POSITION PAPER

Provincial Privileging Project concerns

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We offer for consideration some thoughts on how the Provincial Privileging Project (PPP) might be improved, with particular emphasis on its application to rural BC.

We both understand the context, and strongly support the decision, to improve public confidence in physician competence and the self-regulation of our profession, by moving from permissive, to criteria or competency based privileging.

We call for the full assessment of patient risk and the consequent need for appropriate support, Continuous Quality Improvement (CQI) and the resultant privileging.

Privileging must be linked to *competency*. We find use of *currency* by the PPP to be a concept that is confusing, difficult to define, impossible to measure, and only indirectly related to competency.

We describe our serious concerns about predicted 'unintended consequences' of the PPP as it is now planned – the loss of maternity, anesthesia, surgery and emergency services in rural BC, in fact the loss of full service family practice in many rural communities.

Finally, we offer a practical, effective and evidence-based addition to the process for currency and competence assessment, and the PPP.

Skill Base and Maintaining Competency

A practitioner begins his/her career with a fund of knowledge and skill from which he draws and into which he reinvests continually, over a practice lifetime.

Competency is sustained by ongoing procedural experience, by formal continuing professional development, by engagement with colleagues in local health care teams, and through measured outcomes of practice as examined in local and regional CQI systems.

Early in a career, a practitioner's skill base will be large on training and education and low on actual experience. Practice experience and new competencies are accumulated over time. Any attempt to measure current competence must take into account the initial training, the contributions from professional development, as well as the current and accumulated practice experience.

The literature on deskilling identifies the importance of "over learning" in training - defined as the number of procedures one performs after competency has been achieved - as a critical element, if not the most important determinant of skill retention.

However, we can readily acknowledge that there are some procedures that are complex and to be safe require an extensive support team, for which there is evidence that volume thresholds are, indeed, a prerequisite for good outcomes, regardless of initial training and continuing professional development. Two examples are cardiac and thoracic surgery. None of these procedures are performed in rural BC.

For those procedures that are performed in rural BC, there is no evidence that there is *any* minimum volume to sustain competency, let alone *what* that number might be. In the absence of evidence for a lower limit of procedures accomplished, any methodology to choose a number will be arbitrary and based on opinion. In our rural settings, the methodology chosen by the PPP for setting volume thresholds to attempt to assure competency, is not evidence based rather it is based on unsubstantiated opinion.

Competency, in a low volume generalist setting, does not belong exclusively to an *individual* practitioner. Rather, it must be examined within the context of the program of care in each setting, in which his or her multidisciplinary colleagues using their complementary skills surround the individual practitioner. In a hospital setting, this includes the contributions made by the local team of professional colleagues, including other physicians, nursing, laboratory, and blood banking and transport, as well as the referral networks. It is this theme of team collective competence – well established in rural practice - that is foundational to the success of programs like MORE^{OB} and the CARE course.

In addition, the CARE course teaches, not only knowledge, skills and team-work, but actuation; and the MORE^{OB} course offers decision support between courses.

Risk

In addition to, and as a fundamental in the reasons why we address these issues at all, is the assessment of the risk of any procedure. The profession is well versed in assessing surgical and anaesthetic risk. Contained within this is the appropriate assessment of what any facility can reasonably provide by way of support.

However, it would appear that the total risk for a rural patient has not been accounted in the PPP process. This includes the salient risk of transfer (there are many examples of patients deteriorating and even dying in transfer) and the risk of a patient declining to travel and not getting the intervention at all, or, in the case of some obstetrical patients, not presenting until the last moment thereby by-passing both appropriate pre-natal care and forcing local delivery.

These are occurrences that happen daily in rural BC, and the process may be termed “holistic risk assessment.” This appears not to have been accounted in the assessment of risk in the PPP and therefore the appropriate understanding of the necessary privileging to reduce risk and improve outcomes.

Privileging

Privileging must be linked to actual defined competency. It is possible that at least some of the current anxiety over competency arises from the perception that, in the absence of clear and evidence-based criteria about what constitutes competency, volume markers provide a simple and measurable criterion. This has been adopted as a surrogate for competency. Actual competency has been perceived to be more difficult to measure, but is substantially more important for the well being of the population served.

The literature on competency directs us to the importance of *systems,* in particular, CQI systems. These are built on platforms of measured outcomes, risk identification and risk management protocols. Outcomes are measured, reported, and examined formally on a regular basis. The literature on avoidance of medical error is relevant to the current discussion.

The field of CQI has advanced significantly in recent decades and this advance is marked by the recognition that most quality “failures” are not due to “bad apples” but to the nature of the context or setting in which individuals are or are not supported to do their best work.

This was clearly at play with the issues that precipitated the Cochrane report.

The methodology known as “quality assurance” (QA), as opposed to “quality improvement” or CQI, is often based on numerical cut-offs in order to attempt to guarantee quality. It is based on surveillance of individuals and “weeding out” those who are found to be inadequate. This has

proven to be a failure. In contrast, the CQI approach is designed to move an entire staff or setting in the desired direction and results in the desired outcome, and to monitor and improve this continually.

Rather than numerical cut-offs to attempt to define competency, a move toward a systems approach will help to achieve competency for an entire setting as well as the competency of individual practitioners within that setting.

Unintended Consequence: Loss of Medical Services

We disagree with the assertion offered during discussion around the PPP, that unintended consequences cannot be foreseen. Rather, they are simply unintended. In a service delivery system as complex and interconnected as rural health care, it is incumbent on policy makers to force themselves to anticipate most of the outcomes, intended or otherwise.

It is widely recognized that rural health care is fragile and subject to destruction through loss of single elements in the system/team. The recurrence of rural "Communities in Crisis" (those that have lost a service) demonstrates this most clearly, and the number of "Communities at Risk" and "Communities in Transition" are more prevalent, less widely appreciated, under-supported and often a single individual away from collapse.

We fear that an unintended consequence of the adoption of volume thresholds as surrogates for competency will be the departure from rural Canada of the physicians with advanced skills in surgery, anesthesia, maternity care and emergency medicine, in fact ***the very full service practitioners most needed by rural Canada.***[1]

There are two reasons for this.

Firstly, these practitioners of procedural care operate within a generalist model. This model explains and *validates* their low volumes. (Reference: Cairns Consensus). The PPP proposes to replace this model by one in which the tracking of procedure volumes will identify them as *outliers,* who will then need remediation. This challenge to physicians' confidence, enthusiasm and willingness to work in isolated areas must not be underestimated.

Our collective experience has been that it is difficult to recruit and retain these physicians with both the training and the inclination to practice in rural BC, ideally in a full service model. We expect the proposed method of introducing volume thresholds will worsen the already fragile system.

This is particularly unfortunate when there is a substantial body of evidence documenting that current low volume, rural outcomes are as good or better when compared to higher volume programs.

Equally important, there are no studies documenting poorer outcomes for low volume programs. For example, in maternity care, when low risk women are transferred to larger facilities where they are cared for by well-intentioned skilled strangers, the outcomes are not as good as they would have been if they had been cared for in their own communities by staff that knew them.[2-5]

In addition to this challenge to the competence and confidence of full service rural practitioners, the issue of appropriate preparation of the 'occasional disaster' must be addressed.

Secondly, it will be readily appreciated that in all rural communities, patients will present emergently requiring interventions that are administered by specialist physicians and surgeons

in larger centres. In an emergency situation in a rural setting, there are no alternatives. The full service GP/FP must make the necessary interventions. Fortunately, these situations are not common, but they are very stressful and they are widely seen to be the bane of any rural physician's work experience, often leading to burn out and departure; sometimes to depression and suicide. While there are no regulatory constraints on a rural GP in performing his best in these situations, without some regular complementary practice – at a level of greater complexity than that expected of an urban GP – competence, confidence and peace of mind all erode.

Many examples of "cross-skilling" can be made, all of which enhance the delivery of care in that "occasional disaster" patient, but may be practiced infrequently themselves, and fall outside the usual scope of practice of a GP.

While all the other methods of supporting the isolated, very ill patient and his stressed physician (appropriate, team-based, in-community training; helpful referral networks including video-conferencing; timely and effective transfers; strong peer support; helpful debriefing sessions; etc.) must be pursued and strengthened; improved physician competence and confidence, and better patient outcomes may be obtained through appropriate "cross-skilling" that defies the 'numbers approach' of the current PPP process.

Collectively the maternity, surgery, anesthesia and emergency services stabilize the rural health infrastructure for an entire community. In addition, keeping full service care leads to community sustainability itself.[1] These services appear to be the lynchpin that can hold the very community together.[1,6-8] In our opinion, to lose these services will be a calamity for these communities. The literature has described a cascade of effects where, ultimately, physicians and others leave, and these communities[9] close their ER and other services.

Reassurances

Assurance has been given that The PPP will be engaged in vigilant surveillance for any and all unintended consequences, and further, when identified, action will be taken to mitigate these effects. Unfortunately, our experience in rural health care has been that there has never been, to our knowledge, an example of the rebirth of a single surgical and anesthetic service after they have closed.

There has been a natural experiment from which we have much to learn. Over two decades ago, the Society of Obstetricians and Gynecologists of Canada (SOGC) developed a proactive plan to mitigate their malpractice liabilities by improving their outcomes. One of their initial actions was to recommend through a policy paper that practitioners should have a minimum number of 25 deliveries per year.[10] This recommendation was not based on any evidence. Nevertheless, when the Saskatchewan College of Physicians and Surgeons imposed such a regime, most rural physicians left maternity care. Saskatchewan went from 80 per cent of births attended by family/general practitioners (the highest in the country) to less than 20 per cent of births, among the lowest in the country, in a matter of a few years. In consequence, most rural settings providing maternity care, closed that service—leading to a concentration of most full maternity care in Regina and Saskatoon. Regrettably, this outcome had begun with good intentions, the improvement of care for the population.

The SOGC were more than a little surprised to see large numbers of Family Physicians leaving primary maternity care. Based on this phenomenon, and the paper showing that low volume family physicians in an urban setting had similar results to their high volume counterparts,[11] the

SOGC replaced their previous policy with the current Policy Paper[12] which says explicitly that there is *no* minimum number of deliveries required to remain current or competent. They have subsequently developed the rather remarkable program, MORE^{OB} which provides on-going education and training to ***teams*** of maternity caregivers. This program, together with formal CQI systems, is the standards for the SOGC for both currency and competency.

Importantly, the presence of Family Physicians in maternity care in Saskatchewan never recovered.

Recommendations

To summarize, we offer a privileging system not unlike the current proposal. We suggest changes that would be particularly helpful when the new privileging system is implemented in rural BC.

Firstly, the definition of competence should be expanded to acknowledge the roles of initial training, continuing professional development and that of team competence. Competence in these small volume models is expected both from local care teams and the referral networks in which they are nested. There are no volume thresholds which measure competency or currency appropriately in these systems.

Secondly, we draw attention to the present day methodology of a CQI systems approach to assuring both currency and competency. These systems are built on a platform of outcomes, which are measured, reported, and examined in formal CQI and risk management programs. Components include:

1. a review based upon individual, team and system actions and responsibilities
2. an integrated focus upon rural generalist service rather than the discipline specific processes currently undertaken
3. a system of risk assessment that includes the holistic risk to a rural patient
4. a rational and evidence-based system of CQI including:
    a) full statistical data collection and analysis on outcomes for all cases
    b) regular and frequent 'section 51' for a) above as well as Morbidity & Mortality outcome based case reviews, including multidisciplinary input
    c) "360" reviews
    d) a separate QA process when CQI processes do not result in improved outcomes
    e) an enhanced health Authority process for supporting the above
5. in-community CPD focusing upon skills, knowledge, team-work, actuation and on-going support
6. a peer and specialist provided, province-wide, decision support system for rural practitioners
7. meaningful input from practicing physicians, communities, patients, health authorities, licensing and certification bodies, and the academic institutions responsible for ongoing education of health professionals
8. the further development of the CPD and quality enhancement pedagogy and processes into a system that supports ongoing appropriate and safe services
9. support ongoing research into effective CPD, risk assessment and management, CQI and QA, both in small communities and within their regionalised referral areas.

10. adopt a culture around patient safety:

*patient safety culture:

i. Safety is the priority and is everyone's responsibility
ii. Develop effective teamwork and communication.
iii. Eliminating the culture of blame.
iv. Embracing learning, knowledge sharing and evaluation.
v. Promoting interprofessional collaboration with trust and respect

*principles:

i. Communication is highly valued and regularly practiced
ii. Operations and procedures are a team effort
iii. Emergencies are rehearsed
iv. Hierarchy disappears in an emergency. Decisions on safety issues can be made at any level of the organization
v. There is multidisciplinary review of events and routines

**adapted from the MORE^{OB} Program*

Thirdly, we recommend that a review of the current literature be undertaken and Canadian and International expert opinion be consulted; and that meaningful input from BC rural practitioners be sought including, the Doctors of BC, the Society of GPs, the BC College of Family Practitioners, the Rural Co-ordination Centre of BC, the Divisions of Family Practice that have rural membership and the Society of Rural Physicians of Canada.

Finally, we draw attention to a potential unintended consequence of using volume thresholds as a surrogate for currency and competency – the loss of maternity, surgery, anesthesia and emergency services in rural BC.

A Provincial Privileging Project designed to improve a specialist problem in diagnostic imaging cannot be expected to be equally effective and without unintended consequences, if transplanted to generalist rural medicine. Rural is not small urban.

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