

What Does “Proficient” in Quality Improvement and Patient Safety Look Like?

What does it mean to be *proficient*? The Association of American Medical Colleges (AAMC)^{1,2} and the Accreditation Council for Graduate Medical Education (ACGME)³ identify a “proficient” teaching faculty as the cornerstone of resident education in quality improvement and patient safety (QI/PS). The AAMC states that “all clinical faculty need to be proficient . . .”¹ Likewise, the ACGME states that its focus is on “the proportion of faculty members who report to be *proficient* in the application of principles and practices of patient safety.”³ Clinical Learning Environment Review (CLER) site visitors will ask the teaching faculty, “*Are you proficient in the application and principles of QI/PS?*” But how can they be expected to answer that question until we plainly define what it means to be “proficient”?

As leaders in graduate medical education, we cannot aim for a “proficient” teaching faculty until the targets have been clearly identified. Currently, there are no practical definitions of QI/PS proficiency in the literature. Although the AAMC tried to provide one in its “Competencies and the Path to Mastery in Quality and Patient Safety,”² their proposed definition has noticeable shortcomings:

1. The Milestones themselves are far too nonspecific to be useful to the average member of the teaching faculty (ie, “Applies improvement methodologies to populations”²). They do not provide clear examples of what it means to be “proficient.”
2. Two important QI/PS competencies from the domain of Interpersonal and Communication Skills⁴

were overlooked. These competencies can be tied directly to *transitions in patient care* and *team-based patient care activities*, both of which are integral to being “proficient” in QI/PS.

3. The Milestones focus strictly on faculty achievement and ignore physician development. The QI/PS competencies need to be cultivated over time, starting in the early medical school years. This requires Milestones for each stage of advancement.

The AAMC is to be commended for producing the first effort to define faculty proficiency in QI/PS. Clearly, though, there is still a lot of work to be done. We need carefully selected competencies and easily understood Milestones that define QI/PS aptitude for each stage of physician development. Until then, the road map to becoming “proficient” will be indecipherable—and the teaching faculty’s response to the CLER field representative’s question will be unreliable at best.

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References

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- 2 Association of American Medical Colleges. Competencies and the path to mastery in quality and patient safety. <https://www.aamc.org/download/313174/data/te4qcompetencies.pdf>. Accessed June 11, 2014.
- 3 Accreditation Council for Graduate Medical Education. CLER Pathways to Excellence: expectations for an optimal clinical learning environment to achieve safe and high quality patient care. 2014. http://www.acgme.org/acgmeweb/Portals/o/PDFs/CLER/CLER_Brochure.pdf. Accessed June 11, 2014.
- 4 Swing SR. The ACGME outcome project: retrospective and prospective. *Med Teach*. 2007;29(7):648–654.