Collective Competence:
Adapting our concept of competence to healthcare teams

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AIAMC, Tucson 2016

Schulich MEDICINE & DENTISTRY

Western UNIVERSITY · CANADA

Teamwork.
Communication.
Competence.

But first – what is healthcare?

Healthcare then.

'The Doctor', Sir Luke Fildes 1891

Healthcare now.

January 2011

Seniors and the Health Care System: What Is the Impact of Multiple Chronic Conditions?

Analysis in Brief

Introduction

Concern about chronic condition care is growing as the prevalence of chronic conditions such as diabetes and high blood pressure increases in Canada.[1] For many chronic conditions, prevalence increases with age, causing a disproportionate health burden on seniors—Canadians age 65 and older.[2] Patients with chronic conditions—in particular multiple chronic conditions, also called comorbidity—typically have poorer quality of life and require considerable health care resources. Effective prevention and management of chronic conditions is required, especially in the face of Canada's large boomer generation entering the senior age category.

This study examined the reported experiences of seniors in Canada being treated for chronic conditions in primary health care (PHC) settings. The results of the study can be used to enhance our understanding of patients' use of health care services and health status, the quality of patient–provider communication, patient self-management and medication management. This report is focused on seniors because they are more likely than younger people to have chronic conditions, especially comorbidities that can be complex and difficult to manage.

Key Findings

Healthy seniors need less health care. The amount of health care services seniors will use is largely driven by the number of chronic conditions they have, not their age.

- In each of the age groups (65 to 74, 75 to 84, and 85 and older), seniors with three or more reported chronic conditions had nearly three times the number of health care visits than seniors with no reported chronic conditions.

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Canadian Institute for Health Information
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- 24% of all Canadian seniors report having 3 or more chronic conditions
- These seniors report 13.3 million healthcare visits per year

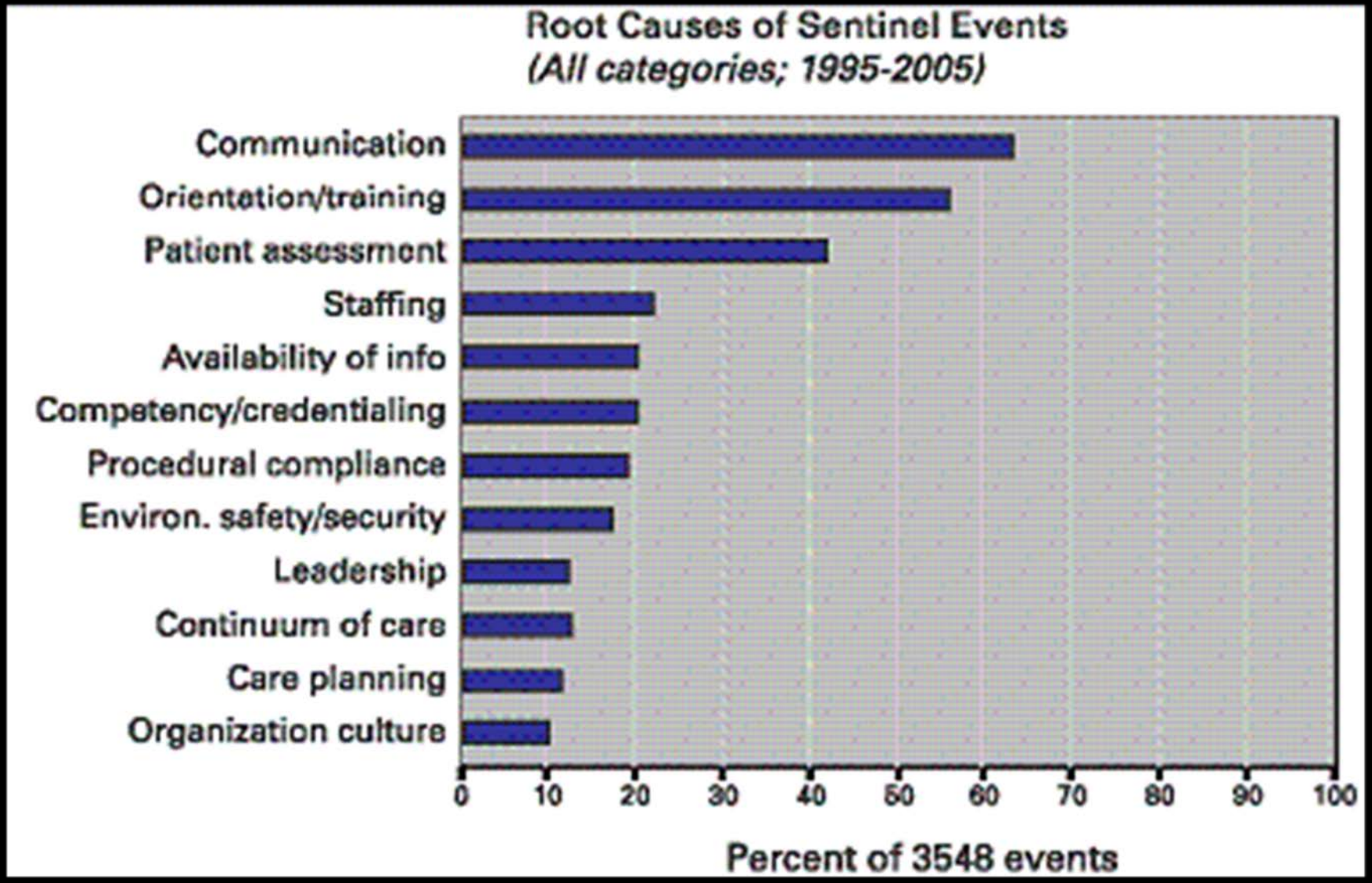
(CIHI, 2011)

Healthcare is a team sport


Chasm
© Kyler Kelly

This is what I study.

As a rhetorician,
I focus on team communication.



JCAHO. Sentinel event statistics. www.jcaho.org

My Objectives

To complicate the idea of ‘communication’

To expand the notion of ‘competence’

In order to encourage us to grapple with the complexities of healthcare teamwork

3 stories

Sharing knowledge in the OR team

Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

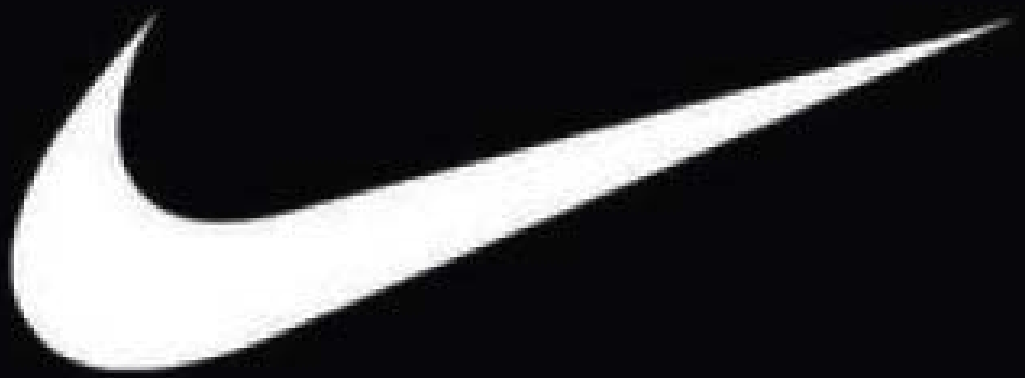
Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

JUST DO IT.




not so
easy

On the frontlines of simple checklist interventions

"We did the big launch, the leadership walk-abouts. And something called a checklist is being counted as 'done' here. But there's such variability in terms of who's there, what they bother to talk about, how seriously they take the whole thing … we've had surgical site errors twice in the last month, both in cases where the checklist was 'done'. Who's kidding who? "

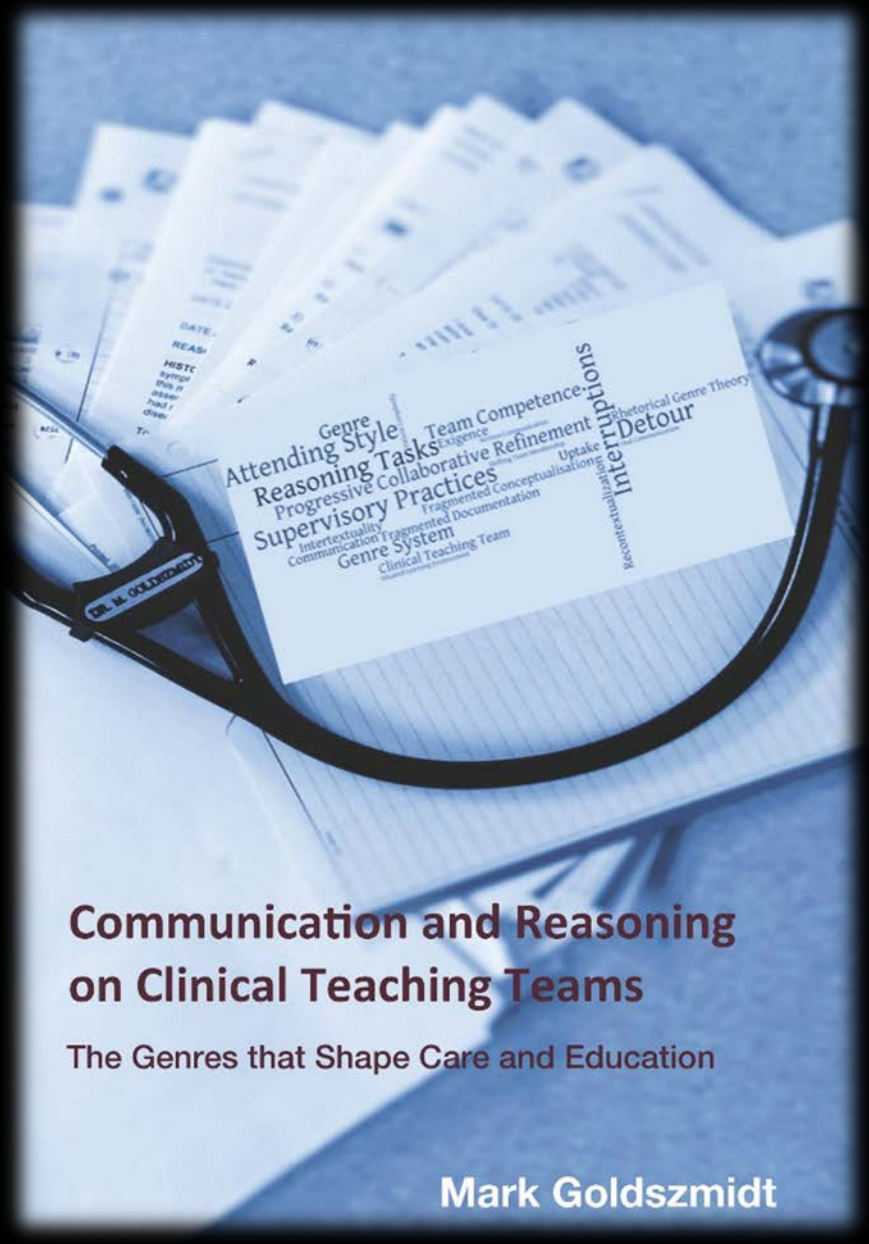
The moral

Information transfer is an enabling communication competency for teams.

A checklist may help.

But a checklist ≠ team competence.

Communicating complexity on the inpatient teaching team


Genre
Attending Style
Team Competence
Reasoning Tasks
Exigence
Collaborative Refinement
Progressive
Supervisory Practices
Fragmented Conceptualisation
Uptake
Rhetorical Genre Theory
Interruptions
Detour
Recontextualisation
Intertextuality
Communication
Fragmented Documentation
Genre System
Clinical Teaching Team
Communication and Reasoning
on Clinical Teaching Teams
The Genres that Shape Care and Education
Mark Goldszmidt

Documentation is translation

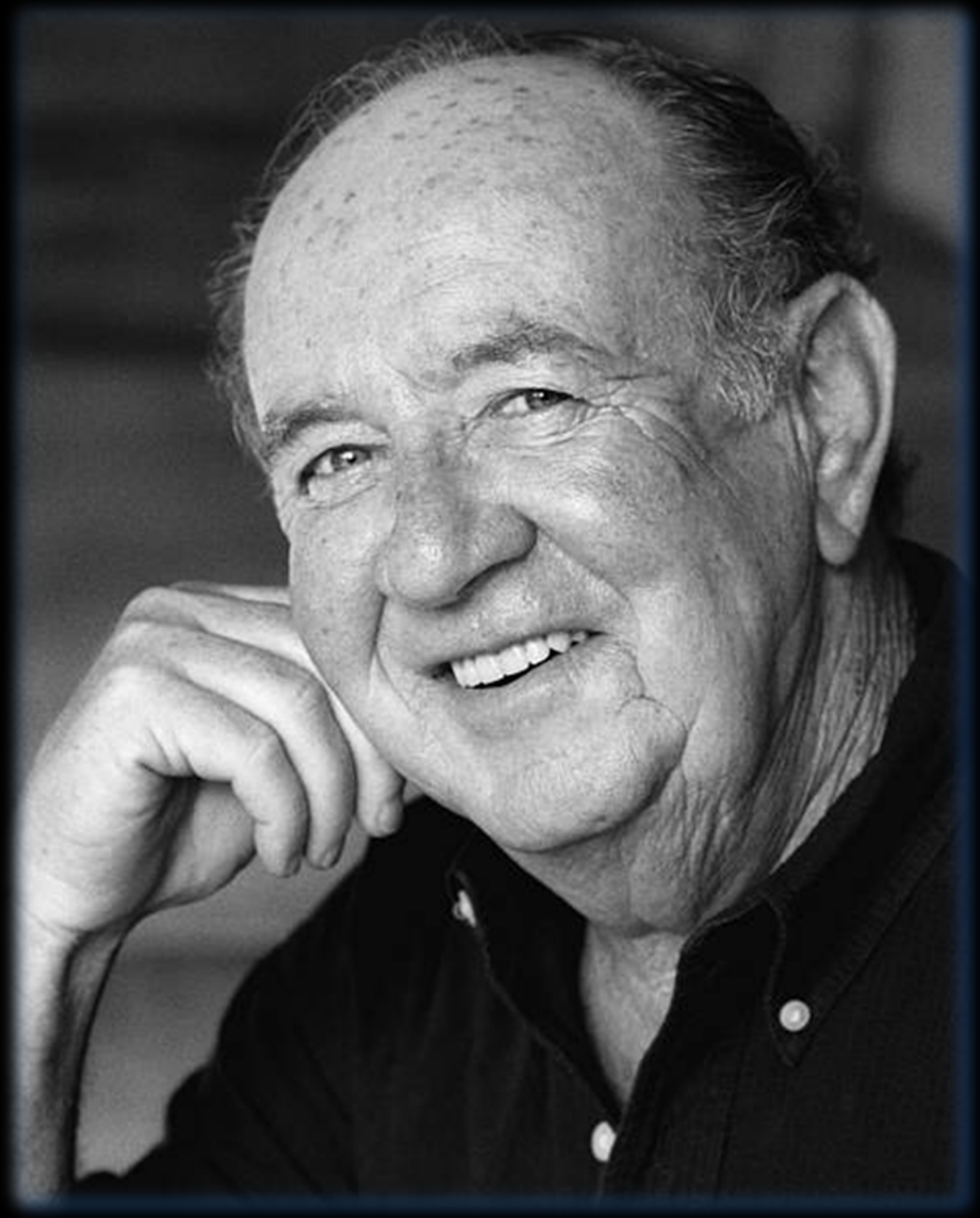
The moral

Conventional team scheduling traditions challenge
progressive collaborative refinement.

Delegating documentation to most junior team member is problematic.

Connections *between* communication events are the key.

Communication on distributed care teams



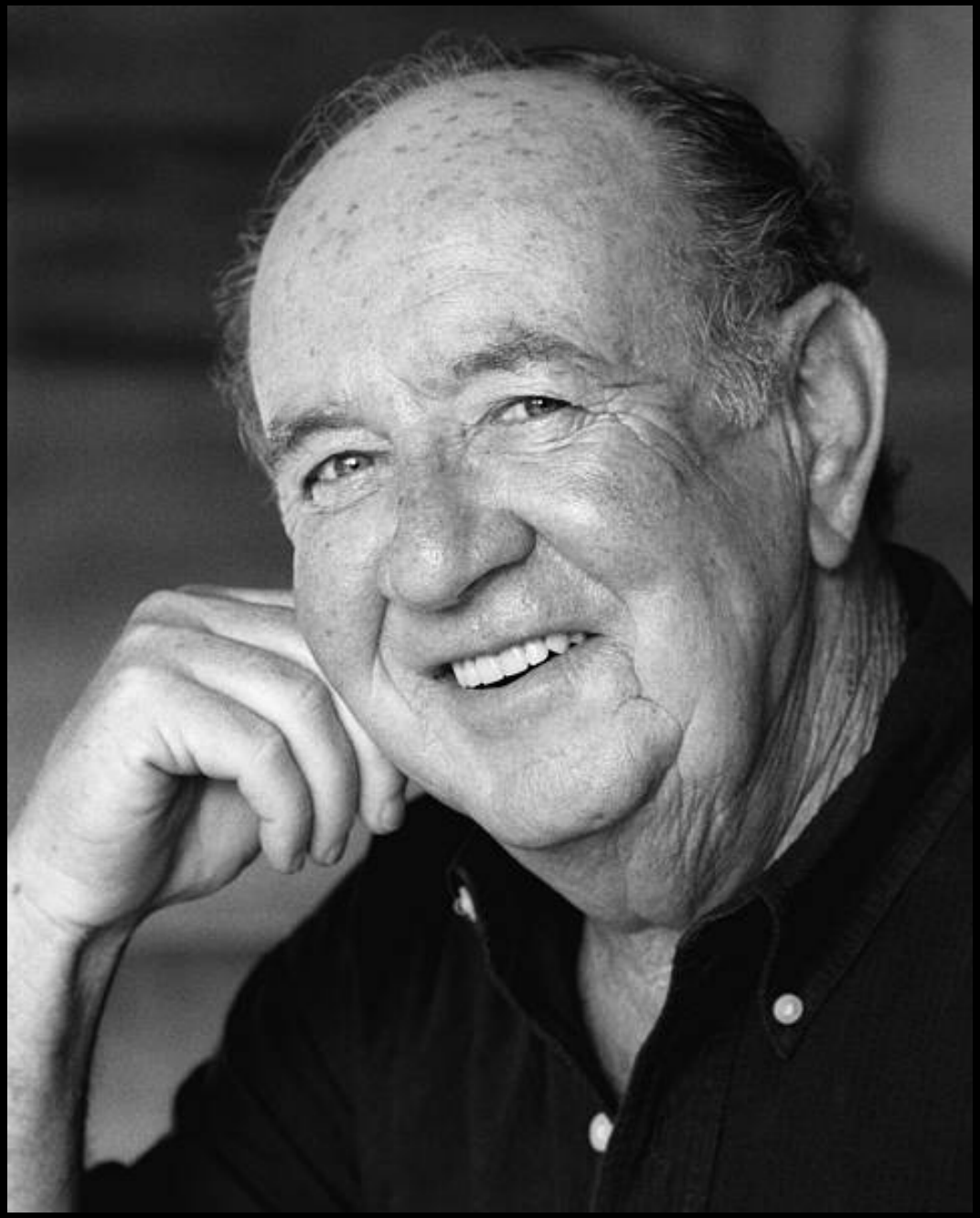
Hospital

Family doctor

Diabetes specialist

Homecare nurses

Pharmacist



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The moral

Individual Competence

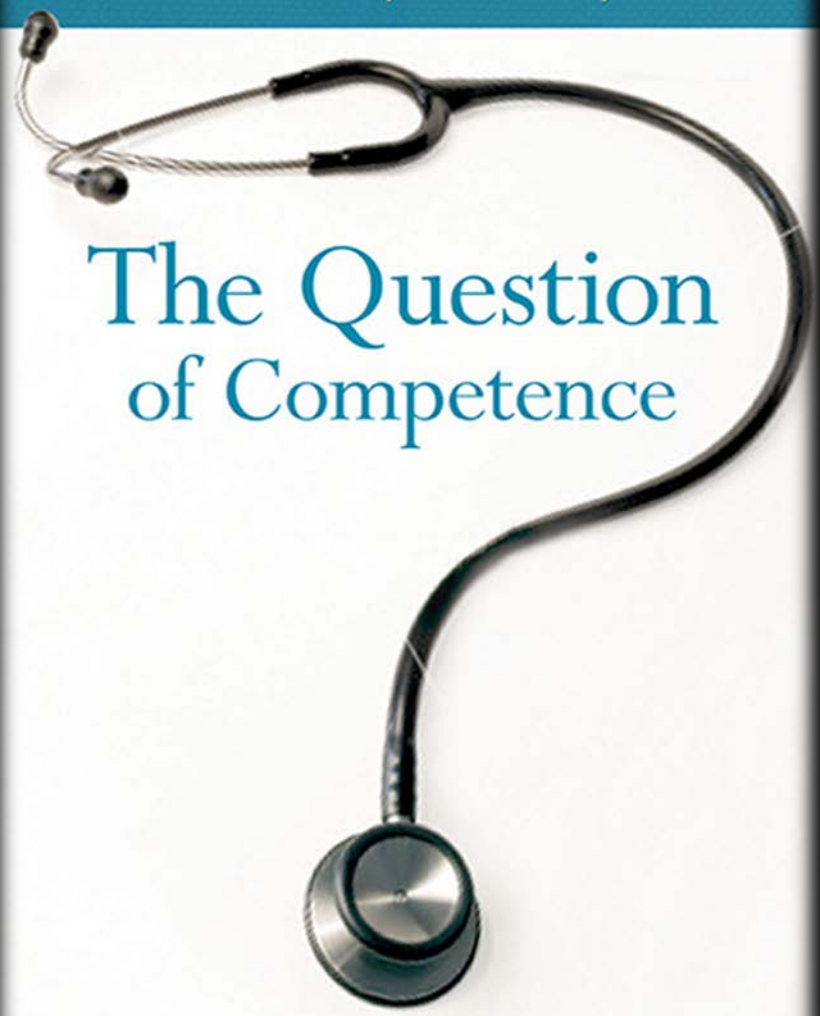
The moral

Individual Competence

≠

Good Healthcare

Reconsidering Medical Education
in the Twenty-First Century



The Question of Competence

Edited by Brian D. Hodges and Lorelei Lingard

With a Foreword by M. Brownell Anderson


Schulich
Schulich
Schulich
Schulich
Schulich

TORONTO STAR

Safety at Home

July 2013

Competence is a way of ‘seeing’

Every way of seeing,


is a way of not seeing.
(Kenneth Burke, 1965)

How we ‘see’
competence shapes
our attitudes
and our actions.

It ‘selects’ and ‘deflects’
our attention.

(Kenneth Burke 1965)

Two ways of seeing Competence

Individualist way of seeing Competence

Competence is:

- a quality that individuals acquire and possess
- a state to be achieved
- context-free, untied to time and space

This individualist notion influences

Candidate Selection

Student Assessment

Licensing and Evaluation

Monitoring of Licensed Practitioners

Remediation

Theoretical roots

``The dominant learning theories (adult learning, reflective learning, experiential learning) take the learner as 'active agent' at the center of the activity of learning.``

(Bleakley 2006)

Collective way of seeing Competence

Competence is

- a constantly evolving set of multiple, interconnected behaviors
- achieved through participation and enacted in time and space

Theoretical roots

Distributed cognition

Collaborative work as ‘joint cognitive accomplishment not attributable to any individual’.

(Hutchins 1991)

Theoretical roots

Situated learning theory

Competence emerges through social interaction, shared experience, development of tacit knowledge, and innovation in response to situated needs.

(Lave 1991; Eraut 2000; Mittendorf 2006)

Theoretical roots

Socio-material and system theories

Individuals are shaped by social, technological and physical structures – the 'activity system.'

(Engestrom 1987; 1995; 2002)

Complex systems are inherently unstable; a change anywhere produces a nonlinear ripple effect. Competence is highly context -dependent.

(Sveiby 1997; Zimmerman 2004)

Two ‘ways of seeing’ competence

- Individual possession
- Stable
- Context-free

- Distributed capacity
- Evolving
- Based in situations

NOT a simple binary opposition.
Collectivist not a ‘solution’ to individualist.
Each ‘selects’ and ‘deflects’.

During a liver resection, the surgeon requests more sponges due to heavy bleeding. She asks the anaesthetist what the CVP is.

“15”, he replies.

She raises her head: “What? 15? No wonder we've got all this bleeding.” Shakes her head, saying to the resident, “It should be kept less than 5 when we’re transecting the liver. We're going to have to try and hurry this up.”

Surgeon asks anaesthetist: “Can you lower the CVP?”

Anaesthetist: “Yes, but he won't tolerate a CVP less than 5. He needs a high preload to maintain output.”

Surgeon: “If you don’t lower it, he’s going to lose a lot of blood and that won’t be pretty either!”

Individualist way of seeing

What do the individuals know?

- Does anaesthetist usually do liver resections?
- Does surgeon understand timing associated with lowering CVP?

What are the individuals' skills?

- Communication, negotiating conflict

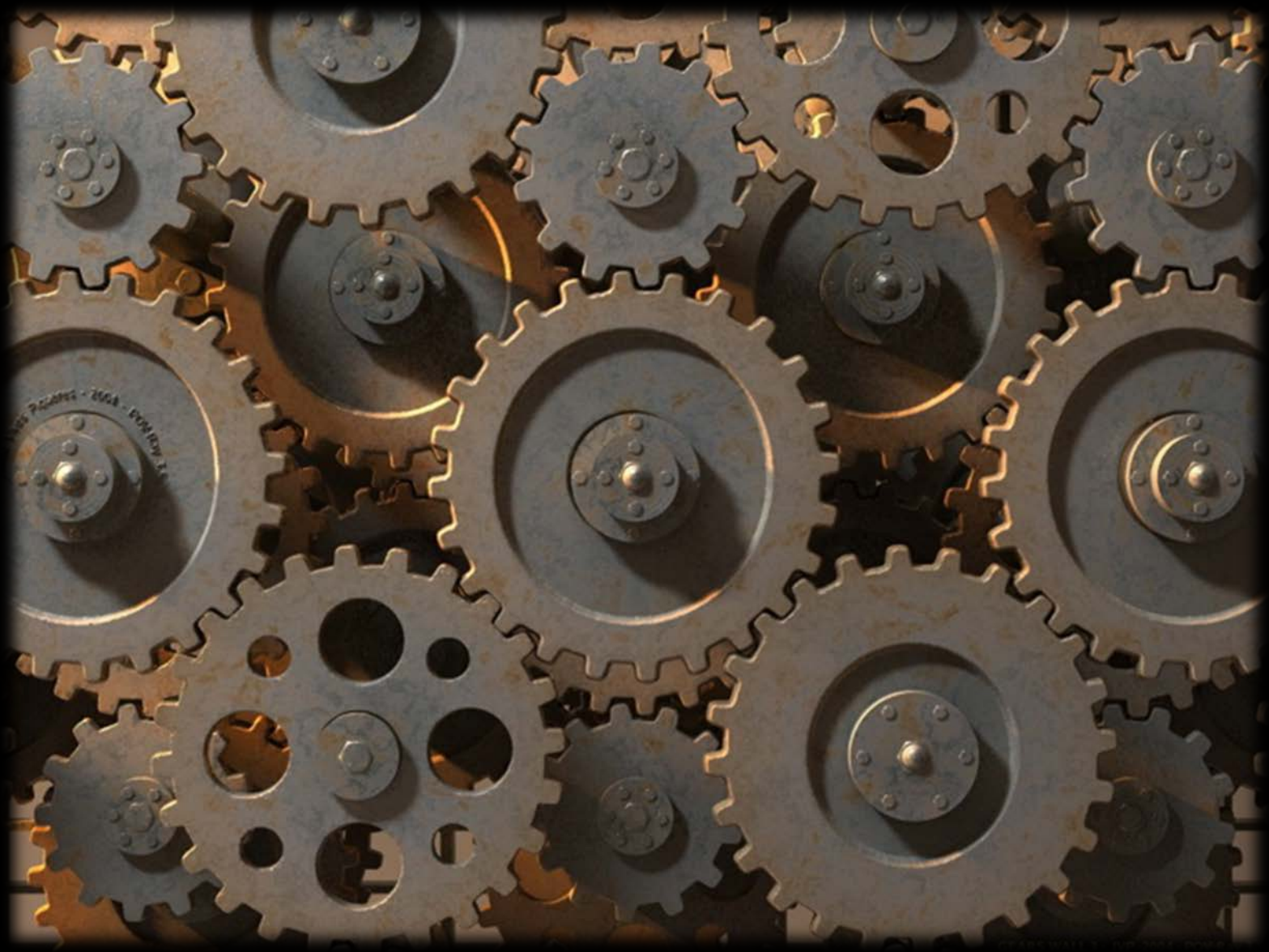
Collectivist way of seeing

What is the access to information across the group?

- Are team members aware of what others know/don't know?

What are similarities & differences in team members' perceptions?

- Of patient's status?
- Of relative advantage of lowered CVP?
- Of the nature of an 'emergency'?



3 stories

Sharing knowledge in OR teams

Progressive collaborative refinement on teaching teams

Communication on distributed care teams

Communication is shaped by…

- Relationships
- Varying levels of experience
- Distribution of tasks
- Scheduling of team members
- Passage of time
- Available technology
- Scope of practice

Very few of these can be reduced to
a focus on PEOPLE
and their communication skill

And very few of these operate exclusively
at the individual level –
they operate at
the points of connection
among parts of the team

And YET

Our education and assessment efforts privilege individual parts of the system

Appendix I

MULTI-SPECIALTY COMMUNITY TRAINING NETWORK

PRECEPTOR EVALUATION OF RESIDENT

(to be completed by Main Preceptor/Clinical Teacher)

Resident: _____ **Specialty:** _____

Main Preceptor /Clinical Teacher: _____ **Site Location:** _____

Dates of Rotation: _____ **to** _____

OBJECTIVES (modified from Can Meds 2000)	Needs Improvement 1 2 3 4 5 6 7 Outstanding / Not Applicable ☐ N/A Comments/Education Plan
Medical Expert/Clinical Decision-Maker ***"Know and do the right thing."*** - Identify the knowledge and skills required for a rural/community based practice and note how they differ from urban practice. - Identify limitations and demonstrate use of referral resources appropriately. - Demonstrate diagnostic and therapeutic skills for ethical and effective evidence-based patient care within the context and limitations of the rural/community environment. - Identify peer review, audit and other methods of assessing one's own practice and rural/community patient care.	
Communicator ***"Communication is the key to success."*** - Identify particular health care challenges and difficulties from a rural/ community patient's cultural and geographic context. - Demonstrate good interviewing and communication skills with patients. - Demonstrate effective communication with all members of the rural/ community health care team as member, co-ordinator and leader.	
Collaborator ***"Don't get swamped."*** - Identify and use local community resources, programs and distant referral resource and clinical support networks. - Demonstrate collaboration as community consultant with both local family physicians and tertiary care subspecialists. - Identify when and how to effectively transfer patients from smaller referring centres, and to tertiary care centres.	
Manager ***"Keep the CEO off your back."*** - Identify effective practice management appropriate for rural/community practice. - Identify strategies to develop your referral base. - Identify and discuss benefits and risks of investigations and treatments available locally, regionally and at tertiary care centres.	
Health Advocate ***"You can make a difference in your community!"*** - Demonstrate preventative health care and health promotion - Advocate for accessible and appropriate rural health care. - Identify existing and potential resources to meet the unique needs of your community patients.	
Scholar Learner ***"Yes, you can be a scholar in the country."*** - Identify and develop strategies for self-directed life-long learning strategies including use of distance education to maintain up-to-date and competent skills relevant to a rural/community setting. - Identify clinical research appropriate to one's scope of practice, interests and rural/community setting.	
Professional Personal ***"Remember yourself, your partner and your children."*** - Identify and experience the joys and challenges of rural/community medical practice and life. - Identify and develop strategies to balance personal, family and professional needs and demands. - Demonstrate positive attitude and working relationships with patients, staff, administration and colleagues.	
Additional Comments	**Use back of form if needed**

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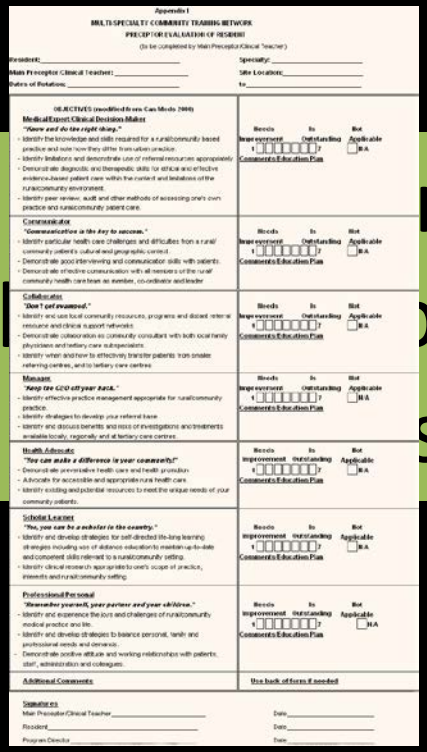

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In summary: A call to…

- Complicate our idea of ‘communication’
- Expand our notion of ‘competence’ to include both individual & collective
- Create education and assessment practices commensurate with the complexities healthcare teamwork

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