Challenges and Solutions in Running Effective Clinical Competency Committees in the International Context

Sawsan Abdel-Razig, MD, MEHP
Jolene Oon Ee Ling, MBBCh BAO
Thana Harhara, MBBS, MSc
Nares Smitasin, MD
Lionel HW Lum, MBBS, MRCP
Halah Ibrahim, MD, MEHP

Last year represented the 10th anniversary of the establishment of ACGME–International (ACGME-I).[1] Since Singapore's initial accreditation in 2010, ACGME-I has contributed to global graduate medical education (GME) reform efforts focused on promoting and supporting competency-based medical education (CBME) in various regions, including Asia, the Middle East, the Caribbean, and Central America.[1,2] GME in ACGME-I institutions involves the implementation of competency-based training and assessment, as well as the adoption of all ACGME regulations and governance, including a clinical competency committee (CCC), with similar roles and responsibilities as in the United States. The diversity of educational environments, scopes of practice, health care delivery models, and regulatory requirements, in the setting of different social and cultural contexts, have spurred a burgeoning body of literature exploring the need for local adaptation of educational standards.[3,4] These initiatives have led to country-specific accreditation criteria and ongoing efforts in adopting international Milestones.[5–7]

The implementation of ACGME-I accreditation has also standardized governance, infrastructure, and operational processes of accredited GME programs, including the critical role of the CCC as an essential component of trainee assessment.[8] CCCs are expected to use a multidimensional approach to assessments to make informed decisions about resident performance and reach a consensus regarding trainee progress and Milestone attainment.[9] The efficacy of international CCCs may be influenced by the sociocultural constructs that affect learning, teaching, and communication among faculty and residents, as well as the different mental models that inform faculty and trainee expectations. Despite these challenges, the multiculturalism and diversity of an international faculty can be leveraged to improve CCC functioning by including diverse perspectives to enhance group function and facilitate more information sharing, leading to well-informed judgments.[10]

Drawing on studies of group decision-making and published literature on CCC effectiveness,[11–13] as well as personal experiences in conducting CCC meetings for the past decade at our respective institutions, we review specific challenges that international GME programs may face in assessing residents, providing feedback and running CCCs, and implement evidence-based solutions in the internal arena.

International Challenges Related to CCC Operations

Diversity of Members and Expectations of Trainee Performance

Group decision-making forms the core of CCC meetings.[13] The 3 main principles of group decision-making that shape CCC process are: (1) utilizing data from multiple assessment tools, (2) having a shared mental model around a competency framework, and (3) having structured discussions to reach a consensus regarding trainee performance.[9,13] It is the latter 2 principles that can pose specific challenges in the international context.

In many ACGME-I-accredited institutions, CCCs consist of faculty members from significantly diverse training backgrounds and health delivery systems, many of whom lack personal experience with a competency-based framework. This lack of experience or familiarity with CBME causes evaluators to rely heavily on their own training, and often shapes their expectations of residents and influences their views on assessments and evaluations, leading evaluators to compare residents against their personal standards and frame of reference, rather than against a standardized competency framework.[14] These variations in cultural and training backgrounds can also influence how faculty rate and interpret assessment scores,[15] impacting the accuracy of evaluations of resident competence.[16] This

DOI: http://dx.doi.org/10.4300/JGME-D-20-00844.1

TABLE
Evidence-Based Strategies for Running International Clinical Competency Committees (CCCs)

Concept (Timing)	Evidence-Based Strategies	International Considerations
Membership (before meeting)	▪ Include members of different experience, academic ranks, and roles within the programs. ▪ Consider including non-physician health professionals. ▪ Limit group to 5–10 members.[17]	▪ Include the different perspectives of multicultural, diverse faculty to improve group decision-making.
Faculty development (before meeting)	▪ Focus on the ACGME-I competencies and Milestones. ▪ Understand the purpose of the CCC, how to interpret the information, and how to make performance assessment decisions.	▪ Consider workshops prior to the meeting, as well as a brief overview at the beginning of each meeting. ▪ Consider additional training on the core competencies and Milestones, especially for faculty unfamiliar with competency-based training. ○ Consider repeating these sessions throughout the year, as international faculty can have high turnover rates. ▪ Consider assigning each of the 6 ACGME-I competencies to faculty members, based on knowledge, expertise, or interest, who can then offer teaching and coaching to other members.[18]
Shared mental model (before meeting)	▪ Have a common understanding of the purpose and goal of the CCC as well as the collaboration and teamwork necessary to accomplish the task.[19]	▪ Members can still have divergent opinions and need not agree on issues discussed. However, they need to understand the task requirements and group processes.[20]
Multisource assessments (before meeting)	▪ Include clinical performance data and patient experience surveys, in addition to end-of-rotation evaluations and examination scores.[21] ▪ Share performance narratives and assessment data before the meetings to enhance discussion.[22]	▪ Be mindful of cultural influences on nursing and peer evaluations. ▪ Consider workshops or discussions on the purpose of feedback and the importance of formative assessment.
Structure (during meeting)	▪ Use a developmental approach, focusing on learner-centric support and feedback to provide residents with the skills to achieve competence.[23] ▪ Facilitate information sharing and optimize group decision-making through well-structured discussions.	▪ Continue to emphasize the importance of a developmental approach as members may be inclined to focus on problematic or struggling residents.[14] ▪ Consider asking members to speak in a predetermined order, starting with the most junior, to ensure that all members have the opportunity to give their opinions.[19]
Information sharing (during meeting)	▪ Establish a system where information is shared in a written, structured way rather than verbally/relying on memory during discussions.[11]	▪ Use elaboration strategies to encourage information exchange: repeating, summarizing, and inquiring about additional information.[12]
Leadership role (during meeting)	▪ Ask each CCC member to provide a written professional judgment of each resident's overall performance.[24] ▪ Remain neutral during meeting so as not to influence other members.[25]	▪ Be conscious of hierarchy relationships that exist among CCC members and encourage and support junior faculty involvement.

TABLE
Evidence-Based Strategies for Running International CCCs (continued)

Concept (Timing)	Evidence-Based Strategies	International Considerations
Time (during meeting)	▪ Allow a fixed amount of discussion time for each resident.[14]	▪ Avoid time pressures, as they can lower the quality of decision-making.[19]
Resident feedback (after meeting)	▪ Each discussion should result in an action plan for each resident with positive feedback and points for improvement. ▪ Establish a culture of assessment and feedback where CCC feedback is part of an ongoing learning process rather than unrelated events.[26]	▪ Encourage faculty to include strengths of each resident, as faculty may be inclined to focus only on areas of improvement. ▪ Embrace a positive, non-hierarchical learning culture that normalizes feedback to encourage residents and faculty to be active recipients and givers of feedback, as faculty may focus on faculty to resident feedback only.[27]
CCC feedback (after meeting)	▪ Review the feedback given to residents after the previous meeting and its effect on the residents' performance.[13]	▪ Incorporate both positive feedback and areas for improvement for each resident being reviewed. ▪ Duly provide praise when excellence/ significant improvement in performance is noted by the committee. ▪ Ensure that feedback from the committee is timely, specific, and constructive to help guide learning.

variability may be compounded at the CCC level, where members assimilate aggregate data into a consensus assessment of resident performance.

Faculty-to-faculty communication affects CCC dynamics. A critical component of successful CCCs is the use of structured open dialogue to facilitate consensus among members.[9,13] Research has shown that communication styles differ across cultural contexts.[28] For example, many non-Western societies demonstrate a preference for collectivistic communication styles, which avoid disagreement and favor harmonious group relations.[28] Diversity in culture also affects assumptions about CCC purpose and how the group's decisions are used to judge trainee performance. In Hofstede's cultural dimensions theory,[29] Asian and Middle Eastern countries have a tightly integrated collectivist society. CCC members in some Eastern cultures may, therefore, be less inclined to participate in the sharing of unknown information, open discourse, or voicing unpopular opinions for fear of disrupting the group's harmony or concerns about potentially provoking offense from peers. Another important factor influencing CCC dynamics is the hierarchical structures of some Eastern cultures, which place a high value on professional position and social status. This might impede junior faculty members' ability to openly voice their opinions, speak out of turn, or openly disagree with senior faculty opinions.[30]

Feedback to Residents

The effectiveness of CCC decisions is closely related to the ability to inform resident performance through effective feedback. These conversations can be complicated if the feedback provider and recipient do not have a shared understanding of the goals of feedback. This challenge is compounded in the international arena where sociocultural factors play an important role and can significantly affect the provision and receipt of feedback.[31] In some countries, faculty may be uncomfortable or unwilling to engage in feedback conversations, as they can be challenging. This is especially true when negative feedback is involved, as there is a fear of offending the trainee, leading to rejection of feedback and subsequent damage to the educator-learner relationship.[27,31] Conversely, while praise can motivate and reinforce positive behaviors, it may not be given, reflecting a cultural stance of excellence as a minimal expectation.[32] In some societies, feedback, irrespective of type, is often taken personally.[32] While this may be a universal challenge, it is especially significant in Eastern cultures, where the distinction between professional and personal attributes is often blurred.[3,4] These dynamics often result in fear of giving, seeking, and receiving feedback.

Another significant cultural construct affecting feedback in Eastern (particularly Asian) cultures is modesty.[32] Individuals who speak highly of themselves and their achievements may be seen as

arrogant, self-promoting, or grandiose. As such, during self-assessment of Milestones or self-reflection for CCCs, residents are often observed to rank themselves lower than expected, with a tendency to focus on areas for improvement while downplaying strengths. They may also avoid seeking feedback for fear of appearing to seek praise.[27]

Tips for CCCs in the International Context

Addressing these challenges within local context, the TABLE summarizes evidence-based strategies to improving CCC function from the US-based literature and provides potential solutions within international cultural settings.

Conclusions

There is a paucity of published studies on the role and characteristics of CCCs in the international setting. Faculty diversity adds unique perspectives and can facilitate rich and meaningful conversations, but can also create challenges for CCCs. From our experience running CCCs in Singapore and the United Arab Emirates for the past decade, this article represents our insights on the impact of the various factors in the international context that can affect the efficacy of CCCs. Primary areas identified include the role of the social context in feedback on trainee performance and best practices in CCC operations, with a focus on potential international adaptations. We hope that these recommendations serve as a resource to educators involved in ACGME-I reform efforts worldwide. More research on the impact of sociocultural practices and behaviors is needed to better direct and define CCC processes and outcomes in the global arena.

References

1. Day SH, Nasca TJ. ACGME International: the first 10 years. *J Grad Med Educ*. 2019;11(suppl 4):5–9. doi:10.4300/JGME-D-19-00432.
2. Ibrahim H, Al Tatari H, Holmboe ES. The transition to competency-based pediatric training in the United Arab Emirates. *BMC Med Educ*. 2015;15:65. doi:10.1186/s12909-015-0340-3.
3. Abdel-Razig S, Ibrahim H, Alameri H, et al. Creating a framework for medical professionalism: an initial consensus statement from an Arab nation. *J Grad Med Educ*. 2016;8(2):165–172. doi:10.4300/JGME-D-15-00310.1.
4. Ho MJ, Abbas J, Ahn D, Lai CW, Nara N, Shaw K. The "glocalization" of medical school accreditation: case studies from Taiwan, South Korea, and Japan. *Acad Med*. 2017;92(12):1715–1722. doi:10.1097/ACM.0000000000001999.
5. Dinchen J, Deslaurers J, Kamran SC, Kahn N, Hamstra S, Edgar L. Milestones Guidebook for Residents and Fellows (Singapore Edition). Accreditation Council for Graduate Medical Education. 2017. https://www.acgme-i.org/Portals/0/Specialties/Milestones_Guidebook_for_Residents_and_Fellows_Singapore_Edition.pdf?ver=2018-01-10-104722-870. Accessed March 8, 2021.
6. Accreditation Council for Graduate Medical Education International. Internal Medicine Milestones for the Middle East. https://www.acgme-i.org/Portals/0/Specialties/InternalMedicine/Internal_Medicine_Milestones_for_the_Middle_East.pdf?ver=2017-07-26-100145-997. Accessed March 8, 2021.
7. Accreditation Council for Graduate Medical Education International. Surgery Milestones for the Middle East. https://www.acgme-i.org/Portals/0/Specialties/GeneralSurgery/Surgery_Milestones_for_the_Middle_East.pdf?ver=2017-07-26-095115-610. Accessed February 22, 2021.
8. Accreditation Council for Graduate Medical Education. Clinical Competency Committees. A Guidebook for Programs, 3rd edition. https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf. Accessed March 8, 2021.
9. Edgar L, Holmboe E. International clinical competency committees: maximizing value for faculty, residents, and the program. *J Grad Med Educ*. 2019;11(4):191–192. doi:10.4300/JGME-D-19-00413.
10. Mesmer-Magnus JR, Dechurch LA. Information sharing and team performance: a meta-analysis. *J Appl Psychol*. 2009;94(2):535–546. doi:10.1037/a0013773.
11. Dennis AR. Information exchange and use in small group decision making. *Small Group Res*. 1996;27(4):532–550. https://doi.org/10.1177/1046496496274003.
12. De Dreu CK, Nijstad BA, van Knippenberg D. Motivated information processing in group judgment and decision making. *Pers Soc Psychol Rev*. 2008;12(1):22–49. doi:10.1177/1088868307304092.
13. Duitsman ME, Fluit CRMG, van Alfen-van der Velden JAEM, et al. Design and evaluation of a clinical competency committee. *Perspect Med Educ*. 2019;8(1):1–8. doi:10.1007/s40037-018-0490-1.
14. Hauer KE, Chesluk B, Iobst W, et al. Reviewing residents' competence: a qualitative study of the role of clinical competency committees in performance assessment. *Acad Med*. 2015;90(8):1084–1092. doi:10.1097/ACM.0000000000000736.
15. Wilbur K, Hassaballa N, Mahmood OS, Black EK. Describing student performance: a comparison among clinical preceptors across cultural contexts. *Med Educ*. 2017;51(4):411–422. doi:10.1111/medu.13223.

16. Hanson JL, Rosenberg AA, Lane JL. Narrative descriptions should replace grades and numerical ratings for clinical performance in medical education in the United States. *Front Psychol*. 2013;4(Nov):1–10. doi:10.3389/fpsyg.2013.00668.
17. Laughlin PR, Hatch EC, Silver JS, Boh L. Groups perform better than the best individuals on letters-to-numbers problems: effects of group size. *J Pers Soc Psychol*. 2006;90(4):644–651. doi:10.1037/0022-3514.90.4.644.
18. Ketteler ER, Auyang ED, Beard KE, et al. Competency champions in the clinical competency committee: a successful strategy to implement milestone evaluations and competency coaching. *J Surg Educ*. 2014;71(1):36–38. doi:10.1016/j.jsurg.2013.09.012.
19. Hauer KE, ten Cate O, Boscardin CK, et al. Ensuring resident competence: a narrative review of the literature on group decision making to inform the work of clinical competency committees. *J Grad Med Educ*. 2016;8(2):156–164. doi:10.4300/JGME-D-15-00144.1.
20. Janis IL. Groupthink. *Psychol Today*. 1971;5:43–46.
21. Schumacher DJ, Michelson C, Poynter S, et al. Thresholds and interpretations: how clinical competency committees identify pediatric residents with performance concerns. *Med Teach*. 2018;40(1):70–79. doi:10.1080/0142159X.2017.1394576.
22. Lu L, Yuan YC, McLeod PL. Twenty-five years of hidden profiles in group decision making: a meta-analysis. *Pers Soc Psychol Rev*. 2012;16(1):54–75. doi:10.1177/1088868311417243.
23. Schumacher DJ, Englander R, Carraccio C. Developing the master learner: applying learning theory to the learner, the teacher, and the learning environment. *Acad Med*. 2013;88(11):1635–1645. doi:10.1097/ACM.0b013e3182a6e8f8.
24. Eva KW, Hodges BD. Scylla or Charybdis? Can we navigate between objectification and judgement in assessment? *Med Educ*. 2012;46(9):914–919. doi:10.1111/j.1365-2923.2012.04310.x.
25. Stasson MF, Kameda T, Davis JH. A model of agenda influences on group decisions. *Group Dyn Theory Res Pract*. 1997;1(4):316–323. https://doi.org/10.1037/1089-2699.1.4.316.
26. Archer JC. State of the science in health professional education: effective feedback. *Med Educ*. 2010;44(1):101–108. doi:10.1111/j.1365-2923.2009.03546.x.
27. Delva D, Sargeant J, Miller S, et al. Encouraging residents to seek feedback. *Med Teach*. 2013;35(12):e1625–e1631. doi:10.3109/0142159X.2013.806791.
28. Smith PB. Communication styles as dimensions of national culture. *J Cross-Cult Psychol*. 2011;42(2):216–233. https://doi.org/10.1177/0022022110396866.
29. Hofstede G. Cultural differences in teaching and learning. *Int J Intercult Rel*. 1986;10(3):301–320. https://doi.org/10.1016/0147-1767(86)90015-5.
30. Hofstede GJ, Pedersen PB, Hofstede G. Exploring Culture: Exercises, Stories and Synthetic Cultures. Yarmouth, Maine: Intercultural Press; 2002.
31. Ramani S, Könings KD, Mann KV, Pisarski EE, van der Vleuten CP. About politeness, face, and feedback: exploring resident and faculty perceptions of how institutional feedback culture influences feedback practices. *Acad Med*. 2018;93(9):1348–1358. doi:10.1097/ACM.0000000000002193.
32. Price S, Vlad C, Taoka M. How to Effectively Give Feedback in Cross-cultural Situations in Japan. *Globis Insights*. https://globisinsights.com/global-japan/challenges-in-the-japanese-workplace-making-a-safe-space-for-cross-cultural-feedback/. Accessed February 22, 2021.

Sawsan Abdel-Razig, MD, MEHP, is Chair of Medical Education, Office of Academics, Cleveland Clinic Abu Dhabi, Abu Dhabi, UAE, and Clinical Associate Professor of Medicine, Cleveland Clinic Lerner College of Medicine, Case Western Reserve University; **Jolene Oon Ee Ling, MBBCh BAO,** is Consultant, Division of Infectious Disease, Program Director, Infectious Diseases Senior Residency Program, National University Hospital, Singapore, and Assistant Professor, Yong Loo Lin School of Medicine, National University of Singapore; **Thana Harhara, MBBS, MSc,** is Internal Medicine Residency Program Director, Sheikh Khalifa Medical City, Abu Dhabi, UAE; **Nares Smitasin, MD,** is Senior Consultant, Division of Infectious Disease, Core Faculty, Infectious Diseases Senior Residency Program, National University Hospital, Singapore, and Assistant Professor, Yong Loo Lin School of Medicine, National University of Singapore; **Lionel HW Lum, MBBS, MRCP,** is Consultant, Division of Infectious Diseases, Core Faculty, Infectious Diseases Senior Residency Program, National University Hospital, Singapore, and Assistant Professor, Yong Loo Lin School of Medicine, National University of Singapore; and **Halah Ibrahim, MD, MEHP,** is Consultant, Department of Medicine, Sheikh Khalifa Medical City, Abu Dhabi, UAE, and Adjunct Assistant Professor, Department of Medicine, Johns Hopkins University School of Medicine.

Corresponding author: Sawsan Abdel-Razig, MD, MEHP, Case Western Reserve University, razigs@clevelandclinicabudhabi.ae, Twitter @SawsanRazigMD