

RESEARCH NOTE

**▲ Continuing Competence:
An Institutional Look at Engagement, Link, and Faculty Perceptions**

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ABSTRACT: This action research project addresses the issue of continuing competence from the viewpoint of allied health faculty members at a community college in Illinois. With input by and feedback from the faculty, the researcher describes how full-time allied health faculty members maintain their clinical competence, determines if efforts toward continuing competence are linked with academic responsibilities, and ascertains the role of the academic institution, the educational programs and the faculty members in ensuring continuing competence. Results of the study indicate that faculty members maintain their competence by attending continuing education courses, reading professional literature, and engaging in clinical work. There appears to be a disconnect, however, between these activities and the academic responsibilities of the faculty members. An analysis of perceptions reveals that the responsibility for ensuring continuing competence increases from the institutional level to the level of the faculty members, whereas accountability is shouldered by the faculty members and the educational programs. *J Allied Health* 2007; 36(2):e-90–e-107.

INTRODUCTION

The issue of continuing clinical competence is at the forefront of all health care professions in part because of demands from regulatory bodies, accrediting agencies, professional organizations, and other influential leaders and groups in the health care industry. The Pew Health Professions Commission,^{1,2} for example, specifically outlines the need for health care providers to validate continuing competence. Moreover, accrediting bodies such as the Joint Commission on the Accreditation of Health Care Organizations require a specific process of assessing the competence of health care providers.³ Professional organizations such as the American Physical Therapy Association address the competence issue in the context of professional development, which "...encompasses the entire scope of a career beginning with preprofessional education and continuing through one's professional life span."⁴

Continuing competence is not limited to clinical practitioners only. Educators who are charged with the competence development of prospective practitioners are also subject to scrutiny. For example, the Commission on Accreditation in Physical Therapy Education requires faculty members to maintain their competence and remain current in their academic areas.⁵ Other educational accrediting bodies such as the Commission on Dental Accreditation⁶ and the National League for Nursing Accreditation⁷ require that faculty members not only have the background and current knowledge about the profession but also have a systematic process of professional development and ongoing competence.

The charge to faculty members of allied health programs, therefore, is not only to educate prospective practitioners but also to keep themselves clinically competent to teach in their respective areas of instruction. Unfortunately, the issue of continuing competence among faculty members takes greater significance when faculty members carry full-time appointments, because a majority of the faculty member's time is devoted to academic instruction when compared to clinical practice. In this regard, the purpose of this action research project is three-fold: to describe how full-time allied health faculty members at a community college maintain their clinical competence, to determine if efforts toward continuing competence are linked with academic responsibilities, and to ascertain the role of the academic institution, the educational programs and the faculty members in ensuring continuing competence.

BACKGROUND

As the pace of technological and scientific development accelerate, one of the greatest challenges to health care professionals is the attainment, maintenance, and advancement of professional competence in an evolving health care system.⁸ This challenge is brought on by the

demands of consumer groups, professional associations, regulatory agencies, accrediting bodies, legal mandates, and other stakeholders in the health care industry to insure that clinicians practiced safely and effectively as health care professionals.

What is competence? What does initial and continuing competence mean? Initial or entry-level competence is attained when a practitioner successfully passes either the certification exam or the licensing exam. This suggests that the practitioner possesses the basic skills, knowledge, and attitudes to practice safely and effectively as a clinician about to enter the profession. According to Lane,⁹ “All licensing boards... require some basic indicators of competence for entry-level practice, specifically graduation from an accredited program that includes a structured clinical internship and a passing score on an entry-level examination.”^(p.49) More specifically, regulatory agencies and licensing boards have a role in assuring the public of the initial competence of their licensees.⁸

On the other hand, ongoing competence refers to the ability of practitioners to practice safely and effectively throughout their professional career. As part its mission to protect the public from incompetent practitioners, licensing boards are challenged to provide assurance to the public that all licensees meet minimum levels of competence throughout their careers and not only at the time of entry and initial licensure.⁸ The Pew Commission Reports^{1,2} suggests that regulatory boards should take on the challenge of ensuring some level of continuing clinical competency of the professionals they regulate.

Norcini and Shea¹⁰ provide three reasons behind the need for continuing competency in any profession. First, there is expansion of knowledge. Clinical practitioners acknowledge the expanding knowledge base of their respective professions, and the consequent need for ongoing competence in the light of these changes. Hutcherson, Sheets, and Williamson¹¹ recognize the

need for continuing competence in nursing due in part to the fact that "...half of what a nurse knows becomes obsolete in two years and half of the technology she uses is outdated within months..."^(p.55) Jensen, Gwyer, Shephard, and Hack¹² report that the practice of physical therapy is becoming increasingly complex. Whittaker, Carson, and Smolenski¹³ acknowledge the need for assuring continuing competence in today's environment where technology and practice are continually changing. The American Registry of Radiologic Technologists¹⁴ echoes the need for continuing competence because "changing technology and job responsibilities may render the technologist less competent if there is failure to acquire current knowledge and skills consistent with new developments."^(p.1)

The second reason behind the need for continuing competence in any profession revolves around changes in the culture and scope of practice. The changing face of the health care delivery system contributes to the ongoing need for practitioners to keep themselves clinically competent. Leaver and Norris¹⁵ acknowledge the impact of the changing health care environment to the practice of radiation therapy. They contend that the most notable factors today are managed care and advancing technologies. Lenburg¹⁶ believes that the escalating complexities of health care and the changing sociopolitical market forces compel professionals to confront the issue of continuing competence. Safriet¹⁷ states that these complexities include the evolution of and backlash from managed care, the increased convergence of criticism, the opposition to cost shifting, and the increased emphasis on regulation at federal and state levels.

The third reason for continuing competence has to do with professional expectations. With health care shifting from being provider driven to being market driven, Decker¹⁸ argues that the performance of health care professionals should meet and exceed consumer expectations because not doing so would be tantamount to a loss of business. Safriet¹⁷ reiterates this shift by

highlighting the increasing role of consumers and consumer groups on the continuing competence of the medical professions. Safriet further indicates that consumers are becoming more engaged in the regulatory apparatus "...through participation on licensing boards, policy advisory groups, and so on."^(p.14)

In a report presented to the Committee on Professional Practice, the Office of the Professions at the New York State Education Department¹⁹ outlines six generally accepted strategies to assess continuing competence, which includes periodic reexamination, mandatory continuing education, educational outreach, peer review of on-site performance or portfolios, self-assessment, and national standards of professional practice. Although these strategies have their inherent strengths and weaknesses, the same report also points out that "there is no general agreement on which strategies are most effective; each has its pros, cons and unknowns."^(p.3) Schwabbauer²⁰ reiterates this sentiment, stating that no one specific tool sufficiently meets the tests for cost-effectiveness, reliability, and validity. Instead, the judicious selection of the right combination of tools based on predetermined competency criteria is crucial.

The action research project that follows addresses the issue of continuing competence among full-time faculty members of allied health departments at a community college in Illinois. More specifically, the research describes how faculty members maintain their ongoing clinical competence, whether or not the activities they engage in are linked to their academic responsibilities, and what they perceive as the responsibility and accountability of the faculty members, educational programs, and academic institution in ensuring continuing competence.

METHODOLOGY

Subjects

Sixteen individuals from the allied health programs participated in the action research project. Eleven were full-time faculty members and five were program directors. Three of the five program directors were also classified as full-time allied health faculty members. The programs represented were Respiratory Therapy, Nursing, Physical Therapist Assistant, Radiology, and Dental Assisting.

Procedure

The study was conducted using the action research methodology²¹ and proceeded through two distinct phases (Table 1). The first phase was known as the “Archival Fact Finding Phase.” This phase described how the faculty members, educational programs and academic institution ensured the continuing competence of the allied health faculty members. Activities in this phase consisted of structured surveys of faculty members and program directors to determine continuing competence activities and behaviors that faculty members engaged in. Reviews of departmental and institutional records were also conducted to determine if the importance of and need for such activities have been codified and pursued at the institutional, departmental, and faculty levels.

The second phase of the study was known as the “Faculty Input and Perceptions Phase.” This phase determined the link between the clinical competence activities and the academic responsibilities, and also studied perceptions of responsibility, accountability and support among the faculty members, educational programs and academic institution. Activities in this phase consisted of open interviews with individual faculty members and focus groups with the program

directors on the subject of responsibility and accountability in continuing competence at the institutional, departmental, and faculty levels.

Table 1. Research Phase Details

Research Phase	Purpose	Associated Activities
Archival Fact-Finding Phase	Described how faculty members, educational programs and academic institution ensured the continuing competence of faculty members	Surveys and reviews of individual, departmental and institutional documents
Faculty Input and Perceptions Phase	Determined the link between the competence activities and academic responsibilities and Studied perceptions of responsibility, accountability and support among the faculty, educational programs and academic institution	Interview and focus groups

Analysis

A general inductive approach as proposed by Thomas²² was used to analyze data gathered from the study. Transcribed proceedings during the interviews and focus groups were categorized and coded (such as FR for “faculty responsibility,” PR for “program responsibility,” and IR for “institutional responsibility”) to determine whether or not perceptions of responsibility, accountability, and support rested with the faculty, the program, or the institution. These were triangulated with the structural analysis of institutional documents, survey responses regarding faculty activities and behaviors and transcribed proceedings from focus groups of program directors to determine links between academic responsibilities and continuing competence activities and behaviors.

RESULTS

Overview of the Population

Sixteen individuals from the allied health programs participated in the action research project. Eleven were full-time faculty members and five were program directors. The mean age of the participants was 44.5 years. Two (12.50%) of the respondents were males and 14 (87.50%) were females. The mean number of years of full-time teaching for the population was 12.74 years.

Three participants (18.75%) indicated that their entry level professional degree was at the certificate level, five (31.25%) were at the associate level, five (31.25%) were at the baccalaureate level, and three (18.75%) were at the graduate level. The mean span of years since obtaining entry level professional degrees was 19.17 years.

Study Findings

Results from surveys of all full-time faculty members, interviews of department heads, and review of records provided information regarding individual, departmental, and institutional efforts toward ensuring the continuing competence of faculty members. At an institutional level (from the office of the dean to the office of the president and board of trustees), the institution gave the individual departments the responsibility of meeting standards of competence specific to their respective professions. The college supported the professional development of its faculty, support staff, and administrative staff. The institution's Bylaws and Policy Manual²³ read, in part, that the institution "...[recognized] that the professional growth of its employees enhance their productivity and benefits the college as well as the individual employees." (Policy 2.312) The same policy stated that employees may attend professional workshops and meetings within the budget constraints of the college.

On a departmental level (from the program directors of the various allied health programs to their respective faculty members), results from surveys and interviews of program directors revealed that three of the five allied health programs did not have a formal method of assessing the continuing competence of full-time faculty members. In addition, although all the directors agreed that their faculty members engaged in professional development, they also suggested that these professional development efforts were independent of the needs of the program or the teaching responsibilities of the faculty.

Table 2. Percentage Distribution of Professional Activities by Faculty

Professional Activities	Percentage
Attendance at professional seminars and workshops	100.0
Reading of professional literature	94.4
Involvement in clinical practice	88.9
Engagement in peer- and self-evaluation	66.7
Membership in and service to professional organizations	61.1
Use of skills check-off sheets	55.6
Participation in evaluated simulations	38.9
Participation in research	16.7
Taking recertification exams	11.1
Authorship of a book, chapter, or article	5.6

On an individual level (includes faculty members of the various allied health programs), results from the faculty surveys disclosed the utilization of activities in which faculty members engaged that contributed to their continuing competence. As seen in Table 2, the most frequently utilized activity was attendance at professional seminars and workshops, and the least frequently utilized activity was authorship of a book, chapter, or article.

An analysis of perceptions reveals that responsibility for ensuring continuing competence progresses systematically from a limited level at the institutional level to primary responsibility

at the level of the individual faculty (Figure 1). Accountability for continuing competence, however, is perceived to be exclusively the responsibility of the educational program and the individual faculty, with the institution assuming no role (Figure 2). The academic institution limited itself to policy making in support of continuing competence efforts.

Figure 1. Responsibility with Continuing Competence

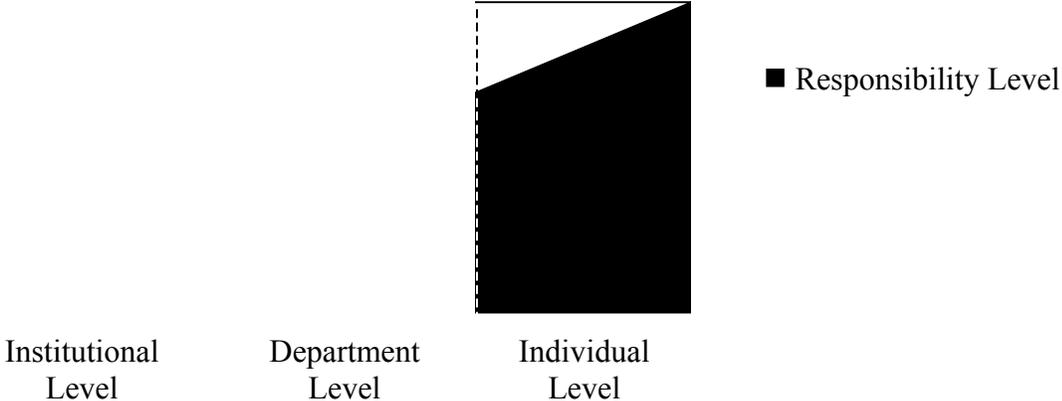
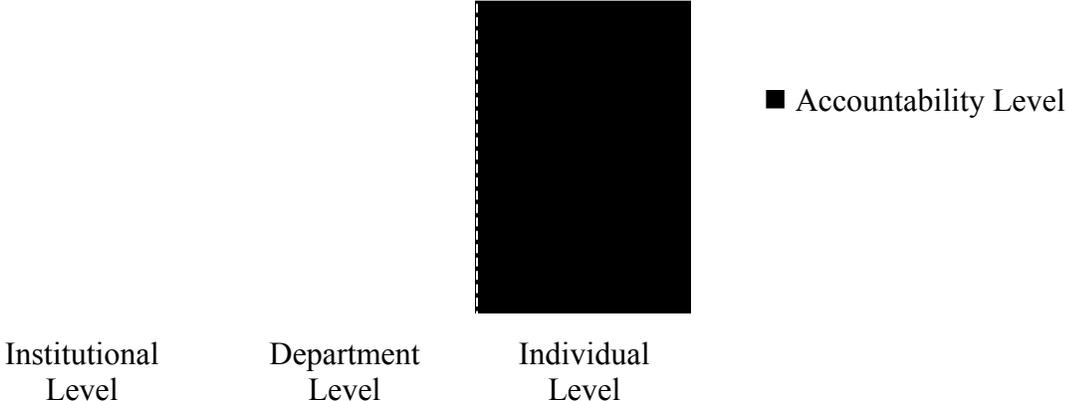


Figure 2. Accountability with Continuing Competence



DISCUSSION

Continuing competence among full-time allied health faculty members is a complex issue. For one, educators are charged with keeping themselves abreast with developments in their professions in order to educate prospective practitioners in the most current practices. In addition, they face the daunting task of engaging in a combination of activities and behaviors that maintain their clinical competence while carrying full-time academic appointments.

In this study, the three most utilized activities by full-time allied health faculty members in the institution (attendance at professional seminars and workshops, reading of professional literature, involvement in clinical practice) and the activity least utilized (authorship of a book, chapter, or article) should be taken in the context of the community college setting. For one, the academic mission of a community college is teaching.²⁴ Research and the generation of scholarly publications expected from most universities is not emphasized at the community college level. Hata²⁵ asserts that community colleges serve as the foundation of undergraduate teaching and learning, and states that community colleges "...[serve] the diverse needs of their local populations with increasingly sophisticated vocational training for the high-tech workplace, lifelong learning opportunities, and a multitude of specialized programs to directly and pervasively affect and improve the quality of life in their communities."

The apparent disconnect between continuing competence activities and academic responsibilities could also be explained in the context of the community college setting. Allied health programs in community colleges often require faculty members who are generalists. In addition, most faculty members teach all the courses in the curriculum. Such arrangement blurs development of faculty expertise and makes linking specific continuing competence activities

with specific academic responsibilities difficult. In this regard, such activities are not necessarily related to the academic responsibilities of the faculty member.

A more proactive mechanism to address individual faculty needs and the needs of the academic programs would be to have a more formalized method of assessing competence. Although annual faculty evaluations have been used in this institution and among the programs, these faculty evaluation forms are institutional and non-specific vis-à-vis linking programmatic needs and faculty needs. In this connection, the use of individualized and program-specific professional development plans may be in order to link the professional development needs of the faculty members and the needs of the program.

The roles of the academic institution, educational programs, and individual faculty members in ensuring continuing competence can be viewed from a managerial framework. Since the academic institution (represented by the administration) is involved with larger, institutional issues, the extent of its responsibility is minimal compared to the educational programs and the individual faculty members. Moreover, since accreditation of each allied health program occurs at the programmatic level, accountability with meeting standards of accreditation falls squarely on the educational program and, by implication, the faculty members in the program.

Integral to the discussion of continuing competence is the duality of roles that allied health faculty members assume—that of clinician and that of educator. On the one hand, the allied health faculty members in this study are practicing clinicians (88.89%) governed by the respective licensure boards. The expectations for continuing competence are therefore governed at the state level and embodied in their practice acts. For example, state practice acts applying to a number of allied health faculty members represented in this study require continuing education

hours for license renewal. This would account for the universal choice of the allied health faculty members to attend professional development courses and workshops.

On the other hand, continuing competence in the “educator” role of the allied health faculty members is more difficult to define. At a minimum, the basis for defining continuing competence as an educator of an allied health program has been the fidelity of faculty members in meeting the accreditation standards when it comes to faculty qualifications. Oftentimes, these qualifications revolve around educational and experiential qualifications of faculty members to meet the academic needs of the programs.

Although not directly addressed in the study, the economic reality that undergirds institutional operations have also influenced the continuing competence activities and behaviors at the institutional, departmental, and faculty levels. For one, although that the institution “...[recognizes] that the professional growth of its employees enhance their productivity and benefits the college as well as the individual employees,”^(Policy 2.312) the same policy states that employees may attend professional workshops and meetings within the budget constraints of the college. Inherent in the policy, therefore, is the fact that institutional assistance with professional development efforts is budget dependent.

Another evidence of the effects of economic reality on continuing competence activities and behaviors is the move toward and development of, on-site career development opportunities. From a fiscal perspective, on-site career development opportunities are less costly than off-site activities. The institution in this study has begun not only to develop and refine faculty workshops, but also link these activities and other institutional offerings to career ladder advancement. In so doing, all faculty members – including allied health faculty – become actively involved in their development. The major drawback to this, however, is that institutional

offerings and workshops may not be able to offer content specific enough to meet the unique needs of allied health faculty members. Another drawback is that this approach denies the faculty access to expertise and perspectives found outside the confines of the institution—expertise and perspectives critical to keeping the faculty abreast of global growth among the various professions.

CONCLUSIONS

Full-time allied health faculty members at a community college in Illinois are engaged in maintaining continuing competence. As an institution, the college is explicit in its support of the professional development of its faculty. Efforts toward ensuring this are addressed at a departmental level and ultimately implemented at an individual level.

Survey results of departmental efforts toward the faculty professional development reveal that faculty members primarily pursue continuing competence by attending professional seminars, reading their professional literature, and engaging in clinical practice. Unfortunately, there is an apparent disconnect between the professional development activities selected by those faculty members and their academic responsibilities. Both the continuing competence activities and the apparent disconnect could be explained not only in the context of the role of the institution as a community college (i.e., the emphasis on teaching and learning versus generating knowledge) and the type of faculty (i.e., the lack of mandate for highly specialized faculty) but also in relation to a range of factors such as those external to the programs (i.e., fiscal considerations by the institution) internal to the program (i.e., the lack of and need for more focused professional development plans), and internal to the faculty members (i.e., faculty

choices and preferences including considerations such as personal convenience, relative cost in terms of time and money, perceived difficulty of the activity, or personal interest).

This action research project provides an institutional perspective not only on the activities that full-time allied health faculty members engage in to maintain ongoing competence and their link or lack of it to academic responsibilities, but also the perceptions of responsibility, accountability, and support between the individual, the educational program, and the academic institution in ensuring continuing competence. Since this study is limited to just one institution with a small sample size, generalizations about its findings and their applicability to other institutions cannot be inferred. As an action research study, the results and impact are specific to the institution, including further actions to address the issue under investigation.

Lessons learned from this study may provide valuable information for similar research studies in the future. At the very least, this study has provided some insight on faculty perspectives when it comes to the issue of continuing competence. Future studies may well investigate the issue from the context of middle management or maybe even central administration.

In the interest of broadening the research scope, future research may want to address the continuing competence issues among community colleges and between community colleges and university settings, including the impact of faculty workload and fiscal considerations on continuing competence activities and behaviors. More specifically, future studies may want to investigate how workload and fiscal considerations may impact the dynamics between competing faculty obligations such as teaching, research, service, and practice.

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