# Are We Afraid to Use Regulatory and Policy Levers More Aggressively to Optimize Patient Safety?

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## Context

Healthcare is a very labour-intensive process. The performance, individually and collectively, of a diverse array of healthcare workers has profound implications for the safety of care provided to patients and clients. It is worthwhile to consider how effectively we have used regulatory and policy levers over the past 10 years to assure optimally safe performance by the entire healthcare workforce.

In any consideration of human performance, it is important to differentiate between human capacity to perform at a high level and the consistency of actual human actions on a day-to-day basis. It is important to remain ever mindful of the factors that influence performance capacity and those that influence workplace actions.

In 1990, George Miller published in Academic Medicine, an article that described four facets of professional expertise and visually depicted these facets as layers of a pyramid (Miller 1990). In Miller's Pyramid, "knows" forms the base, followed sequentially by "knows how," "shows how" and "does." Although Miller applied this construct to professionals, I believe it is applicable to all workers.

Patient safety is compromised when there is a gap between worker capacity to perform safely (know how) and actual worker performance (does). Both regulatory and policy levers can narrow that gap if they are applied effectively. Historically, we have applied regulatory and policy levers quite differently to professional workers as opposed to non-professional workers. We have also applied these levers differently to healthcare system employees as opposed to workers who hold independent contractor status in the system.

I will explore some of the implications of our differential application of regulatory and policy levers to different categories of healthcare workers. I will also issue a challenge to reconsider how such levers might be used more effectively in the future to enhance patient safety in Canada.

## We Are In This Boat Together – or Are We?

Although there are certainly important differences in the nature of the work undertaken by professional and non-professional workers in the course of patient care, over the past 10 years, we have come to appreciate that we have significantly undervalued the impact of the non-professional workforce on patient safety. For example, in respect to our management of risks such as hospital-acquired infections, we have come to better appreciate how pivotal the work of hospital cleaning staff is to reducing this risk of patient harm.

We have also come to appreciate that non-professional workers are just as resourceful and insightful as professional workers in their capacity to identify workplace and work process changes with potential to enhance patient safety. Consequently, we now routinely bring together teams of professional and non-professional workers to jointly explore opportunities to make healthcare safer.

The ascendency of patient safety as an important issue for the entire healthcare workforce has had a very salutary impact

on the historical social and class divisions between professional and non-professional healthcare workers. In many respects, patient safety has modulated health workplace cultures to create a sense of shared purpose and goals among the entire workforce.

However, notwithstanding a growing sense that all healthcare workers are "in the same boat," we continue to apply regulatory and policy levers very differently to various groups of workers. The regulatory levers applicable to health system employees are different from those applied to "independent contractors" such as physicians.

## Tensions Between Professional Autonomy and Accountability for Patient Safety

Healthcare is increasingly becoming a team-based activity, and patient safety is heavily reliant on a diverse array of healthcare personnel functioning effectively as teams.

When critical incidents occur, which cause patient harm, suboptimal team performance is often identified as a contributing factor. Accountability mechanisms for effective performance as a team member are different for various members of the team. That variance in accountability mechanisms is often linked to the concept of professional autonomy. While all professionals attach some value to the concept of professional autonomy, this concept accounts for the medical profession having a working relationship with health authorities (HAs) and hospitals that is distinct from most other professions.

An HA or hospital may adopt a policy or regulation that is applicable to all of its employees but may not be applicable to physicians unless they voluntarily agree to comply. The mechanisms for monitoring and assuring physician compliance with HA or hospital policies and regulation remain different than for most other members of healthcare teams. In some instances, unreasonable physician insistence on professional autonomy compromises the potential for HAs and hospitals to optimize patient safety.

The implementation of the surgical safety checklist across Canada has served as an interesting case study in respect to the application of policy to different members of the surgical team. When HAs and hospitals elected to implement this evidence-based policy, compliance by all employees was not optional. However, in many instances, obtaining surgeon compliance required protracted dialogue and negotiations.

## Effectiveness of Professional Regulatory Agencies in Assuring Patient Safety

Before being deemed eligible to provide any patient care, professionals must acquire and sustain registration or licensure with their respective professional regulatory agencies.

These agencies place a great deal of emphasis on the first level of Miller's Pyramid as a condition for initial registration. That means that they expend much effort to ensure that the professionals they license have acquired the knowledge essential for competent practice. All define entry-to-practice education programs that are perquisite to licensure. Many also require successful completion of national standardized examinations. All of these examinations measure knowledge, while some, such as those offered by the Medical Council of Canada, also reliably measure problem-solving skills and performance in simulated clinical situations (the second and third tiers of Miller's Pyramid).

However, once they admit individuals to a profession, professional regulatory bodies have very limited capacity to reliably assure their continuing competence. Most require their members to complete a minimum volume of continuing professional learning activity as a surrogate for maintenance of competence.

Professional regulatory agencies have even less capacity to effectively monitor and reliably measure the daily performance or actions of their members (the apex of Miller's pyramid). They are too remote from the environments in which their members practice to effectively assess their day-to-day performance.

In respect to professionals who practice as employees of health service agencies, most professional regulatory bodies rely on employers to measure and manage the day-to-day performance of their members. Many have convinced governments to adopt legislation that obligates employers to notify the regulatory body of any decisions to suspend or terminate the employment of one of their members. However, bilateral information sharing between employers and professional regulatory bodies at a lower level of concern is uncommon and is actively opposed by many professional associations and unions.

Because a significant proportion of medical practice is conducted in private practice settings, medical regulatory authorities have expended considerable effort over the past 10 years to periodically review physician performance in office settings. Most medical regulatory agencies now operate systems for peer inspection and review of doctors' office practices at five to ten year intervals. This is akin to the periodic evaluation of HAs by Accreditation Canada. It is commendable but remains insufficient to assure patient safety on a day-to-day basis.

Many of the professional medical regulatory authorities in Canada have developed quite sophisticated systems for real-time monitoring of the prescribing of all narcotic and controlled drugs by physicians and quickly intervene when they identify prescribing patterns that put patients at risk of preventable harm. Some are beginning to explore future opportunities to use data from electronic health records (EHRs) and electronic medical records (EMRs) to evaluate physician performance. To date, no college of physicians and surgeons has been granted statutory authority to access data in EHRs or EMRs.

## Using Policy and Regulatory Levers More Effectively to Enhance Future Patient Safety

Through my service on the board of the Health Quality Council in Saskatchewan over the past 11 years, I have had some wonderful opportunities to study high-performing healthcare systems beyond Canada's borders. In contrast to most hospitals and HAs in Canada, many of these high-performing healthcare systems consistently deliver safer care than we do.

I have reflected on how these systems use policy and regulatory levers to achieve and sustain their enviable patient safety standards. I believe there is much we can and should learn from these systems and apply those learnings in Canada.

These are some of my observations about high-performing healthcare systems that deliver safer healthcare than we do. These systems:

- make patient safety a high and publicly transparent priority;
- engage all service providers as well as patients and families in a continuing quest to make patient care safer;
- define very explicit and publicly transparent safety goals;
- clearly define the behaviours and actions of each provider group that are essential to achieving those goals;
- assist and support providers in maintaining those behaviours and actions but hold them very explicitly accountable for consistent compliance with expected behaviours and actions;
- measure provider compliance with expected behaviours and actions;
- provide timely feedback to providers regarding their compliance and offer coaching support where there is a gap between expected and actual provider performance; and
- terminate the working relationship with any provider who proves to be unwilling or incapable of compliance with the behaviours and actions essential to achievement of the organization's patient safety goals.

There is one very striking difference I observe between the safety culture and values in these high-performing systems and our culture and values. In respect to patient safety, these organizations apply accountability expectations to all provider groups, including their physicians, in a remarkably uniform manner. A physician who proves to be unwilling or incapable of meeting expected performance standards related to safety will be at the same risk of being severed from the organization as might be a member of the cleaning staff. In these organizations, safety trumps professional status and egos.

High-performing healthcare organizations that are committed to patient safety also devote considerably more energy and resources to reliable performance measurement for all providers. Data from that measurement are used to provide formative feedback to service providers coupled with supportive coaching. Where coaching fails to achieve expected levels of provider performance, the data are also used to make objective and defensible decisions to sever unsafe providers from the organization.

It is noteworthy how these organizations manage to hold their physicians accountable for safe behaviours and actions without circumventing the medical profession's historical expectation of control over its own affairs. As a condition of physician enrolment, high-performing systems make it very clear that the enrolled medical community will explicitly define policies and medical practice standards that ensure patient safety and hold its members accountable for compliance with those standards. On paper the model may not appear substantially different from the "internal self-regulation" concepts inherent in our hospital and HA medical staff bylaws. However, the application of these professional accountability precepts in high-performing systems has very real meaning and implications.

It is often said that the Canadian culture is defined by our inclination to "be nice" to one another. In some domains, that attribute may be a virtue. In other domains such as healthcare safety, that attribute may actually cause much preventable harm to patients. I will cite one very pragmatic example.

Back in 2008, the Canadian Patient Safety Institute and the Royal College of Physicians and Surgeons of Canada collaborated in defining a set of safety competencies relevant to all healthcare professionals. Those competencies were defined in the following six domains:

1. Contribute to a culture of patient safety
2. Work in teams for patient safety
3. Communicate effectively for patient safety
4. Mange safety risks
5. Optimize human and environmental factors
6. Recognize, respond to and disclose adverse events

Being the nice people that we are, these competencies were promulgated as a framework to influence the future education of health professionals in Canada. They are being integrated into the educational programs that are preparing future generations of physicians and other health professionals .On that basis, their positive impact on safe patient care would be deferred by a generation. And, given the enormous influence of role modelling on values and behaviours among future professionals, what is the likelihood that the next generation of healthcare professionals will fervently embrace, master and apply these competencies if they do not see them having current application to their teachers and mentors.

In Canada, we stopped short of making these safety competencies part of our current performance expectations of all practicing professionals and administering them through policy

or regulatory levers. No professional regulatory agency, HA or hospital has ever sanctioned or dismissed a professional for failure to apply these competencies.

In high-performing healthcare organizations, these same safety competencies drive real-time decision-making about hiring professionals, evaluating their daily performance, coaching them to enhance their performance and terminating professionals who are unable to master and demonstrate these competencies.

In Canada, we tend to write guidelines and fervently hope that altruism will motivate professionals to follow them. In optimally safe healthcare organizations, the very same document is more likely to be adopted as a policy with very explicit expectation of compliance.

We need to consider whether our comparably more timid approach to the use of policy and regulation as levers to protect patients from harm is appropriate. If the choice is one between being nice to healthcare professionals and saving the lives of patients, there can be no doubt that our decision must always be in the favour of patient safety. HQ

## References

Miller, G. 1990. "The Assessment of Clinical Skills/Competence/Performance." *Academic Medicine* 65(9): S65-S67. Accessed August 26, 2012 <winbev.pbworks.com/f/Assessment.pdf>

## About the Author:

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