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CHAPTER 4

The Incapable Professional

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This short account of professionals who are lacking in capability draws on the research I have been doing for the past years on how professionals cope with change. Although this study is not directly concerned with capability, it offers a fair amount of indirect evidence on the subject, deriving from some 190 in-depth interviews with practitioners in six professions: medicine, pharmacy, law, accountancy, architecture and structural engineering, together with an extensive search of the literature. A fuller discussion will be found in Becher (1999).

My choice of topic is based on the premise that one way of helping to throw light on a concept is by looking at its antithesis: more specifically that an understanding of competence may be helped by exploring its lack. It is of course important to distinguish incompetence--or if you prefer it, an inadequate level of capability--from other forms of professional malfunction. In particular, you can be a perfectly capable practitioner and yet be arraigned for unethical conduct (especially if you are a doctor) or fraud (especially if you are a lawyer or accountant). My concern in what follows will be exclusively with those aspects of misconduct that stem from a lack of capability in the technical aspects of a professional's work.

If one asks why the issue of professional incompetence is important, the answer is obvious in most professions, but there are different reasons for that answer. As might be expected, the problems loom largest in medicine--and to a lesser extent in pharmacy--where lives can be directly at risk. Accordingly, many of my examples will be drawn from medical practice. Incompetence assumes a different importance in the other four professions involved in the study. In law and accountancy, inadequate professional service is likely to lead to some form of financial or even criminal problem for the client. In architecture and structural engineering, the consequences may have a deleterious effect on the environment, or at worst cause fatal danger through structural failure.

The perceived political importance of professional capability is usefully brought out in relation to one of the many professions not included in my research. In early December 1995, the proposals announced by the New Left for improving educational standards sought to outdo those of the Old Right by undertaking to "sweep away the second-rate [teachers] and tackle head-on the half-baked and the ineffective." Like many political nostrums, this would seem more resonant in words than realisable in deeds. In particular, it notably begs the question of how to identify incompetence and how to prove its existence.

It is a widely remarked feature of current professional life that clients are far less subservient, more questioning, and more sophisticated than they used to be. It is not therefore surprising that many of the complaints about unsatisfactory levels of professional competence

received by the relevant professional bodies come from members of the public rather than fellow members of the profession. As far as the latter are concerned, a number of professional associations--such as the Institute of Chartered Accountants--require, in their codes of ethics, that any member identifying a significant degree of incompetence in a colleague should report that colleague to the profession's disciplinary committee for further investigation. In its recent guidance to doctors on "good medical practice," the General Medical Council has for the first time explicitly laid it down that "you must protect patients when you believe that a colleague's conduct, performance or health is a threat to them . . . if necessary, you must tell someone from the employing authority or from a regulatory body." However, enforcing this requirement is easier said than done. All of us are aware of a deep cultural tradition in schools against "telling on" other pupils.

There are similarly strong informal sanctions against "blowing the whistle" on someone in hospital medicine. Among my interview data, there is a case of an anaesthetist who reported a leading consultant surgeon whose incompetence had caused several fatalities. The anaesthetist was sacked; the surgeon was allowed to go on killing people.

It is one thing to identify a lack of professional competence and quite another to establish it. But even supposing incompetence is proved, the question remains what can be done about it. In cases in which a professional's poor performance can be seen to be remediable, various kinds of training programme can be required, perhaps leading to recertification. In more serious cases, a professional may be persuaded to resign or retire early. Being relieved of one's appointment, though it occurs in larger professional organisations, can be subject to unfair dismissal procedures and tends to be shied away from. At the extreme, of course, one's name may be removed from the professional register, which makes it illegal in some professions to go on practising at all.

According to a television documentary, Nicholas Siddle, a well-regarded consultant, was able to go on unsuccessfully using a particular surgical technique for some years before being finally struck off. Even then, he clearly believed that he had been unfairly treated, and apparently found it difficult to accept the grounds for the General Medical Council's verdict. So the process of proving a seriously inadequate level of professional capability can be not only protracted but highly legalised and adversarial, leading to a clear view that prevention is better than prosecution.

It is a notable characteristic of the current scene that much is being done, mainly by professional bodies and national agencies, to safeguard against inadequate performance. As far as individuals, as opposed to professional organisations, are concerned, one can distinguish two main strategies. The first, quality assurance, concentrates on guaranteeing to the public at large that practitioners are suitably licensed, usually through some form of certification. The initial requirements before an individual can act professionally on his or her own are in general clearly defined: What is as yet less established are the proper prerequisites for more specialised activities, though the incidence of these is increasing. For example, practising laproscopic, or "keyhole," surgery now requires compulsory prior training, and accountants dealing with cases of insolvency are currently expected to earn an additional qualification in this specialism. One problem is, of course, that notions of capability change as the content and methods of the profession change, so that possession of a certificate is not an automatic guarantee of sound performance.

This is where the second strategy--quality control--comes in. Where assurance is passive, relying on the recognition of past achievement, control implies a more active and regular monitoring of current capability. One example is compulsory legislation, which is usually policed more or less effectively by some form of inspection. Another, adopted in some of the larger professional firms, is formal peer review or appraisal. Again, in all the six

professions in my study, the relevant professional bodies lay down voluntary or semi-compulsory requirements for continuing professional development. These CPD policies do not, unfortunately, seem very effective in dealing with what the medical profession graphically calls the “rotten apples”. In practice, monitoring them is usually far from easy and it is readily possible for those who are unmotivated merely to go through the motions of compliance.

Even the many strongly committed professionals in my interview sample commented on the burden of regulatory and other demands. As in other sectors affected by the quality industry, the problem is to prevent the whole apparatus from becoming too overelaborate, particularly as the best available estimates of those lacking adequate professional capability tend to come out at less than 5% of the population in question. As one medic in my sample, centrally concerned with maintaining quality, remarked:

“There is an awful lot of wasted effort just to get a bit of benefit, so there are going to be a lot of perfectly competent doctors who do all the things like being re-assessed and re-accredited and getting resentful because of it. It’s like getting in a long queue at the airport, going through a security check: you know it’s right and proper but you know very well that you haven’t got a bomb in your case, so why shouldn’t you go through? Yes, of course it is desirable to prevent incompetence and bad practice, but you need to pay careful attention to making sure that it isn’t heavy handed.”

But despite all the difficulties in ensuring that incompetence is limited in its scope and that capability is promoted, the prospects for overall improvement seem good. Even if there will always be cases that are a cause for concern, their incidence is likely to be steadily reduced. I have already suggested that clients have become more vigilant and professional bodies have become more proactive than before. In addition, professional firms are more competitive, and professionals themselves are more conscious of the need to keep up to date with the best of current practice. The professions, in short, would seem a richer field for cultivation by the capability movement than they have ever been.

Reference

Becher, T. (1999). Quality in the professions. *Studies in Higher Education*, 24, (2), 225–236.