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Continuing Competence in Selected Health Care Professions

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▲ Continuing Competence in Selected Health Care Professions

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Health services professionals are confronting the challenge of maintaining and improving competence over the course of lengthy careers in diverse practice specialties. This article reviews the efforts of a selection of health care professions to ensure lifetime competence and reviews some of the challenges encountered in these efforts. Although each profession has its own issues, significant generic questions are common to all. J Allied Health. 2002; 31:232–240.

IN THE FACE OF RAPID developments in science and technology, changes in reimbursement and practice patterns and in expectations of care, health care professionals face a challenge in skills development throughout their careers. State health professions regulatory boards rarely have required, however, demonstration of continuing competence after initial licensure. Disciplinary boards deal with egregious instances of failure in competence for single practitioners. Traditionally, continuing education requirements are imposed across a profession with the belief that such requirements ensure competence. There is evidence to indicate, however, that there is no link between continuing education and improved professional practice.[1,2] Hewlett and Eichelberger[3] suggested that not only is there no established link between continuing education and competence, but also there is none between continuing education and patient outcomes. It is the consumer who bears the costs of continuing education. Begun[4] reported that consumers paid nearly $70 million yearly in higher eye examination costs alone in states that had continuing education requirements for optometrists.

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Concern for the continuing competence of health professionals has been an important issue at least since the consumer movements of the 1960s.[5] In 1967, the Bureau of Health Manpower of the Department of Health Education and Welfare recommended that physicians undergo periodic reexamination.[6] The issue of continuing competence is part of an increased interest in the general concept of competence, which has been manifested in the evolution of reforms since the 1970s. Health care and academic institutions have been prominent in setting competency standards.[7] Possibly the most pronounced influence on promoting interest in continuing competence were the Pew Health Profession Commission Reports of 1995 and 1998.[8,9] The Commission argued that the accumulation of continuing education credits and the activities of disciplinary boards do not ensure competence. A regulatory solution was recommended. States were advised to develop definitions of competence and criteria by which private sector competence assessments would be deemed to satisfy state requirements. A national policy advisory board would coordinate activities.[9] In light of the Pew reports, many states (7 in 1998 and 12 in 1999) introduced continuing competence legislation for health care professionals.[10]

Although generally favorable, professional responses to the Pew Commission Reports raised questions of responsibility, validity of standardized testing, diversity of practice, economic concerns, and lack of empirical data.[11] This article reviews the continuing competence activities of a selection of health care professions and discusses some of the issues involved in ensuring continuing competence.

Dental Hygienists

In general, the only requirement for continuing competence for dental hygienists is mandated continuing education for relicensure in 46 states and the District of Columbia. The average requirement is 8 to 12 hours per year. A few states require active practice to maintain licensure and require retesting or special classes for return to active practice after an extended time away. One state, Utah, has considered performing a dental records review for a sample of patients.[12]

The profession is experiencing pressures from the American Dental Association (ADA) with regard to ensuring competence. In its 1998 meeting, the ADA adopted reso-

lutions that would allow on-the job training for dental hygienists and a shift from independent agencies to state dental boards as accrediting organizations for dental hygiene programs.[13] The ADA has continued to call for *alternate pathway* programs for the preparation of dental hygienists.[14] Although this discussion has centered on initial preparation, it is not unreasonable to expect that a shift in oversight might apply to continuing competence also.

Dentists

In 1991, after 2 years of study, the American Association of Dental Examiners (AADE) established a committee to explore the assessment of the continuing competency of dentists. The committee expanded to include representatives from the American Association of Dental Schools, the American Dental Association, and the Academy of General Dentistry. The committee developed many definitions and criteria and nine models for assessments of continuing competence. The models showed considerable diversity ranging from in-office audits to written examinations.[15]

The AADE has released "Criteria and Mechanisms for Continued Competency in Dentistry."[16] This document establishes 17 criteria for competency mechanisms and suggests that continuing competence could be shown by many different means, including:

- Examinations
- Credentialing through a uniformed service of the Department of Veterans' Affairs
- In-office audits
- Case presentations
- Standardized, simulated case evaluation
- Continuing dental education programs with measurable outcomes assessment

Dietitians

The American Dietetic Association's Commission on Dietetics Regulation offers certification for specialty areas and certification that reflects increasing levels of accomplishment: entry level, beyond entry level (eligibility after 3 years of practice), and advanced level practice (fellow credential). Specialists must have been registered dietitians for at least 3 years, meet experience requirements, and pass a certification examination. Specialty certification must be renewed every 5 years.[17] It is intended that fellow applicants should show exceptional professional abilities, documented professional achievement, commitment to self-growth, innovation, and service to others.[18] Fellow designation applicants must submit a portfolio that includes information on the following:

- Education (master's degree minimum)
- Experience (at least 8 years of work experience)
- Professional achievement
- Professional roles
- Professional contacts
- Approach to practice

Fellow certification is granted for a 10-year period. Fellows who wish to recertify must submit an updated portfolio for evaluation.[19]

Occupational Therapists

The American Occupational Therapy Association (AOTA) has performed entry-level certification for occupational therapy practitioners and related activities since the 1930s. In 1986, AOTA created the National Board for Certification in Occupational Therapy (NBCOT) to perform entry-level certification. AOTA and NBCOT have had serious disagreements concerning NBCOT's authority to require recertification examinations. Their differences occasioned a court case, and on March 2, 1999, an agreement was reached between them concerning the certification designation. It is the AOTA's position that the central question is "whether members of our profession, through the institutions and processes we have established, will continue to define standards of occupational therapy practice and determine critical issues of continued competency and quality of care, of whether those core responsibilities of the profession will be relinquished to a private corporation which has no accountability to occupational therapy practitioners." The AOTA executive board has recommended that AOTA not establish, at this time, an initial or renewed certification program that would compete with those of NBCOT. An AOTA/NBCOT task force was convened to establish an ongoing communication plan.[20] In 1999, NBCOT issued a report on continuing competence in occupational therapy with the following recommendations[21]:

- All occupational therapists should be required to maintain and verify continuing competence throughout their careers
- National, uniform standards for continuing competence should be adopted
- A national, uniform, system of measuring continuing competence should be adopted
- A defined collaborative model for maintaining and verifying continued competence should be implemented
- A periodic review mechanism should be established to evaluate the effectiveness and efficiency of the continuing competence system, and improvements should be implemented as indicated
- A comprehensive plan to inform and educate stakeholders about the importance of continuing competence and systems to support it should be developed and implemented.

The NBCOT Board of Directors has developed six principles to guide the development of the continuing competence program. A final draft of the plan to develop a continuing competence program was anticipated in late 2001.[22]

Pharmacists

In 1995, the American Pharmaceutical Association House of Delegates adopted a policy on continuing competence. The policy:

- Advocates that pharmacists maintain their professional competence throughout their professional careers
- Recommends that employers evaluate prospective and current pharmacist employees based on demonstrated competencies in pharmaceutical care and experience, in addition to education
- States that the American Pharmaceutical Association will develop and implement curricular-based continuing education programs leading to certificates of competence in pharmaceutical care
- Proposes the convening of a task force to develop and implement a voluntary program that enables pharmacists to assess and improve their continuing competence

By 1997, Many continuing competence initiatives had begun. The Washington Board of Pharmacy, for example, is exploring a pilot program to measure continuing competence by means of reviewing a self-compiled folder of activities.[23]

The National Association of Boards of Pharmacy has announced that it is developing a competency examination for voluntary use by state boards of pharmacy.[24] The Association offers advanced credentialing in disease state management in four specified areas; however, it is not clear whether there will be a recredentialing requirement.[25]

Physical Therapists

In 2001, the American Physical Therapy Association published "Assessing Competence: A Resource Manual" authored by an appointed Task Force on Continuing Clinical Competence. Although the publication is rich in tools for measuring competence, it says relatively little about the questions surrounding the issue. The report allocates the responsibility for continuing competence to regulatory agencies, employers, educators and professional associations as well as to the individual practitioner. The measurement tools provided, however, are largely designed for use by employers.[26]

Certification is available for physical therapists practicing in a variety of specialty areas. To maintain certification, practitioners must recertify every 10 years. Recertification requirements differ by specialty area; documentation of sufficient recent direct patient care experience in the specialty area is a minimum requirement.[27]

Physician Assistants

All 50 states, the District of Columbia and the American territories require physician assistants to pass the Physician Assistants National Certifying Examination to use the title *Physician Assistant-Certified (PA-C)*.[28] The National Commission on Certification of Physician Assistants, an independent agency formed by 14 organizations in 1974, is responsible for the administration of all nationally recognized physician assistant examinations. Specialty certification in surgery also is offered. The certification period is 6 years.[29] Recertification is a complex process requiring the practitioner to complete a specified number of continuing education hours within each 2-year period and to sit for an examination at the end of the 6-year period. Specialists must meet additional educational and experiential requirements.[30]

Physicians

In 1998, the Federation of State Medical Boards House of Delegates adopted the recommendations of their Special Committee on Evaluation of Quality of Care and Maintenance of Competence. Ten of the recommendations dealt with the discipline of individual physicians. As their final recommendation, the Committee recommended that "State Medical Boards should develop programs to enhance overall physician practice." To meet that goal, the committee suggested the following strategies[31]:

- Sponsorship of educational programs
- Sharing information regarding best practice and established practice guidelines
- Communications to licensees in the form of newsletters or other means regarding recommendations for best practice problematic areas (i.e., pain management, record keeping, and boundary issues)
- Collaboration with medical schools to educate students as to compliance with state laws governing the practice of medicine and professional and boundary issues
- Establishment of a state-wide consortium consisting of the state medical board, medical professional societies, medical education programs, hospital and health care organizations and professional liability carriers to sponsor medical educational opportunities to licensed physicians (continuing, focused, or remedial)

Time-limited (7–10 years) certificates now are coming due for most of the 24 American Board of Medical Specialties (ABMS) boards. An ABMS task force on competence is looking beyond reliance on cognitive examination methods and debating how patient outcomes, quality improvement, and physicians' lifelong learning could be incorporated in the certification process. One proposal is that boards could require their diplomates to submit regularly patient satisfaction data, specific outcomes indicators, and proof of participation in relevant continuing medical education courses.

Physician-submitted information could be used in a nonpunitive way. For example, internists could be required to submit the results of their blood pressure control efforts for their last 50 hypertensive patients. This information could be compared with that of their peers, and the board could suggest changes or educational programs for outliers.[32]

The American Medical Association (AMA) believes that maintenance of competence is a responsibility of the individual practitioner. Continuing competence requirements should not be imposed until "reliable and cost-effective means of assessing competence are developed."[33] The AMA has urged the ABMS to reconsider its position concerning recertification. The AMA believes that recertification, rather than being a mandatory requirement, should be a "voluntarily sought and achieved validation of excellence."[34] In no case should recertification be tied to licensure.[34] The AMA did develop its own voluntary physician accreditation program, however. The American Medical Accreditation Program, which would require rereview of participating physicians every 2 years was perceived by some as a challenge to ABMS certification.[32,35] Although approximately 4,000 physicians had begun the accreditation process, the implementation of the program first was placed on hold for reevaluation, then discontinued at least in part because of failure to market successfully the value of such accreditation to health plans.[36,37]

Registered Nurses

The National Council of State Boards of Nursing (NCSBN) was engaged in activities concerning continuing competence before the previously mentioned Pew Commission reports. Since 1985, NCSBN has published many reports addressing diverse issues in continuing competence[38] One of the Council's major contributions has been the development of a model for a professional portfolio for promoting professional development for all nurses and for regulatory boards to work with nurses who meet criteria that trigger an audit.[39] Similar models have been developed by the Oklahoma Board of Nursing and the College of Nurses of Ontario. The models share certain common features: assessment of personal strengths and weaknesses, determining measurable strategies to improve practice, and personal accountability for achieving learning objectives and improving practice.[40] Jasper[41] suggested, however, that the creation of individual portfolios also engenders common problems. Among these are a requirement for different types of education (e.g., self-reflection), a change in teacher/student roles (e.g., students set educational goals), costs of portfolio keeping and evaluation, validation issues, time requirements for nurses in keeping their profiles, and ethical issues (e.g., description of incidents relating to patients). Because consumers are often the forgotten component in discussions of continuing competence, the Alabama Board of Nursing authorized a project to determine public attitudes and expectations about the issue. One finding indicated that 89% of the public believes there is a need for nurses periodically to show competence.[42]

The American Nurses Association (ANA) sees its role in continuing competence as threefold: 1) establishment of standards of practice and provision of the framework for the construction of the nurse-patient relationship, 2) development of tools to help practitioners assess and improve their performances, and 3) influencing statutes and regulations concerning safe nursing care within institutions. The ANA is collaborating with the NCSBN in the development of a joint model practice act that would address the issue of continuing competency and has convened an Expert Nurse Panel on Continued Competence. The Panel, which includes representatives from many nursing organizations (including NCSBN), is charged with developing research recommendations, defining the elements of continuing competence, and discussing the role of education in its measurement.[43,44] However, the first assembly of the newly created United American Nurses, the ANA's labor union, has called for a delay, however, in all action for a proposed process to document continuing competence to allow staff nurses to have greater input.[45]

Issues in Continuing Competence

It is evident from the varied approaches described previously that the issue of continuing competence will be a challenge to health care professions for many years. Many issues must be addressed by all health care professions to deal with maintaining and improving the competency of their practitioners. Many health care professions have recognized their common interest in these issues. An Interprofessional Workshop has been meeting to address common regulatory interests since 1995. Continuing competence is now on their agenda.[46] Four major issues that overarch all professional efforts in continuing competence are discussed subsequently.

Definitions and Evaluation of Continuing Competence

The issue of continuing competence is intimately bound to the issue of competence itself—how it is defined and measured. The NCSBN definition of competence focuses on applied skills within a health care environment. Competence is "the application of the knowledge and the interpersonal, decision-making and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare and safety."[47] Kane[48] offered what may be the simplest definition: "The level of an individual's competence in some area of practice can be defined in terms of the extent to which the individual can handle the various situations that arise in that area of practice." This perspective raises the notion, however, that competence varies according to the situation. If so, the measurement of competence in one area is not generalizable to other areas.

The definition of competence must be understood in the context of professional activity (i.e., how professionals make and implement decisions). Combset al.[49] note:

> [T]he system of evaluation rooted in multiple choice examination questions reflects the theory that a physician's clinical practice, and by extension that of other health professionals, is based on the dominant epistemology that professional practice is one of technical rationality. In other words, health professionals learn information, and, in a clinical situation, make decisions based primarily, if not solely, on that information.

Schon[50] noted that professional schools often follow a two-tiered curricular model in which initial studies deal with the science of the discipline and later studies address application. In this, they have followed a Positivist cultural paradigm in which science-based technical practice supplanted craft and artistry and in which problem solving became the end of practice. By this analysis, the technical rationality model severely restricts the definition of professional activity and ignores the notion that problem setting is central to professional activity. According to Schon,[50] "problem-setting is a process in which, interactively, we name the things to which we will attend and frame the context in which we will attend them."

Schon[50] argued that professionals reframe each situation in terms of the application of their discipline's body of knowledge and of the unique elements of that situation (e.g., that particular client). Professionals construct each situation, a process that resembles art at least as much as science. By Schon's model, evaluation of competence is possible only in the actions of professionals and only on a case-by-case basis. It also suggests that evaluators should attend to the questions professionals ask, not simply the answers to questions that are put to them.

Building on Schon's work, Shapiro and Reiff[51] built a multilayered model of reflective practice in which distinct moves made by practitioners reflect theories, which in turn are based on the core philosophy of the profession. Is competence multilayered? How would a profession go about testing multiple layers of knowledge and action and the changes in them over time? Grossman argued[24] that it is not possible to evaluate competence for every professional experience. It is possible only to evaluate a sample of behaviors and extrapolate to the practice totality. Such a procedure not only presents issues with regard to generalizability, but also with a test's ability to predict future and present performance.[24]

Others suggested that competence is multidimensional rather than multilayered. Girot[53] identified the coordination of cognitive, affective, and motor skills as basic to competence in nursing. The AMA identified five continuing competence domains.[6] Competence may involve not only the coordination of personal characteristics, but also the ability to perform in many roles. The Royal College of Physicians and Surgeons of Canada (RCPSC) identified seven professional roles played by physicians: medical expert, communicator, collaborator, manager, health advocate, scholar, and professional.[54] Lenburg[55] described a model of competencies that includes eight dimensions. Cheetham and Chivers[56] suggested a model that is multi-layered and multidimensional. They proposed that there are "meta-competencies (or trans-competencies) that underlie professional competencies. These include such abilities as communication, creativity, problem solving. and, above all, reflection. Competencies include the following:

- ▲ Knowledge/cognitive competence
- ▲ Functional competence
- ▲ Personal/behavioral competence
- ▲ Values/ethical competence

Appropriate mechanisms for ensuring continuing competence must depend on the accepted definition of competence. In theory, if capacity is the core of the definition, basic knowledge testing may address the issue. If the ability to apply skills is included in the definition of competence, however, testing methods must allow for demonstration of that ability. Shimberg,[57] who also questioned the notion that a practitioner's cognitive knowledge is a trustworthy indicator of his or her professional competence, suggested evaluation methodologies that include practical assessments and tests of abstract information. These may include but are not limited to the following:

- ▲ Peer review
- ▲ Client/case review
- ▲ Supervised practice experience
- ▲ Computer simulations
- ▲ Client feedback
- ▲ Use of standardized practice scenarios
- ▲ Practice evaluations. [64]

Nontechnical aspects of practice present special challenges in terms of assessment and evaluation. How does the professional interact with clients? How does he or she approach ethical obligations? Grossman[24] suggested that peer review, patient satisfaction surveys, credential verification, and review of disciplinary actions might provide information concerning nontechnical aspects of practice.

Certain health care professions have implemented or are considering implementing methods that assess skills application. Several Canadian provinces require physicians periodically to undergo peer review of their practices. In Quebec, all physicians' practices are visited by a peer reviewer every 7 years. Practice characteristics (e.g., ease of access) are evaluated, and patient records are audited. In Ontario, approximately 400 physicians are selected for peer review each year. Because older physicians are considered to present a higher risk for practice errors, the selection is biased to overselect physicians older than age 69 years. The reviewers assess skills in interviewing and history taking, physical examination, and interpersonal communication. The purpose of these

reviews is primarily educational; however, more in-depth assessment, remedial education, and possible limitations on practice may be enforced as required.[58,59]

Core Competencies and Specialized Practice

Role and work setting diversity further complicate the development and implementation of mechanisms for competence assurance. Graduate health care practitioners enter practice settings requiring specialized skills development. Professionals practicing in different settings necessarily acquire and perfect differing competencies. Practitioners also may move from specialty to specialty acquiring new skills with each move. It is common for state regulatory boards to require nonspecified continuing education as a requirement for relicensure. Typically, voluntary certification organizations deal with specialized competencies. (Certification is a confusing term. This article addresses certification as granted by private organizations. States also may certify professionals. In this case, certification is a form of title protection.)

Certification is a voluntary process for the demonstration of the mastery of specialized skills. In 1996, the Citizen Advocacy Center reviewed the continuing competence requirements of 52 voluntary health care professional certification organizations. The uncertainties inherent in ensuring continuing competence are well reflected in the varying methodologies employed by these organizations. Most require continuing education hours or recertification examinations (written or oral) or both. There also were occasional requirements for self-assessment, peer review, medical record review, office site visits, institutional input, experience reports, and practice hours. Little agreement existed concerning the time intervals between recertification processes. Ten years is common, but so is 5 years. At least two organizations require recertification every 2 years. Degree of risk in practice did not seem to be the determining criterion for frequency of recertification. Physician specialty organizations tended to have the lengthiest interim periods whereas personal trainers had one of the shortest. With the rate of turnover of knowledge now estimated to be 4 to 7 years,[49] serious questions must be raised considering the appropriate time interval for recertification processes.

The link (if any) between periodic certification and continuing competence remains to be established. Does certification ensure competence, or do competent professionals seek certification? With no regulatory requirement to be met for specialized practice, professionals who seek specialty certification may be self-selected. They have elected to take a proactive posture with regard to ensuring competence, and certification validates that posture. More basic is the question whether certification is positively associated with competence and whether competence is positively associated with better patient outcomes.

Goals and Responsibilities for Ensuring Continuing Competence

Different professional organizations have differing perspectives concerning the responsibility for continuing competence. By and large, federations of state boards see continuing competence as a regulatory responsibility. The Pew Health Professions Commission[8,9] supports a regulatory model, as does the Citizen Advocacy Center.[61] Professional organizations often view continuing competence as a voluntary responsibility of the practitioners in their disciplines. There are gradients, however, in *voluntary* continuing competence requirements. Medical specialty boards generally require recertification after a period of 7 to 10 years.[24] Without such recertification, a physician may practice, but he or she cannot call himself or herself board certified. Failure to recertify may affect the ability to maintain hospital privileges and managed care contracts. The authority to administer recertification examinations extends the influence and the economic capacity of the examining board. The conflict between occupational therapy organizations illustrates the desirability of possessing recertification authority.

In a minimum competence scheme, basic responsibility falls to the state regulatory process. If the public goal of continuing competence is to eliminate performance below the minimum acceptable practice level, mechanisms currently in place (e.g., complaint and disciplinary processes) are designed to address this need. If the goal is not simply to maintain competence, but to increase it, responsibility for improvement becomes broader, falling not only on the state regulatory board but also on the work setting and the individual practitioner. The College of Nurses of Ontario (Canada) differentiates three approaches to continuing competence. The competence assessment component places responsibility on the regulatory arm to ensure that nurses' practices meet legal and professional expectations. The College evaluates the competence of members, registers nurses who meet criteria, and investigates and acts as appropriate when nurses' practice is below standard.[61] Nurses themselves are to engage in *reflective practice*. This methodology requires nurses to annually identify areas to improve to retain their competence in the changing health care environment.[62] The College offers many options for nurses to fulfill this requirement. The third component is practice setting consultation which uses a model developed by the College to support and encourage agencies to develop and maintain the characteristics (e.g., communication systems, organizational supports, professional development system) needed to promote quality of care.[63] The Practice Setting Consultation Program involves 10,000 nurses at almost 40 sites.[64]

The NCSBN identifies an additional player in terms of accountability. The NCSBN[66] maintains that educators bear a part of responsibility for continuing competence by:

- Incorporating standards into the curriculum
- Promoting integration of standards by the student
- Evaluating student performance based on standards
- Providing the first role model for students as to the expectation of lifelong learning and professional accountability

Economics of Continuing Competence

The costs of ensuring competence in the end are borne by the consumer. The administrative costs (e.g., remediation programs) necessary to enforce continuing competence requirements are relatively easy to evaluate. Administrative costs may be only a small component of the price, however, for increased stipulations for licensure. In a lengthy study of professional regulation, the Manitoba Law Reform Commission[67] argued that licensure itself diminishes competition, drives up the costs of services, and reduces access to care. The addition of continuing competence requirements to the already high costs of licensure can only exacerbate the situation:

> High standards for entry or continuing practice force practitioners to invest in their own education and training. In order to recoup this investment, practitioners will tend to charge higher prices than would have been the case if obtaining or maintaining a license had been less costly_To the extent that high entry and practice standards erect a barrier to the service, they undermine the purpose of a licensing regime and may, in fact, be counterproductive.[66]

The first two recommendations of the Commission were to refrain from the implementation of occupational regulation unless its benefits outweigh its costs and to enforce licensure only if it would reduce substantially the threat of serious harm to the public. Similar arguments can be made regarding certification by professional associations. By the time the AMA discontinued its AMAP program, the organization had spent more than $12 million on its development.[36] It would seem prudent for state and professional groups to engage in research that would show whether continuing competence requirements would confer benefits outweighing their costs.

Costs might be minimized by targeting practitioners who may be at high risk for deficiencies in competence. In essence, this method is an elaboration of the present method of identifying specific practitioners for intervention. Recognizable triggers do exist for at least some groups of health care providers that could alert professional regulatory boards (or professional associations) to the need for requiring interventions for certain individuals or groups. Practitioners who have been subject to disciplinary action, who engage in high-risk procedures, who have taken time off from practice, or who have changed their area of specialization might be targeted for continuing competence assessment.[57] The Province of Quebec uses markers to identify physicians whose ongoing competence may warrant a closer review by regulatory authorities. Physicians whose practices involve a significant amount of in-hospital work are considered to be competent if the hospital has a credible peer review process. Physicians are subject to in-office evaluation if:

- Their work is primarily office-based
- They are older than 65
- They have changed the nature of their practice dramatically
- They have had a complaint filed against them

FSMB[31] has proposed that triggers for evaluation might include the following:

- Health status or age
- Number of complaints
- Number of malpractice claims, settlements, or judgments
- Multiple or frequent changes in practice location
- Changes in area of practice without formal retraining
- Adverse actions by PROs or third-party payors
- Failure of specialty board recertification examination
- Practice that is not subject to other peer review (e.g., no affiliation with a hospital)

Alsop[68] suggested a method by which benefits of requiring continuing competence for all practitioners might be enhanced by tying the need for evidence-based practice to continuing competence activities. Research-focused professional development programs could be developed to help practitioners develop and use skills that would help in closing the research-practice gap. If so, such programs themselves should be based on evidence of effectiveness. Instead of asking participants in a continuing education class about the quality of the presentation, participants could be surveyed at a later date to inquire whether the class had changed their practice. In a rare contribution to the continuing competence literature from the consumer perspective, Glasser[64] suggested that the improved outcomes of research-based care might bring about cost savings. If true, the union of continuing competence requirements and evidence-based practice could improve care and lower costs.

Discussion and Conclusion

Ensuring continuing competence is a problem of daunting complexity. We suggest that health care professionals take a step back to consider certain ironies that are present in the midst of all this well-intentioned activity. First, demanding additional credentials from practitioners is an anomalous activity at this time when public and professional attention has been turned to the necessity of examining entire systems to eliminate errors and improve care. With the exception of the requirements for registered nurses in Ontario, there is almost no mention in the literature of the place of institutions and health care systems in ensuring, or at the least not obstructing, improvements in competence. The responsibilities and activities of individ-

ual practitioners do not exist in a vacuum. Even the most competent practitioners encounter difficulties in delivering high-level care if the system is not organized in such a way as to allow them to do so. All groups engaged in the study of continuing competence should pay greater attention to the roles of institutions and health care systems in ensuring competence to ensure that professional practice exists in a competence-friendly environment.

A second example of irony in this process is the amount of energy expended on improving competence with so little attention paid to the outcomes of such improvement. No health professional would implement an intervention with a client unless it had been well shown that the intervention was likely to improve the client's health outcome. Health care professions define for themselves what competence means, but surely competence should be what benefits clients. Professional organizations are investing considerable resources in the development of new requirements for practitioners with little or no evidence to tie the new requirements to improvement in health outcomes. Little attention has been paid to the costs the requirements would add to a health care system that is already the world's most expensive. If we squander resources that might have been better spent, if we increase system costs, if we make access more difficult, with no concomitant gain in improved outcomes, we will not have lived up to the first requirement of health care practitioners that we do no harm. We recommend no additional requirements on practitioners without careful examination of the costs and benefits of such requirements.

Issues of continuing competence exist in a dynamic health care environment. In a rapidly shifting health care milieu, practitioners who are competent today may not be competent tomorrow, not because of erosion of skills, but because new skills are required to meet client needs. Ensuring continuing competence has its own complexities. In examining some of these complexities, however, it is evident that basic issues that underlie the entire area of competence also affect the issue of continuing competence. All agree that competence must be ensured at all times during a practitioner's working life, but the variety of approaches taken make it clear that there is little evidence that supports specific, successful methods for doing so. Many basic issues, including the appropriate role of regulatory bodies versus professional associations; of legal requirements versus private certification; of the optimum mix of personal, institutional, and state responsibility; and of costs and benefits, remain to be determined.

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