Conceptual Framework Paper
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INTRODUCTION

As legislated regulation of the medical profession approaches the end of its second century, it is timely to reconsider the very basis of medical regulation and propose a conceptual framework within which issues such as fitness to practise, public protection and discipline can be considered.

Regulatory authorities such as Medical Boards and Councils, are charged with responsibility for public protection and maintenance of professional standards. Regulatory authorities register those practitioners whose professional training meets an established minimum standard and historically, registration was renewed on payment of an annual fee. Unless a complaint was made about their practice, the regulatory authority's only interaction with practitioners was this simple, annual financial transaction.

Many authorities, including the New South Wales Medical Board, have recognised that this simplistic approach is anachronistic and inconsistent with their stated responsibilities, and are developing renewal processes that require practitioners to demonstrate their ongoing fitness to practise.

FITNESS TO PRACTISE

'Fitness to practise' is a term that is familiar in the United Kingdom, and is gaining currency with other regulatory authorities including the NSW Medical Board. It is a term that is easily understood in the general community, and adds another dimension to 'protection of the public' as a description of a regulatory authority's responsibilities.

It is important to recognise that fitness to practise can never be ensured or guaranteed by a regulatory authority, and it is impossible to design a system that will provide an absolute guarantee of every practitioner's performance on every day with every patient. Regulatory authorities will continue to be reliant on notifications of poor performance, impairment or aberrant behaviour, no matter how robust their processes and programs are. The Shipman case in the United Kingdom graphically illustrates this point.

A practitioner's ongoing fitness to practise is determined by a multitude of factors, and any assessment should consider all of the following areas, as each has the potential to impact on the quality of the service delivered to patients.

1. **Qualifications and experience**
   Medical practitioners must possess accepted qualifications and experience commensurate with the nature of their work.

   Regulatory authorities rely on processes involving the recognition of medical qualifications gained at an accredited medical school, or awarded by a national examination or professional body.

2. Health

Medical practitioners' personal health may impact on their capacity to practise medicine safely and effectively.

Most regulatory authorities have developed programs to manage impaired medical practitioners. These programs are generally non-disciplinary and have the dual objectives of public protection and the supported and supervised maintenance of the practitioner in the workplace.

Impaired practitioners come to attention as a result of either mandatory or voluntary notification. In addition, the NSW Medical Board requires all practitioners to make an annual declaration in relation to their health. Although this mechanism relies on the practitioner's insight and honesty, it has been effective in making the Board aware of significantly impaired practitioners, otherwise unknown to it.

3. Professionalism

In the context of medical regulation, professionalism encompasses both professional expertise and professional behaviour.

Professional expertise

Medical practitioners must possess and apply a large body of up to date knowledge and procedural skill.

Professional expertise is determined by a practitioner's competence (possession of knowledge and skill sufficient to practise safe and effective medicine), and by their professional performance (application of their knowledge, skill and attitudes in the safe and effective practice of medicine).

While competence does not guarantee acceptable professional performance, it is unlikely that a practitioner who lacks knowledge and skill will perform well.

Regulatory authorities address the competence aspect of professionalism in a variety of ways. The NSW Medical Board requires practitioners to make an annual declaration, supported by documentation, about their participation in Continuing Professional Development, and explicitly states its expectation that every registered medical practitioner will participate in CPD that is relevant to their practice of medicine.

professional behaviour

Medical practitioners must exhibit behaviours and attitudes that reflect the expectations of those with whom they interact and the society in which they work.

Departures from acceptable behaviour are generally detected in patient or employer complaints. The NSW Medical Board also requires practitioners and the Courts to declare criminal charges and convictions in relation to certain offences.

MANAGEMENT OF COMPLAINTS AND NOTIFICATIONS

Regulatory authorities' responses to complaints against medical practitioners are many and varied, but historically, most have centred on disciplinary action.

Disciplinary responses may result in deregistration / erasure, suspension, reprimand, censure, fines, restricted / conditional registration. Most jurisdictions emphasise the public protection aspect of their disciplinary response and down-play the punitive and exemplary aspects of their action.

In NSW and most other jurisdictions, disciplinary action is limited to the particulars of the complaint which triggered the action. There is no scope to look more broadly into the practitioner's professional competence and performance or the contribution of system errors. The outcomes are therefore of limited value in improving the quality of care delivered by the practitioner or the system in which they work. This is compounded by the adversarial atmosphere in which proceedings are conducted.

Professional misconduct is variously named and variously defined. There is a spectrum of professional behaviour which at its extreme constitutes grounds for disciplinary action against the practitioner concerned. Universally, the sexual assault of a patient would appear to constitute such grounds.

Increasingly, jurisdictions are introducing non-disciplinary programs that address issues of clinical performance. The first Australian Performance Assessment program was introduced by the New South Wales Medical Board in 2000. The Victorian Medical Practitioners Board is on the verge of implementing a similar program, and several other Australian jurisdictions are actively exploring the area.

These programs deal with professional performance in an environment that is non-disciplinary, broad-based, remedial and at all times cognizant of public protection, and have opened up an alternative pathway for managing practitioners who are neither impaired nor guilty of professional misconduct, but whose standard of practice appears to have slipped below an acceptable level.

Outcomes most commonly include counseling, re-education, retraining, supervision, and restricted / conditional registration. Specifically omitted from this list are those responses that could be considered punitive or exemplary, such as fines, reprimand, and censure. To be effective, performance assessment programs must focus on remediation and public protection, rather than punishment or censure.

In stark contrast to its disciplinary options, the NSW Performance Assessment Program is supported by legislation that allows all aspects of a practitioner's performance to be assessed on the basis of the triggering notification. A by-product of this broad-based assessment is an opportunity to understand and comment on the system in which the practitioner works.

Both discipline-based and performance assessment-based responses to complaints incorporate mechanisms by which the public can be protected. The essential difference between disciplinary and non-disciplinary responses is that the punitive and exemplary options present in the former are absent in the latter. This then begs the question, '*When should a regulatory authority take punitive and / or exemplary action against a medical practitioner?*".

An analysis of New South Wales Medical Board matters, both clinical and non-clinical, that proceeded to disciplinary hearings and resulted in punitive and/or exemplary responses, points to patterns of behaviour in four distinct categories.

Behaviours resulting in punitive / exemplary responses

1. Unethical
This is behaviour outside the accepted boundaries of professional conduct.

Clinical example; failure to obtain consent
Non-clinical example; sexual relationship with a patient

2. Reckless
This is behaviour in which practitioners are apparently heedless of the consequences of their actions.

Clinical example; prescribing drugs of addiction to known addicts
Non-clinical example; failing to supervise junior staff

3. Criminal
Criminal behaviour may occur in the context of medical practice or external to it.

Clinical practice example; accepting kick-backs for referral
External example; sexual assault

4. Wilful
Wilful behaviour is the least represented category, and involves practitioners deliberately causing harm.

Clinical example; performing an unnecessary procedure, purely for financial gain
Non-clinical example; falsifying research

It is also apparent that many matters proceeded to a disciplinary hearing and resulted in protective responses such as conditional registration without any punitive

or exemplary component. For the most part, these matters were of a clinical nature and had none of the characteristics described above. It would appear therefore that matters devoid of markers of unethical, reckless, wilful or criminal behaviour are suitable for a non-disciplinary approach to their management, provided that the approach is able to fulfil the Board's public protection role.

Based on these observations and a critical review of the NSW Medical Board's philosophy in relation to disciplinary action, a new framework for managing the various matters that come before the Board has been developed.

A NEW FRAMEWORK

Any routine or exceptional interaction with a medical practitioner is approached within the fitness to practise model, and each area contributing to a practitioner's fitness to practise is explicitly considered. Although the Board works within its registration, health, professional performance and professional conduct sections, it has maintained flexibility to move matters between programs according to its assessment of the dominant issue.

On receiving any notification or complaint about a practitioner, the NSW Medical Board first evaluates it for markers of unethical, reckless, wilful or criminal behaviour. Only if these markers are present does the Board proceed to have the matter investigated with a view to disciplinary (protective + punitive / exemplary) action.

In all other matters, for which there are no markers of unethical, reckless, wilful or criminal behaviour, public protection is achieved through the application of non-disciplinary, non-adversarial and educative responses. These responses match the severity of the matter under consideration. At one end of the spectrum is a simple educative and advisory letter from the Board. At the other end may be a full performance assessment, usually in response to repeated minor indications that the practitioner's performance has slipped below an acceptable level. Performance assessment can result in protective conditions being placed on a practitioner's registration, although every practitioner is given the opportunity to undertake the remediation necessary to have the conditions removed.

The New South Wales Medical Board's experience with this approach reveals many advantages.

- Fitness to practise is the common theme in all sections of the Board, and flexibility to move between sections ensures the broadest possible approach to any matter before the Board, including the annual renewal of medical registration.
- Effective, targeted intervention can occur in response to relatively minor complaints that do no meet the threshold for investigation.
- The majority of complaints are resolved quickly, and with the full cooperation of the practitioner concerned. The profession and defence organisations are more accepting of a timely, non-adversarial, non-disciplinary response than a protracted investigation and adversarial hearing.

- Investigation and prosecution resources are conserved for a defined and relatively small caseload. Since 2000, the percentage of complaints about medical practitioners that is investigated in NSW has declined from 29% to a current 9%, with a corresponding increase in non-disciplinary, early intervention responses. (Total annual complaints ≈ 1200)

CONCLUSION

The NSW Medical Board has moved on from more than a century and a half of slow evolution into a decade of revolution in the way it perceives itself and its responsibility to the people of New South Wales. It has clarified the essence and purpose of disciplinary action against medical practitioners and developed a suite of timely and effective non-disciplinary responses to complaints, aimed at early intervention and remediation. It has defined the areas in which practitioners' fitness to practise should be considered in both their routine and exceptional interactions with the Board.