Professionalism in a regulatory context: Transcript

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Professionalism in a regulatory context

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The focus of this presentation today is professionalism in a regulatory context. With that in mind there are four key areas I’m going to cover.

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Firstly I’d like to introduce the concept of chiropractic professionalism.

Then I’m going to highlight how professionalism is relevant to regulation of the chiropractors in terms of education, assessment and remediation of practitioners.

My next focus will be a brief summary of the current professionalism literature and I’ve placed an asterix here as much of this work has been done in other health professions but I think there is much overlap with our profession.

And finally I’m going to highlight some recent developments and future possibilities around regulation of professionalism related issues.

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So what is professionalism?

In 2009 Tim Wilkinson and colleagues performed a systematic review with three key aims.

They wanted to collate the various definitions of medical professionalism, to identify the various assessment tools used to measure professionalism and then match these tools to the aspects of professionalism that they assessed.

The overall aim of this was to identify gaps in assessment of professionalism which may then stimulate development of new assessment tools.

Following an extensive literature search, they identified five major themes of definitions or interpretations of professionalism.

And these included:

1. Adherence to ethical principles. This included things like honesty, integrity, truthfulness, moral reasoning, respect of privileges and codes of conduct and confidentiality.
2. The second group was around effective interactions with patients and those important to them such and this included things such as respect for diversity and uniqueness, politeness, courtesy, patience, and appropriate manner or demeanour, respect for professional boundaries, the ability to balance availability and self-care, and other attributes such as empathy, care, compassion, rapport and shared decision-making.
3. The next theme was around effective interactions with others working within the health system and this again included many of the previous aspects such as respect for diversity or uniqueness, politeness, courtesy, patience, and appropriate manner or demeanour, professional boundaries, balance availability and self-care but also this of course included teamwork.

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1. So the fourth area of themes related to reliability including accountability, completion of tasks, punctuality, being able to take responsibility and being organised.
2. The final theme relates to commitment to autonomous maintenance and continuous improvement of competence and this was considered in three areas:
* in relation to the self and including things such as reflection, seeking and responding to feedback, being focussed on lifelong learning and the ability to deal with uncertainty
* this was also focussed on interaction with others such as providing feedback and teaching and appropriate people management, and
* it also included interaction with systems and that involved such aspects such as advocacy, seeking and responding to results of an audit and advancing knowledge in the profession.

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There is a much smaller literature dealing specifically with chiropractic professionalism, however there is clear overlap between the definitions identified by Wilkinson and colleagues, and the information contained within the websites of both Australian professional associations.

The Chiropractic Association of Australia lists core values on their website, and this includes reference to ethics and professionalism.

It also includes focus on integration of research evidence, appropriate clinical expertise, makes reference to patient values and choices and attributes of inclusiveness and collaborative relationships within and outside the chiropractic profession.

They also have an ethics statement which highlights the importance of personal, patient, community, clinical and professional ethics and they make with specific reference to maintaining and developing competence within this.

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Chiropractic Australia outlines in their mission statement that they expect members to provide safe, ethical and effective evidence-based chiropractic care.

They make reference to inter-professional, high quality, patient-focused care. And they highlight their commitment to key values around honesty, integrity and clinical practice which is ethical, accountable and visionary.

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From a regulatory perspective, professionalism also features within the National Law[[1]](#footnote-2).

The National Law is heavily focused on patient safety. Section 3 highlights that the main principle for administering this Act is that the health and safety of the public are paramount.

It’s perhaps not surprising then, that the focus of professionalism is more on what it is not, rather than what it is.

In section 5 of the National Law there are definitions for both professional misconduct and unprofessional conduct:

* professional misconduct is defined as conduct substantially below the standard reasonably expected of a registered health practitioner, whether occurring in connection with practice or not, and
* unprofessional conduct is considered to include contravention of conditions or undertakings, convictions, over servicing, influencing other health practitioners to compromise patient care, inducements for referrals and so on.

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This infographic (taken from the AHPRA website) shows the objectives of the National Registration and Accreditation Scheme or the National Scheme and the various actions that support them.

AHPRA[[2]](#footnote-3) and 14 health profession boards (National Boards) work together to deliver the scheme.

Starting from the 12 o’clock position all the work of the National Boards and AHPRA is focused on protection of the public and this is done through setting national standards, auditing compliance, managing complaints about health practitioners, publishing the online register, accrediting training and education, facilitating a mobile health workforce and registering the over 630,000 health practitioners from the 14 health professions covered under the National Registration and Accreditation Scheme.

There are a number of areas where professionalism features in these roles:

* the setting of national standards is how Boards educate the professions about their expectations for professionalism
* auditing compliance is one way the Board assesses professionalism
* and complaints management has elements of both assessment and, if required, remediation of professional behaviours, and

accreditation functions for us via the Council on Chiropractic Education Australasia relates to both education, assessment and in some cases remediation of professionalism as well.

I’ll provide some more detail around the Board’s role in education, assessment and remediation of professionalism now.

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In terms of professionalism education in a regulatory context the Board has a number of ways to educate the profession about the requirements for professional practice:

* the Board develops codes and guidelines and publishes these on the AHPRA and Chiropractic Board of Australia websites
* the Board sends updates to the profession on various matters, often related to professionalism, through newsletters and communiqués
* the Board holds seminars, such as this one, for various stakeholders which often focus on issues around professionalism, and
* education of students and assessment of overseas practitioners is undertaken by the Council on Chiropractic Education Australasia as delegated by the Board.

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It’s interesting to again note the overlap between the aspects of professionalism identified by the Wilkinson systematic review, and the *Code of conduct for chiropractors* as published on the Board’s website.

This code outlines the National Board’s expectations in relation to the professional and ethical conduct of registered chiropractors and as you can see from this *Wordle*, which represents the relative frequency of words used by the size of font, there is a strong focus on many of the same aspects such as:

* ethical principles
* effective interactions with patients and with others in the health system
* reliability, and
* commitment to self-improvement.

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In terms of professionalism assessment the Board is involved in this through a number of areas.

Through notifications which often involve professionalism issues such as;

* poor communication
* confidentiality
* objectification of patients
* boundary violations, and
* consent issues.

There is often an aspect of professionalism assessment involved in Board initiated investigations, panels or tribunals.

And if conditions have been placed on a practitioner’s registration, then monitoring of those conditions will often involve a focus on professionalism issues.

And – through audit where a proportion of registrants are checked for their compliance with requirements for renewal of registration, including declaration of criminal history, maintenance of professional indemnity insurance, appropriate continuing professional development, first aid certification and appropriate levels of recency of practice – and during this process false declarations may also be identified.

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When the Board becomes aware of instances of unprofessional behaviour or professional misconduct there are a range of options available to work towards remediation.

These options range from the very mild, such as a caution, to the very severe, such as suspending or revoking registration.

In between these two is the more frequent educative approach taken by the Board with may include further education through distance education modules, seminars, workshops, one to one education or mentoring.

The focus for this educative approach is often on topics such as record keeping, ethics of practice, working with other health professionals, risk management, advertising, informed consent, adequate assessment and appropriate differential diagnosis.

The Board may also require a subsequent audit following this further education in order to determine if the approach has been effective.

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So now on to the professionalism literature\*. Again, this is highlighted with an asterix to indicate that there is a real lack of literature around professionalism within the chiropractic profession, but, if we look at the literature across other health professions a number of consistent themes emerge.

The existing data around assessment of professionalism suggests that it’s important to use multiple tools, and given all the themes and dimensions involved in professionalism I guess that makes perfect sense.

The other thing that seems to come up consistently is that patients are a helpful source of data on the professionalism of health practitioners and again that is not surprising given they are at the coal face.

And in the existing data round remediation of professionalism issues there’s a suggestion that it’s important to develop individualised programs for these practitioners, to use role models in the remediation programs and to design programs which have a flexible pace of delivery.

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Looking at assessment of professionalism in more detail, Wilkinson’s systematic review identified a number of tools for assessment of professionalism many of which you would be familiar with and many of which are used primarily in the assessment of students in the health professions.

So these various assessment tools include:

* methods involving an observed clinical encounter such as the mini-Clinical Evaluation Exercise or mini-CEX
* they include simulations such as objective structured clinical examinations or OSCEs and high fidelity patient simulations
* they include paper-based tests which are focused on professionalism issues, so things such as multiple choice questions or defining issues formats specifically designed to focus on professionalism issues
* the global view of supervisors can be obtained using some of the professional assessment instruments, and
* other specific assessment tools such as those relating to cultural competence, interpersonal reactivity and other specific professionalism questionnaires can be used.

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Wilkinson’s review also identified a number of tools which are arguably used more often in the assessment of professionalism of practitioners.

These include:

* self-administered rating scales and there are tools focused on time management and others on reflection ability for example
* collated views of co-workers can be used as a method of multisource feedback
* patient opinion can be gathered via questionnaires or rating scales, and
* there are also measures such as records of incidents of unprofessionalism and of course things like critical incident reports.

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What Wilkinson’s review helped to highlight is that there are many attributes which are still not well assessed and for which there is a clear need to develop assessment tools.

Attributes like:

* reflectiveness and abilities in self-assessment
* tools which measure commitment to lifelong learning
* or that measure the ability to deal with the uncertainty which is inherent in clinical practice
* tools which can assess for skills in advocacy
* or the practitioners ability to balance availability to others with their own self-care
* tools which can determine the tendency to seek and respond to results of an audit, and
* tools which explore the commitment to advancing knowledge in the profession and in healthcare more generally.

So all these are all not particularly well measured by existing tools… so there is much work to be done in this space!

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Looking at remediation of professionalism in a little more detail. In 2009 a thematic review of literature around remediation in medical education but spanning undergraduate, graduate and continuing education levels was published.

The authors found only 13 studies which met their inclusion criteria and they acknowledged that these studies were mostly small and single institution studies which described efforts to remediate deficient knowledge, or clinical skills of trainees or below standard practice performance of practicing physicians.

They concluded saying that there is an urgent need for multi-institutional; outcomes-based research on strategies for remediation which included long-term follow up.

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On the basis of their review of the literature on remediation and using selected studies in the learning sciences, they proposed a model of the essential elements of successful remediation programs that would enhance existing efforts.

The four core components of their suggested remediation program are illustrated in this diagram.

1. So at the top you will see there is a focus on initial assessment or screening using multiple assessment tools to identify any deficiencies.
2. The next box down shows diagnosis of problems and development of an individualised learning plan.
3. The next step is provision of instruction that includes deliberate practice, feedback and reflection.
4. And finally there’s the reassessment and certification of competence.

It’s also interesting to note, over on the left side of this diagram, key emphasis placed on mentoring and coaching in their model and this is highlighted as having involvement in both diagnosis of the problem or problems, development of the learning plan and instruction incorporating the practice, the feedback and reflection.

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So now we move to the fourth part of this presentation which focuses on recent developments and future possibilities around regulation of professionalism related issues.

There are a number of key challenges or tensions in regulation.

One is the challenge of evidence-based regulation – making good regulatory decisions on the basis of clear evidence of what works.

Another relates to regulatory issues being just the tip of the iceberg.

As Marie Bismark and colleagues state in their 2013 paper, complaints are best understood as sentinel events and complainants as representations of much larger groups of harmed or dissatisfied patients.

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There’s also a constant tension between reactive and proactive regulation.

That same research group went on to describe how medico-legal agencies such as malpractice insurers, medical boards and complaints boards are mostly passive regulators – they react to episodes of substandard care, rather than intervening to prevent them.

And then there is that ongoing and very practical issue of regulators being charged with the responsibility of ensuring public safety versus their regulatory measures causing interference with practitioners in their own clinical practice and the potential to provide assistance and guidance for practitioners in their own self-assessment and pursuit of self-improvement.

So I’m going to look at each of those issues in a little bit more detail.

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One of the recent attempts to move towards expanding the evidence base for regulatory decisions and dealing with the tip of the iceberg phenomenon is illustrated in the work of Marie Bismark and colleagues.

Their 2013 paper describes the use of Health Services Ombudsmen data consisting of 18,907 formal patient complaints against doctors between the years of 2000-2011.

They focused this study on doctors with at least one complaint and used a recurrent-event survival analysis to identify characteristics of doctors at high risk of recurrent complaints.

They found that around 3% of doctors accounted for 49% of patient complaints lodged. And importantly, that it was feasible to predict doctors at high risk of incurring more complaints in the near future.

The multivariate predictors of recurrent complaints in medical practitioners were identified as the number of previous complaints, the specialty, for example plastic surgery was high up the list, the practitioners being male practitioners and practitioners being older than 36 years of age.

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Subsequent work from these researchers then went on to develop the PRONE Score (or the predicted risk of a new event).

This 22 point scoring system indicates future complaint risk-based on four variables and these variables are specialty which is given a ranking of 0-6, gender which is given a ranking of 0 for females or 2 for males, number of previous complaints again given a score this time of 0-11 and the time elapsed since the last complaint given a score of 1-2.

In this paper they highlight their next steps in this work, and what they are interested in doing next is converting these predictions into a simple algorithm for use by regulators and to subsequently integrate these scores with appropriate interventions.

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One of the challenges of evidence-based decisions is access to the evidence.

In that respect the move to a national regulatory framework in Australia provides huge advantage.

The AHPRA database is a national dataset of Australian health practitioners with information about over 630,000 individuals.

The sources of data include the practitioners themselves when they provide information on registration or renewal of registration, but the sources of data also include independent assessors, notifiers who might be employers, educators, peers or patients and the Boards or tribunals.

The kind of information included in the database includes age, sex, profession, specialty, country of training and practice location and other information collected in the voluntary workforce surveys which are conducted from time to time.

There are a number of ways that the data can be accessed, through searching the online national register, through purchasing a copy of the register or by lodging a specific data request.

Applications for access assessed by a Strategic Data Access and Research Committee and they are of course bound by very strict research protocols.

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There are a number of current research projects underway using various components of the AHPRA dataset.

There is a University of Melbourne study exploring the impact of mandatory reporting on practitioner and public safety.

A University of Sydney study is currently comparing the complaints investigation and management processes undertaken in New South Wales and comparing those with AHPRA’s management processes, and there’s a International Nurse Regulator Collaborative conducting a review of registered nurses’ health, performance and/or professional conduct matters.

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So now on to a example of an approach to remediation of practitioners often focused on professionalism which is both evidence-based and proactive, and this comes from the Peer Assessment Program run by the Ontario College of Physicians and Surgeons.

Their work has focused on identifying poorly performing physicians, designing of relevant education programs and then evaluating the effectiveness of these programs.

This approach has been going on for quite some time. Their group developed a pilot in the 70’s and after initial success the program has been ongoing since 1981.

As you can see from this diagram the program involves:

* an individual practitioner providing basic practice information to assist in matching them to an appropriate assessor
* the assessor then reviews 20-30 randomly selected patient files from the practitioners practice
* then the practitioner and assessor have an interview and discuss the files, and
* then the College of Physicians and Surgeons of Ontario reviews the assessment documents and makes decisions regarding any requirement for mandatory follow-up.

The college essentially will make one of three decisions.

The first is that there’s no further action required and this is on the basis of clearly of satisfactory performance.

The second decision they can make is that the practitioner needs a reassessment in order to obtain more clarity around their performance.

And the third decision they can make is to refer the practitioner to have an interview with the Quality Assurance Committee and obviously that happens if care concerns are discovered.

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They reviewed the effect of their program after the first five years of full operation and they published the results in this paper by McAuley and colleagues in 1990.

So they found that between the years of 1981-1985, 918 practitioners had been involved in the program.

101 or 11% were identified as having significant care concerns and these practitioners were therefore interviewed by the Quality Assessment Committee with patient records and one assessor present.

66% of these practitioners were judged to have serious deficiencies necessitated specific recommendations and reassessment.

29% of the practitioners received suggestions but required no reassessment as all had initiated improvements by being visited in their practice by the assessor and most of these areas of improvement related to record keeping.

3% of practitioners were referred for further regulatory action due to risk to their public and 2% of practitioners retired.

Interestingly they noted a significant relationship between poor patient records and deficient care.

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Within that same five year period there were 56 practitioners who were reassessed, so they had been assessed twice during the study period.

Of these practitioners:

* 29 or 52% had satisfactorily addressed the concerns of the Peer Assessment Committee
* 12 practitioners or 21% had made improvements but still caused some concern
* 11 practitioners or 20% had failed to make the recommended improvements, and
* four practitioners or 7% had subsequently retired from practice.

What is really interesting to me and encouraging is the fact that over 50% of practitioners who were reassessed had addressed the concerns raised.

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Further developments to the original Peer Assessment program in Ontario have resulted in the Enhanced Peer Assessment program.

Now this program was rolled out in Ontario in 2003 as a result of the perceived need to value add for the more than 80% of practitioners who were judged to be practicing well.

This frames peer assessment as an educational opportunity for practitioners based on the principles of self-directed learning.

As such it involves the key components of:

* reflection on practice
* determining individual learning needs
* establishing learning goals and objectives
* identifying resources for learning, and
* implementing appropriate learning strategies.

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This diagram serves to illustrate how the program works.

* An initial step involves the physician reflecting on their practice and establishing their learning objectives for the assessment.
* Then there is an initial telephone call between the assessor and the doctor to discuss the learning objectives of the assessment.
* Then the usual visit takes place with:
	+ the assessor reviewing patient files, but with specific attention on identifying care gaps and opportunities for improvement
	+ there is the one on one interaction interview discussing practice-based learning needs and recommendations for improvement identified through the patient file review
	+ then a discussion of the pre assessment learning objectives set by the physician and the development of the practice-based education plan, and
	+ the assessor directs the physician to appropriate learning resources.
* There is the usual college of physician and surgeons review and decisions – with the same three outcomes of – no further action, reassessment or interview with the Quality Assurance Committee if care concerns are found.
* But independent of those recommendations, the assessor follows up with the practitioner to review the educational plan, to discuss progress and to identify and discuss any barriers to learning.

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So to conclude this presentation, I hope I’ve made it clear that professionalism is a multidimensional construct and as such it is challenging to specifically define and to specifically assess.

I hope you can see how the education, assessment and remediation of professionalism are all a key part of the Board’s role.

The existing literature suggests that we should be using multiple tools in the assessment of professionalism but it recognises that we currently lack assessment tools for all aspects of professionalism.

And there is very limited research in the area of remediation but it appears initial screening, individualised programs, feedback, reflection and role models or mentors are likely to be really important in ensuring success of remediation programs.

And I hope you have now seen there is very interesting recent work in evidence-based regulation focussing on:

* detection of practitioners at risk with recognition that existing complaints data probably under-represents the problem
* there’s work done to design remediation programs where effectiveness of these programs into the long term is being monitored, and
* I think we can see that there is quite a bit of potential to balance proactive regulation requirements with provision of resources for self-assessment and practice improvement.

Much of this work has been undertaken in other professions and so the next logical step for us is to consider what might work for the chiropractic profession and most importantly what might provide benefit for our patients.

Thank you.

**-ENDS-**

1. Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). [↑](#footnote-ref-2)
2. Australian Health Practitioner Regulation Agency (AHPRA). [↑](#footnote-ref-3)