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Evaluation of Professionals: What Criteria? What Distribution?

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According to a *What's Up Doc?* survey, 82% of doctors say they know at least one dangerous practitioner in their practice. In 64% of cases, the problem involves therapeutic choice. Among surgeons surveyed, in 63% of cases, the problem involves the quality of technical procedure. The question is therefore not "Should doctors be assessed?" but "What criteria and what distribution of assessment results are necessary to eradicate practices that are, according to the majority of doctors, dangerous?"

1. The consumerist approach to health

Information and knowledge are no longer the preserve of an elite. Health is increasingly seen from a consumerist point of view. Before "consuming" a health-related service, people want as much information as possible. In an article in September, *Le Parisien* featured the website Hospitalidee, which allows you to rate practitioners and establishments. This site has been called the TripAdvisor of healthcare.

2. The zero-risk society and continuous evaluation

Western societies and their populations are becoming increasingly risk-averse. Evaluation procedures are intended to reduce hazards. The development of social networks has made assessments and rankings a widespread, everyday thing. The younger generations are no longer trusting.

3. From evaluation of practitioners to improvements in training

It would be illusory to think that all practitioners could achieve the same level of excellence. This is why assessments must aim at strengthening understanding of how and why things go wrong and improving the content of training to ensure that quality levels keep rising over time.

4. What, ultimately, should be evaluated?

Initially, it involves assessing doctors' competence, i.e., theoretical and practical knowledge, as well as the ability to handle diverse situations. But this does not adequately develop skills. Indeed, adverse events are frequently linked to a misunderstanding between people on the same team. Although it does not replace individual assessment, collective assessment must become essential, particular in surgery. In addition to being individual or collective, it should not focus on practitioners' formal knowledge, but on the results obtained.

5. And how should it be evaluated? What criteria should we use?

Before any assessment, it is obviously necessary to agree on the qualitative and quantitative indicators to be evaluated. On the quantitative level, a lot of information is known by the Trustees. Learned societies should therefore be invited to give their opinion on what would be a first set of indicators. Initially, just some simple and reliable criteria could be used. From that point of view, the level of patient satisfaction must absolutely be taken into account. Their quality of life must be the central concern.

6. Evaluation, but to do what?

In the United States, the primary purpose of assessments is to re-rate practitioners and establishments. In France, the French National Authority for Health (HAS), however, regards assessments more as a way of encouraging practitioners and teams to undertake continuous improvement programmes in the quality of care. Assessments should also, by publishing results, lead to the development of benchmarking and stimulate establishments to undertake improvement programmes. Despite the great reticence of practitioners and establishments, it seems inevitable that assessments will eventually be published as a matter of course.

7. The primary condition for success: lift the fear of sanction-based evaluation

For evaluations to become commonplace, we must lift the fear of sanction-based assessment and make everyone understand that evaluations are not to stigmatise or penalize, but to improve. Lastly, the profession must itself take control of evaluation data before others step in and do it for them.