Three lessons from the literature about competence

Three lessons can be taken from the literature about fitness to practise and competence and how these topics relate to the development of a recertification framework. These are that:

- only a small percentage of practitioners will face competence and/or fitness to practise allegations during their career
- poor practice happens at individual practitioner and systemic levels
- there is a sliding scale of risk when it comes to competence and fitness to practise.

These three points are described in further detail below.

Only a small group face competence allegations

The evidence suggests that only a small percentage of health practitioners are not practising at an acceptable level and will face competence and/or fitness to practise allegations over the course of their career.[22] [43] [3] It is a point that may reassure regulators whose core function is to assess and assure the relative safety of the public.

The literature also highlights some additional points that need to be addressed in the development of a recertification framework. Namely, that it is possible for a practitioner to:[66]

- act in an unprofessional manner without their competence and fitness to practise being called into question
- be subjected to a competence and/or fitness to practise review and/or programme to rectify a deficiency in skills or behaviours, but remain a professional because the incident/s are not sufficiently serious to warrant removal from the Register
- demonstrate clinical or technical competence in their practise and not meet other thresholds relating to professionalism such as communication, management or leadership skills.

Poor practice happens at individual and systemic levels

The Act requires health regulators in New Zealand to examine competence and fitness to practise matters predominantly in the context of the individual practitioner's actions. In this regard, the practice environment for New Zealand dentists is worth noting. While they share characteristics with other oral health and health practitioners, the majority of dentists are sole practitioners. While some do practice within the District Health Board or team practice environment, many of the systemic factors identified may not apply to them.

However, the literature, especially as it relates to other professions and jurisdictions, suggests that poor practice can and does occur at both the individual practitioner and systemic (i.e. the systems and local environments in which the individual works) levels.[57]

Examples of practitioner factors that may contribute to poor practice include where a practitioner:[57]

- makes a poor treatment decision relating to a patient
- has existing habits that prevent them from responding or adapting to adjustments, new recommendations or new guidelines
- lacks confidence in making clinical decisions
- has biological factors (e.g. anxiety, depression, feeling demotivated) that impact on their clinical decisions.

Examples of systemic factors that may contribute to poor practice include where:

- an organisation and/or employer has poorly developed performance targets for their practitioners[57]
- there is discontinuity between practitioners and team leaders due to staff turnover problems[57]
- there is a lack of teamwork between managers, practitioner and/or practice groups[57]
- there is a dysfunctional team structure[57]
- there are poor governance arrangements[57]
- the use of organisational targets potentially compromises patient safety[57]
- a regulatory policy overrides the individual nature of the regulator/practitioner relationship, even where a practitioner is cooperating with the regulator on competence and/or fitness to practise matters[67]
- regulatory responses are dictated by a practitioner's cooperation/non-cooperation, rather than by the seriousness of the issue[67]
- policy focuses on administrative processes that make scrutiny and accountability difficult for the regulator to achieve[67]
- poorly designed risk-based approaches may lead to persistent non-enforcement by a practitioner.[67]

Researchers have also questioned the necessity of looking beyond individual non-compliers to system difficulties that look beyond punitive approaches to regulation, as is the case in the United Kingdom.[67]

Competence has a sliding scale of risk

For regulators, the literature has two clear messages.

First, any mechanisms concerned with competence and fitness to practise should be proportionate to the risks posed by practitioners.[60] This approach presupposes that as the level of risk increases, so does the regulatory force required to manage that risk.[22] [68] [60]

A 2012 paper by the Council for Healthcare Regulatory Excellence refers to a multistage funnelling process designed to manage competence and fitness to practise issues. The paper acknowledges that the funnelling process will inevitably identify practitioners for further investigation who are, in fact, fit to practise. However, it also anticipates the use of other tools/mechanisms that would screen out this group of practitioners in subsequent stages of the funnelling process. Other aspects of the multistage funnelling process include:[60]

- high-level screening tool/s to initially screen a large number of practitioners
- triggers/filters to identify practitioners who require further investigation or examination of more detailed information and evidence
- referral and assessment processes
- regulatory actions that can be used if a practitioner is deemed incompetent and/or unfit to practise.

Second, while there are some common factors in health regulatory approaches to competence and fitness to practise issues, the mechanisms are likely to vary to meet the particular (if not unique) circumstances of the profession being regulated.[60]

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