Maintaining the Public Trust in Clinical Competency Committees—Societal Representatives

We enjoyed the informative review by Hauer et al[1] on group decision making and membership of Clinical Competency Committees (CCCs), and we would like to suggest a helpful innovation from our program's CCC that highlights several of the recommendations made in the review. Since our CCC's inception, we have designated a "societal representative" whose role is to remind the membership that "the ultimate purpose (of the CCC) is to demonstrate our accountability as medical educators to the public," while ensuring the safety of patients under the care of residents during their training and in the future.[2] Unfortunately, data suggest that the profession of medicine frequently fails to fulfill this social contract. Failure rates in US medical schools are lower compared with those of other countries, and they are much lower than those for US students in other professional degree programs.[3] In a recent national sample of student affairs deans, 79% reported that their institutions had graduated medical students who should not have graduated.[4]

The reasons for this have been well documented.[3–5] Faculty often personally know the individual student or resident, and find it especially difficult to fail someone they consider a "nice person" or "trying their best." Awareness of other factors, such as the amount of learner debt and time invested in their professional education, make it difficult to dismiss learners. This information is generally well known to all members of the CCC, and the groupthink described by Hauer et al[1] can introduce a strong bias in the decision-making process. Because CCC members often have the experience and time, many are directly involved in the remediation program for struggling learners. Such engagement requires close personal interactions and investment of time. As such, faculty members often become the learners' advocates in the process. Even when faculty are not directly involved, some may perceive the inability to remediate an individual as a failure of the program itself and a poor reflection of themselves and their colleagues. Faculty may also find it more difficult to fail or dismiss residents than medical students, since the former are closer to the goal of independent practice.

Our societal representative is 1 of our fellowship coordinators, and, while she is well aware of the training requirements for residents, she does not know most residents in our core internal medicine residency on a personal basis. Her role on the committee is to remind CCC members of our social contract with the public in order to ensure the safety of the patients cared for by our residents-in-training, as well as for those patients cared for by the graduates of our training program. As recommended by Hauer et al,[1] the CCC chair will often ask her first to express her view as the societal representative to offset any hierarchical influence by physician members or senior administrators on the committee. The presence of the societal representative for the CCC has been key in ensuring the accountability, public trust, and privilege that society has given the profession of medicine to self-regulate.

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References

1. 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.
2. Andolsek K, Padmore J, Hauer KE, et al. ACGME Clinical Competency Committees: a guidebook for programs. https://www.acgme.org/Portals/0/

DOI: http://dx.doi.org/10.4300/JGME-D-16-00533.1

ACGMEClinicalCompetencyCommitteeGuidebook.pdf. Accessed September 16, 2016.
3. Guerrasio J. "The prognosis is poor": when to give up. In: Kalet A, Chou C, eds. *Remediation in Medical Education: A Midcourse Correction*. New York, NY: Springer; 2014:323–338.
4. Guerrasio J, Furfari KA, Rosenthal LD, et al. Failure to fail: the institutional perspective. *Med Teach*. 2014;36(9):799–803.
5. Cleland JA, Knight LV, Rees CE, et al. Is it me or is it them? Factors that influence the passing of underperforming students. *Med Educ*. 2008;42(8):800–809.