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Competence and Engagement: Two Sides of the Same Coin?

This article is based on a presentation by Zubin Austin, BScPhm, MBA, MISc, PhD, Professor and Murray Koffler Chair in Management, and Academic Director – Centre for Practice Excellence Leslie Dan Faculty of Pharmacy, University of Toronto, at the 2016 FSBPT Annual Meeting.

Is competence actually an either-or process? Ask most practitioners and they will say "no": day-to-day or moment-to-moment individuals feel more or less competent depending on context, situation, and their general mood or frame of mind. Understanding the psychology of competence drift can provide regulators, educators, employers, and practitioners with new insights into how best to manage and avoid the label of "incompetence." This presentation reviewed recent literature exploring the role of personal and professional engagement in competence drift and focused on strategies to support practitioners across a lifetime of professional practice.

The audience was asked, "What keeps you up at night?" The audience was asked to answer not as regulators but as human beings who from time to time may need the services of a professional. When you ask regulators that question you rarely hear terms like standards of practice or competence. You hear things like, I hope the professional cares and will go the extra mile to help me.

The concept of competence in the workplace is relatively new. The term began to refer to people in the 1990s with a few high-profile "breach of duty of care" cases among professionals. As a result, the public and politicians began calling for accountability and action. But competence is the answer to a question, not a problem. The rate of incompetence in any profession is rarely more than 1%.

The reason we have physical therapists, doctors, lawyers, and teachers is because we realize many things in life are not clear-cut. If there was a clear answer to everything, an algorithm to solve everything, a guideline to answer every question, we would need technicians, not professionals. Professionals who have wisdom, judgment, and perhaps most importantly a willingness and an ability to fire on all pistons, are needed to work in the messy areas of life.

Several "typical day in healthcare" scenarios were offered to draw out the complexities of competence.

"A patient in a hospital has been very agitated and anxious and requires medication. The

nurse has been trying to get the physician to write the prescription. Finally, at 9:00 pm the prescription is written and the nurse sends it off to the pharmacy … which closed at 9:00 pm, even though the nurse had indicated to the pharmacist that a prescription was pending." Is this pharmacist not competent?

"A physiotherapist is trying to assess a patient's mobility and joint status, and needs an X-ray to do so properly. He approaches a medical resident from the team, and is informed that the patient in question "isn't mine," so no X-ray order is written." Is this medical resident not competent?

"A social worker is trying to help his patient who is homeless and without employment. The patient has just received chemotherapy and is suffering nausea at discharge. There is no drug plan coverage. The social worker takes several tablets of anti-nauseant the patient has already received and gives it to the patient so he can at least get through the night at the shelter." Is this a breach of competence?

"A midwife attending what was meant to be a routine delivery is now confronted with an emergency situation. On-call medical personnel have been summoned but delayed in arriving. The midwife independently initiates vacuum extraction in an effort to save the baby, without physician support, but with an additional midwife present." Is this considered a competency issue?

So many of the issues boards have to consider when we think about competence are not necessarily the gross incompetence of people defrauding healthcare systems or people who simply don't know how to practice their profession. Instead, many of the problems the healthcare system faces occur when people have an opportunity to fire on all pistons and have an opportunity to go the extra mile, arguably the way the midwife and social worker did, but suddenly think, "Oh, what's my regulator going to say if I do this? No, I'd better not do anything." The real competence issue is professionals don't feel empowered to act professional.

Traditionally, competency has been defined as, "The quality of being adequately or well-qualified, physically or intellectually." It's a pretty vague definition, but it's the basis of evaluating success and defining readiness for practice, in education, regulation, and employment. Yet, in reality, it means different things to different people at different times in different contexts.

From a patient's perspective, they want accessibility, affability, and acknowledgement from healthcare professionals. They want someone there when they need help. They want someone who's nice, who's funny, who's pleasant, who's down-to-earth. And they want somebody to say, hey, that has to be really tough for you. Conspicuously absent from this list is knowledgeable, skilled, knows the latest evidence in their field. For patients, competency is an interpersonal process.

Complaints about practitioners are rarely due to "an honest mistake." Rather, impoliteness is the most frequent cause of complaint. Fewer than 2% of practitioners are generally complained about in most professions. Even fewer end up before a disciplinary or fitness-

to-practice committee. Competency to the patient equals interpersonal savvy.

Day-to-day professional practice is tough, and getting tougher. Professionals face decreasing autonomy, increasing demands, burnout, and fatigue. Legalism dominates clinical judgment. In today's team environment, if one person makes a mistake, the entire team is scrutinized. Organizations and colleagues affect our ability to be competent in ways we don't necessarily acknowledge. To a practitioner, competency often equals good luck and not being in the wrong place at the wrong time.

Regulators have an extremely challenging middle road to walk. To a regulator, competency is a contested and contestable, some might say political, construct. Regulators must be concerned with the public's safety. They must maintain transparency to the members. They are accountable to multiple stakeholders. They must judge similar cases consistently. And they must take an adversarial position and follow the principles of administrative law. The idea of collegiality within a profession seems to be evaporating very rapidly.

From an educator's perspective, tension exists between developmental and psychometric dimensions, and increasingly financial constraints. Combine that with an idealistic desire to prepare individuals for a lifetime of practice, not simply pass tomorrow's test, that is at odds with financial reality and league-table mentality. As a result, the certification function trumps most others. We have the commodification of personal/professional development.

Competency from an employer's perspective equals fitness for purpose or context. They look for operational efficiency and economies of scale, which drive a "production model" of care delivery. Standard operating procedures dominate the practice to facilitate standardization, predictability, and efficiency. Data and workload measurement dominate resource allocation and decision making.

From a lawyer's perspective, there is no absolute definition of competence. It's a contestable construct. Incompetence is an evolving construct built upon precedents that reflect changing contexts. If making a mistake is a measure of incompetence, heaven help all of us because we are human and we all are going to make a mistake from time to time.

American literary theorist Kenneth Burke once said, "Every way of seeing is also a way of not seeing."

What this suggests is, depending on your role and your perspective, individuals are likely trapped in a fairly narrow view of what competence actually is. A better approach is to balance pragmatism with idealism and theory with reality. A fundamental tension in competence work is that there cannot be a single grand unified theory or approach. It's more a question of priorities and principles than answers.

It's very easy to reduce complexity to numbers. It's really easy to reduce the messiness of all this to saying, you just have to follow this checklist. But the problem is when we start to narrow our own view of something like competence we can forget the significant steering effect regulators in particular have on the profession as a whole.

Discourses are the words we use to describe our world in a way that short-cuts questioning. They act as filters and lenses that unwittingly allow some things but block out other ideas.

Our behaviors and actions flow from these discourses. French philosopher Michel Foucault postulated that words have a meaning and the meaning can shift over time. Dominant discourse is the idea that words have different meanings over time and everybody just accepts that's what the word means at any given time.

Take Foucault's study of the word "madness" and how the meaning of the word evolved over 300 to 400 years. In the 1700s, madness equaled spiritual possession and one ran for a priest. In the Victorian era, it was deemed criminal activity and one called a police officer. In the early part of the 20th century, madness was deemed to stem from a chemical imbalance and you ran to a pharmacist and took a pill. In the latter part of the 20th century the discourse of madness evolved to mean that it's a simple human variation, so you do nothing. In the next 10 to 20 years, it could be seen as a gateway to creativity, and we'll cultivate it.

The consequences are immense and it relates back to what we think competence is. If we were raised in the 1990s meaning of competence, most of us are going to think of it as being adversarial. "Let's use a checklist to see if you meet all these criteria. I'm going to watch you to see if you're competent. You're going to prove to me you're competent because you've taken 20 continuing education units."

The 1990s views on competence are similar the earlier stages of our understanding of madness. Boards were urged to consider a more 21st century notion of what competence is and recognize the incredibly powerful role regulators have in shaping that discourse.

The problem with using a dominant discourse in professional practice is that the scopes of practice are in continuous flux. What it meant to be a physical therapist, a pharmacist, or a doctor 20 years ago is different than it is today. There is an evolution of roles/responsibilities and alignment with societal expectations. Over a professional's lifetime, the discourse of professional practice will evolve considerably.

Dominant discourses narrow our understanding of nuanced, complex constructs and cause us to unquestionably select certain facets for emphasis. What we select to emphasize drives behavior in a way that actually can, inadvertently, produce certain types of incompetence. Within professional regulation, there are unintended consequences and unintentional side effects of prescribing a specific discourse of competence.

For example, the world of pharmacy has evolved considerably over time. In the 1940s, a pharmacist was a compounder of medicines. In the 1950s, when pharmaceutical companies began to manufacture drugs in mass, pharmacists became dispensers of medicine. Then, big business largely packaged medicines and in the 1980s, pharmacists managed a local drugstore. As big box drugstores became the norm in the 1990s, pharmacists became advisors to physicians. In the 2000s, they became advisors to patients. And now, they are clinicians, administering flu shots and vaccinations.

Hungarian psychologist Mihaly Csikszentmihalyi's psychological concept of flow, a highly focused mental state, and "competency drift" was also considered during the presentation.

No one sets out to study to become an incompetent professional. But competency drifts for good reason. You get married and have children and a life. How much continuing education

can I do when I have three children, seven birds, this problem, that problem? You begin to miss out in small changes in your profession. And, if you miss out on one step of the evolution of something, it is so much harder to catch up. You feel shy. You feel hesitant. It makes it much harder to catch up, to disclose, I've missed something, and makes it easier to start the process of drifting from your profession. It is not malicious. It is not even necessarily dangerous, but what it is is a wall that starts to build up between the practitioner and her colleagues, between the practitioner and his profession, between the practitioner and the workplace. As the wall grows, the practitioner begins to feel helpless.

Csikszentmihalyi's model relies on a human characteristic called engagement. Engagement is this notion that you are actually connected in a real and meaningful way to the things that you do. Csikszentmihalyi describes the concept of flow as that moment when you are firing on all pistons. When you really care deeply about what you are doing. Many of us experience flow in our personal lives when we do things we love. The goal should not be to create competent practitioners, but engaged practitioners who are interested in their profession, their patients, and their practice.

Regulators are in the most unique position imaginable to lead this charge because regulators are the only part of a profession that every professional touches. There's a certain bully pulpit regulators enjoy that allows them talk more about engagement rather than competence. Every employer cares deeply about what a regulatory body thinks, so the effect is cumulative.

Engagement utilizes Csikszentmihalyi's concept of flow. It is characterized by a sense of timelessness, productivity, subjective satisfaction, constructive, and purposefulness.

To create engagement we need to provide a social incentive for competency. We need to give practitioners a reason to stay competent, not simply a reason to not be labeled incompetent. Competency systems need to support and reinforce good behaviors, not simply catch and punish bad behaviors.

If we are really interested in engagement, it means we must think about things like trusting our practitioners, empowering our practitioners, doing something they are doing in the United Kingdom called right-touch regulation. Perhaps we need to reduce regulatory burden, reduce regulatory requirements, and find alternative ways of identifying that 1% of practitioners who are in deep trouble and instead provide the 99% who are actually doing their jobs with a greater springboard to be empowered.

This year Canada shifted from regulators who count things to regulators who coach. Pharmaceutical regulators go into pharmacies and coach the pharmacists. If they catch them making a mistake, they don't yank the license, they talk about it. How did this happen? What can we do to safeguard it from happening again?

Trying to create engagement is going to be a multi-organizational task. Regulators can't do it alone. Educators can't do it alone. Employers can't do it alone. But regulators can be in the driver's seat.

The concept of engagement is evolving. What needs to happen first is a discussion around

how our dialogue about competency should evolve and the steering effect regulators can have in facilitating discussion across the entire profession.

Zubin Austin, BScPhm, MBA, MISc, PhD is professor and Murray Koffler Chair in Management, and Academic Director – Centre for Practice Excellence at the Leslie Dan Faculty of Pharmacy, University of Toronto. His research interests focus on professional and personal development in the health human resources workforce. He has published more than 100 peer-reviewed manuscripts and authored three reference texts. He has won awards for his research from national and international organizations. He is also an award-winning educator, having received numerous teaching awards, and has been named undergraduate Professor of the Year by students at the University of Toronto on 16 separate occasions.