

A step in the right direction: continuous mentorship programs as part of a multidimensional credentialing and privileging process for rural surgery and obstetrics

*Bret Batchelor, MD,
CCFP, ESS (USask)
Department of Family
Practice, Faculty of
Medicine, University of
British Columbia,
Vancouver, BC*

*Fred Janke, MSc, MD,
CCFP, FCFP, FRRMS
Department of Family
Medicine, University of
Alberta, Edmonton, Alta.*

*Brian Geller, MD,
MBA, CCFP, FCFP,
FRRMS
Department of Family
Practice, Faculty of
Medicine, University of
Saskatchewan, Saskatoon,
Sask.*

*Correspondence to:
Bret Batchelor,
bret.batchelor@hotmail.com*

In the fall of 2016, the *Canadian Journal of Rural Medicine* published an article on volume-based privileging programs for physicians working rurally in Canada.¹ The authors warned of the threat to medical services of an already at-risk Canadian rural patient population. They outlined numerous examples of the consequences of volume-based programs, such as the decrease in rural maternity care in Saskatchewan years ago.² Owing to the reductionist nature of such programs, they fail to recognize holistic risk when one is planning for service delivery in rural settings. We propose that a continuous mentorship program, although not the sole answer, might be a step in the right direction toward a multidimensional credentialing and privileging program for surgical and maternal care in rural Canada.

Nowhere do the problems outlined in the *CJRM* article affect care more than in rural maternity care and surgery. Rural operating rooms are the foundation of safe maternity care.³ They unfortunately have been hit hardest by the low-volume debate, and, consequently, their numbers have dwindled over time. There is often the assumption that low volume equates to decreased safety. However, there is a growing body of evidence that surgical and maternal care can be safely done in small-volume centres.⁴ In addition, there is growing evidence that travel is detrimental to patients. For example, major maternal morbidity increases by

0.1% per minute of travel.⁵ Thus, it is imperative for patient safety that surgical and operative delivery services be maintained in smaller centres.

Continuous mentorship programs are still in their infancy. In British Columbia, they are being piloted in several rural hospitals both for general practitioner anesthetists and general practitioners with Enhanced Surgical Skills.⁶ Continuous mentorship programs are formal partnerships between rural practitioners and their specialist counterparts in regional centres. They involve site visits, side-by-side work in operating and delivery rooms, and continuing professional development. Within the program, evaluation and education occur side by side in real time. This ensures that rural practitioners are kept up to date and confident in their skills. Most important, these programs foster important relationships between family practitioners with enhanced skills and their specialist counterparts.

Credentialing is the practice of establishing the authenticity and credibility of a practitioner's skills. This has traditionally been done by a local or regional committee that determines whether a practitioner's training program was legitimate. However, there is often no way to validate training because the committee members may not actually witness the practitioner at work. A mentorship, because it involves real-time observation, would

be helpful in determining the legitimacy of a practitioner's training program. Moreover, any identified areas in which improvement is needed could be addressed by the coaching component of the program.

Initial privileging is the process of granting a practitioner's right to perform his or her skill set within a specific institution and geographical location. Validating a practitioner's credentials is part of initial privileging. This could occur with enrolment in a mentorship program. Privileging is also about regional planning of delivery to patients by the right practitioner in the right place. The formal partnerships between rural practitioners and specialists in a mentorship program would foster collaboration for planning of surgical and maternal services in rural areas. Within this partnership, both parties can ensure that patients safely receive as much care as possible close to home, provided by physicians living and working in their community.

Continuous privileging takes into account a practitioner's currency and competency. Currency and competency are not synonymous, nor are they mutually inclusive. Currency is the volume of specific work a practitioner is doing. Competency is the level of care being provided by that practitioner. Currency has been shown to be an inconsistent, if not poor, marker of competency.¹ Unfortunately, low-volume centres have insufficient data for statistical significance when enrolled in continuous quality-improvement programs such as the National Surgical Quality Improvement Program. Thus, the determination of competency remains nebulous. A mentorship program for surgery and maternal care could contribute to the overall solution. Side-by-side work not only allows direct observation but also provides coaching and education for the skills required by rural practitioners. Such mentorship allows identification of competencies needing improvement and immediate education and coaching in those areas.

There is currently a lack of a formal modality by which any practitioner acquires new skills in surgery or maternity care. Traditionally, a practitioner would be taught by his or her peers in an informal setting. Alternatively, short courses in new procedures and emerging technologies were offered by firms involved in manufacturing equipment or academic centres. However, when such courses are

taken without additional training, higher complication rates have been reported.⁷ A mentorship program is an ideal avenue for acquisition of new skills. The mentor and mentee can work together to identify an area of need, as well as work with their university's continuing professional development department to determine how to acquire the required experience in that area. Once the skill is learned, the mentorship then allows for continuous monitoring of confidence in the skill, which falls back into continuous privileging.

Continuous mentorship programs hold many possibilities for ensuring that rural patients receive surgical and maternity care as close to home as possible, provided by competent and confident practitioners. Considerable work still needs to be done to determine the particulars of these programs, but they promise to be part of a multidimensional modality for credentialing and privileging. The ability of continuous mentorship programs to foster relationships between rural practitioners and their urban counterparts will allow us to move away from isolated practice toward integrated practice. This collaboration, we hope, will ensure that rural patients in Canada continue to receive the highest-quality maternity and surgical care as close to home as possible.

REFERENCES

1. Soles H, Larsen Soles T. SRPC position statement on minimum-volume credentialling. *Can J Rural Med* 2016;21:107-11.
2. Johnston CS, Klein MC, Iglesias S, et al. Competency in rural practice. *Can J Rural Med* 2014;19:43-6.
3. Kornelsen J, McCartney K. Optimal perinatal surgical services for rural women. Vancouver: Applied Policy Research Unit, Centre for Rural Health Research; 2014. Available: http://ess.rccbc.ca/wp-content/uploads/sites/5/2014/12/Policy-Brief_Optimal-Perinatal-Surgical-Services-for-Rural-Women_FINAL.pdf (accessed 2016 Nov. 22).
4. ESS family physician library. Enhanced Surgical Skills Working Group. Available: <http://ess.rccbc.ca/ess-family-physician-library/> (accessed 2016 Nov. 22).
5. Ravelli AC, Jager KJ, de Groot MH, et al. Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands. *BJOG* 2011;118:457-65.
6. Parnell T, Sinova A, Nash M. Clinical coaching: literature review. Vancouver: Rural Coordination Centre of BC; 2014. Available: <http://ess.rccbc.ca/wp-content/uploads/sites/5/2017/01/Parnell-2014-Clinical-coaching-literature-review.pdf> (accessed 2016 Nov. 22).
7. Sachdeva AK, Russell TR. Safe introduction of new procedures and emerging technologies in surgery: education, credentialing and privileging. *Surg Oncol Clin N Am* 2007;16:101-14.

Competing interests: None declared.