Competence to practise: an unmistakable fact or a holy grail?

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Saturday 8th March 2014
› Professionalism and professional regulation
› Elements of professional regulation
› The question of competence assurance or continuing competence.
› The interface between regulation and workforce.
“An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society” (Cruess, Johnston & Cruess, 2004, p.74).
The regulation of health professionals

- Forms part of a branch of law known as administrative law
- Is described as a “protective jurisdiction”
- ICN & WHO agree that “The purpose of professional self-regulation is to safeguard and champion patient safety” (ICN/WHO, 2005 p.7)
- Primary objective of the national registration and accreditation scheme in Australia under *Health Practitioner Regulation National Law 2009* (Qld) Part One, s.3(2)(a)
  - “to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered"
- In most countries this is achieved by a combination of processes:
  - 1. Standard setting to ensure the right people get into the profession –this includes standards for courses (accreditation) and standards for entry (registration)
  - 2. Advice and guidance to assist practitioners to practise “in a competent and ethical manner”
  - 3. Mechanisms to protect the public when they do not practise in a competent and ethical manner, for whatever reason
The “privilege of self-regulation”

› Professional regulation may be taken to read that the profession regulates itself

› To some extent this is correct, albeit in most countries through a statutory framework to give “teeth” to the regulatory processes

› Professions therefore tend to decide
  - who should enter the profession,
  - what those who enter might look like,
  - how they might properly conduct themselves as members of that profession and
  - what criteria would need to be breached in order for them to be excluded from the profession
Professional regulation is not favoured by all

› There is debate as to whether professions should self regulate, set their own standards and determine who comes in and who leaves ((van Mook et al, 2009; Chief Justice of Ontario Advisory Committee, 2001)

› However, there is also concern that our self regulation can create monopolies and limit market competition - itself an interesting debate in a service such as health care (Siebert , 2006)

› “Whereas public regulation was meant to ensure “public protection”, the word is now increasingly associated with central control, unreasonable bureaucracy and restraint in international trade and worker mobility.” (ICN, 1998, p.7)

› Given the global migration of nurses today, and the fluctuation between countries in supply of nurses, both under and over, there is much debate amongst governments and employers alike about how influential a profession's hold on regulation ought to be (Ameringer, 2008)
Self-regulation or co-regulation?

› Arguably in most countries the model is not one of complete self-regulation, but co-regulation

› Governments already play a significant role in regulation of health professionals

› Through remuneration systems in both the industrial and commercial domains

› Through legislation that grants access to the use of therapeutic drugs and devices

› Through such structures as admitting and visiting rights to hospitals and other health care facilities; and

› Through processes such as adverse incident reporting and, where serious adverse events occur, investigations and recommendations from Commissions of Inquiry.
Elements of professional regulation(9) include

- **Registration**: who should enter the profession and what those who enter might look like.
- **Accreditation**: oversight of how those who might enter should be prepared.
- **Codes and guidelines**: how they might properly conduct themselves as members of that profession;
- and
- **Complaints and notifications**: what criteria would need to be breached in order for them to be excluded from the profession.
The elements of professional regulation (Chiarella & White, 2013)

- Registration Standards
  - Endorsements

- Codes and Guidelines
  - Competency standards
  - Codes of conduct
  - Codes of ethics
  - Professional guidelines

- Accreditation
  - Curriculum standards
  - Course guidelines
  - Site reviews/inspections

- Complaints and notifications
  - Performance
  - Impairment
  - Professional Misconduct
Registration – deciding who should enter the profession

• Registration Standards
• Endorsements

- Curriculum standards
- Course guidelines
- Site reviews/inspections

- Codes of conduct
- Codes of ethics
- Professional guidelines

- Performance
- Impairment
- Professional Misconduct
Deciding who should enter the profession

- Determining (inter alia)
- Age of entry
- Physical and mental well-being
- Fitness to practise
- Prior educational experience
- Educational qualifications (see accreditation also)
- The need for proficiency in the relevant language
- Criminal record checks
- Professional indemnity insurance
- Recency of practice.
Domains of RN standards for practice

› Professional Practice
› Critical Thinking and Analysis
› Provision and Coordination of Care
› Collaborative and Therapeutic Practice (NMBA, 2010)

› Each domain then has a number of elements, and each element has a number of behavioural cues to assist in assessment.
› In New Zealand nurses undertaking their assessment of continuing competence are expected to self-assess against the competency standards (Vernon et al, 2010)
› This use of competency standards is similar to developments in America and Canada for medicine (WHO, 2005)
Codes and Guidelines and Professionalism

- Codes of conduct
- Codes of ethics
- Professional guidelines
- Competency standards
- Registration Standards
- Endorsements
- Curriculum standards
- Course guidelines
- Site reviews/inspections
- Performance
- Impairment
- Professional Misconduct
- Accreditation
- Codes and Guidelines
- Complaints and notifications
May include

Sets of competency standards that a health practitioner is required to meet before entry to the relevant section of a professional register

Codes of conduct and codes of ethics (the “floors and ceilings” of professional expectation) (Chiarella, 1995)

Professional guidelines, that provide assistance and advice to health professionals on a range of relevant and often difficult matters. (NMBA, 2010)
Examples of how to conduct oneself in a profession

The professional Decision-Making Frameworks (DMF) for nursing and midwifery (NMBA, 2010)

› The decision-making frameworks assist nurses and midwives

› To identify and work within their relevant and appropriate scopes of practice

› To make careful and informed decisions about when to delegate work to another health professional or health care worker with a more confined scope of practice

› To decide when to take on tasks or assignments that might fall outside their normal scope of practice.
Complaints, notifications and professionalism

- Performance
- Impairment
- Professional Misconduct

Complaints and notifications

- Registration Standards
- Endorsements

- Codes of conduct
- Codes of ethics
- Professional guidelines

- Curriculum standards
- Course guidelines
- Sire reviews/inspections
Managing those who breach the standards set by the profession

› This may be due to

› A lack of competence in the performance of their professional role

› An impairment issue such as a physical or mental illness disability or an addiction to drugs or alcohol

› A conduct matter, whereby the individual behaved in such a way as to incur a determination of unsatisfactory professional conduct or professional misconduct.
Consistent with self/professional regulation?

› Much of the work that is done in terms of assessment and decision making in relation to complaints and notifications is undertaken by peers.

› The judicial decision making bodies that hear complaints that are prosecuted are also usually mainly populated by peers (although they usually have at least one legal and one lay member)

› A number of the changes that have occurred (for example, the introduction of the HCCC in NSW) came about because the professions did not act when they needed to do so

› For the public to have faith in us as professionals, they need to be assured that we will act appropriately when there is the possibility of public risk

› From an educational perspective, there is rich cautionary material within the professional disciplinary case law (Adrian & Chiarella, 2010)
Accreditation and professionalism

- Registration Standards
- Endorsements

- Codes of conduct
- Codes of ethics
- Professional guidelines

- Performance
- Impairment
- Professional Misconduct

- Curriculum standards
- Course guidelines
- Site reviews/inspections

Accreditation
Only just become a separate body for nursing and midwifery in Australia, although all other registered health professions had separate accreditation bodies.

For nursing and midwifery the task was formerly undertaken by the jurisdictional registration authorities.

However, WHO makes the point that “the legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government” (p.4). (WHO, 2005)

The accreditation body sets the standards for the courses and programs leading to entry to the professions and for post-registration or specialisation programs where appropriate.

These standards are developed and agreed by the education providers and key professional stakeholders and in this way, can clearly be seen to be an arm of professional self-regulation.
Issues for today’s conversation

› It is recognised that there are significant variations between countries in the extent and locus of nurse regulation (Benton & Morrison, 2012)

› However, the elements presented above (Chiarella & White, 2013) are fundamental to any scheme and need to be present to fulfil all criteria for a professional regulatory process that provides public protection.

› I want to explore continuing professional development and it’s relationship to competence

› The interface between regulation and workforce
Now an annual mandatory requirement consistent across all registered health professions in Australia.

The Medical Board of Australia defines CPD as

“the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal qualities required in their professional lives (MBA, 2010)”.

CPD is a means of ensuring that health professionals keep up to date and hence are more likely to be safer,

This relates to the first objective of the national registration and accreditation scheme in Australia under Part One S.3 (2)(a) of the National Law, which is

“to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered,

Health practitioners also believe that CPD is an essential component in continuing competence (Vernon, Chiarella, Papps & Dignam, 2010)
However…

- It is difficult to ascertain how either CPD or indeed recency of practice can assure competence.
- For example, is there any link between a person who attends a lot of lectures and a person who is competent?
- Clearly there are people who do complete their requisite CPD but still are found to be unsafe to practise.
- Indeed it is difficult to be certain that continuing competence can be assured.
- For example, just because a health practitioner performs competently during one assessment of competence, they will perform competently the next time they undertake the same skill.
- I might bake a perfect cake today and burn one tomorrow. Drive my car well today but have an accident tomorrow.
- Consider the risk matrix below.
# Risk matrix for the assessment of competence

(Chiarella & White, 2013)

<table>
<thead>
<tr>
<th>Evidence of sufficient CPD</th>
<th>No evidence of sufficient CPD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>competent</strong></td>
<td></td>
</tr>
<tr>
<td>Sufficient CPD Competent</td>
<td>No CPD Competent</td>
</tr>
<tr>
<td>No problem</td>
<td>No problem – they will be picked up but they are not dangerous</td>
</tr>
<tr>
<td><strong>Not competent</strong></td>
<td></td>
</tr>
<tr>
<td>Sufficient CPD Not competent</td>
<td>No CPD Not competent</td>
</tr>
<tr>
<td>Problem – won’t get picked up as will meet renewal requirements but not safe</td>
<td>Potential problem but we should pick them up through lack of CPD</td>
</tr>
</tbody>
</table>
So is continuing competence just a holy grail?

› Perhaps the important aspect of CPD is not necessarily the assurance of competence, but rather a heightened sense of self-awareness of risk and the ability to reflect on competence.

› Reviewing our practice against the competency standards or standards for practice cannot guarantee that we will always be competent. But then nothing can.

› However, it is perhaps more important that we are aware of our limitations and strengths and are able to measure these against the requirements of a given situation.

› Perhaps the more important issue is that we are aware of our level of competence or incompetence in any given situation.
### Competence awareness matrix

<table>
<thead>
<tr>
<th></th>
<th>Competent</th>
<th>Incompetent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware</td>
<td>Aware that they are competent</td>
<td>Aware that they are incompetent</td>
</tr>
<tr>
<td>*Unaware</td>
<td>Unaware that they are competent</td>
<td>Unaware that they are incompetent</td>
</tr>
</tbody>
</table>

*Checkmark* for awareness, *X* for unawareness.
As previously stated in the discussion earlier on accreditation, there is a strong Government interest in health professional regulation and therefore concomitantly the education of health professions.

This is at one level absolutely right and proper – Governments should be interested in the provision of health services and such services are not possible without an adequate workforce.

However, the level of oversight and emphasis on workforce in Australia at present in what is primarily a protective jurisdiction is interesting and probably relatively novel in terms of its incursions into the “privilege of self-regulation”.
A shift from professional regulation to regulation of professionals?

The other objectives of the Australian national registration and accreditation scheme (apart from the protection of the public) are—

S. (3) (2)

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
› (e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

› (f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners. (italics added)
Does this create an unbalanced professional regulatory climate?

- This is the first time that workforce considerations have been overtly canvassed in health professional regulation in Australia.
- One of the difficulties in regulation is that regulators have the protection of the public as a primary concern.
- This may require setting standards that a government in search of a workforce might think are too high or too exclusionary.
- When professional regulation legislation makes specific provision for government oversight and right of veto, this may make a mockery of the advice of educators or the concerns of regulators in conjunction with educators.
In conclusion

- Professional regulation is more than registration of health professionals
- It consists of four key elements that together are designed to protect the public from unsafe practitioners (in whatever field)
- There is a strong interface between professional education and professional regulation
- The question of the extent to which this ought to be self regulation by the health profession or not is vexed, particularly when a practitioner makes a series of public and significant mistakes or behaves in a way that is completely contrary to professional standards
- However, it is fair to say that professional regulation is a key element of professionalism as it is one of the ways in which the public bestows its trust and confidence in us as health professionals
“Regulation touches the point between the public and the personal. Over regulation is seen as an interference in personal conduct; under regulation is seen as an abdication of public responsibility. When harm happens we blame ineffective regulation but when we are stopped from doing something risky we say regulation is excessive. The public, media and politicians often face both ways wanting more or less regulation depending on the moment and the mood”.

Harry Cayton, Chief Executive, Commission for Health Care Regulatory Excellence. Address to AHPRA Conference September 2010


Health Practitioner Regulation  National Law 2009 (Qld)


Waring T (2009) Independence of the accreditation body is paramount Australian Psychological Society
[http://www.psychology.org.au/inpsych/independence_accreditation/]