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CHAPTER 5

Incompetence: An Unspoken Consensus[1]

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Editorial Introduction

As we have seen, the observation of, and fear of, *in*competence is a strong force driving the competence movement. This short chapter (consisting of excerpts from Chapter 2 of Ilott & Murphy, 1999, which dealt with the unspoken consensus relating to *competence* as well as incompetence), reports an interesting study of perceptions of incompetence. It graphically illustrates components of competence or capability that tend to be missing from studies in which no attempt is made to direct the attention of those whose views are canvassed to aspects of incompetence which would not normally spring to mind when the word "competence" is used. Not reproduced here are the sections of the original publication reporting results which suggest that most people believe that the solution to these problems is to be found through training and retraining. The chapter therefore raises issues to which we will return in our concluding comments to this section of our book.

Incompetence: An Important Construct

There is a plethora of literature presenting the philosophical or practical pros and cons about the different conceptualisations of competence. In contrast, there is little about incompetence, even though accusations and evidence of malpractice, negligence, or misconduct are costly for all parties. The cost may be measured in lives, distress, or monetary terms. The case of the nurse Beverly Allitt, convicted of murdering four children and harming nine others, is perhaps the most tragic. An editorial in *The Times* (1993) noted the similarity of career patterns between Allitt and a residential social worker, Frank Beck. He was convicted of abusing 200 children, both physically and sexually, over a 13-year period. The estimated cost of medical negligence claims--£52.3 million for England in 1990–1991 (Fenn et al., 1994)--almost pales into insignificance when compared with these extreme cases of abuse of power.

These cases and costs may have contributed to an increasing interest in incompetence in a range of professions. For example, the branding of 15,000 teachers as "incompetent" attracted much attention from the media, politicians, and policymakers. One headline proclaimed a "quarter of pupils have bad teachers" (Scott-Clark & Hymas, 1996). Another

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report describes how the funding system is "designed to . . . discourage keeping on students who seem unlikely to make good teachers, just to avoid losing associated funding" (Tysome, 1996).

Statutory and professional bodies responsible for "kite marking" (i.e. giving approval to standards of) education and practice are also interested in misconduct as part of their disciplinary responsibilities. Statutory bodies as the governing bodies of self-regulating professions have a "duty to protect the public against the genially incompetent as well as the deliberate wrongdoers" (Law Report, 1995). These include the General Medical Council (GMC), the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and the discipline-specific boards of the Council for Professions Supplementary to Medicine (CPSM). Some 1,600 doctors are reported to the GMC annually with reference to their professional conduct. Donaldson describes his experience of dealing with problem doctors as "difficult, distasteful, time consuming, and acrimonious work. For these reasons the temptation to avert one's gaze . . . is at times very great . . . I have no doubt that many employers do look away when they should not" (1994, p. 1281). This statement highlights a tendency to avoid, rather than confront, incompetent, unsafe, or unscrupulous practitioners.

Method: Identifying a Criteria for Assigning a Fail Grade as a Baseline Definition of Incompetence

The research to identify the constituents of incompetence was part of a wider investigation into the assessors' perspectives on awarding a fail grade (Ilott, 1993). This element concentrated upon the margins of the competence-incompetence continuum. It drew upon the assumption that competence "is recognisable more by its absence than by readily measurable behaviours" (Burrows, 1989). Initially, the aim was to devise an instrument containing knowledge, skills, and attitudes considered to be unsatisfactory or inappropriate to complement existing assessments of "competence to practice." Positive evidence of both is necessary for good judgements. However, as the research progressed an unspoken consensus became apparent.

Information was collected from different sources using different methods for triangulation purposes. These included in-depth, focused, interviews with 25 academic and 5 work-based assessors; syndicate sessions with 398 health-care professionals as part of a training course about failure held in the UK and Sweden; and a literature review to analyse competence. All informants were responsible for judging "competence to practise" either in academic or work-based settings, primarily for occupational therapy but also physiotherapy, radiography, nursing, and social work. The interview questions focused on their criteria for failure, encompassing how they differentiated between a borderline and clear fail, differences in criteria between academic and practice settings, and the influence of attributions of effort, ability, and task difficulty. The syndicate groups, comprised of those with and without experience in assigning a fail grade, compiled a minimum standard or checklist of behaviours, skills, and attitudes to define student failure and differentiate between borderline and unsatisfactory performance (Ilott, 1995).

While acknowledging the limitations of each method and the self-selected samples, the results revealed a surprising degree of convergence about the constituents of incompetence and competence.

Constituents of Incompetence and Competence in Some "Caring Professions"

The criteria for failure consisted of an array of implicit and explicit assessment constructs. Professional behaviour and personal transferable skills, not profession-specific

knowledge, were the most preferred criteria elicited during the focused interviews and syndicate groups. These results are summarised in Table 5.1 and a number of the main categories are discussed in more detail in the paragraphs which follow.

Table 5.1
Constituents of Incompetence

Construct		Frequency	Percentage
Unprofessional Behaviour:	Lack of initiative, irresponsible, unprofessional, unreliable, misconduct, breaches of confidentiality, inappropriate appearance	144	23%
Skills Deficits:	Interpersonal, communication, general, clinical, practical	109	17%
Personality:	Too little or too much confidence, immaturity, lack of insight	58	9%
Knowledge:	Limited application, inadequate knowledge, poor understanding	55	9%
Inappropriate Attitudes:	General, toward clients, staff, and profession	47	7%
Unsafe:	General, Health and Safety, dangerous practice	41	7%
Response to Feedback:	Inability or unwillingness to learn and change	39	6%
Lack of Motivation:	Disinterest, low effort	38	6%
Self-Management:	Limited self-evaluation, poor time management	26	4%
Miscellaneous:	Feedback from MDT, intuition, stage of training	24	4%
Objectives Unmet:	General, departmental, school	23	4%
Personal Factors:	Personal problems, prejudice	20	3%
Implicit Assessment Construct:	Employ or accept treatment	7	1%
Source: Ilott (1993)			

Professional Unsuitability

This is another intangible, elusive concept. Yet what does it mean? Some personal and professional qualities are embodied in codes of ethics and professional conduct and statements of professional misconduct or infamous conduct. The multifaceted criteria of unprofessional behaviour was the most frequently reported reason for assigning a fail grade by the syndicate groups. It consisted of lack of initiative (n=27), irresponsibility (n=20), unprofessionalism (n=19), unreliability (n=18), and misconduct, defined either as a general term (n=8) or specified as lack of punctuality, dishonesty, aggression, theft, fraud, abuse (including alcohol and cruelty) (n=19), breaches of confidentiality (n=16), inappropriate

appearance (n=10), untrustworthiness (n=4), unethical behaviour (n=3), and passive or manipulative avoidance of situations (n=3).

Interestingly, these items mirror the two most frequent problems among senior hospital doctors cited by Donaldson (1994, p. 1279). These were poor attitude and disruptive or irresponsible behaviour (n=32) and lack of commitment to duties (n=21). Brandon & Davies (1979) defined unprofessional attitudes as lying, breaching confidentiality, causing unjustifiable offence to clients, lack of punctuality, and inadequate standards of attendance and record-keeping. Such "abstract moral traits" including loyalty, honesty, and reliability are consistently highly rated by employers (Hyland, 1991).

Poor Communication Skills

Deficits in communication, interpersonal, and, to a lesser extent, practical skills constituted the second most frequently mentioned category. The issue occurs and recurs in the inter-professional international literature. Deficiencies in communication and interpersonal skills were the largest categories for Holmes et al. (1990) and Battles et al. (1990). This is unsurprising, considering that what is traditionally termed "the bedside manner," or the equivalent, "therapeutic use of self," is the primary tool of many health care and social welfare professions.

Dangers: Unsafe Practices and Lack of Learning

The danger of overconfidence leading to practising beyond the limits of knowledge links the criteria of safely, knowledge, and personal factors. Hausman et al. (1990) revealed a significant relationship between overconfidence and lower examination scores in paediatric residents.

Although unsafe practices were infrequently reported by occupational therapists (seeming to be an implicit criteria) they were prominent in the medical, nursing, physiotherapy, and radiography professions. The issue is multifaceted, consisting of trust that was defined by a work-based supervisor as "Can you leave the student with the patients for 30 seconds?" It also includes respecting Health and Safety policies, the ability to recognise significant cues and act appropriately, and awareness of limitations to prevent practising beyond the level of knowledge or skills. This is one of the criteria for unsafe practice adopted by Darragh et al. (1986).

Interestingly, although profession-specific knowledge forms the checklist of "how to spot a bad teacher" (Scott-Clarke & Hymas, 1996), it did not figure in this research. The focus was upon the process of learning that included evidence of improvement, application of knowledge, the ability to learn from mistakes, and a willingness to change to enable the integration of theory with practice. This is another constant criteria across time that is noted by Towle (1954), Wong (1979), and Ford & Jones (1987), for example.

Implicit Criterion

Implicit constructs ranged from the temptation to reward effort, interest, and hard work even though the threshold standards had not been achieved to a global definition of competence. This was encapsulated by two questions: "Would I employ him/her?" and "Would I want him/her to treat me or my family?" These simple questions epitomise "fitness for purpose" from the perspective of both employer and consumer. Although this criteria appears in the literature (Green, 1991) and has been used to validate assessment tools (Crocker et al., 1975) it seems to be an implicit rather than explicit assessment criteria.

Conclusion: Supporting the Unspoken Consensus

The consensus about the constituents of competence and incompetence between diverse professions was as fascinating as it was unexpected. It may be related to several factors, including working within public sector organisations, using person-centred partnership models of practice, and the requirement to abide by codes of ethical behaviour. Informants seemed to find it easier to articulate the criteria for assigning a fail grade--to identify the constituents of incompetence--than define competence. This approach avoids the semantic confusion and conflict between the different definitions of competence or capability.

Competence remains a vague, elusive concept. But perhaps this is appropriate because:

> "practice . . . depends on a subtle blend of values, attitudes, knowledge and skills; and on the capacity for making flexible responses to an infinite variety of situations, many of which cannot be anticipated" (Brandon & Davies, 1979).

This quotation mirrors the definition of higher-level National Vocational Qualifications (Mitchell, 1993) and Capability. Because this global definition has a sound foundation in the constants of professional and ethical behaviour, it allows flexibility for development, to ensure that these retain priority within the new health care and social welfare industries. It is also important to consider how these metadisciplinary concepts are integrated into earlier stages of the educational process, in the admission criteria and curriculum, for example.

A global conceptualisation may become a heretical suggestion as explicit standards and outcomes dominate the competency movement. Academic and work-based assessors *can* balance objective and subjective evidence of "intuitive and analytic thinking . . . to grasp the situation as a whole" (Blomquist, 1985). This ability may be grounded in an unspoken consensus about what constitutes incompetence. It is enhanced by clarifying and comparing criteria and reviewing the use and misuse of implicit or explicit constructs with intra- and inter-professional colleagues (Ilott, 1995). The reassurance gained from recognising similar criteria and threshold standards affirms their expert role by confirming both the validity and interrater reliability (Friedman & Mennin, 1991) of their judgements. Such preparation is important to enable all assessors fulfil their obligation to protect the public and minimise the number of "horror stories."

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