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How Competent are We at Assessing Competency - Video Transcript

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Event

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Presenter

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Dr. Zubin

Austin: Well, thank you very much for that kind introduction and the emphasis on the warm welcome. Coming from Toronto, I can't tell you how happy I was that this conference wasn't held in upstate New York or something like that. Thank you very much, to Linda and Colleen. Boy, talk about competence in terms of organizing a conference. Thank you to both of you for an excellent job of pulling things together.

[applause]

As was mentioned, I am a professor at the University of Toronto but in the Ontario health care system, in order to continue call myself a pharmacist I'm required to work about four hours a week as a front line practicing pharmacist and I do that in a hospital setting. It's a wonderful way of keeping me humble, keeping me honest, and keeping me connected to things, despite what I do in the other 36 hours of the week that I work. There's an old joke that I like to tell about pharmacists and that is, "What do pharmacists use for contraception?" The answer is, "Their personalities."

You really don't need to applaud that joke, actually.

But I hope after this presentation, you'll have a different perspective from a different profession on an issue and a challenge that is common across not just the health professions but across all professions. That is the issue of competency.

When I was young, many, many years ago, the word "competence" or "competency" we used to apply that to bladders and to cervixes, not to people. It's amazing how in the last ten, 15, 20 years the word "competence" has become just part of the air that we breathe.

We assume it applies to people. And, of course, it's a word and words shift their meanings and words have some power to them. Trying to understand how we got to this point of being so interested in competency, how the United States, Canada, the U.K. around the world and every profession, every school, everywhere you go competency, competency, competency has become the dominate discourse, the dominant rhetoric that you hear.

Perhaps, it's interesting to try to go back a little bit to try to better understand where this came from so perhaps we understand why we are on the trajectory that we are. There are a million and six different versions or definitions of competency but here's one that comes from the dictionary and it simply states that competency is the quality of being adequately or well-qualified physically or intellectually.

A definition like this doesn't necessarily help us along the way, in terms of trying to figure out what it is that we are trying to do. Whether you are educators, regulators, a patient, anybody concerned about this issue.

One of the things that we know about the word competency is that it has really taken over much of our thinking. Anytime a word takes over our thinking, it perhaps behooves us to try to better understand why that actually occurred. One of the people that has really helped us to see the importance of words and its significance on our behaviors is a philosopher by the name of Michel Foucault, who many of you may know. Especially, if you've taken qualitative research courses at some point in your life.

Foucault talks a lot about the power of language to shape thinking and thinking to shape behavior. One of his favorite examples is the way in which we think about a certain word and its influence on our behavior. The word that he deconstructed, many years ago, was the word "madness". Think about that word today. 300 years ago, what did the word "madness" actually mean? Madness, 300 years ago, meant spiritual possession.

It meant "the spirits", "the gods", whatever, had infected you. If you believe madness is spiritual possession, what's the remedy? Call in a priest. Perform an exorcism. The Victorians evolved the concept of madness.

And 150 years ago, what did madness evolve into? It evolved into the concept of criminality. If you think madness is criminality, you don't call in a priest. You call in a police officer. After that, the dawn of the 20th century, what did madness turn into? It turned into pathology. Madness became chemical imbalance. It's not your fault, it's your neurotransmitters' fault.

If you think madness is chemical imbalance, you don't call in a priest, you don't call in a policeman, you call in a pharmacist, you call in a psychiatrist. You call in drugs. Chemistry will make things better.

Today, at the dawn of the 21st century, madness has evolved somewhat again. In some contexts in places, what is madness today? Variation. You don't medicalize it. You don't arrest someone. You don't call in a priest. You simply say, "Huh. Aren't you interesting?"

The illustration around the evolution of the word "madness" plays out in so many other places in our worlds. Including, I would suggest, when we think about competency. Think about other words that have taken on different meanings. Think about in both Canada and the United States, the rhetoric around taxpayers. Politicians talk about taxpayers. Not citizens, but taxpayers. An entire philosophy flows from that.

In all of our lifetimes, there has been one of the most breathtaking cognitive shifts in the meaning of a word and behaviors that flow from it. Think of the word "homosexuality". What did that mean 30 or 40 years ago and what does it mean today? The fact that words change and evolve and we simply accept, "Oh, that's what things mean today," is, I think, a fitting starting point for trying to understand how we got to this point of competency dominating the discourses not only of regulators but of educators, employers, or anybody involved in health professions work.

Why does any of this matter? It matters because if you think madness is spiritual possession and you are calling a priest to cure it, you might be having the wrong answer to the wrong question.

Unless we really understand what it is we are trying to accomplish, what is the problem that competency assessment is actually supposed to solve, we might be pursuing the wrong path and in the process causing a lot of stress, wasting a lot of time and money and not actually making things any better for patients, professionals, or the system.

One way of trying to understand all of this then is to think about what the word competency might mean from different stakeholder's perspectives.

To begin with, we know that competency has, for now at least, taken over the worlds of people like me. In every health profession that I am aware of, across North America, we have all shifted to competency based assessments, competency based curricula.

The idea that somehow our curricula will ensure people are ready for practice at licensure. Competency is the foundation of post-graduate and continuing professional development programs. It has moved from being something that might be an interesting way of looking at a problem to being the de facto answer to all cases when we're concerned about people's behaviors.

But when we look at the word "competency" from different people's perspectives, we see very different ideas about what it actually means. Most of the literature in this area that focuses on what patients think competency actually is, focuses on what is sometimes referred to as the "three a's".

A competent health care professional is someone who is accessible, who is affable, and who acknowledges me. Conspicuously absent from this list, of course, is the fact that they actually know anything.

Now, this is not to diminish or discount or dismiss the patient's perspective, but what patients understand and very powerfully communicate to us with this sort of research is that mistakes are going to happen. We know that no one is perfect.

What's more important to us than technical perfection, is that you're a nice person who cares and when you make a mistake - not if, you at least feel sorry about it and tell me about it. This notion that competency then is actually about interpersonal savvy rather than technical skills is a powerful thread that patients might want to bring forward to the competency discussion.

You may go no further than your own state complaints and discipline processes. In virtually every jurisdiction where this has been studied, what drives complaints against practitioners, it is very rarely error. It is almost always incorrect management of error. Impoliteness, rudeness, brusqueness. The idea that honest mistakes are expected to happen. Patients don't expect technical perfection. What they expect is, "I'm so sorry. I'll make sure this doesn't happen again. Let me fix this." That perhaps starts to shift if we are truly interested in public protection the way we ought to be thinking about measuring and dealing with competency issues.

Let's look at the word "competency" from a different perspective. That is from a practitioner's perspective. Many, if not most of you in this room, are actually practicing health care professionals. If like me, you take a deep breath and go, "Okay. I have to work my four hours a week in the pharmacy now. Gosh, I hope it's going to be okay. You recognize that day-to-day professional practice is tough and is getting tougher. There are so many stresses on health care professionals.

We know about increased reporting, the use of technology, collaboration, do more with less, and all those sorts of things. For most of the practitioners, much of the research in this area suggests that they, too, like patients, recognize error is inevitable.

When it comes to a practitioner's perspective of competency and making mistakes, the thought is simply, "There before the grace of God, go I. If I happen to show up at the wrong shift at the wrong time, if I happen to have the wrong team leader, if I happen to have the wrong resident, if I happen to have the wrong team members, that becomes my problem."

From this perspective, competence is much more driven from the context and the good or bad luck of the draw of who happens to show up on your shift than by anything that internal. The idea, then, that competency is really no more or no less complicated than good scheduling luck, is a significant challenge to the way we think about competence.

As I think about my own life and work as a pharmacist, I'm extraordinarily sympathetic to this. I always like to tell the story about the day I received a letter from my regulatory body

saying, "Congratulations. The exams have been passed. The in-service training is done. You are now a fully qualified independent pharmacist in the province of Ontario." This letter arrived for me at the place I was working. Opened it. "Yee-hee. It's all done." I am sorry to say that the very next set of prescriptions that I dispensed, I made a mistake. You could tell how old I am by the story I will now recount but it was an anti-tuberculosis regimen I was dispensing that contained an ethambutol INH and rifampin.

I got them all in the wrong bottles. Fortunately, the patient receiving them have been taking it for a long time and I was chatting with her and I was excited about being licensed and I was an affable and lovely young man at the time. She smiled and nodded and five minutes in the conversation she said, "Dear. Those ones don't go in that bottle. That doesn't go there."

I just, "Ugh." Switched everything back in. I realized, I think I need to go work at a University as soon as possible.

The point again, being that from a practitioner's perspective, stuff is going to happen. It doesn't isolate a dispensing error the moment after you are licensed to make me incompetent? Does that negate the previous years of training, education, and assessment? Does one error make incompetence? Do five errors make incompetence? At one point, do you actually draw the line? Especially if context is such an important thing.

Many of you in the room, all of you in the room, work within a regulatory context but all of you come with the question of competence from other perspectives as well. As practitioners, as patients, as educators.

The regulatory perspective is a particularly interesting and complicated one because there are so many things that need to be juggled. Public protection and safety is critical. Accountability to multiple stakeholders. Transparency. Especially in highly litigious times. Consistency and procedural fairness are incredibly important, and leads most regulators then, to think of competency as something that has to be a one size fits all answer.

Can competency actually be something that is that context specific? There's something unfair or inconsistent about the notion that I can be competent in my own way and Linda will be competent in her own way and that's all okay. The need for consistency and procedural fairness drives regulators to think in a 'one size fits all' kind of way. Which tends then to lead to single types of competency assessment models that are developed.

The regulatory perspective, I would argue, is so complicated that it has driven most of us that work within regulatory context to think about the opposite. It's too hard to define competence. Let's define incompetence instead.

As we'll see shortly, sometimes defining the opposite might not lead us down the best possible path. What has evolved over the last 15 to 20 years around competency within a regulatory context, of course, is that the system that has evolved is generally adversarial.

"You prove to me that you're not incompetent and I will let you continue to work as a health care professional." This starts to change relationships then between boards and practitioners. Between employers and employees. Between practitioners and patients. What it starts to do is congest that perhaps competency is a sliding scale. In many jurisdictions, what it takes to be competent has shifted considerably within the last 15 or 20 years.

I'll give you one example from my own jurisdiction, Ontario. Ontario is a place in Canada that welcomes many immigrants and as an area that is quite reliant on internationally educated foreign trained professions, there's been significant interest in English or French language fluency. Over the last decade, the English language or French language fluency standard for safe and effective practice has ratcheted it up significantly. Does that mean the people who were licensed ten years ago during an easier time aren't competent?

This notion that competency could be a sliding scale starts to make us question, "Is this a monolithic construct that really requires everybody to demonstrate the same thing to be competent?"

I, and many of you in the room, will have the great good fortune at looking at competency from an educator's perspective. And at its purist and best, what do educators think about competency? My job as a teacher is to make you the best you that you can possibly be. The idea being that as educators we relished the role of trying to release potential in people. But as most educators, know, that potential is so individually specific. People come to us at different stages to begin with. We want to make everybody as good as they could possibly be without necessarily saying, "You all have to be at this level."

That very pure idealistic form of educational perspective of competency has of course evolved considerably. Increasingly, a psychometric definition of competency has evolved where, as teachers, we're worried about giving out to many A's. As institutions we're worried about passing too many people.

As people involved in clinical education were worried about sending people into clinical placements when they may not quite be ready. Even if they're the best person they can possibly be. As a regulatory context, the educator's perspective is undergoing significant evolution right now. It, of course, is impossible to talk about competency without bringing in a legal perspective.

As anybody who has worked in a regulatory context for any period of time knows, the legal challenges to competency assessment continue to grow and grow. "Who are you to say what is competency? We're the state board."

"Uh-huh. And?"

From a legal perspective, in the absence of agreed upon meanings of competency, standards are generally interpreted through litigation and contestation. Across North America, what this means is that 'Sure, you can say whatever you want as a board but at a

certain point, it might be a judge that actually decides. Are you giving the right definition of competence?"

This notion of continual contestation, litigation, and evolution means that from a legal perspective competency is a moving target. If we look at these five perspectives and then reflect again on, "Okay. This is nice and interesting and all good in sunny San Diego on a random Wednesday but I got a job to do."

People expect a state board to define standards, to have a competency assessment system. What are we actually supposed to do about it? One thing that we might want to do about it is actually go back into the literature and see what 10, 20, 30 years of study suggested about competence and competence drift in the health professions.

There is an abundant literature in this area. Most of it coming from medicine. A growing amount of it coming from nursing and some of it coming from other health professions. What much of this literature tells us, regardless of profession, geographic location or context, are a few things that we can now start to accept as probably being relatively true.

The first is...and apologies to all of you who are signing up for CE credit for this event, attendance and continuing education does not directly translate into change or enhancement of practice.

Completion of compulsory CE credits does not predict whether or not an individual meets objectively defined competency standards. This is a little bit of an "ouch" for many of us.

Whether you're an educator or a regulator. This notion that simple attendance at CE, especially traditional didactic CE, where somebody talks, you eat floppy chicken at a nice hotel, and then go, "That was nice," filling out the multiple choice test and then go back to your regular world and what happened yesterday doesn't connect it today is one of the most consistent findings, especially for medicine, but it has been reinforced in nursing, pharmacy, and other professions as well.

If we think that competency should or can be built on continuing education alone, especially the traditional didactic education that most practitioners sign up for and by didactic, I mean this kind of this type of lecture format, self-study, multiple choice, those sorts of things, the literature tells us we probably need to look at things again.

The profession of pharmacy in Ontario has a relatively unique method for evaluating, continuing competency of pharmacists. About 18 years ago, we undertook a significant re-examination of our continuing competency mechanisms and decided that a direct assessment method was required for the profession of pharmacy in Ontario.

Today, if you are pharmacist in Ontario, you sit around in fear for much of the year, waiting for a big envelope in the mail from your regulatory body, inviting you to come to Toronto one day and demonstrate that you are still competent as a pharmacist.

How do you do that? You do that by completing a 60 question case based multiple choice question, test of clinical knowledge, and an eight station OSCE, Objective Structured Clinical Examination.

Think about it if you have been working for 35 years as a pharmacist, you own your business, everything has been going fine. MCQ, OSCE, this is alphabet soup. These testing methods didn't exist when you were in school and suddenly you're supposed to prove... "Did someone complain about me?"

"No. You've just been randomly selected to demonstrate that you are continually competent." This model of direct assessment of competencies has many other examples. We came to it actually, through the simple aviation world. Where many of you know that if you are a pilot you have to continuously demonstrate your ability to land planes and ensure when engines drop off you can still fly. All of those sorts of things. But you continuously demonstrate competency through performance in controlled test situations. Certain specialties in medicine utilize this. It's certainly not uncommon.

Yet, amongst health professions, we relatively early out of the gate in using this system to measure competence of practitioners. We have about 18 years of data from that program that has led us to some interesting insights into who is at risk of not being competent.

What this data suggests to us is that competency drift tends to foster, demographically, along three distinct but intersecting dimensions.

In the profession of pharmacy, those at highest risk of not meeting competency standards are people who have been out of school for 25 years or more. It's a very peculiar finding because it's not 24 years and it's not 26 years. It's 25 years. There's just this drop off a competency cliff that seems to happen at 25 years.

The second characteristic is people that work by themselves. In pharmacy, it means you own and operate your own pharmacy. You don't work in a hospital. You don't work in a large team environment. You never get to see other people doing your job.

The third characteristic are people who receive their initial training as a pharmacist outside Canada and the United States. These are intersecting risk factors. If you are a foreign trained pharmacist working by yourself, who has been out of school 25 years or more, you get compounded risk factors for not meeting competency standards.

This consistent finding of these are the three highest at risk groups in the profession of pharmacy, this has been consistent for 18 years, has led us to really think a little bit about the notion of competency drift.

Competency drift tells us that people don't wake up one morning and say, "Ah-hah. I fooled them all, they gave me a license. Now, I'm not going to do anything ever again. That will teach them a lesson."

The term 'competency drift' is used to describe the gradual, casual, accidental, inadvertent movement away from competence towards incompetence. What our data from pharmacy suggests is that this is a better way of understanding what happens with competence.

People don't choose incompetence. But when you get into a phase of "Ah, mañana. I'll do that tomorrow. I'll think about that tomorrow. Things don't change that much day to day," over the course of a career, it does feel like you've just woken up suddenly and suddenly you're incompetent.

In large part, this is because professions change significantly. If you are as old as I am and perhaps some of you are, you will know that when you signed up to be a nurse it bears no resemblance to what nurses do today.

When I signed up to be a pharmacist, you weren't supposed to talk to patients about medications. You might give them notions. Today, most pharmacists in Canada and many in the United States do wild and wacky things like immunize people.

I wanted to become a pharmacist just because I didn't want to touch people.

[laughter]

And now, you're supposed to actually immunize people. You're supposed to. In many jurisdictions in Canada, British Columbia, Alberta, pharmacists are actually doing independent prescribing.

I didn't sign up for that. Professions have evolved and unless people have a context to understand how they need to evolve with that evolving profession, competency drift is simply exacerbated.

The flipside of all of this is that the competency literature tells us that those most likely to meet competency standards on standardized assessments of such competencies demonstrate certain characteristics.

A: they tend to be very well connected and networked professionally. Every single person in this room should breathe a big sigh of relief because the simple fact that you actually are interested in volunteering for your boards, whatever it is, the simple fact of professional networking appears to inoculate you, somewhat, against competency drift.

The second protective factor is that you actually express satisfaction with your career and for your choices. Thirdly, you express satisfaction with your personal lives. Again, conspicuously absent from this list is, "Did you graduate with honors? Did you do really well in school? Did you get 100% on all those multiple choice tests you filled out after you completed CE Units?" No.

Competency seems to be a much more psychologically intrinsic feature of people than simple, professional, technical skills. The idea that competency is linked to networks, life

satisfaction, and professional satisfaction, is something that perhaps requires us to think more closely about what we're doing in terms of competency assessment.

The competency assessment literature also tells us, this is an emerging thread, this definitely needs to be taken with a grain of salt, is that one of the most powerful features of life-long competency as a professional is peer referencing.

The people who are 25 years out of school, work by themselves, or are internationally educated all have in common is that they tend to be relatively lonely. If you didn't go to school here, you don't necessarily have the same professional contacts that you have.

Many of you in the room, this may be more of a feature in Canadian society than American society, we don't tend to be quite as mobile as Americans are, but if you grew up in a place, went to school in that place, and worked in that place, you have friends from school. Those friends and professional networks are really important. If you work by yourself, you don't have access to peers.

Peer referencing seems to be one of the most important missing links in helping to prevent competency drift. If we can find ways of connecting those who are at risk for competency drift to peers in a real way, not in an engineered way, we might be accomplishing something. This is sometimes referred to as "learnworthiness". The notion that in order to truly learn things, we need a filter generated by pure referencing to assist us with that.

The competency literature also tells us that regulators, educators, and anybody thinking about or doing competency assessment may be barking up the wrong tree and points to the notion that there are at least four different models for competency assessment that have evolved and these models definitely flow from the perspective you have on what competency is. If you think competency is all about psychometric standards and a one size fits all type of approach, you are most likely to go down one competency assessment route.

The four routes that have been identified are the behaviorist, cognitivist, developmental, and psycho-analytic approaches.

Most of us who work in educational and regulatory settings, unconsciously and sometimes simply because we don't think there are any other options, utilize behaviorist approach. The behaviorist approach, folks, is on carrots and sticks. Rewards and punishments to motivate learning and encourage a particular kind of performance.

"If you don't keep yourself competent, we're going to take away your license and then what are you going to do? If you don't study hard for this test that you're going to take you're going to fail the course, you're going to be kicked out of school, you're never going to get a job, no one is going to love you, and you're going to die alone with hundreds of cats."

Much of the communication around competency, maintenance of competency, tends to have a "carrots and sticks" approach to it. "You'd better do this or else." While this may appear fair and reasonable. The reality is that for most adults, behaviorist techniques to

modify behavior, have a fairly dicey track record of success. We know this as human beings.

We know that when someone is hectoring us and lecturing us and finger wagging at us, if we are powerless to say anything to their face, what do we do? "Absolutely. You're so important. I'm going to listen exactly to what you say." Then the minute the person is gone, you're gone.

You know this if you have teenagers, as well. You can talk until you're blue in the face. "Don't smoke. Don't do this. Study hard." Sure, sure. Yeah, and the kid's out behind the rec center, smoking, the next day. If we rely too heavily on carrots and sticks as the only trigger for competency maintenance, we are at risk of encouraging something called "code shifting".

Code shifting is that lovely human behavior that occurs when a somewhat powerless person looks straight into the eyes of a powerful person and goes, "Mm-hmm. I'm going to do exactly what you say." Then when they're no longer looking, they do exactly what they want to do. No one is better at subversion than a health care professional. No one knows about work-arounds better than a health care professional.

Limitations of that behaviorist approach had led us to understand things, perhaps, from a different perspective and that's the cognitivist or constructivist approach. It begins from the perspective and belief that no one chooses to become incompetent. One is incompetent because they simply don't know how to be competent. From a cognitivist perspective, competency assessment systems are focused on inculcating, in generating, and developing lifelong learning skills that simply don't exist.

If any of you have worked with middle aged practitioners, you will know that one of the things that is quite difficult, frankly, is trying to encourage them to engage in reflective practice.

Reflection is something that many of you, probably, come by quite easily that may be the sort of the thing that is in the air you breathe. But for many practitioners, they'd just rather not reflect. "Just tell me what I need to do."

Learning self-reflection is part of this cognitivist approach. If you don't know what you don't know, none of us can help you. So let's help you to figure out what you don't know. This is a very different perspective from carrots and sticks. The behaviorist approach views punishment as a lever for behavioral change. A cognitivist approach encourages people to say, "You know what? Tell me what you don't know. I'm not going to punish you. I want to help you."

Now, many practitioners may have a really hard time believing a state board is going to change its colors overnight and suddenly is going to be really interested in helping you. That's a very important thing to recognize, that this is not the sort of thing you can turn on a dime. Perhaps there are other organizations within your profession or within your state that might be able to take on that type of mantle.

As you move sort of down the continuum, the developmentalist approach builds on that and explicitly recognizes that competency means different things at different ages and different stages. If you are taking a truly developmental approach you would recognize that you cannot use a one size fits all competency assessment model. A national licensing exam for nursing? No. That doesn't make any sense.

Some kind of entry to practice assessment or a continuing competency assessment that works for everyone? That doesn't make any sense. When we first started our continuing competency assessment in pharmacy in Ontario, 18 years ago, we endured enormous blow back from the profession.

Why? Because those 60 multiple choice tests, test questions that were used, and that eight station OSCE exam that was used...everyone is familiar with what an OSCE is? Okay. An OSCE is an Objective Structure Clinical Examination.

It's a testing method that utilizes actors playing the part of patients. You have about seven to ten minutes to solve a problem. So, in a pharmacy context, you would have an actor walking into them and going, "Cough, cough. I have a cough." Go. Eight minutes.

"I've got a rash." Go. Eight minutes. "I've got this..." you actually observe somebody working within a standardized way with an actor to determine the effectiveness of their clinical interventions.

The idea that we had a standardized test, the test of cough and cold remedies, absolutely irritated beyond words Pediatric/Oncology Pharmacists who said, "I haven't dealt with athlete's foot ever. This might be on the test? Huh"

Interestingly, what we found was it didn't matter where you worked, you could still do really well on the athlete's foot case. Those Pediatric/Oncology pharmacists, those highly specialized teaching hospital pharmacists, they score the highest across all the cases consistently.

Not because they spend any time in their professional lives dealing with coughs, colds, or athlete's foot but because they work in these highly engaged environments where they're constantly thinking on their feet, constantly problem solving, whether or not it's multiple myeloma or athlete's foot. There's a certain thinking pattern that helps them to actually solve problems. The developmentalist approach tells us though, that if you're truly interested in competency it means you have to be truly interested in the individual.

Competency doesn't sit outside people, it resides within them. You want to help people become competent? You want to help them actually connect to their professions. The needs and wants of a 22-year-old are different from a 42-year-old or a 62-year-old. So one size fits all, simply won't work.

The psycho-analytic approach takes all of this to where I think is the next, newest, and the most exciting part of the whole competency discourse. It builds on the insight that

competency is much more than technical professional skills and more of a reflection of who we are as human beings. It's based on an assumption that professional practice is really, truly, but simply, an extension of the individual practitioner's own personality and day -to-day life.

This is a really radical way of looking at what professional practice is. When I was in school and you were in school and today when many people are still in school, we talk a lot about professionalism. We tell students, "You've got to be professional. You need to check your emotions at the door. You need to check your feelings at the door. You've got to behave like a professional." As though being a professional is different than being a human being. Psychologically, that's probably not possible. Human beings don't work that way.

So, this notion that our professional selves and our personal selves are entirely decoupled or that we can have a personal life that's a train wreck but still be a completely competent professional, those kinds of things are increasingly being questioned.

Certainly, some of the data that I mentioned earlier about who has the highest likelihood of meeting competency standards suggest that people are actually happy in their jobs and happy in their lives, have the easiest time of demonstrating competence.

You are going to have the great good fortune after the break to have a presentation by a renowned scholar in this field, Dr. Csikszentmihalyi.

Csikszentmihalyi coined the "flow" to describe a certain type of process that I think is absolutely pivotal to our discussion. That is engagement. We use the term competency to describe something that is extraordinarily complicated and in the process we reduce it, perhaps, overly simplistically.

I mentioned earlier, we have a hard time with competency so sometimes all we can do is define incompetency, the opposite. I wonder, however, if we're going around this competency question in the wrong way. To use another example of a word that has different meanings, let's think about the word "love". That's nice. Many of you smiled when I said love.

What do you think the opposite of love is? Maybe it's because there's a certain ethos in the nursing profession but the words I heard were "boredom, disengagement, and ambivalence."

When you talk to a bunch of pharmacists about this, they immediately say the opposite of love is hate. But has anybody who has lived for a period of time will probably tell you that love and hate may not actually be opposite of one another. Why? Because they're both strong emotions. Where there is hate there is actually a possibility of love and where there is love, there's a possibility of hate. There is a strong internal emotion that is common to both.

But what is actually alien to love? Boredom. Disconnection. Ambivalence. What I would suggest then is that if the opposite of love is boredom, perhaps the opposite of competency is disengagement. It's not incompetency.

If most of our structures, our systems, our thinking, our rhetoric, our discourses have always focused on the opposite of competency is incompetency, we've tried to measure things, developing testing systems, develop support systems that focus on incompetency, I would actually suggest that we've missed a very important boat.

I would suggest that the opposite of competency is boredom. Professional boredom, life boredom, whatever you want to call it. That it may not be possible over 25, 30, 35 years of a career to remain competent if you're bored. That the real thing we need to be pursuing, whether you're a regulator, an employer, an educator, whoever you are, are strategies to try to engage practitioners.

What we need to do is give them a reason to be competent. Not give them reasons to not be incompetent. So much of what we have done and so much of our language and practice over the last ten years has focused on incompetency. Not on engagement.

You will hear from Dr. Csikszentmihalyi about his model of flow but I would like to perhaps put it into a little bit of a context as a springboard for his discussion. Flow is that situation that is uniquely human where we are firing on all pistons. All of us know what this is like at some point. For some of us, we are at that point of flow when you are cooking Thanksgiving dinner for your family, when you are driving a sports car down a windy California street, when you are on a beach doing nothing but listening to waves. There are certain transcendent moments we experience as human beings where time flies by, where we just feel so happy and at one with things where the ideas are just flying, things are just riffing off all over the place and we are totally engaged and connected in our worlds.

Of course, that happens precious few times in the working world. To Csikszentmihalyi though, that single moment of flow is what makes us truly human. What connects us to other people, what connects us to our work to other people, to our contexts? Without those moments of flow, boredom starts to kick in. Disconnection. Disengagement. All of the things that are significant challenges to competence.

According to the flow model, one can consider the way in which an individual's interests and skills match the environment that they find themselves in. If you are a person that has high skills and the reality is every health care professional does, you don't get to be a licensed health care professional without demonstrating you've got high skills.

If your high skills are matched by an environment where there is a high challenge at an appropriate level for those skills, you are in flow.

But if you have high skills and your environment is just filled with low challenges, mundane routine challenges, that produces boredom. If you have low challenge

environment matched by low skills of the individual, that produces apathy. If you are a low skilled individual within a high challenged environment that produces anxiety.

You will see all of these in a clinical setting. The key, of course, is to try to figure out how it is for each individual that they find context, whether that's at work, in continuing professional development events, professional networks, whatever it is to allow their high skills to be met by high challenges and thereby, produce conditions that may produce flow.

The problem then with all of this, of course, is that as regulators, you still have a significant job that needs to be done and that is to ensure safe and effective practice. I hope that no one interprets anything I have said as suggesting we should throw the baby out with the bath water. The kind of competency assessment techniques that have evolved in various professions are, I think, important. But what I would suggest is that they are necessary but insufficient. If we think we have solved the problem of competency by introducing an OSCE plus multiple choice test question, random selection process for health care professionals, we haven't.

All we have done is serve to frighten members, enhance antagonism between members and the regulatory body and produce some numbers that might be of comfort to somebody else but don't necessarily mean anything in the end.

Balancing the need to demonstrate that you're doing something good for public safety but recognizing that the roots to competency may flow through engagement, really raises the bar for all of us and the work that we need to be doing. We need to recognize, of course, that this whole discussion, might, in some quarters, make people roll their eyes.

You're an extraordinarily friendly audience and it's wonderful when you start to talk. Very rarely do you get to stand in front of a group of professional colleagues and say, "What's the opposite of love?" And people go, "Oh, okay."

There is more than a whiff of flakiness that some may read into these examples and into this whole way of thinking. That certainly needs to be understood and accounted for.

You've all been very polite but I'm sure for some of you, you're going, "Mm-hmm." That code shifting thing? "Mm-hmm. Seriously? They brought him to speak?"

All of these are things that need to be managed. I hope what you get out of this presentation is the notion, though, that competence is a moving target. Just as our understanding of the word "madness" evolved over centuries.

Our understanding of what homosexuality is has evolved over 20 or 30 years. Our understanding of what competency is evolving rapidly right now. Competency frameworks, competency assessments and definitions of competency that don't recognize that there's actually a person there. Not just a box containing a bunch of technical skills.

Models that don't recognize the person within the professional, I fear are going to be doomed, not necessarily to failure, but to not actually succeeding in the way that we hoped they would.

Where does this lead us then? I think to a collective challenge that we need to start thinking about ways of providing social incentives for competency. We need to give practitioners a way to stay competent, not simply a reason to not be labeled incompetent. These are vastly different challenges. Engagement may or may not be the toggle that connects all of this. It's something that some of my research is focusing in on now and it's something that I'm quite interested in because I really do believe that when people are connected to their profession, the rest of it comes easily.

If people are disconnected from their profession, no amount of carrots or sticks are going to move them along. They're going to do the bare minimum just to fool you. But at the end of the day, are they really competent?

What then I would like to leave you with is the challenge to think about and share with the rest of the world, once you've figured it out, of how we can change the rhetoric and the culture that has evolved in the health professions, the culture of competence and have it evolve to be a culture of engagement.

These need not be necessarily mutually exclusive terms. An engaged culture is a competent culture. An engaged practitioner should be a competent practitioner. Finding true, authentic engagement in the day-to-day work of the profession is, I believe, one of the most important ways of inoculating an individual from that competence drift.

If we can rethink the strategies that we have, don't throw the baby out with the bathwater, don't abandon everything that's being done but simply think of what do we need to do differently to add on to, modify, so that we start to create a rhetoric, a discourse, a culture of engagement, not simply competency assessment. In that way, I suspect, we will see significant advances in not only the way our practitioners view the work that we do but also in the quality of work that they undertake.

Thank you all very much for your attention. I think we have about ten or fifteen minutes for questions or comments or thoughts.

Woman 1: Thank you very much for your presentation, Dr. Austin. I'm new on a state board of nursing in Montana and we're very, very rural. Similar to many areas in Canada. When I'm thinking about this competency, we kind of seen a pattern where it's either a mental, drug, alcohol, incompetence that we must deal with versus an educational issue that frequently is systematic.

We'll write a nice letter to the employer saying, "You need to look at evidence regarding practice and avoiding this error." Have the nurse go and take online education about administration or ethics or HIPAA. We're ruining that congruence and that connection in doing that but we're so rural, how do we really engage people that may be the only quality

critical care person in their community? How do we create those environments where they can create that competence?

Dr. Austin: That's a great question. These sort of social models of engagement presume a certain critical mass of practitioners, who you actually have a hotel that you can go to for a CE event. You have an organization that you can join such as this. The reality is that's not the case in many parts of North America.

The short answer to your question, of course, is I haven't got the foggiest idea.

But what I would actually say is that again speaks to the point that there's not a once size fits all solution here. That different solutions are going to be needed for different people and in different contexts.

The unique challenges but equally the unique rewards that might be available within more rural settings might breed a different kind of engagement. Off the top of my head, one of the things that I would think is that within some of those more rural settings, inter-professional collaboration and Inter-professional engagement is going to be a more prominent theme than unit-professional. That if you only have a couple of nurses, a couple doctors, a couple pharmacists, physios, they are going to become each other's peer groups.

There's some really unique and interesting opportunities that that model of engagement might actually produce. In other centers, you might be able to bring together 450 nurses in a room and special interest groups can evolve and the people can find the thing that really turns them on and turns those flow conditions. It really will be, I think, a question of experimenting. Trying different things.

Then most importantly, reporting. Letting the world know. "We tried this. This worked with it. This didn't work with it." You don't have to score a touchdown but if you can move the ball five yards, that's a huge accomplishment. Especially because this is really about changing a culture and a mindset and a dominant discourse that is really being in play for many, many years. Thank you very much for that thought.

Woman 2: I think what I'm hearing is that you perceive engagement as a precursor to competency. I may or may not be okay with that one. I'm still percolating your discussion. My question is, how are you measuring engagement in your own research?

Dr. Austin: Great question. I wouldn't want to suggest that there is a causal straight line relationship between engagement and competence. I don't think it's that clean and neat, unfortunately. I think there's certainly an association between the two of those. But then, I don't think it's going to be quite the same kind of connection. There's more work to be done to try to really figure out what that toggle actually is. The question of measurement of engagement is a hugely complicated one.

We are very good at measuring satisfaction. Satisfaction is a very low level proxy that sometimes people mistake for engagement but I would suggest they're very different. It's not a question of simply asking a nurse, "Are you happy at work? Do you like your

coworkers? Do we pay you enough? Do you get enough CE?" Whatever it is. It's not those types of markers of engagement. The markers for engagement are probably at this point still much more qualitative. I don't know of any good quantitative markers yet but it would be, for example, things like this.

Not just attendance at events like this but contribution to events like this. "Did you stand up and ask a question?" That's probably a higher level of engagement than simple satisfaction.

What we're actually trying to do, in pharmacy at least, some of the work that my graduate students are involved in right now, is trying to understand what does engagement actually look like when you are a pharmacist? What we're seeing, this is very unique to the profession of pharmacy, is that you actually spend more time talking to patients.

One marker in pharmacy is that you spend less time hidden behind a counter and more time actually talking to patients. You are much more likely, willing, and able to delegate technical tasks to technical staff, pharmacy technicians, because you need the time to talk to your patients.

You actually contribute, not simply attend professional types of events. What we're actually collecting now are stories of engagement. Ultimately, if we can find a way, finding those stories into something that might be a little bit more quantitative might be an ultimate goal.

I'm not convinced, though, that it has to be the ultimate goal because we're really going down a very psychological route here. I think the process of attempting to standardize and quantify, we might start to lose some of the essence of what this is actually all about. I'm not in a huge rush to do this.

Having said that, if you're a regulator, if you are an educational administrator, hospital administrator, you probably are in a huge rush. You probably want something that's more quantitative and scalable that you can put into any report those sorts of things.

It's a work in progress right now. I'd be curious to see what engagement looks like in Montana versus San Diego versus New York City versus an Indian community. Whatever it is. Things will look different for different people in different contexts.

Woman 3: Hello.

Dr. Austin: Hello.

Woman 3: I'm interested in how you perceive some of your work relating to retaining competence. Specifically in relation to when professionals leave practice for a period of time. Often as regulators, I think we're looking at how long can an individual be out of practice whether that be years, hours. Do you perceive any of this work relating to retaining competence?

Dr. Austin: That's a really, really interesting question. Again, forgive my reference back to the pharmacy profession. That's where most of my work is actually focused on. Pharmacy is actually an interesting profession.

In the last 30 years, in the United States as well as in Canada, pharmacy has shifted from being a male dominated to a female dominated profession. Within that time, there's been lots of interest in actually trying to understand what that actually means. Again, we have to go back to my fundamental assumption that there isn't this Berlin Wall that separates this person and profession. The reality is many smart, talented women select pharmacy as a career. Specifically, because it gives them a lot of options, in terms of taking time out of the workforce.

Because, I'm sorry, professional regulator or professional association, my priority between the age of 25 and 40 is going to be my children. I'll do exactly what I need to do in order to not kill people but really, don't expect me to be a booster or a cheerleader or rah-rah-rah.

The question of how you maintain engagement during absences from the workforce is a really interesting one. We've done some preliminary work around this in pharmacy, one of the things that we actually found, again, is it's those professional networks that will sustain you even if you're not in direct practice. The extent to which, even if you're not going to work as a nurse for any period of time, if you are still connected to a professional community during absences from the workforce, that seems to have a slight inoculating affect.

It's easier for you to reintegrate into the workforce after that period is done. Of the things that we try to encourage, men, women, whoever is taking sabbaticals from the work force is to say "You don't actually need to necessarily do the day to day work of the profession but similarly, you can't just read the monthly journal that comes out and think that's all you need to do. There's a very powerful factor of talking to, connecting with, being engaged with other people that do your job, even if you're not physically doing that work right now, as a way of protecting you during those gaps in the workforce.'

Thank you all very much for these questions. Very interesting.

Woman 4: Thank you, for your wonderful talk. I'm a researcher, not a regulator. I was wondering if there's been work done...oh, and I fell off my bike. That's why I have those bruises.

Anyway, has there been work done to relate competency to social network theories and just social media because just of all this notion about connectedness and engagement?

Dr. Austin: Yep. That was actually a little bit of a blind alley we went down initially. When my research group started to think a little bit about this competency and engagement thing, the first thing we tried to do was some social network mapping.

The idea being basically, the more organizations you belong to, the more people you know, the more events you attend, would that somehow be associated or correlate with performance on standardized assessment. We didn't find any correlation.

Again, it's not simply about amount, there's a qualitative component here. That's the slippery and somewhat frustrating part of all of this. That if you have two or three good people that you are connected with, in some cases, that's going to be better for you from a competency and inoculation perspective than attending a CE event every night and belonging to all these organizations. The quality of something, that's probably more important.

Kathy: I'm Kathy Loupes Boucenelle [sounds like 1:01:05] from New Mexico. The question that comes up with, we've dealt with all in this room, is burnout of nurses. Nurses work long hours. I work in an institution, a trauma hospital that has 2,000 nurses. Those nurses really get PTSD and they get burnout. We've studied that. Is that, in your opinion, the same experience of disengagement or is it something different? Because it's a huge issue in nursing. I even noticed that the young nurses, with the high tech that they seem to be disengaged. I'm not sure what the phenomena is.

Dr. Austin: I would actually see burnout as being qualitatively different than disengagement. It may be sort of along a similar path but at a certain point. Burnout actually starts to tip into pathology in many ways. It needs to be dealt with in that way, that it's a significant...it's a mental health issue.

Disengagement need not necessarily be a mental health issue. I frame it more as a choice that people are made...they're simply choosing. 'I'm just not interested so I'm not going to do this.'

Whereas burnout, I think, is somewhat more problematic as a construct. You're raising a point about technology. I think that's another piece of this, particularly in nursing. Again, I'm old enough to remember working in a hospital in a very high touch era where nurses were just right in the center of things.

My perception at the time was, "Why did you want to become a nurse?" Because you really cared. There's a certain thing that drives...people don't become nurses for fabulous wealth or fame. They become nurses because they have this drive to connect to other people. If you aren't interested in connecting to other people, you're not going to make it very much as a nurse. Having said that, has technology produced more barriers between the nurse and the patient and so much of nursing work has become technologist's work, in terms of programming pumps and I still work...this is a good example of me working four hours a week as a pharmacist in a hospital.

The amount of time that we spent programming pain pumps and trying people...pumps change every six months, it seems. New contract comes in. those are the sorts of things that are profoundly disengaging within the workforce itself and about the job itself.

Where this ties out to some of your burnout question is, of course, this is not something that me as an educator or you as a regulator can do on your own. We can't go off on a fancy foot pathway and say, "You all want to hold hands, sing Kumbaya and dance around the May Pole, because we're an engaged profession."

If the reality is the work place doesn't support this. At the end of the day, wherever other worldly and futuristic thing that we might want to think about in terms of engagement, if employers are still saying, "Yeah. You need to take care of 17 patients on a 12 hour work shift and you need to do this, you need to do it. You need to document all those things." No amount of rhetoric from us is going to incentivize engagement.

A lot of my work right now in pharmacy is actually trying to connect with employers because the employers, the advantage in pharmacy is that the vast majority of employers from the pharmacy are from the private sector.

Although, I suppose, maybe in the United States and hospitals there's a lot of private sector and employers too, so maybe this does apply to you as well.

We're getting quite a positive reception around this engagement script with employers because they, too, recognize that burnout, disconnection. All these things influence customer service.

The only thing worse than having no pharmacist in your store is having a bad pharmacist in your store. Trying to make the argument that the engagement not only produces competency but links to productivity, links to customer service, these are some of the arguments that we're trying to make. We've actually had a very receptive audience on the part of employers, who actually say, "Maybe we need to look at the way we're structuring work. Maybe we can give some administrative support or technical support and that will actually improve the workplace conditions." But it's one pharmacy at a time, one hospital at a time, one employer at a time. We can't omit them from this thinking or this discussion. Thank you.

Kathy: Interesting. Thank you.

Woman 4: As an investigator, we have seem both the apathy trend as well as the personal life spilling over into the professional life of making them unable to function, for whatever reason, or to do a good job. CEUs don't necessarily seem like a good option to give these people, because like you said, taking a test doesn't really do much. Anybody could take the test. How do you motivate those who don't seem motivated or unmotivateable [sic]?"

A couple of very important questions. I think the first one is this notion of "unmotivatable". As an educator, I would like to think there's no such thing but as a human being I know there are. In those situations, it's probably most important to have some kind of vehicle. Say, "Maybe this isn't the field for you."

It's hard. It may not work but at the end of the day, not everybody should be a nurse. It's not more complicated than that and it is as complicated as that. The issue of trying to motivate is at the core of this whole issue.

I think it's a generations long project, actually. The first step in motivating is to try to remove as many demotivating things as possible that we have in the environment already.

In my environment around the demotivating thing, I would say, make-work project. A big make-work project we have in pharmacy is the learning portfolio. We abandoned, based on this evidence, we abandoned compulsory continuing education for pharmacists in Ontario about 15 years ago.

We said, you don't need to produce 20 hours of certificates every year. There's no evidence it does anything anyway so you're now responsible for your own continuing professional development but we don't really trust you. so we're going to make you submit a learning portfolio that uses the continuing professional development module that says you identify a learning gap, you address that learning gap.

You do this. There's this lovely cycle and there's this online version of a learning portal and there's all these things that are unbelievably fakeable exercises. A very ruthless and honest appraisal of the things that you do that are demotivating might actually be the first and most important step.

Nurses, pharmacists, no one expects you to make their world sunshine and roses. That's sort of like patients. They don't expect perfection but if we want to be authentic and talk about engagement but we're still making people do things that they just perceive as make-work exercises, it kind of puts the lie to everything else that we try to do.

Every organization has these make-work exercises and we still have our learning portfolio and pharmacy despite the fact that I'm actually very honest with my regulator and say, even me. I fake it. I get the envelope in the mail that says "Submit your learning portfolio" and it's like, "Uh-oh. What have I done for the last three years?"

It's this model that it's actually something that's woven into practice. It just doesn't work that way. Honestly acknowledging that and at least trying to remove those demotivators is probably a good first step.

Woman 5: Just two quick things. The Oncology Nurses Society has a really good learning portfolio process for their continuing ed. They pretest you. They show you where your gaps are. They focus you on continuing education for their certification. They have a really good model and I have friends that really appreciate it.

The other thing I want to bring up with regards to technology, is as a Nurse Informatics specialist, somebody...this is my anecdotal theory, right brained versus left brained, if you're worried about where to click you cannot think critically. How do we give nurses the opportunity to step away from the computers to think about what they're doing? Minimize

where they need to click. How do we create those environments for them so that they're not going to be at risk for error because we took away their critical thinking ability?

You phrased that so well. In my world, it's pain pumps. If there was an easy way to actually program pain pumps, jobs satisfaction for nurses in my facility would skyrocket.

Those seeming simple but important demotivators to engagement in the workforce, they're so important. Thank you for bringing that up.

Maybe final question?

Terry

Crawford: Just a couple of comments. I really enjoyed this. I'm Terry Crawford and I'm in college of registered nurses in Nova Scotia. We had developed a quality monitoring and improvement program. We've done it for the last five years and as we are going into our next five year cycle, what I've been struck with is the constant tension for a regulator to try to improve quality and have nurses do better and our role as a regulator.

When you have someone that has learning needs, when do you cross the line over into regulation and professional conduct? It's becoming more and more of an issue for me. This, I think, in engagement, in talking about engagement and how we approach those nurses with learning needs is going to be critically important as we move forward. So thank you very much for this.

Dr. Austin: There's a messaging piece to this that a lot of it has to do with how you communicate with what the regulator's role is. If there's the bludgeon of public protection, public protection, "We're out to get you." Okay, I'm not telling you anything. It's that simple. Finding ways of sort of striking that balance, challenging. Very specific but it's something that I look forward to hearing how each of you in your context figures that out in the years ahead.

Thank you all very much for your very engaged questions and contributions today. It's been absolute pleasure. Best wishes for the rest of the conference.

[applause]