Forum

Professional regulation: *Esse quam videre**

Graham Howarth

Health care professionals face medicolegal threats from numerous quarters – complaints, inquests, litigation, and investigation with possible disciplinary action by their regulatory body. To the individual practitioner the regulatory body is the most personal, as not only do they run the risk of public criticism by the regulatory body but also the possibility of censure. Sanction may include the temporary or permanent loss of their ability to practise with concomitant loss of income.

To date most regulation has been dependent upon either a complaint to the regulatory body or the regulatory body having become aware of an issue or issues that may concern them – a reactive approach. Unfortunately, for health care professionals at least, there can be little doubt that medical regulation is going to increase and become more intrusive. The reasons for this are manifold.

Currently, once one qualifies there is no universal formalised monitoring of your practice and it would be difficult to argue against the premise that a health care professional's knowledge, unless kept up to date by ongoing reading or training, wanes or dates over time. Attempts have been made to ensure medical professionals' knowledge remains up to date through compulsory continuing professional development but actual practice remains largely unmonitored or unregulated.

The public have progressively higher expectations of health care workers and medicine. They are increasingly better informed, less deferential to authority and more assertive. Add to the mix medical misadventures, both justified and unjustified, the facts of which are quickly and broadly disseminated thanks to modern communication. Hardly a day goes by without some article about a medical misadventure in the lay press. It is hardly surprising that public-opinion polls suggest that doctors require periodic re-evaluation. An increasingly sceptical and questioning public is undoubtedly concerned, and this has led to political pressure for greater control. Rest assured, politicians are responding – more intrusive regulation is on its way.

What, you may ask, has this to do with South Africa? Health care regulation cannot be seen in isolation and is now far more international than previously. In September 2000 medical regulatory authorities from around the world, including the Health Professions Council of South Africa, formed the International Association of Medical Regulatory Authorities (IAMRA). The 2008 IAMRA Conference was held in Cape Town in October. The *raison d'être* of IAMRA is to support medical regulatory authorities worldwide in protecting the public interest by promoting high standards of physician education, licensure and regulation, and facilitating the ongoing exchange of information among medical regulatory authorities. Developments in medical regulation overseas are now also important to health care professionals working in South Africa and it is sensible to take into account what is happening elsewhere.

If we take cognisance of the above, it is worth noting that the General Medical Council in the UK is preparing to introduce ongoing professional assessment. As a profession we are going to have to accept that ongoing professional monitoring is coming to South Africa. Unsurprisingly the move is being driven politically and it is worthwhile listening to what the politicians are saying. 'For any consideration of the regulation of health professionals, the preservation of trust has to be the starting point. Professional regulation must create a framework that maintains the justified confidence of patients in those who care for them as the bedrock of safe and effective clinical practice and the foundation for effective relationships between patients and health professionals.'[1]

Clearly the primary goals and overriding interests of medical regulation are patient safety and quality of care, in an attempt to re-establish the public's trust in the medical profession. It is apparent that ongoing regulation should not only strive to sustain, improve and assure the high standards of the vast majority of health care professionals but also identify and address poor practice or behaviour. Careful reflection suggests that while both are worthy goals it is unlikely that both will be achieved by the same means.

It is not difficult to accept the goals of regulation – public confidence in the profession based on safe quality care. For the public confidence and trust to be justified the goals of increased safety and quality of care have to be achieved. To know whether or not they have been achieved the goals need to be monitored. If the goals are not achieved, we either need to re-evaluate the goals of regulation, or the methods of regulation, or indeed the need for regulation.

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* *Esse quam videre* is the motto of Queen's College, Queenstown – 'To be, rather than to seem'. The motto well describes the thrust of the article – ongoing regulation seems to be a good idea but research is needed to show it is worth while.

But how will the goals of safe quality care be achieved through regulation? Firstly, the regulators will have to decide what they wish to assess, to improve or at least maintain safety and quality of care, and then develop assessment tools to perform the assessments. These are not easy decisions or tasks.

Once one has decided what one needs to assess, one then has to develop assessment tools. Assessment is a science in its own right but there are certain parameters of assessment tools that are relatively easy to understand. A valid assessment tool is one that measures what it is intended to measure – if you are assessing knowledge then the assessment tool, to be valid, must assess knowledge. The tools must also be reliable in that they consistently achieve the same results with a similar or the same cohort. Health care professionals with similar knowledge and ability should achieve similar results. Questions will also have to be asked about how often and in how many different ways a particular skill or ability should be assessed to be reasonably certain that the result is representative. Of course it is not the assessment tools themselves or indeed their results that really require assessment but how the results are interpreted and utilised.

Additionally the assessment tools must also be practical, relatively straightforward, not unduly onerous to perform or administer, and acceptable to those who are going to be assessed, society and government who are driving the process, and the regulatory body itself. The assessment must not be seen as some form of punitive process.

Costs will have to be carefully assessed. Assessment must also be affordable – the GMC proposals for ongoing assessment run into millions of pounds on an annual basis. The question will have to be asked, could this money be better spent? The question could be particularly salient where funding is poorer. Financial costs are not restricted to the costs of the ongoing assessment – there are costs to the individual in attending continuing professional development programmes, and the costs of investigating, prosecuting and defending those who fall foul of the system. There are also the costs of retraining or re-educating those whose skills are found wanting.

Costs are not merely restricted to financial costs – time involved in assessment will invariably mean time away from patients which may be particularly difficult in resource-poor environments. Difficult to evaluate but invariably present will be the frustrations and anxieties of those being assessed. We all know that assessment of one's work, however good it is, can be anxiety provoking.

The regulatory approach taken by the regulator is also important. The two extremes are either a deterrence-based or a compliance-based approach. In the former there is a tendency to use summative assessment with an adversarial approach with investigation and ascribing fault that may eventually be punitive as there is a tendency to use sanctions and penalties. In the latter there may be more reliance on formative assessment with a supportive approach aimed at rehabilitation and remediation; formal sanction or penalties are used as a final resort.

Analytic assessment determining whether the goals of regulation are being met, comparison of the success of methods of assessment, and comparison of the success of the regulatory approaches are undoubtedly methodologically challenging – but this cannot be used as an excuse not to assess them. The approach should not be 'because it is difficult we cannot evaluate regulation', but 'because it is difficult we must evaluate regulation'.

More intrusive regulation can be justified, and we have to accept it is going to occur but it has to be done properly. A nihilistic approach is not being advised. It is not being suggested that programmes should not be introduced until they have been shown to work. Given the current socio-political climate this would be unreasonable and unacceptable.

As has already been pointed out, the primary goals and overriding interests are safety and quality of care to ensure public trust, and therefore there is an obligation to ensure that the public trust is justified. The goals of regulation, methods of assessment and regulatory approach need to be rigorously assessed and compared to ensure that the most efficient methods are being employed to achieve the goals. The public is entitled to be assured that their trust is justified and that money, ultimately paid by them, is being appropriately utilised. If not, new methods will have to be sought. This is not a plea to deny or weaken regulation; on the contrary, it is a plea to strengthen it. It has to be fair to society and fair to the profession with time and money well spent and confidence well founded.

1. Secretary of State for Health. *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*. London: Stationary Office, 2007.