters that can be evaluated. There are also different components of practice that need to be assessed—practice outcomes, the potential to practice, and the nontechnical or professional aspects of care (Norcini & Shea, 1993). The evaluation of patient outcomes appears to be the best method of assessing practitioner competence, but there are many limitations in this approach. The traditional medical outcomes, mortality and morbidity, have been supplemented with other measures such as functional outcome, community integration, and life satisfaction. Nonetheless, there are many confounding factors influencing outcomes for patients with chronic conditions such as compliance, motivation, and other interventions. Because of the current limitations in outcome evaluation, it may be more feasible to measure the process of care—what the practitioner actually does. This may be evaluated by methods such as simulations, chart or record review, oral examination, and other methods of peer review to assess clinical decision making.

In addition to competence in daily practice, it is important to examine the potential to respond to important, although infrequent, aspects of care. This is measured by knowledge of the most recent developments in the broad discipline and the latest advances in technology. Assessment tools may include diagnostic tests, case studies, written tests, computer-based examinations, and video simulations. A number of professions are developing computer adaptive testing, but the more sophisticated computer simulation testing is expensive and still under development for wide-scale use.

The nontechnical aspects of care include professional qualities such as interpersonal abilities and ethical conduct. These areas are difficult to assess; some possible methods include peer review, patient satisfaction surveys, and verification of the practitioner's credentials and reported disciplinary action.

A fundamental decision for each profession is whether the continuing competency system should include self-assessment and multiple methods to evaluate competence. A small number of professions currently recommend self-assessment tools and more self-directed learning activities as part of the continuing competency plan. Proactive models combine evaluation methods such as continuing education, peer evaluation, professional portfolios, and other professional improvement goals, such as specialty certification. There is some indication that providing multiple options for practitioners to meet recertification or relicensure requirements will increase their support for mandatory programs, and grassroots support is critical for the successful implementation of these programs.

If there are multiple pathways to meet the requirements for continuing competence, there must be some psychometric justification that different methods measure the same aspect of competence. The validation of assessment tools is problematic; there are strengths and weaknesses with each of the methods currently administered to evaluate competence (Kane, 1992). There is also growing support, in spite of time and financial constraints, for more complex performance-based assessments that simulate professional practice (McGaghie, 1993). A valid evaluation method must be nonpunitive, nonthreatening, reasonably priced, and objective. The problem is not the concept of periodic evaluation of competence, but validating a reliable and efficient method. There are two additional areas for decision making in the development of a continuing competency system, which are as follows.

**How frequently should the practitioner be required to**
demonstrate continuing competence or submit documentation that he or she has completed continuing competency requirements? The majority of specialty and board certification programs require recertification every 5 to 10 years, depending on the field. For general practitioners, state-mandated continuing education requirements vary in number of contact hours and annual, biannual, or 5-year reporting cycles. There is also controversy regarding a snapshot of disciplinary action by a regulatory agency, practitioners with a high probability of inadequate performance. The criteria may include practitioners who have been recipients of disciplinary action by a regulatory agency, practitioners who use high-risk procedures or who work with high-risk populations, and practitioners who have taken time off from practice or changed their area of specialization. The current view is that the cost of evaluating all licensed practitioners is prohibitive; therefore, some of the professions that advocate continuous quality improvement recommend random audits combined with markers for high-risk practitioners.

Who Is Responsible for Assuring Continuing Competence?

Failure of the federal role in health care reform has only increased the power of the states to regulate the health professionals to protect the health and well-being of the public. At present, state governments do not impose specific mandates for continuing competence other than continuing education requirements.

However, the professions do recognize that the assurance of continuing professional competence is a regulatory responsibility. All of the professions examined in the Study of Professions, except dietetics and occupational therapy, have an umbrella organization of state licensing boards that is monitoring developments in the area of continuing competence (Grossman, 1997). One of the issues in the additional costs and administrative tasks associated with designing and implementing a comprehensive continuing competency system. Regulatory boards have limited financial resources and budgets controlled by state government. The investment of time and money required to develop a system of periodic review of practitioner competence is a disincentive to begin such a process.

Professional associations also have a role because of their grassroots affiliation with members and commitment to practice standards. To varying degrees, the professional associations are monitoring pressures for continuing competence and taking strategic positions to protect their members.

The question may not be who is responsible for monitoring practitioner competence, but what the appropriate roles of the regulatory board, the professional association, and voluntary credentialing organizations are. Collaborative relationships among all stakeholders will be needed so that the professions can regulate themselves and be accountable to managed care and consumer demands for competent and ethical health care providers.

What Is Being Done To Assure the Public That Health Professionals Remain Competent?

The findings from the Study of Professions clearly indicate that most of the established professions believe strongly that it is the state's responsibility to assure continuing competence, just as they are responsible for assuring that the practitioner meets minimum standards for licensure. The informants representing chiropractic, optometry, physical therapy, podiatry, psychology, social work, speech-language pathology and audiology, and veterinary medicine reported that their organizations have no current plans to develop a system of continuing competence other than continuing education requirements. However, they are following the issue until such time as a superior system is validated or external pressures mandate the periodic evaluation of practitioners.

Dietetics and nursing have taken a proactive stance and are in the process of developing comprehensive systems with multiple pathways to assess the continuing competence of all practitioners. The Commission on Dietetics Regulation (CDR) plans to implement a recertification system in the year 2001 "to protect the health and well-being of the public by fostering and facilitating lifelong learning...of dietetics practitioners" (CDR, 1996, p. 4). The CDR is the credentialing agency for the American Dietetics Association, and it has financial and administrative responsibility for enforcing certification and recertification standards. The proposed recertification requirements include personal evaluation of learning needs, a learning plan, directed continuing professional education, and an evaluation of outcomes. The proposed system offers flexibility through multifaceted learning opportunities. According to leadership in the profession, the proposal has growing membership support because of the ongoing collaborative activities of the CDR and the American Dietetics Association (Grossman, 1997).

In 1997, the National Council of State Boards of Nursing (1997) issued a report with strong recommendations for a regulatory role in continuing competence. One of its guiding principles is that "attaining, maintaining and advancing competence is a joint responsibility among the individual nurse, employer, licensing board, educator and profession" (p. 2). It proposed a personal accountability profile (PAP), which includes a diagnostic profile of learning needs, a learning plan and documentation of implementation strategies, and an evaluation of goals and objectives. The PAP will be pilot tested in one state during 1998. It is too early to judge membership reaction (Grossman, 1997).
The National Association of Boards of Pharmacy is developing an examination to evaluate continuing competence, but because of practitioner resistance and backlash, it has decided to make the program voluntary rather than mandatory. Dentistry has also made some initial attempts to examine the issue of continuing competence, and individual states are experimenting with different options such as record review, computer simulation, and self-assessment. The American Board of Medical Specialties and the American Nurses Credentialing Center are devoting resources to the development of new technologies to assess the continuing competence of board-certified physicians and advanced-practice nurses (C. Lewis, personal communication, 1997).

A more immediate outcome of the pressures to assure continuing competence is targeted continuing education. Across the professions, there is a trend for states to mandate a greater number of hours and more specific requirements for continuing education. For example, some professional boards require specific training in substance abuse, multicultural competence, and HIV/AIDS risk management. Continuing education can be effective at improving knowledge, performance, and patient outcomes, but the impact depends on many factors related to program intensity. More research is needed to examine the specific components of continuing education programs that enhance performance (Umble & Cervero, 1996).

Another critical responsibility for the professions is professional conduct, as evidenced by the increase in the number of complaints and disciplinary actions related to unethical behavior. There is consensus that professional ethics education needs to be strengthened. Although continuing competence is typically associated with a practitioner's knowledge, technical skills, and clinical reasoning skills, the informants interviewed for the Study of Professions were fundamentally concerned about unethical practice and fraudulent behavior.

Conclusion

On the basis of the interviews conducted for the Study of Professions, there seems to be consensus that the health professions will need to develop mechanisms to assure the public of the continuing competence of all practitioners. The issue is who is to develop the continuing competency system and what should be done. The assurance of continuing competence has traditionally been a regulatory responsibility through mandated continuing education requirements. Proactive approaches such as personal learning assessments and multiple pathways to assess learning outcomes are desirable, but regulatory board involvement is limited by lack of funds and inadequate budgets to implement comprehensive systems.

A number of the informants suggested that licensing boards, voluntary certification organizations, and professional associations work together to develop continuing competency programs that assure the public that health professionals remain competent to practice. One evolving view is that "continuing competence is the goal of public protection and the heart of professional practice. It must be the focus of regulation of the professions by government and proactive professional associations." (Gray, 1997, p. 3).

The primary purpose of professional associations is to establish standards for education, clinical practice, and professional ethics and to promote the profession and advocate for members. Professional standards become practice guidelines for regulatory boards and specialty certification organizations.

The credentialing organizations for board certification must continue to refine criteria for recertification to maintain high standards in specialty practice. The relationship among independent certification organizations, the profession association, and regulatory boards needs greater clarification for quality control and uniform standards. Employers also are responsible for providing staff development, or opportunities for staff development, and documenting staff competence. Ultimately, though, continuing competence is an individual responsibility.

The Study of Professions identified differences in the position and activities of the various professions in regard to continuing competence. Some of the differences can be explained by historical developments; some of it relates to a profession's similarity to medicine; and some of it relates to the profession's willingness to take a proactive stance on some of the issues.

There is a delicate balance between public accountability and professional self-regulation. This is an unprecedented time of opportunity for nonphysician providers. The health care system is moving from self-regulation toward more government, third-party payer, and consumer participation in decisions regarding health services. At the same time, nonphysician providers have opportunities for more autonomous practice and increased self-regulation.

To function autonomously, the professions are obligated to prepare well-qualified practitioners and develop systems to establish, implement, and monitor continuing competency requirements. This will demand partnerships among regulatory boards, professional associations, and specialty certification programs as well as demand member support for new initiatives. The enormous changes in health care are forcing institutions, organizations, and individual practitioners to create new methods to assure the public that entry-level and experienced clinicians meet the standards for competent and ethical practice. Occupational therapy and other health professions must be proactive; leadership will need to take important steps in strategic adaptation (White & Begun, 1996) to meet the changing needs of society and the concerns of multiple stakeholders.

Acknowledgments

I thank Wendy Cleary, MPH, CHES, Research Associate, and Ron Szczykowski, EdD, President, MAGI Educational Services, Inc., for their support.
their assistance and collaboration. The Study of Professions was conducted under contract to The American Occupational Therapy Association, Inc.

References


