

## Backgrounder, British Columbia Privileging Project

4 December 2014

While some of our colleagues have more fear/distrust of the Provincial Privileging process (PPP), we fully support the stated goals of an improved Privileging process, including carefully accountable portability of credentials for all physicians.

Our concerns are directed as follows:

### 1. The substitution of “currency” for competency.

We understand that the initial request of the Health Minister Hansen in commissioning, on 11<sup>th</sup> February 2011, a review of several errors in the interpretation of CT scans, was review the quality of diagnostic imaging in BC.

This was expanded later to include “...a review of physician licensing, credentialing and privileges and the roles played by the College and BC’s health authorities.”

We expect the actual objective of the Minister was to ensure the accuracy of reporting and therefore, of course, the competence of physicians.

We are confused, therefore, by the opening set of definitions on the BC Provincial project website which state:

*“Currency: the level of current experience that gives a practitioner a reasonable chance of remaining competent in that activity.*

*Competency: measurement of competency is outside the scope of this project”.*

These appear to be both contradictory and falling short of what the Minister has requested, and what we might expect the average person to want.

In addition, the term “currency” lends itself to a discussion around “when did you last do x?” and “how many times have you done x recently?”. The danger of this is that neither of these address the underlying question.

## **2. The use of numbers to judge competency.**

The manner in which the BC Provincial Program attempts to achieve safe outcomes through the use of numbers of repetitions as a surrogate for competency is fundamentally flawed. It has been shown that safe interventions in the rural or low volume milieu are the rule, and conversely, that mere repetition does not beget competence. The radiologist that precipitated this entire process had plenty of repetitions, the unfortunate part was that some of them were repeatedly wrong.

## **3. The Quality Assurance (QA) process.**

The QA process, even when thoughtfully led, is inherently oppositional and closed. The manner that is, and will continue to be, prevalent is of the defensive, rather than that of a modern, supportive, continuous quality improvement (CQI) process. A volunteering of close shaves/errors/observations of others' management cannot be expected in a QA approach.

The alternative of an extension of the "crew resource management" approach to medical work, to include collegial, post-hoc observations and discussion, with resulting continued professional development (CPD) recommendations will achieve full information sharing and supportive recommendations for improvement. This will be successful for both the 'known' and the 'unknown' areas for improvement.

## **4. Holistic risk assessment**

We suggest that the real objective of this entire process is improved patient safety.

Patient safety includes not only the 'pathological' risk assessment (i.e. the risk of the disease process alone) but the additional risks and costs of transfer. These include delay in management and disease progression during transport; the dangers of injury and even accidental death, during transport; delay in presentation by patients trying to avoid transfer (e.g. obstetrical non-presentation until in established labour).

If we are to help improve patient outcomes in BC's rural communities – which account for 27 per cent of the provincial population (2011 Census) – these real risks must be factored into our management plans and, consequently, into privileging.

## **5. Cross skilling and preparation for emergency management**

It is well supported that proficiency in one intervention may, with appropriate support, be translated into infrequent, but life saving, interventions. Of course, instruction on mannequins etc. will be an important part of this preparation. An example of this is proficiency in chest drainage and/or central line placement will augment the ability to place an infrequent surgical airway in an emergency. Privileging must therefore take into account interventions by local GP/FPs that would not be the purview of a GP/FP in larger communities.

## **6. Generalism**

The growing realization that generalism – as well as an expanded scope of practice – is an essential part of expert, cost effective rural health care delivery is very important. (A current description of the generalist is provided at the end of the bibliography). The current PPP makes no allowance for this approach to service delivery and consequently privileging. While this might seem too complex for a bureaucratic approach, it remains essential to adequate

service delivery, and is best judged by peers in the proposed CQI process.

#### **7. Team based care**

Similarly, in most – if not all – rural hospitals, the norm is team based care. We ignore the observations and assistance of our nursing and other health care colleagues at our peril. It also, is difficult to meld into a ‘check box’ approach to physician privileging, but as it forms a very significant part of our management decisions and actions every day, it seems foolish to ignore this. Team based, CQI discussion will include these important pieces of feedback.

#### **8. CFPC curriculum**

The FM Competencies and CanMEDS-FM roles, that are still in the process of being developed into curricula and examinations by CFPC, will guide not only the training, but the expectations of our most recent practitioners, as well as – ultimately – the public. It is entirely appropriate to include this approach to FM/GP work in the review of privileges.

This approach emphasizes the cognitive rather than the easy-to-count procedural interventions that are proposed in the current FP/GP dictionary. It is understood that most of the difficulties that practitioners get into are around decision making, not procedures. Therefore, not only does counting procedures become of little significance, and may even be harmful, but the alternative of colleagues addressing cognitive outcomes is clearly much more important.

#### **9. Shared concerns**

The Section of General Surgery shares many of the concerns around the inadequacies of the current PPP processes.

#### **10. Five GP dictionaries**

We are told that GPs will need to qualify for as many as five dictionaries. These are GP/FP, GP with Anaesthesia (GPA), GP with Enhanced Surgical skills (GPS), GP with advanced obstetrical skills (GP Ob) and GP with Emergency Medicine skills (GP EM). These are currently often combined (e.g. GPA/GPEM, GPS/GPOb) and the segmented approach to privileging with the current repetitions (numbers of procedures, number of hours, etc.) will push both experienced and incoming physicians into more limited practice. This is precisely what rural medicine does not need.

It will also be an unreasonable addition to the work of the Health Authorities (HA).

#### **11. Modern Quality Improvement methods.**

The supportive environment for quality improvement recommended in the CQI approach has much to do with physician recruitment and retention. Physicians want to know that they are practicing to their best of their ability and will look to their peers for that reassurance, when they are not threatened in an adversarial QA process.

To squander the chance to build better health care delivery, improved relationships and improved recruitment and retention through an enhanced CQI process seems dilatory at best.

In the most fortunate rural communities there is an infrastructure supporting rural generalist medicine

built on a platform of General Surgery, Family Practice Obstetrics, Family Physicians with Enhanced Surgical Skills, and Family Practice Anesthesia. This sustains local maternity care programs that are woven into the essential fabric of these communities. There is good evidence, both in Canada and elsewhere - Australia for example - that this generalist procedural platform is characterized by excellent clinical outcomes.

In rural BC, the potential for harm, program closures in particular, is very large. Similar experiences in other provinces for different reasons, did lead to the closure of programs that have never re-opened.

CQI activities are the vehicle by which individual practitioners, and the entire health care team, remain engaged with clinical activity. For example, participation by the entire team in MORE OB programs is a much more useful measure of competency/engagement than the procedural volumes of any particular participant.

### **Privileging recommendations.**

1. A robust, Section 51 protected, 360, team based, properly facilitated, CQI process, informed by risk adjusted outcomes for a local and regional program, should be the centre piece of the proposed changes, and will accurately inform the health authority on the continuation of current privileging.
2. If a physician requests new or different privileges, then it should be the recommendation of the CQI group that advises upon this review, with the proper appreciation of the need for the work locally, the authentication of training and experience, and in the setting of the HA's regional and hospital objectives and facilities. Decisions must remain the purview of the HA.
3. Where a physician does not meet the satisfaction of their colleagues and the health authority participant in the CQI process, it is expected that the scope of the CQI process will end and the physician will be directed to the HA or CPSBC QA processes.

Rural health care is defined by a delivery system built on generalism rather than specialization. Rural generalist medicine describes a distinct scope of medical services that encompasses community-based primary care; hospital and emergency services; a population health approach; teamwork in a system of care; and provision of care in areas of focused practice as required to sustain medical services required in the community.

Indeed, this model of care offers advantages in comprehensiveness, efficiency and effectiveness, which could be a model for urban areas.

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## The Generalist

The generalist is a skilled clinician who, serving a defined population, is competent in the relationship-based, person-centred

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clinical method; integrates a sensitive, skillful, and appropriate search for disease; acknowledges uncertainty; utilizes the cure/attenuation/comfort spectrum of treatment and addresses community health status indices.

The generalist, working collaboratively with the patient, their family and the health care team to optimize care, will provide comprehensive continuum of care throughout a person's illness experience, and throughout a patient's lifespan, from pre-conception to death. The generalist understands the central role of the person-physician relationship and competently applies the concepts of evidence-informed care, advocacy and stewardship to improve the bio-psycho-social-spiritual health, regardless of the clinical setting. With reflection and self- and peer-assessment, the generalist will undertake continual professional self-improvement.

The generalist will undertake to mentor and teach colleagues to the best of his/her ability.

The generalist will strive, wherever possible, to improve the system of care within which he/she works.

Generalism thus, is more than the ability of a practitioner and the health care team to provide 'specialised' medical knowledge and skills where appropriate, but also supporting full continuity of care through an illness experience by accepting, supporting and guiding a patient's care from initial contact through to resolution.

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