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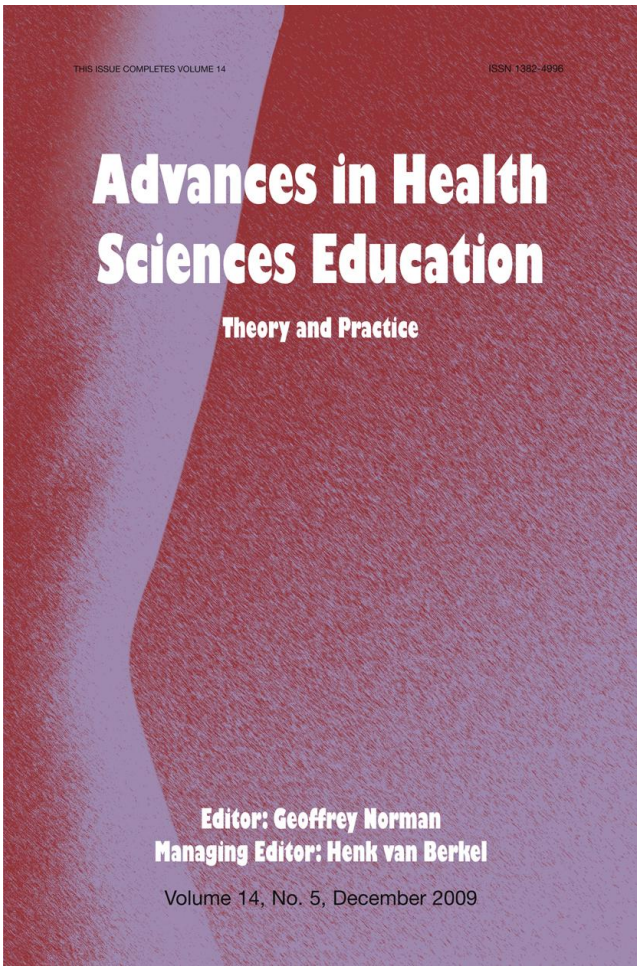

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EDITORIAL

What we see and don't see when we look at 'competence': notes on a god term

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'Competence' is one of health professional education's most cherished ideas. It's what the 20th century rhetorician Kenneth Burke would call a 'god term' (Burke 1952): a sort of education idol, an "expression to which all other expressions are ranked as subordinate" (Weaver 1953). This god term presides over many of our conversations in health professions education, conversations including curriculum reform, evaluation systems and program accreditation, to maintenance of certification. And, like other god terms of our era ('patient safety' has recently emerged as one, 'objective assessment' has long been another), 'competence' is a rhetorical trump card, regularly played as the last word in debates about how health professions education should function.

To a rhetorician, any bit of language with that kind of power cries out for a closer look. "Every way of seeing is also a way of not seeing", as Kenneth Burke asserted (Burke 1935). He drew attention to how words function as "terministic screens": "even if any given terminology is a *reflection* of reality, by its very nature as a terminology it must be a *selection* of reality, and to this extent it must function also as a *deflection* of reality" (Burke 1966) (emphasis in original). What aspects of competence are we attending to, and what aspects are we avoiding? What actions and values are made possible by our way of seeing competence in health professions education, and what actions and values are rendered impossible? This editorial presents a preliminary teasing apart of our way of seeing competence, in order to draw critical attention to what the god term invokes and what it elides.[1]

In its conventional usage, competence is an individualist notion. The emphasis is on producing and maintaining "the competent physician" whose knowledge and skill is performed and assessed over the course of his or her training and practice. In this regard, the god term reflects the reality of health professional education's focus on the individual.

[1] The arguments expressed in this editorial are drawn from a more comprehensive consideration of the discourse of competence, which is being prepared as a book chapter in an edited volume entitled *Blind spots: Health Professional Competence in the 21st Century* (Hodges and Lingard, eds).

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We admit candidates based on individual academic qualification; we assign individual grades to students (even in context of group activities such as problem-based learning); we license trainees based on examination of individual knowledge and skill; we monitor licensed practitioners' ongoing development through accrual of individual CME credits; we remediate problematic performance by targeting the individual performer.

Based in learning theories such as adult learning and reflective practice, the god term of competence selects for our attention the autonomous learner (Bleakley 2006). With its roots in cognitive psychology, it isolates for careful consideration constructs such as memory, problem-solving and decision-making, which take as their starting point the individual learner or expert (Regehr and Norman 1996). By selecting the individual learner for emphasis, the god term also invokes the notion that competence is context-free, untied to time and space. This, in turn, gives rise to the concept of what Hodges has called a "state of competence", something novices move to "from a state of incompetence" (Hodges 2006). In conceiving competence as a state to be achieved, we not surprisingly end up talking about the *generically* competent practitioner, one whose, say, communicative competence in one situation should predict future communicative performances in other, similar situations. And while cognitive psychology research warns us against the claim that an individual can be universally competent in all contexts, still our competence discourse evokes the notion of generic abilities and generically competent practitioners. CanMEDS is a good example: "a competency-based framework that describes the principle [sic] generic abilities of physicians" with a strikingly acontextual byline—"Better standards. Better physicians. Better care" (Frank 2005). Yes, the CanMEDS framework includes a "Collaborator" role, but it's conceptualized at the level of the individual, with competencies and enabling competencies characterized as behaviors that individual physicians are able to enact.

We should not be surprised that our way of seeing competence reflects the individualist orientation of the education system. This makes good sense, because the education system is predicated on the individualist orientation of the larger healthcare system, in which licensure, billing, and medico-legal accountability function on an individual practitioner basis (Sidhom and Poulsen 2006). As Burke put it, a god term manifests the "ultimate motive" of a community or context. Given that western medicine is motivated by a depiction of the healthcare provider as an autonomous force (Gordon 1988), so too will the development of healthcare providers be motivated by similar values.

To summarize then, 'competence' *reflects* our individualist healthcare system and education culture. It *selects* for our attention the individual learner and the knowledge, abilities and values they possess in their heads, hands and hearts. What, then, does it *deflect* our attention from? What blind spots does it produce? An example from my own work comes to mind: competent individual professionals can—and do, with some regularity—combine to create an incompetent team. The conventional discourse of competence doesn't really help us grapple with this reality; it deflects our attention from this sticky educational and clinical problem. However, alternative ways of seeing competence are emerging that may help us address this.

The emergence of what I will call a 'collectivist discourse of competence' reflects growing attention in the social and organizational spheres to healthcare's nature as a complex system. 'Collective competence' draws on social learning theory with its premise that knowledge is constructed through participation (Lave and Wenger 1991). This focus is particularly appropriate in apprenticeship or work-based learning settings like medicine, where what is 'learned' is not in the complete control of teacher or learner; it emerges as a

consequence of the social interaction, which is shaped by the physical, social and organizational context.

Social learning theories move our focus beyond capturing, codifying and documenting knowledge of individuals, and towards the ways through which knowledge is shared, discussed, and innovated in a collective setting (Eraut 2000; Mittendorf et al. 2006). Similarly, the concept of distributed cognition helps to characterize competence as dynamically produced in situations, taking as its unit of analysis a culturally constituted functional group rather than an individual mind (Hutchins 1990; Hutchins and Klausen 1998). Distributed cognition conceptualizes collaborative work as "cognitive accomplishments" that "can be joint accomplishments, not attributable to any individual" (Hutchins 1990). This concept is particularly useful in this era of clinical training in which knowledge is dynamic, learning is complex and uncertain, and information and rules are stored in technologies and in social rituals of clinical groups. As Bleakley and Bligh argue, "learning is largely a meta-process concerning legitimate access to situated (context-linked) and distributed knowing. This is not to deny the value of one's own store of knowledge, but to place this in the wider and more pressing context of learning how to learn or how to access knowledge" (Bleakley and Bligh 2007). Similarly, the theory of knowledge-building communities has as its hallmark a sense of collective group operation rather than an assemblage of individuals (Bereiter and Scardamalia 2003).

In the context of team performance, competence includes knowing how to jointly produce knowledge, rather than simply reproduce information. The "coordination" made possible by distributed cognition is one representation of collective competence: shared knowledge helps produce shared mental representations of tasks, which assists shared expectations, which support coordinated actions (Salas et al. 2007). Such models of team cognition reflect the key notion of "coupling", the idea that parts of a system are not discrete but, rather, that their connectedness is such that a change or weakness in one part of the system affects both other parts and the performance of the whole.

The emerging discourse of collective competence provides a basis for understanding my example of an incompetent team comprised of competent individuals. It is not, however, without its own blind spots. Among the critiques of collectivism (and related terms, like "systems approach to safety" and "inter-professional collaboration") is the problem of deflected attention from individual accountability. Thus, I'm not proposing 'collective competence' as a replacement god term. Each way of seeing, the individualist and the collectivist, selects and deflects, drawing our attention to some aspects of competence and leaving unaddressed other aspects. And each discourse is constructed by a set of theoretical constructs and disciplinary values that shape educators' sense of what to teach and what to assess in the health professions. Recognizing that our cherished idea of competence *is constructed*, and that it consequently *selects* and *deflects*—this is the necessary first step in guarding against naïve acceptance. For as Burke suggests, the danger with god terms is that, through repeated use and familiarity, they become suggestive of a natural, universal and inevitable order of reality. Teasing them apart is an exercise in making them unfamiliar, excavating the motivations that underpin them, and opening space for an adaptive and flexible discourse of competence.

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