HealthManagement.org
The Journal
LEADERSHIP • CROSS-COLLABORATION • WINNING PRACTICES
VOLUME 17 • ISSUE 3 • 2017 • € 22
ISSN = 1377-7629

People

- LEADING THE WAY: CUTTING EDGE HUMAN RESOURCES
- WORKFORCE PLANNING, *A. LOVEGROVE*
- GREAT LEADERS EMBRACE CONFLICT, *S. JOHNSTON*
- EARLY HUMAN RESOURCES INVOLVEMENT IN M&A ESSENTIAL FOR SUCCESS, *F. ROEBROEK*
- PATIENTS MENTORING EXECUTIVES, *D. CRYER & C. DAVIS*
- CHALLENGING PARADIGMS, *A. SPIRO*
- LEARNING WITHOUT LIMITS, *M. LESTER*
- TEACHING ULTRASOUND IMAGING ONLINE, *J. VAN ZANDWIJK*
- *USA RADIOLOGY WORKFORCE, E. I. BLUTH*
- PURSUING A CULTURE OF SAFETY, *W. O. COOPER*
- APPRAISALS IN HEALTHCARE, *A. LAYLAND & N. LEENA*

Challenging Paradigms

Practising at the Top of Your Licence

Is a division of labour approach in which health professionals limit their practices to the top of their licence and training best for high-quality, patient-centred care?

Alan Spiro

Senior Vice President and Chief Medical Officer
Blue Health Intelligence
Chicago, USA

alan.spiro@bluehealth-intelligence.com

@AlanHSpiro

The industrial revolution has come to healthcare. Old paradigms—from routine physicals to even the concept of the doctor as the captain of the ship—are being challenged as we try to find more efficient ways to deliver high-quality care. However, as fast as we break down the rigidity of past practices in order to foster better systemisation we seem to build new paradigms that may have negative unforeseen consequences. These new "truths" can rapidly be set in concrete while the problems they create are given little attention. We must always be asking ourselves whether we are truly improving care or if we are merely swinging the perennial pendulum of change too far as we try to reject shibboleths of the past.

A new paradigm that I see in many realms of medicine is the concept of having each professional practising at the top of their licence and their training. What that means is that a doctor should not do something that a nurse practitioner can do; a nurse practitioner should not do something that a nurse can do, and a nurse should not do something that a nurse's aide should do. In practice this concept has manifested in a variety of ways. During a hospital stay, which I described in a blog post (Spiro 2015), the nurses rarely touched me or even saw me as they stayed at the nurse's station monitoring my cardiac rhythm, watching my trends on the computer, and only coming in to give me medications twice a day. The nurses' aides took my vital signs, helped me get to the bathroom and changed my bedding. The doctors did not come in at all as they were able to access the record from multiple locations, and I only saw the physician at the time of my procedure. In psychiatry, this same concept has developed to the point at which it is unusual for a psychiatrist to engage a patient in talk therapy and instead the psychiatrist is involved mainly in medication management with talk therapy being performed by licensed therapists who are not MDs. For surgeons, it means that they are often focused totally on their work in the operating room, with nurse practitioners assessing the patients and caring for them before and after the surgery.

The fact is that this type of approach has some attractive features. For the system, it could potentially save money. For the health professional, it frees them from doing tasks that they may not like to perform and allows them to focus on the tasks they are trained to do. But is this better for the patient? Is this strict division of labour really conducive to high-quality, patient-centred care?

> "DIVISION OF LABOUR CAN BE TOO STRICT IN ITS APPLICATION"

In some ways, this new paradigm is related to the industrial revolution that healthcare is now undergoing. The assembly line was a key component of the industrial revolution of the nineteenth century, and the movement towards a new industrial revolution in healthcare can be seen to be following that tried and true formula. A true division of labour approach in which everyone limits their practices to the top of their licence and training has advantages. Assembly lines allow for specialisation of roles, and that often leads to less variability, which is associated with higher-quality products being produced at a significantly lower cost. The cost of labour goes down as each person involved only performs a small number of tasks. That allows for training requirements to be narrowly focused as well, with the jobs themselves than more easily filled at a lower salary level. If more can be done by nurses' aides who are lower paid than nurses, the theory goes that nurses can focus more on the "important" nursing roles, which results in a decrease of total costs and a more effective and efficient system.

However, the disadvantage of the assembly line is that unique craftsmanship is lost. From the worker's point of view, the work becomes repetitive and the "big picture" of the ultimate goal, complete with individual pride in reaching that goal, can be lost. The individual ownership of the product (and in healthcare the product is the wellbeing of the patient) risks being lost in a system that is based on assembly-line principles. There is a reason that the finest products in the world are often not made on an assembly line, but are

made by master craftspeople who take great pride in their work. We see some of these disadvantages in this new medical paradigm, as physicians and nurses are rewarded for how well they do their individual tasks rather than how well they treat the whole person.

Medicine is filled with the risk of low-probability and high-consequence events, some of which are due to our treatments and not only to the underlying disease. Quality medical care demands anticipating and avoiding those events and treating people in such a way as to minimise the risk of any intervention. That may require more holistic thinking about the patient rather than task-based thinking. A health professional who is very hands-on—even if that is "below" their training and licence—may be the best defense against poor quality care. An article in ProPublica that focuses on surgery risks and patient safety makes this point when the authors describe two surgeons in a small community hospital in northwest Alabama who are among the best in the country at doing joint replacements (Allen and Pierce 2015). Dr. Aaron Joiner and Dr. John Young have performed 282 knee and hip replacements over the last five years with zero complications. The way they accomplish this is the antithesis of practising at the top of your licence. As described in the article, they often operate together, even though that hurts their income. They believe that having two surgeons in the operating room provides a backup and an immediate quality control. They describe a typical interaction in the operating room as one in which they are open and honest when they see their partner doing something that does not measure up to their own standards. "I may look at something a little backwards or get turned around," Joiner said. "It's nice for one of your partners to say: 'What the hell you doing? You're not out huntin' this morning. You're doing a knee replacement!" They also do all the post-operative care themselves rather than having physician assistants or nurse practitioners do that for them. As Dr. Joiner puts it: "We don't cut corners. We do it the right way every time."

I remember when I was training in gastroenterology, serving alongside Dr. William Silen, a giant in the world of surgery, who was also a dedicated teacher, mentor and patient advocate. At Harvard Medical School, the William Silen Lifetime Achievement in Mentoring Award honours his leadership. We would make our rounds with Dr. Silen to see patients at 5am every morning and at 6pm every evening, personally seeing each patient pre- and post-operatively twice a day with our operating room duties in between. The fellow or resident who just wrote an order without actually seeing the patient, talking to the patient, and examining the patient would not last long with Dr. Silen. The doctor in training, who thought that removing a nasogastric tube or changing an intravenous line was a nurse's job and not his or her direct responsibility, would quickly learn that that attitude was not acceptable. For Dr. Silen every task that involved caring for a patient was in the physician's scope of practice and was, by definition, practising at the top of their training and licence, because medicine was about ownership of the entire patient—their problems, their hopes and their lives—not about the specific task that needed to be done.

Conclusion

The idea that all health professionals practise at the top of their training and licence when used in the context of a true team all sharing full accountability for a patient can help both quality of care and the human caring that patients need. However, it is very easy for that pendulum to slip past the midpoint into the realm of assembly-line care that focuses on the immediate task rather than the entire patient and their family. In an age of ever-expanding health systems, employed physicians, corporate medicine, government medicine and large mega-health benefits companies, it is far too easy to focus on an assembly-line mentality rather than a team mentality that can truly improve care. Let's not allow the new paradigm that demands division of labour to ever divert us from the idea that all care for a fellow human being in need is by definition at the top of one's training and licence. ■

KEY POINTS

- ✓ Having health professionals practise at the top of their licence is necessary for optimal healthcare efficiency
- ✓ However, the ownership that each health professional has for the total wellbeing of every patient is at risk of being undermined by a division of labour that can be too strict in its application
- ✓ The key to success in healthcare is for each health professional to take responsibility for the holistic wellbeing of the patient while trusting teammates to have that same attitude
- ✓ Practising at the top of your licence should lead to teamwork rather than a strict division of labour

REFERENCES

Allen M, Pierce O (2015) Making the cut: why choosing the right surgeon matters even more than you know. ProPublica, 13 July. [Accessed: 30 May 2017] Available from propublica.org/article/surgery-risks-patient-safety-surgeon-matters

Spiro A (2015) My recent hospital stay and the care of the computer. [Blog post] [Accessed: 30 May 2017] Available from healthwealthandlife.blogspot.com/2015/06/my-recent-hospital-stay-and-care-of.html