Part II

Professional relationships
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Regulating professional practice

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Professional regulation of medical practitioners has undergone substantial change in recent decades. While medicine has traditionally been a self-regulating profession, calls for greater oversight of professional practice have encouraged new regulatory models. Using examples from the United Kingdom, Canada and Australia, this chapter analyses recent trends in the regulation of medical practice, charting the move from professional self-regulation through to contemporary models of oversight and accountability. The introduction of more rigorous requirements for assessing professional competency – including new requirements for recertification, revalidation, performance, health and the character of practitioners in addition to traditional conduct-based assessments – has been a key feature of the move to contemporary regulatory frameworks. Further developments have also introduced measures to regulate unregistered health practitioners, and to avoid the potential adverse impacts of a ‘brain drain’ that recruiting international health personnel might have on health systems in poorer countries.

9.1 From self-regulation to external regulation

Medicine has traditionally been a self-governing profession. Professional standards were established and enforced through systems of peer review. Medical regulatory bodies were comprised of medical members who sought to uphold the professional standards, and to hold individual practitioners to account (Davies 2007: 11; Thomas 2004: 382). Indeed, self-regulation was seen as a hallmark of the profession. Self-regulation was premised on the idea that doctors themselves were in the best position to decide about the acceptability of particular medical practices, and that practitioners would comply more willingly with standards if decisions were made by members of the profession itself (Irvine 2006a: 203).

In the period following the Second World World War, medicine became increasingly specialised and ‘high-tech’. Doctors were seen to know best, and paternalism typified their relationships with patients (Irvine 2007: 256–7). Changing social contexts, however, placed pressure on the sustainability of the self-regulation model. Patients are increasingly regarded as consumers of medical services with a growing recognition of patients’ rights and autonomy, while the Internet has facilitated access to medical information (Freckelton 2006: 149). In addition, a series of high-profile cases of poor professional performance prompted calls for tighter regulation of medical
practice (Freckelton 2006: 149–50), amid concerns that peer-based self-regulation may be too soft (Freckelton 2006: 150; Irvine 2007: 257). Waring et al. note that ‘[o]ne prominent feature of these inquiries was their casting of the professional ethics of medicine as part of the problem’ (2010: 547). There were two aspects to this argument: first, that the profession’s claims of trustworthiness ‘were seen to provide a cloak under which nefarious activities could be conducted’; and second, that the professional culture made doctors reluctant to raise concerns about their colleagues (Waring et al. 2010: 547–8).

Against the backdrop of challenges to self-regulation, both governments and professional bodies sought to restore the public’s trust in medicine (Allsop 2006; Irvine 2006b). There has been debate over the contemporary meaning of professionalism in medicine (Godlee 2008). The Charter on Medical Professionalism, published in 2002, was developed by the American Board of Internal Medicine, the American College of Physicians and the European Federation of Internal Medicine (for discussion see Blank et al. 2003). It lists the primacy of patient welfare, patient autonomy and social justice as its fundamental principles. It also lists a set of ten responsibilities which require a commitment to:

- professional competence;
- honesty with patients;
- confidentiality of patient information;
- appropriate relationships with patients;
- improving quality of care;
- improving access to care;
- just distribution of limited resources;
- integrity and appropriate use of scientific knowledge;
- maintaining trust by managing conflicts of interest; and
- fulfilling professional responsibilities.

On the issue of trust and professionalism, Donald Irvine has argued that ‘[m]odern professionalism is about both the encouragement and celebration of good practice and the protection of patients and the public from suboptimal practice. They are one of a piece – indivisible. Public trust is dependent on both’ (2006b: 205).

The shift away from self-regulation toward greater external regulation and professional accountability is apparent. Lay (i.e. non-medical) membership of regulatory bodies has increased in response to the perceived need for greater public involvement in regulatory decision-making (Davies 2007: 267–80). In the United Kingdom, lay membership in the General Medical Council dates back to 1926, when one lay member was included to represent the interests of consumers (Davies 2007: 271; Irvine 2006a: 204). The proportion of lay membership has increased in recent decades, such that six out of the total 12 members who currently sit on the General Medical Council are lay members (General Medical Council 2013a).

Canada regulates medical professional practice at the provincial level. Membership of the councils of provincial colleges includes lay members, although the size of the councils and the proportion of lay membership vary between provinces. For example, the College of Physicians and Surgeons of British Columbia comprises ten physicians and five lay members (College of Physicians and Surgeons of British Columbia 2013: 3), while the lay members of the College of Physicians and Surgeons of Ontario number 13–15 in a council of 32–4 members (College of Physicians and Surgeons of Ontario 2011: 2).

Until July 2010, State and Territory Medical Boards managed medical regulation in Australia using the legislative framework found in the Medical Acts of various jurisdictions.
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(Dix et al. 1996: 7–41). These bodies, the first of which was established in Tasmania in 1837, were responsible for maintaining professional standards, and had the power to discipline practitioners in response to complaints (Reid 2006: 91–2). They were comprised primarily of medical practitioners, thus reinforcing the principle of peer review (Thomas 2006: 55). New South Wales introduced a co-regulatory model in the early 1990s, whereby the Medical Board and the Health Care Complaints Commission were required to consult on any proposed action against a professional in response to a complaint (Thomas 2004). The co-regulatory model marked the end of peer review as the sole determinant of professional standards (Thomas 2004: 388).

The system of medical regulation in Australia developed at the state and territory level because the Australian Constitution did not grant any specific federal power relating to health (Carlton 2006: 22). However, concerns about the regulatory system provided an impetus for change. These concerns included: barriers to the movement of professionals between states and territories imposed by state-based registration and regulation; inconsistencies in legislation between states and territories; the implications of such inconsistencies for consumer protection and quality assurance; a recognition of the limits of the peer-review model of regulation; and the need for flexibility and sustainability in the health workforce (Carlton 2006: 23–31).

On 1 July 2010, Australia introduced the National Registration and Accreditation Scheme (the National Scheme) with the entry into force of the Health Practitioner Regulation National Law Act 2009. Since 1 July 2010, this Act regulates health practitioners for states and territories other than Western Australia, which joined the National Scheme on 18 October 2010. Ten professions were part of the National Scheme from 1 July 2010: chiropractic, dental, medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology (Nesvadba and Forrester 2009; Freckelton 2010). On 1 July 2012, four additional professions joined the National Scheme: Aboriginal and Torres Strait Islander health practice (Freckelton 2014), Chinese medicine, occupational therapy and medical radiation practice. There is a National Board for each profession (Health Practitioner Regulation National Law, section 31), comprising both practitioner and community (lay) members. The Australian Health Workforce Ministerial Council (comprised of health ministers from each jurisdiction) determines the composition of the National Board with the proviso that practitioner members must account for at least half and no more than two-thirds of each Board, and each Board must have at least two community members (Health Practitioner Regulation National Law, section 33). New South Wales retained its co-regulatory approach under the new National Scheme (Freckelton 2010: 207) and Queensland will also become a co-regulatory jurisdiction following the introduction of new legislation in that state (Forrester 2013).

9.2 Maintaining knowledge

A requirement for continuing medical education is a common feature of regulatory systems for medicine in Australia, the United Kingdom and North America. Increasingly, regulators are moving beyond continuing professional development (CPD) towards recertification and revalidation (Shaw et al. 2009). Canada, for example, uses a Maintenance of Certification (MOC) approach. The program runs on a five-year cycle and requires medical practitioners to earn a specified number of CPD credits each year, which are awarded for participation in CPD activities. These activities are divided into group learning activities, self-learning activities and assessment (which includes self-assessment of knowledge and performance assessments) (Royal College of Physicians and Surgeons of Canada n.d.).
In the United Kingdom, the General Medical Council initiated a system for revalidating medical practitioners. While the debates over revalidation in the United Kingdom date back to the mid-1970s (Davies 2007: 334; Shaw et al. 2007: 170), it was not formally implemented for United Kingdom doctors until 2012. Changing public and professional expectations over fitness to practise are important elements of the revalidation debates. The 2007 report ‘Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century’ noted:

Public and professional opinion has moved on in the course of this debate, from a position where trust alone was sufficient guarantee of fitness to practise, to one where that trust needs to be underpinned by objective assurance. Public opinion surveys suggest that people expect health professionals to participate in the revalidation of their registration and that many believe that this already takes place every year.

(Secretary of State for Health 2007: 32)

The revalidation process includes two arms: an annual appraisal required for all medical practitioners and revalidation on a five-year cycle (General Medical Council 2013b).

In Australia, the Health Practitioner Regulation National Law requires that National Boards develop registration standards on certain matters, including requirements for continuing professional development (section 38(1)(c)).

Recertification and revalidation processes are designed to ensure that medical practitioners remain competent to practise medicine. Reviewing the debates over revalidation in the United Kingdom, the Picker Institute noted that ‘[d]iscourses of patient and public involvement (PPI) are virtually absent from the large volume of publications devoted to the subject of medical revalidation’ (Sheldon et al. 2011: 21). However, the Picker Institute identifies four discourses: ‘[t]wo relate to the conceptual rationale for revalidation (patient benefit and patient-centred professionalism) and the other two cover practical processes (lay input to the process and patient feedback)’ (Sheldon et al. 2011: 21).

9.3 The changing regulatory environment

Registration was once the traditional means of regulating health practitioners. Upon achieving the desired competencies through examinations at accredited tertiary institutions, they were then able to renew their registration on a yearly basis thereafter, unless complaints were made to the regulatory body. While many adverse events in healthcare may never result in a complaint, research indicates that serious, permanent injuries were more likely to result in complaints (Bismark et al. 2006). Australian research also indicates that a small number of doctors are the subject of multiple complaints (Bismark et al. 2011; Bismark et al. 2013). There is growing consideration of how best to identify and respond to doctors who receive many complaints (Gallagher and Levinson 2013; Lloyd-Bostock 2010; Paterson 2013).

Health practitioners and regulators must also be mindful of the potential for broader social changes to impact professional regulation. The emergence of social networking, for example, poses new challenges, particularly in relation to duties of confidentiality and privacy in relation to patient information, and by posting inappropriate content (Chretien et al. 2009; Mansfield et al. 2011; Terry 2010).

The traditional annual registration review without further evaluation of competency fails to have regard to the evolution of technologies and knowledge subsequent to initial registration and to systemic and cultural issues within the workplace, and ignores the many personal factors
that can compromise safe medical practice. As Dame Janet Smith stated in her fifth Shipman report, there are multiple reasons why a conclusion might be arrived at that a doctor is unfit to practise or that his or her fitness to practise is impaired:

... (a) that the doctor presented a risk to patients, (b) that the doctor had brought the profession into disrepute, (c) that the doctor had breached one of the fundamental tenets of the profession and (d) that the doctor’s integrity could not be relied upon. Lack of integrity might or might not involve a risk to patients. It might or might not bring the profession into disrepute. It might be regarded as a fundamental tenet of the profession. I think it right to include it as a separate reason why a doctor might be regarded as unfit to practise, because it is relevant even when it arises in a way that is quite unrelated to the doctor’s work as a doctor.


Physical illness, psychiatric disorders, personality issues, substance abuse and cognitive decline are health indicators pertinent to practitioner health. Each can adversely affect competence in medical practice temporarily or permanently. In recognition of their influence on professional performance, regulators are considering professional performance, the health of practitioners and matters of character as relevant factors to continued registration.

9.3.1 Regulation by reference to performance

A focus on professional performance, in addition to conduct, is a comparatively new phenomenon in health practitioner regulation. In the United Kingdom, it was introduced by the Medical (Professional Performance) Act 1995 with a requirement to have regard to the track record of the practitioner in the work he or she had actually been doing, but not to conduct an examination equivalent to that of a student’s examination board (Krippendorf v. General Medical Council [2000] UKPC 45, para. 35 (Krippendorf)). Deficient professional performance is to be distinguished from negligence and misconduct:

It [deficient professional performance] connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor’s work. [...] A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute ‘deficient professional performance’.


Under Australia’s national regulatory legislation ‘unsatisfactory professional performance’ is defined as ‘the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience’ (Health Practitioner Regulation National Law, section 5). Thus evaluation of whether a practitioner’s performance is unsatisfactory is broadly informed by, but by no means confined to, individual instances of substandard conduct.

Performance assessment systems exist in the United Kingdom, Canada, Australia and New Zealand. A distinction exists between competence and performance, the latter being the applied notion – a concentration upon the former in the performance assessment
process can constitute an appealable error (Krippendorf, para. 48). Typically, performance assessments involve assessors pertinent to the particular area of the practitioner’s practice. They identify gaps or deficits in a practitioner’s performance and help to develop a plan for ensuring the practitioner meets the expected standards and protecting public safety. As Reid comments:

These programs deal with professional performance with a non-disciplinary, broad-based and remedial approach and are at all times cognisant of the regulatory authority’s responsibility for public protection. They 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.

(2006: 97)

There is a high degree of commonality across jurisdictions in how performance assessments are conducted. The board funds the assessment, while the assessor(s) write a report. It can be broad-ranging.

A knowledge-based competence test often forms part of a performance assessment (General Medical Council [2014a]). In procedural areas of practice, simulation assessments may be used and provide data about the practitioner’s knowledge, techniques, judgment and responsiveness (General Medical Council [2014a]). As Reid comments on the New South Wales approach, ‘[a]s performance assessment is designed to be broad-based, the assessment exercise employs a range of tools which aim to cover the competence-performance spectrum’ (2006: 104–5), and may include an interview, observed consultations or procedures, a medical record review, a facilities assessment, a clinical practice interview, interviews with colleagues, supplementary assessment for matters relating to the practitioner’s health, and simulation-based assessment (Reid 2006: 105–6).

In Roehrich v. NSW Medical Board [2004] NSWSC 1264 Justice Hulme observed:

Although an assessment may lead to the making of a complaint, or a review of a practitioner’s professional performance by a Performance Review Panel, or one of the other courses referred to in … the Act, an assessment cannot of itself affect a practitioner’s right to practice nor be regarded in any sense as of a disciplinary nature. True it is that the powers given to assessors are calculated to involve some imposition of the time of the practitioner or other persons and the privacy or confidentiality of his records but, considered against the totality of sanctions for which the Act provides and the importance of ensuring that medical practitioners’ professional performance is adequate, this interference can only be regarded as of a minor or relatively minor nature.

(para. 51)

If a practitioner chooses not to cooperate or submit to a performance assessment, he or she can be referred to a decision-making body (General Medical Council [2014b]).

The practitioner being assessed generally must be supplied with a copy of the report, unless it contains information that may prejudice their health or well-being. After receiving the report, the regulatory body in the United Kingdom and Australia nominates a consultant to discuss the report with the practitioner (see, for example, Health Practitioner Regulation National Law, section 176). This provides procedural fairness, especially in situations when serious consequences may ensue thereafter. If there are any recommendations in the report for upskilling, education, mentoring or supervision, or any adverse findings, this provides an opportunity
for the practitioner and the representative of the regulatory body to discuss ways of dealing with them in a collegiate and constructive manner.

After this discussion, the relevant regulatory body formally receives the assessment report and a summary of the interview. It then decides the next steps, which may include (see, for example, *Health Practitioner Regulation National Law*, section 177(1); see also Reid 2006: 106–7):

- taking no further action;
- investigating the practitioner;
- referring the matter to a performance and professional standards panel;
- imposing conditions on/accepting an undertaking from the practitioner;
- requiring the practitioner to undergo a health assessment;
- cautioning the practitioner;
- referring the matter to a tribunal; or
- referring the matter to another entity (such as a health complaints entity).

Generally, matters are resolved without referring the case to a disciplinary panel or tribunal. Outcomes may include counselling, education, and conditions on registration (Reid 2006: 106–7).

The main advantage of focusing on performance measures is that the investigation need not focus upon determining whether a particular incident or interaction between a health practitioner and patient was deficient. Rather, it enables a general evaluation of the practitioner’s competence in their chosen area. Evaluative measures include analysis of documentation, treatment planning, relevant knowledge, choice of techniques, ability to concentrate and exercise judgment, capacity to function in a teamwork environment and administrative or even forensic issues. The investigation can consider patterns of substandard practice and persistent issues. The practitioner’s peers undertake the assessment, as it is expected that they will be better attuned to clinical deficits but able to undertake the assessment in a way that appreciates the context of decision-making and performance in the relevant area. As such, the assessment avoids the adversarial environment of a panel or tribunal. It often resolves concerns in a (relatively) private way, and centres on professional improvement, depending on the practitioner’s willingness to acknowledge and address his or her difficulties.

For regulators, the principal disadvantages of performance assessments are that they can be burdensome, expensive and difficult to structure. Furthermore, the overlap between conduct, performance, health and character can be difficult to delineate.

From a practitioner’s perspective, the performance assessment can be unpredictable. It can encompass issues beyond those originally identified and expose global issues in practice which may not be easily remediable. An example of the latter is cognitive impairment. Identifying relevant issues too is not always straightforward. Guidance from the Privy Council in *Krippendorf* confirmed that theoretical questions are not relevant to the functions of a performance assessment unless they shed light on the practitioner’s professional performance in his or her specific area of work (para. 35). However, assessments may become unreasonable if assessors pose questions which are too extensive and detailed (*Krippendorf*, para. 39). It may also be crucial for assessors to identify and communicate the parameters of inquiry in advance so that the practitioner is not unfairly disadvantaged by answering on matters while labouring under a misimpression (*Krippendorf*, para. 40).

For complainants/notifiers, the performance assessment process can be relatively unrewarding as it does not generally involve any formal finding regarding the professional conduct under review in respect of a particular incident or incidents which may be the content of aggrievement. The overt focus of the performance assessment on mentoring and remediation can frustrate those who seek vindication of their complaint/notification and the imposition of harsh consequences.
However, as Reid comments (2006: 108): ‘[a]lthough the particulars of the triggering notification or complaint are not specifically investigated and are not the subject of findings […], the program’s broad-based assessment and remediation-focused outcome ensures that complainants and employers are generally satisfied with the outcome.’

Although in some situations the performance pathway can be attractive for practitioners who are open to remediation, assessments may lead to litigation, directed to calling into question the assessment process and impugning its fairness, the criteria used and the findings made. Questions have been raised by practitioners relating to the independence of assessors (see Sadler v. General Medical Council [2003] UKPC 59), the quality of testing asked of the practitioner (see Sulaiman v. General Medical Council [2011] EWHC 1903 (Admin)), whether the assessment was sufficiently thorough or sufficient time was devoted to it (Roomi, R (on the application of ) v. General Medical Council [2009] EWHC 2188 (Admin)), and also whether sufficient opportunity was provided to the practitioner to address the issues raised in the performance assessment (see, for example, Krippendorf, at para. 49).

These matters considered, performance assessments provide a constructive opportunity to identify the reasons for patient/client concerns about health practitioners’ conduct. They allow for a remedial focus (Freckelton and Flynn 2004; Reid 2006), avoid adversarial legal arguments about particular instances of conduct and inform the practitioner as to whether clinical knowledge and skills need to be improved. However, in spite of its constructive potential, the shift to performance evaluation has been slow in most countries due to the expense and difficulties inherent in performance assessments.

9.3.2 Regulation by reference to health

One of the major reasons for a decline in health practitioner performance can be ill health. This can take many forms. Arguably, it is an ethical and professional obligation to be aware of changes in one’s health and its implications for discharging clinical care satisfactorily. However, this is not always possible. Regulatory bodies require information be provided (arguably by an obligation for mandatory notifications) to regulatory bodies so that they can initiate health evaluations of fitness for practice, and take necessary measures to assist the practitioner and protect the public. These measures may be negotiated, although the potential for litigious disputation over impairment and its outcomes for patient safety remain.

Many health conditions impact upon a practitioner’s fitness to practise. Some are remediable while others are not. The demands of health practice are apt to manifest in stress-related health problems, such as elevated rates of suicide and substance abuse. In 2011, the Australian Medical Association observed that:

Internal stressors may come from the personality traits of the individual that chooses to practise medicine. These qualities include dedication, commitment, and a sense of responsibility, competitiveness and altruism. These attributes underpin professional success but can become a source of pressure in a doctor’s or medical student’s working or study life and increase the risk of anxiety and depression. A proportion of doctors and students have obsessional traits, which can predispose them to stress.

There are also a large number of external pressures including but not limited to:

- innate professional responsibilities of doctors;
- increased clinical workload due to insufficient staffing and resources in the health system;
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- lack of control over work–life balance;
- professional, social and geographical isolation;
- the requirement for ongoing medical education;
- the demands of keeping pace with rapid developments in medical technology and knowledge;
- changes in the administration and regulations in the health system; and
- community expectations.

(pp. 1–2)

There is a growing body of evidence that doctors, for instance, exhibit elevated rates of psychiatric symptomatology (Baldwin et al. 1997; Centre et al. 2003). In addition, there are concerning attitudes within the health professions about how to deal with illness suffered by health professionals. A 2003 Australian survey of 358 doctors showed that 90 per cent of respondents believed it was acceptable to self-treat acute conditions, while 25 per cent believed it was appropriate even to self-treat chronic conditions (Davidson and Schattner 2003; see also Bosch 2000; Chen et al. 2008). Ninety per cent of the general practitioners surveyed and 83 per cent of specialists believed doctors are reluctant to see another doctor, especially if the problem is not somatic (Davidson and Schattner 2003). Another difficulty has been the propensity of many doctors to try to ‘work through’ illness (Thompson et al. 2001; Cupples et al. 2002; McKevitt et al. 1997), a trend also witnessed in other health practitioners, including psychologists (Freckelton and Molloy 2007).

In response, a number of doctors’ health programs have been established to support medical practitioners when they fall ill (Freckelton and Molloy 2007). Some are wholly external to regulatory agencies, some work closely with them and others exist within regulatory bodies. For those outside, such as the Victorian Doctors’ Health Program (VDHP), there are particular challenges in providing or facilitating effective health services (VDHP 2013; Warhaft 2004), including balancing the confidentiality of private health information and providing necessary information to regulatory bodies so that they can make informed decisions about matters such as restriction of entitlement to practise.

The situation is further complicated in jurisdictions such as Australia. It mandates the provision of information to regulatory bodies if, among other things, a practitioner has a reasonable belief that another practitioner has ‘placed the public at risk of substantial harm in the practitioner’s practice of the profession because the practitioner has an impairment’ (Health Practitioner Regulation National Law, section 140; Parker 2011; Hewitt 2013). The purpose of such mandatory notification regimes is to enable regulators to acquire the information when collegial discomfort and fraternalism may silence the very practitioners who are best placed to identify deterioration in others’ clinical capacity.

In many jurisdictions, a regulatory body can request that a practitioner submit to a health assessment if there is a notification that a practitioner may be impaired. In British Columbia, for instance, such a process is triggered in respect of medical practitioners when:

[The registrar or executive committee] has reasonable grounds to believe that a registrant may be suffering a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practise medicine and causes the continued practice of medicine by the registrant to constitute a danger to the public.

(Health Professions Act 1996, section 25.6(2))
The procedure that ensues is comparable to a performance assessment, complete with a formal report and discussion with both the practitioner and assessor to address emergent issues in a supportive manner. The outcomes from most such interactions are the acceptance by practitioners of the need for conditions upon registration and sometimes temporary suspension of registration while the issues are addressed. The health of such practitioners is generally monitored during the periods of conditional registration with a view to determining when it is appropriate for them to resume their previous practice. Such decisions are informed by further medical assessments.

There are a number of areas in which such decision-making is difficult, such as persons with substance dependencies with which they may not have fully come to terms or about which they may be prepared to be disingenuous (Marshall 2008; Warfe 2013). Other problematic areas include practitioners whose cognitive state is deteriorating with age and the onset of degenerative conditions, but who may not be ready to retire or scale down their work (Adler and Constantinou 2008). More generally, too, practitioners with chronic psychiatric conditions, such as bipolar disorders, or with personality disorders can pose difficult challenges for regulatory bodies’ health programmes.

9.3.3 Regulation by reference to character

An aspect of regulating health practitioners is the insistence in many jurisdictions that those entering the ranks of the registered practitioners and those remaining under the registration umbrella, with all the benefits that accrue from such a status, be persons worthy of such a designation – that they be ‘of good character’ or, put another way, be ‘fit and proper persons’ to be registered (Freckelton 2008a).

In British Columbia, ‘professional misconduct’ is prescribed to include ‘conduct unbecoming a member of the health profession’ (Health Professions Act 1996, section 26). Similarly, under Australia’s national regulatory scheme, a component of ‘professional misconduct’ is prescribed to be ‘conduct of the practitioner, whether occurring in connection with the practice of the health practitioner’s profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession’ (Health Practitioner Regulation National Law, section 5). Such a designation harkens back to the notion that professionals must ‘set a good example’ for others and be persons of integrity. Insofar as it is based on antiquated or contextually undifferentiated psychological notions of good traits of character, such a designation is somewhat anachronistic (Freckelton 2008a).

However, there can be discontinuity from the perspective of patients between a person who in some aspect of their life has displayed attitudes and behaviours that are prima facie incompatible with being a trusted health practitioner and their professional qualifications for remaining in practice. Such issues may arise from sexual predation, dishonesty, gross insensitivity, sadistic attitudes or lack of empathy for patients’ well-being, to name but some ‘characteristics’. However, such evaluations are not readily made because their moralistic criteria can be highly judgmental.

Registration in the health professions and misconduct in practice are continually assessed in reference to old-fashioned concepts in many countries, such as character and being a ‘fit and proper person’. Yet, there are probably few options but to preserve reference to these indicia of suitability to practise. This is not a licence for regulatory bodies to be moral policemen of the health professions, but it is reasonable to postulate that some attributes are prima facie incompatible with being a registered health practitioner. Generally, these are manifested in the context of clinical practice, but in exceptional circumstances they may also become apparent in other aspects of professional practice or even in a practitioner’s private life (Freckelton 2008a).
9.3.4 Regulation of unregistered practitioners

A growing percentage of unregistered health practitioners, variously described as ‘non-mainstream’, ‘unorthodox’, ‘alternative’ or ‘complementary’, are providing health services. These practitioners offer holistic, flexible and responsive services to patients’ needs in ways beyond those provided by mainstream medicine. They afford patients an element of choice in healthcare, which is consistent with principles of patient autonomy. Disillusionment with the increasingly commercial, technical and impersonal nature of conventional healthcare has popularised alternative medicine as a result.

However, these forms of complementary practice can also be counter-therapeutic. Studies demonstrate unsafe drug toxicities for certain alternative medicine approaches and warn of the risks patients assume in undergoing (potentially fatal) treatment that lacks evidence of scientific efficacy (Freckelton 2003, 2012a, 2012b). In addition, some practitioners who have been deregistered continue to conduct themselves unethically and without the constraints that accompany registered status. This risks confusion among consumers of such services.

These realities inspired a re-evaluation of registered status in many countries. While the term ‘registered’ connotes respectability and legitimacy, there is another perspective that focuses overtly on risk. Registered status can oblige complementarity in practice – namely practice that genuinely provides patients with options – and requires evidence-based standards of practice. In doing so, unscientific forms of practice are much more difficult, meaning that registration requirements help to support patient safety.

Some jurisdictions have increased the number of health professions that are subject to registration requirements. As of 2013, there are 14 such professions in Australia, including Chinese medicine, Aboriginal and Torres Strait Island Health Practice, chiropractic, medical radiation therapy and osteopathy. In New Zealand there are 16 professions, including dieticians, psychotherapists and midwives. In Alberta, Canada, there are 30 registered professions, including denturists, naturopaths, respiratory therapists, social workers and speech-language pathologists.

New Zealand, New South Wales and South Australia adopted an additional approach which enacts some measure of regulation for unregistered health practitioners (for discussion see Freckelton 2008b, 2012b; Weir 2013) through a code of conduct that binds all providers of health services. It permits an entity such as a Health Services Commissioner to issue prohibition orders precluding practice or a certain form of practice by an unregistered provider who has infringed basic tenets of ethical health service provision. This is sometimes referred to as a ‘negative licensing scheme’.

In June 2013, this approach was consolidated in Australia. The Standing Council on Health in Australia decided to strengthen state and territory health complaint mechanisms relating to unregistered health practitioners by introducing ‘a statutory code of conduct and powers to prohibit those who breach the code from continuing to provide health services’ (Australian Health Ministers Advisory Council 2013: 7).

This decision was made based on a Regulation Impact Statement (RIS) which estimated around 40 incidents of serious harm involving unregistered health practitioners occur per year across Australia (Australian Health Ministers Advisory Council 2013: 83). The options considered by the RIS were: no change, strengthening industry self-regulation, strengthening complaints mechanisms and extending registration to unregistered health professions (Australian Health Ministers’ Advisory Council 2013: 6–7). The RIS concluded that ‘a single National Code of Conduct with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community’ (Australian Health Ministers’ Advisory Council 2013: 7). Such measures can be supported by the option of consumer protection actions for
false, misleading and deceptive advertising for treatment and other spurious health services (Freckelton 2012b).

There are challenges in placing constraints upon unregistered health practitioners. These challenges have become the centre of international discussions, as jurisdictions gradually broaden their regulatory umbrellas. The Australian initiative to impose basic ethical obligations on unregistered health practitioners is an important step in rendering such practitioners more accountable for the services that they offer.

### 9.3.5 Migration of health practitioners

The global migration of health practitioners has become an important element in contemporary health workforces. Typically migration is from poorer to wealthier countries, leading to concerns over a ‘brain drain’ of skilled health professionals from poor countries (Ahmad 2005). There are both ‘push’ and ‘pull’ factors contributing to the global movement of health practitioners. Low wages, poor job opportunities, civil unrest and other factors in many developing countries contribute to the ‘push effect’, while the prospects of job security and enhanced economic opportunities serve as ‘pull’ factors (Ahmad 2005: 43).

In 2010 the World Health Organization (WHO) adopted the ‘WHO Global Code of Practice on the International Recruitment of Health Personnel’. The Code is not binding (article 2.1) and is designed to provide guidance to Member States working with stakeholders (article 2.2). The Code recognises the rights of health personnel to migrate, subject to relevant laws (article 3.4), but also recognises the needs of the health systems in developing countries (for discussion see Taylor et al. 2011). For example, article 3.2 states:

Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. However, the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel.

*WHO 2010*

The Code recommends that developed countries assist with the capacity-building of health systems in developing countries and transitioning economies (article 3.3).

While codes such as the one discussed above focus on international migration, Connell and Buchan have argued:

International mobility is just one of many flows of health workers. Many others move within countries, from rural to urban areas, from the public to the private sector, and from the health sector to other sectors. A focus on only international migration deals with just one symptom, and not the root causes, of skill shortages: limited funding, low pay, restricted career opportunities, inadequate facilities, poor management, and economic and political instability.

*(2011: 13)*

Clearly the movement of health practitioners both within and between countries will continue to pose challenges for health workforce planning and for medical regulation.
9.4 Conclusion

Regulation of medical practitioners has undergone significant change in recent years. Increasing expectations of accountability and of commitment to ethical values in clinical practice, as well as of regular and demonstrated evidence of professional competency, characterise this change. Awareness of the multiple contributors to adverse outcomes as a result of health practitioner interactions has also grown. Such contributors include performance deficits as well as poor health. With greater external oversight of professional practices, the concept of professionalism within medicine has also evolved to recognise the greater partnership between the profession and society. As professional regulation continues to evolve, with more categories of health practitioners coming under the regulatory umbrella, there are opportunities for continued dialogue around the contemporary meaning of professionalism and of professional ethics in the context of medical practice.

References

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Legislation

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