Provincial Privileging Standards Project

Thoughts on how to make the provincial Privileging Standards Project more relevant and effective, and a consideration of the project's unintended consequences, followed by a reply from the authors of "Changes to medical staff privileging in British Columbia" (*BCMJ* 2014;56:23-27).

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We fully support the decision to improve the self-regulation of our profession and the resultant reassurance of the public about doctors' efficacy. We offer some thoughts on how the provincial Privileging Standards Project might be made more relevant and effective, moving from permissive to criteria-based privileging, for rural medicine. We also anticipate unintended consequences from the project's reliance on numbers—loss of maternity, anesthesia, surgery, and emergency services in rural BC.

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This article has been peer reviewed.

Currency

A practitioner begins his or her career with a currency capital account—large on training and education and low on experience. The account is sustained by procedural experience, CPD, team-based care, and measured outcomes of practice examined in local and regional continuous quality improvement systems.

Some procedures, all complex and requiring extensive support, show evidence that volume thresholds are, indeed, a prerequisite for good outcomes. Examples are cardiac and thoracic surgery.[1,2]

For procedures that are performed in rural BC, there is no evidence that there is any minimum volume to sustain either currency or competency.[3] Unfortunately, the methodology chosen by the provincial Privileging Standards Project to find a number seems to belong more to gaming theory than it does to evidence-based medicine and is unlikely to be helpful is assessing competency or currency.

Competency

Privileging must clearly be linked to competency. Is currency (in the absence of clear statements about competency) being used as a surrogate for competency?

The literature on competency and the avoidance of medical error directs us to the importance of systems—in particular, continuous quality improvement systems, including measured outcomes, risk identification, and risk management protocols.[4] Outcomes are formally assessed in protected discussion, directing improvement strategies.

Currency, in a low-volume generalist model, does not belong exclusively to an individual practitioner. Rather, it must be examined within the context of a program of care as typically delivered in a rural setting. It is this theme of team currency and competence that is foundational to programs like MORE-OB and the CARE Course.

Unintended consequence: Loss of medical services

We fear that an unintended consequence of the adoption of volume thresholds as markers of currency and competency will be the departure from rural BC of physicians with advanced skills in surgery, anesthesia, emergency, and maternity care. Indeed, this has already happened.

These practitioners of procedural care work within a generalist model, which validates their low volumes.[5] The provincial Privileging Standards Project proposes to replace this model

with one in which the tracking of their procedure volumes would identify them as outliers.

As everyone is aware, it is difficult to recruit and retain physicians with both the appropriate advanced skills and the inclination to practise in rural BC. Volume thresholds and identification as an outlier will cause physicians to further avoid these work environments.

There is a substantial body of evidence confirming that small volume rural outcomes are as good or better when compared to higher volume programs.[3,6,7] Equally important, there are no studies that document poorer outcomes for these programs. Collectively, maternity, surgery, anesthesia, and emergency medicine services stabilize rural health. In their absence, the literature describes a cascade effect where, ultimately, affected communities lose services.[8-10]

A privileging project designed to improve a specialist problem in diagnostic imaging cannot be effectively transplanted to generalist rural medicine.

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A link to the group's position paper, *Provincial Privileging Project concerns*, is available at bcmj.org.

Dr Slater and Ms Bloch-Hansen reply

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We have read the commentary from Drs Avery, Boyd, Iglesias, Johnston, Klein, Ruddiman, and Woollard with some concern. We accept that change engenders fear, but we disagree with the assertions made. The privileging dictionary project is only one of a larger suite of projects to address credentialing and privileging activities across the health system. In responding to the concerns raised we appeal to hope and to a better future for the physicians of this province. We anticipate, once implemented, the privileging dictionary project will grant physicians the opportunity to enter into conversations regarding the supports they need to maintain and exercise the skills employed in clinical practice.

In undertaking this work (56 expert panels participating), we have consulted widely with practitioners from all disciplines, with boards of governance, and with administrators across the province, and we are using what we have learned to articulate the guiding principles below. While these guiding principles are not the reason this project was initiated, they are a beneficial by-product.

First, all practitioners in the province should feel supported in clinical practice. While a certain skill set is required for each medical staff position in the province, many physicians are reluctant to discuss their level of comfort performing these skills. This project creates a safe environment and context for this to occur and for discussions on how comfort may be maintained or restored.

Second, we must not confuse currency with competency. The training colleges are only now beginning to address the challenge of defining competence for the practising physician. We are interested in this issue, but it is beyond the scope of our project. Other initiatives will address competency.

Third, currency is an estimate of the level of activity below which a collegial discussion about support should be triggered. It is not a disqualifier. This discussion should be guided not only by the expectations and standards outlined in the dictionary but also by the risks inherent in the privilege being discussed and by similar activities that contribute to the skill under consideration. This is an opportunity to reflect with a respected colleague on one's professional practice and to deliberately plan an approach to skills maintenance.

Lastly, we do understand that the

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Southern Medical Program complete 2 years of undergraduate academic training at UBC Okanagan and the clinical teaching campus at Kelowna General Hospital. They transition to area hospitals and clinics for their third and fourth years. UBC's 2-year family practice residency training program is distributed throughout the province, involving 16 educational sites.

A new emergency medicine residency training site in Kelowna is also being launched, along with the Vancouver Coastal Health site for family practice residencies in North Vancouver.

Expansion of the family practice residency program is part of a combined effort by the provincial government, health authorities, UBC Faculty of Medicine, and local communities.

Recycle electronic medical devices

Unwanted electronic medical equipment can be dropped off at a Return-It Electronics collection site for recycling, including items such as electronic stethoscopes, microscopes, and blood pressure monitors. No fees apply when recycling any of these products. For hospitals and clinics with a large quantity of electronics, pickup can be arranged at no cost through the large-volume program. Information on depot locations, large-volume pickup, and a list of acceptable items can be found at www.return-it.ca/electronics/products, or call 1 800 330-9767.

The Return-It Electronics program is a provincially approved and regulatory compliant stewardship program that recovers unwanted or obsolete electronics and for recycling in a safe and environmentally responsible manner.

Correction: Author credentials

Authors of the article "Canadian endocrinologists' views on growth hormone replacement therapy in adult survivors of pediatric brain tumors following achievement of final height" (*BCMJ* 2014;56:230-235) have corrected information pertaining to three of the authors' names and credentials. The affected authors' corrected information is: Haroon Hasan, BSc, MPH; A. Fuchsia Howard, RN, PhD; and Karen Goddard, MBChB, MA, FRCP (UK), FRCPC. The information has been corrected in the online version of the article, available at bcmj.org/articles/canadian-endocrinologists'-views-growth-hormone-replacement-therapy-adult-survivors-pediatr.

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dictionaries being developed will need maintenance and improvement. This is an iterative process; its implementation will be closely monitored by the province, the colleges, and the health authorities. Any unintended consequences will be addressed quickly.

In the absence of a comprehensive strategy of support, rural health care has continued to face difficulties. Some may assert that our approach will lead to physicians leaving rural health. We point out that this is already happening and we believe that a planned and collaborative approach to maintaining skills may be part of the solution. BCMJ