

Regulation and Control of Health Care Professionals

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Summary

This thesis is concerned with the regulation and control of health care professionals. In particular it examines the current regulation to which health care professionals are subject.

The hypothesis put forward by this thesis is that the regulation of health care professionals is not fit for purpose. Fit for purpose being defined as satisfying the need for public protection and patient safety, its primary aim, but also enabling to the health care professional by allowing them autonomy to undertake their practice.

In examining its hypothesis, the thesis provides an analysis of the nature of a health care professional as well as determining the context within which health care professionals undertake their professional practice.

The regulation of health care professionals is analysed through a framework of five elements of regulation that are considered necessary for regulation to achieve its primary aim. These five elements are: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practise.

Consideration is given to proposals for reform of the regulation of health care professionals, that are yet to be introduced.

The thesis finds that some of the elements of regulation are individually fit for purpose but that the current regulation of health care professionals is not fit for purpose as a whole. Recommendations are put forward to improve the effectiveness of regulation.

The scope of this thesis is limited to that of health care within England.

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For the original submission

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Contents

Declarations	i
Summary	ii
Acknowledgements	iii
Contents	iv
Table of legislation	
Statutes	xi
Bills	xiii
Statutory Instruments	xiii
European	xiv
Table of cases	xv
European	xvii
Introduction	
Preface	2
1. Background to the research and thesis	2
2. Aims and scope of thesis	6
2.1 Aim of the thesis	7
2.2 Hypothesis	7
3. Structure of the thesis	8
3.1 Scope and limitations of the thesis	9
Part 1: Regulation	
Introduction	12
<u>Chapter 1 – The nature and purpose of regulation</u>	
Introduction	14
1. What is regulation?	15
2. Forms of regulation	18
2.1 Self-regulation	18
2.2 State sanctioned self-regulation	23
2.3 The State and regulation _ State administered regulation	26
2.4 The politics of regulation	28
2.5 The current form of regulation of health care professionals	30

3. Reasons for regulation of health care professionals	33
3.1 Summary – reasons for the regulation of HCPs	36
4. What is being regulated	37
4.1 The definition of regulation adopted by this thesis	40
4.2 The five elements of regulation	41
5. Regulation as enabling	43
Conclusion	45
Part 2: Setting the context of the thesis	
Introduction	48
<u>Chapter 2 – The context of health care</u>	
Introduction	51
1. Origins and structure of the NHS	52
1.1 Health care before the NHS	53
1.2 Structure of the HNS at its inception	55
2. Reviews and reforms of the NHS following its inception	59
2.1 Changes in NHS structure	59
3. The current NHS in England	62
3.1 NHS Foundation Trusts	65
3.2 Diagram of NHS structure in England in 2008	71
3.3 Non-NHS health care provision	72
3.4 Treatment abroad by the NHS	76
3.5 Regulatory issues raised by non-NHS provision of treatment including treatment abroad	80
4. Size of the health service in the United Kingdom	81
4.1 Size of the NHS	81
4.2 Size of the independent sector	83
Conclusion	84
<u>Chapter 3 – Health care professionals</u>	
Introduction	89
1. What is a profession?	89
2. What is a Health Care Professional?	97
2.1 Competence	98
2.2 Autonomy and accountability	100
2.3 Comparisons with other professionals	101
2.4 Boundaries between health care professionals	102
2.5 Legal definition of health care professional	103

2.6 Definition of health care professional	104
3. Preparation of health care professionals – entry to the profession	106
4. Traditional roles, functions and responsibilities of health care professionals	107
5. Changes to health care professionals’ boundaries	112
5.1 Internal challenges to health care profession boundaries	112
5.2 External challenges to health care profession boundaries	115
5.3 Boundaries in health care	120
6. Contemporary health care professionals’ roles	121
6.1 Extension of nurses’ roles	121
6.1.1 Role extension	123
6.1.2 Protocols	125
6.1.3 Support, or lack of support, for nurses’ role extension	126
6.2 Boundary changes and the doctor	129
6.3 Prescribing as an example of role extension	131
6.4 Implications of extension and changes in roles	134
6.5 Contemporary roles of health care professionals	135
7. Other health care workers	137
7.1 Health care assistants	138
7.2 Medical assistants	142
Conclusion	143
Part 3: The regulation of health care professionals: applying the wide definition	
Introduction	147
<u>Chapter 4 – Applying the wide definition of regulation to health care professionals</u>	
Introduction	150
1. Classification of regulatory influences	151
2. Regulatory dichotomies	153
3. Identification of types of regulation	157
3.1 Method of identifying regulation	158
3.2 Methodology utilised	158
3.3 Types of regulation identified	159
4. Application of classification to the regulation identified	161

5. Analysis and commentary on the four categories of regulation	163
5.1 Commentary on informal-internal regulation	163
5.2 Commentary on informal-external regulation	166
5.3 Commentary on formal-internal regulation	168
5.4 Commentary on formal-external regulation	170
Conclusion	174
Part 4: The regulation of health care professionals: applying the narrow definition	
Introduction	177
<u>Chapter 5 – The professional regulatory bodies: the General Medical Council and the Nursing and Midwifery Council</u>	
Introduction	179
1. Role of the professional regulatory bodies	181
2. The General Medical Council	182
3. Nursing and Midwifery Council	184
4. Changes to the constitution and functions of the GMC and NMC	188
4.1 Process of change	192
5. The Council for Healthcare Regulatory Excellence	194
Conclusion	196
<u>Chapter 6 – Protection of titles and registration</u>	
Introduction	199
1. Protection of titles and the professional registers	199
2. Maintaining the registers	204
2.1 The General Medical Council Register	204
2.2 The Nursing and Midwifery Council Register	208
2.3 Checking the registers	212
2.4 Registration fees	216
2.5 Registration requirements	218
3. Commentary on protection of titles and registration	218
3.1 Protection of titles and registration	219
3.2 Provisional registration	223
3.3 Registration fees	226
3.4 Health care workers	227

3.5 Register of HCPs	230
3.6 Notification of intent to practise	232
Conclusion	233
<u>Chapter 7 – Education for initial registration</u>	
Introduction	238
1. Education for initial registration	238
2. The process of pre-registration education	240
2.1 Content of pre-registration programmes	241
2.1.1 European requirements for pre-registration programmes	243
2.2 Provision of pre-registration education programmes	244
2.3 Quality assurance mechanisms	245
3. Other requirements for initial registration	248
4. Commentary on education for initial registration	251
4.1 The GMC, the NMC and the provision of education	251
4.2 Provisional registration	253
4.3 Level of education programmes	255
4.4 Registration of students	256
Conclusion	261
<u>Chapter 8 – Clinical competence</u>	
Introduction	267
1. Clinical competence	268
2. Maintaining competence	271
3. Competence for advanced practice	275
3.1 Education and training for advanced practice	276
4. Proving competence	282
4.1 Appraisal	283
4.2 Clinical supervision	285
4.3 Revalidation	288
5. Commentary on clinical competence	289
5.1 Maintaining competence	289
5.2 Competence for advanced practice	294
5.2.1 Education and training for advanced practice	295
5.3 Proving competence	298
5.3.1 Appraisal	298
5.3.2 Clinical supervision	299

5.3.3 Revalidation	300
5.4 Underperforming HCPs	305
Conclusion	306
<u>Chapter 9 – Standards for performance</u>	
Introduction	311
1. The role of standards for performance	312
2. The professional regulatory bodies and codes of conduct	313
3. Commentary on standards for performance	319
Conclusion	320
<u>Chapter 10 – Fitness to practise</u>	
Introduction	323
1. Fitness to practise as an element of regulation	323
2. Legislative basis of fitness to practise	325
3. Fitness to practise procedures	327
3.1 Allegations regarding a HCP’s fitness to practise	327
3.1.1 Raising an allegation	329
3.2 Fitness to practise process	331
3.2.1 Committees and panels	331
3.2.2 Investigation stage	332
3.2.3 Adjudication stage	335
3.2.4 Interim Orders	337
3.2.5 Sanctions	338
3.2.6 Appeals	340
3.2.7 Restoration to the register	341
4. Commentary on fitness to practise	341
4.1 Fitness to practise	342
4.2 Legislative basis of fitness to practise	343
4.3 Fitness to practise procedures	343
4.3.1 Allegations regarding a HCP’s fitness to practise	344
4.3.2 Fitness to practise process	345
4.3.3 Transparency of proceedings	346
4.3.4 Committees and panels	349
4.3.5 Investigation and adjudication stages	352
4.3.6 Interim Orders	362
4.3.7 Sanctions	363
4.3.7a Guidance regarding sanctions	366
4.3.8 Appeals	367
4.3.9 Restoration to the register	368

Conclusion	369
Part 5: Conclusion and summary of recommendations	
Introduction	375
1. Thesis summary	375
2. Recommendations	377
3. Discussion of recommendations	379
Conclusion	380
Bibliography	385
Websites	408

Table of Legislation

Statutes

Abortion Act 1967

Access to Health Records Act 1990

Births and Deaths Registration Act 1953

Care Standards Act 2000

Data Protection Act 1998

Education Act 2002

Fatal Accidents Act 1976

Female Genital Mutilation Act 2003

Freedom of Information Act 2000

Health Act 1999

Health Authorities Act 1995

Health and Social Care Act 2001

Health and Social Care (Community Health and Standards) Act 2003

Health Services Act 1980

Human Rights Act 1998

Human Tissue Act 2004

Medical Act 1886

Medical Act 1950

Medical Act 1969

Medical Act 1978

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Midwives Act 1902 (repealed)

Midwives Act 1951

Medicinal Products: Prescription by Nurses etc. Act 1992

National Health Service Act 1946 (repealed)

National Health Service Act 1977

National Health Service and Community Care Act 1990

National Health Service (Primary Care) Act 1997

National Health Service Reform and Health Care Professions Act 2002

National Health Service Reorganisation Act 1973 (repealed)

National Insurance Act 1911

Nurses Act 1943 (repealed)

Nurses Act 1957

Nurses, Midwives and Health Visitors Act 1979

Nurses, Midwives and Health Visitors Act 1992

Nurses, Midwives and Health Visitors Act 1997

Nurses Registration 1919

Opticians Act 1989

Police and Criminal Evidence Act 1984

Police Reform Act 2002

Poor Law Amendment Act 1834 (repealed)

Protection of Children Act 1999

Road Traffic Act 1988

Road Traffic Offenders Act 1988

Statute Law (Repeals) Act 1986

Statute Law (Repeals) Act 1998

Tattooing of Minors Act 1969

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Venereal Disease Act 1917 (repealed)

Bills

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Employment Equality (Age) Regulations 2006 (SI 2006/1031)

General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (SI 2003/1250)

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Rao v General Medical Council [2002] UKPC 6

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Introduction

Preface

In assessing the regulation of health care within the United Kingdom (UK), regulation is one of several aspects of health care delivery that could have been chosen as being suitable for investigation and further exploration. This is because there are many aspects to regulation of health care. For instance, there is the regulation of the provision of care on an individual basis, the allocation of resources to the specific needs of patients and how an individual receives the care they need or desire; then there is the regulation of the agencies that exist to provide health care, the hospitals and GP surgeries through to the Trusts that co-ordinate their activities; then there is the regulation of the actual individuals who undertake the provision of health care, the health care professionals (HCPs) themselves.

Rather than take an approach that attempts to cover all the various aspects of regulation in health care delivery, the focus of this thesis is on an examination of the regulation of HCPs, the individuals who provide the care and treatment to the individuals in need.

HCPs are a large, diverse group of professionals and, although they share many characteristics, both in terms of their clinical practice and regulation, do have significant differences. Therefore this thesis concentrates on doctors and nurses as representative of HCPs in general, because they form the two HCP groups that may be said to be the most dominant and numerous respectively. Consequently, when examining the regulation to which HCPs are subject, from what this thesis terms the narrow respective, it is the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) that will be analysed.

1. Background to the research and thesis

Trust is an essential element of health care relationships. Patients need to be able to trust HCPs. Without this trust the doctor-patient and nurse-patient relationship will deteriorate. At the same time mechanisms are needed to protect the public from incompetent or malicious health care practitioners

The research for this thesis commenced against a background in which there were calls for more regulation, stricter regulation, new forms of regulation, and a call for regulation to be removed from the hands of those being regulated. It may be said that the overwhelming feeling of the time was one of mistrust of HCPs in general.

Some of the activities that led to the genesis of the research for this thesis are as follows:

- There was a surge in interest in the regulation of health care workers, most noticeably in the aftermath of the Public Inquiry in to the Shipman case (2000)¹ and the Bristol Heart Surgery Inquiry (2000).² As a result of these two inquiries alone, there were calls for stricter regulatory bodies, with greater disciplinary powers. For instance, in response to the recommendations following the Bristol Inquiry, the then Secretary of State for Health (Alan Milburn) announced that the government would be announcing proposals to reform the GMC.³
- The review of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), in 1998, which also raised questions about the nature of professional regulation.⁴
- There was recognition that although HCPs were being regulated not all those workers who worked within health care, in direct patient contact, were currently being regulated, for instance health care assistants. This led to calls for all those who worked within health care and had direct patient contact to be regulated.

¹ See The Shipman Inquiry website at <http://www.the-shipman-inquiry.org.uk/> accessed on 10th May 2008.

² See the Bristol Royal Infirmary Inquiry website at <http://www.bristol-inquiry.org.uk/index.htm> accessed on 10th May 2008.

³ Hansard House of Commons vol. 372 column 292 (debates 18 July 2001 The Secretary of State for Health).

⁴ For instance see JM Consulting (1998) The regulation of nurses, midwives and health visitors: report on a review of the Nurses, Midwives and Health Visitors Act 1997 JM Consulting, London.

- One of the major themes of discussions was whether self-regulation offers adequate protection to the public, or whether there should be some form of external regulation of health care professionals and workers.
- It was also suggested by some commentators that all HCPs should be regulated by one unified body, and hence be subject to the same regulatory framework.

It is generally well known that the medical profession is regulated by the GMC, whilst nurses are regulated by the NMC, and that other health care professionals have similar regulatory bodies, for example the General Dental Council which regulates dentists. What may be less known is how this regulation is undertaken and, in particular, how these regulatory bodies actually do to achieve their regulatory function and aim. Indeed there may be some confusion regarding the purpose of regulation, as well as the means by which this regulation occurs.

Whilst there are fundamental differences in the professional roles that doctors and nurses undertake, both regulatory bodies have similar responsibilities with regard to professional regulation. Both have the legal authority to oversee their respective professions, and currently undertake this through self-regulation.

It may be said that self-regulation, which refers to the situation where responsibility for the control of the profession lies with the profession itself, '*is often seen as the hallmark of professional status*'.⁵ Indeed, self-regulation may be seen as being the favoured mode of regulation for professions within the UK.⁶

Likewise, it may be said that the aim of professional regulation is the protection of the public from unqualified or inappropriate professionals.

⁵ Kennedy I. & Grubb A. (1998) Principles of Medical Law Oxford University Press, Oxford, at page 70.

⁶ For instance see Abel R (1988) The legal profession in England and Wales Basil Blackwell Ltd, Oxford.

However, some commentators note that self-regulation has an additional role that may conflict with this aim, that '*the profession preserves its own valuable monopoly of professional services*'.⁷

Several commentators have suggested that the current regulatory bodies are more interested in protecting the interests of the members than in public protection, and self-regulation facilitates this self-interest.⁸ However, in its submission to the review of the Nurses, Midwives and Health Visitors Act 1997, the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) stated that professional self-regulation was the regulatory system that was best placed to ensure the protection of the public.⁹

Recognising that the regulation of HCPs was in need of reform, the Government announced that it was undertaking a review of the Nurses, Midwives and Health Visitors Act 1997. Although there was not a change in the form of regulation away from self-regulation, the review led to a proposal for a new regulatory body.¹⁰ Subsequently, following a wide consultation process, the Government announced that '*a new, modernised and strengthened system of self regulation for nurses, midwives and health visitors*', would be established under a single professional body.¹¹

One reason for the establishment of a new regulatory body to replace an existing regulatory body and subsequent legislative changes was that the existing act '*fails explicitly to put public protection as its paramount purpose*' and '*the Central Council [UKCC] has restricted and inflexible*

⁷ Kennedy I. & Grubb A. (1998) Principles of Medical Law Oxford University Press, Oxford, at page 71.

⁸ For instance see Boseley S. (1998) 'Reform of nursing watchdog 'will offer greater degree of protection'' The Guardian February 1998 p. 5; and Rogers L. (2000) 'Focus' The Sunday Times 6 February 2000 p. 21.

⁹ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997) The future of professional regulation United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

¹⁰ JM Consulting (1998) The regulation of nurses, midwives and health visitors: report on a review of the Nurses, Midwives and Health Visitors Act 1997 JM Consulting, London.

¹¹ Department of Health (1999) New single body announced to regulate nurses, midwives and health visitors Press Release 9 February 1999 available at http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4025131 accessed on 16th November 2007.

powers in the area of conduct and discipline which adversely affects public protection and does not assist the rehabilitation of practitioners who could return to useful practice'.¹²

Likewise the then Secretary of State for Health (Alan Milburn) announced in February 2000 an independent inquiry '*into the issues raised by the murder of patients by Harold Shipman*', stating that '*the GMC must genuinely exist to protect patients*'.¹³ Indicating, whether intentionally or not, that this was not the case at the time of the announcement and that change was necessary.

The Nursing and Midwifery Council (NMC) subsequently replaced the UKCC in 2002, being established by the Nursing and Midwifery Order 2001.¹⁴

2. Aim and scope of thesis

The subject matter of this thesis is that of the regulation and control of HCPs. It examines the current regulation to which HCPs are subject.

For the purposes of this thesis, it is not the origin of the regulatory effect but rather the nature of the regulatory effect itself upon the HCP that is the important aspect. Likewise this thesis is not concerned with the reduction of clinical error per se but in how the regulation to which HCPs are subject achieves its purpose.

Regulation may occur for a variety of reasons and the form of that regulation can be varied as well. As will be seen, regulation can be a controlling factor; it can control the actions of HCPs. However, regulation does not have to be an entirely control based entity, if it were, then it could

¹² JM Consulting (1998) The regulation of nurses, midwives and health visitors: report on a review of the Nurses, Midwives and Health Visitors Act 1997 JM Consulting, London at page 3.

¹³ Department of Health (2000) Alan Milburn statement to House of Commons Press Release 1 February 2000 available at http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4002542 accessed on 16th November 2007.

¹⁴ Nursing and Midwifery Order 2001 (SI 2002/253).

be argued that the regulation was not fit for purpose as it only addressed one side of the regulation requirement, that of the control of HCPs and not the other side of enabling the HCP in their clinical roles.

For regulation to be effective and efficient it is argued, within this thesis, that regulation has to undertake a balancing act between being enabling for HCPs as well as controlling. It is further argued within this thesis that both elements of regulation, the controlling and enabling, have to be present for regulation to be fit for purpose.

It is this interplay between the two sides of regulation, the controlling and the enabling that will be examined throughout this thesis in order to address the hypothesis that current regulation of HCPs is not fit for purpose.

2.1 Aim of the thesis

The aim of this thesis is to examine the current and potential regulation of HCPs. The analysis aims to assist in determining whether the current form of regulation of HCPs is an effective and efficient means of professional regulation. It does this by questioning whether the current regulation of HCPs is fit for purpose; that is, does it present an effective and efficient means of providing public protection and patient safety without restricting the clinical autonomy of the HCPs that it is regulating?

2.2 Hypothesis

At the centre of the thesis is the hypothesis that the regulation that HCPs are currently subjected to is not an effective and efficient means of regulation; that the regulation of HCPs is not fit for purpose and that there needs to be changes within the regulation of HCPs for it to become fit for purpose.

One of the ways in which the current regulation of HCPs is thought not to be fit for purpose is that it restricts the HCP's autonomy (clinical decision making).

3. Structure of the thesis

In addressing its subject matter and answering the hypothesis, this thesis is structured into five parts as follows:

Part 1 explores the nature of regulation and also identifies the purpose of regulation of HCPs. It advances two definitions of regulation, the wide and the narrow. For the purposes of testing the hypothesis it is the narrow definition that will be utilised. However, in order to put the professional regulation of HCPs into context, the wider definition will be employed. Additionally, Part 1 highlights five elements of regulation that are considered necessary to regulate, if the primary objective of regulation is to be achieved. It is these five elements that will be used to analyse the narrow definition of regulation in Part 3

Part 2 sets the scene and context of the thesis. It undertakes this in two ways. Firstly, it examines the context within which HCPs provide health care; the health care arena in which they work. Secondly it analyses what it is to be a HCP and considers the ways in which the roles of HCPs have evolved from those traditionally associated with them to the contemporary ones they undertake.

Part 3 provides an overview of the regulation of HCPs utilising the wide definition of regulation identified in Chapter 1.

Part 4 consists of a commentary and analysis of the professional regulation to which HCPs are subject, utilising the narrow definition of regulation, and, where appropriate, makes recommendations regarding changes to the regulation of HCPs. It is organised by utilising the five elements of regulation identified in Chapter 1.

Part 5 has the concluding comments to the thesis and also a summary of the recommendations made in Part 4.

3.1 Scope and limitations of the thesis

Although the analysis and examination that this thesis will undertake can apply to all HCP groups and professions, this thesis will concentrate upon medicine and nursing, using doctors and nurses as case studies, to illustrate the various points and issues raised within this thesis. It is argued within this thesis that the medical profession retains a dominant position within health care and the nursing profession is the most numerous within health care delivery. The two chosen health care professions are also closely allied to one another, having a long established tradition of working with each other, indeed both may be said to have traditional roles that complement each other. As will be seen, as medicine has changed in response to both internal and external drivers, it is nursing that has attempted to take on new roles and responsibilities thus allowing medicine the freedom to undertake this change. In this thesis HCP will be shorthand for doctor and nurse where the point that is being made is common to both. Similarly the use of the term doctor within this shorthand term is taken to include all forms of registered medical practitioner, that is, all grades from the newly qualified up to and including consultant. Whilst the term nurse includes midwives and health visitors in all grades as well as all branches of nurses, that is, general, learning disability, mental health and children's nurses. Although in this thesis other HCP groups and professions will not be considered in detail, they will be utilised where their experiences can illustrate a particular point or issue.

This thesis limits its scope to that of England; this is because there are differences in the structural arrangements of the health service and the delivery of health care within the four countries of the UK. Although this thesis will limit its scope to England, where appropriate reference will be made to the UK where this illustrates specific points, for instance in Chapter 2 when discussing the development of the National Health Service (NHS) and also when discussing the size of the NHS.

Research for this thesis was conducted to 25th June 2008.

Part 1

Regulation

Introduction to Part 1

In order to address the hypothesis of this thesis, that the regulation of Health Care Professionals (HCPs) within England is not fit for purpose, it is necessary to explore the nature of regulation itself and to identify the purpose of that regulation within the health care context. It is only after this has been undertaken that the regulatory structures and processes can be identified and analysed to determine if the hypothesis is correct, or whether the current regulation to which HCPs are exposed is appropriate and at a level necessary to achieve its aim without being over onerous.

Chapter 1 therefore introduces this thesis by providing a framework with which to discuss the regulatory structures that will be identified and examined in Part 3.

Following an examination of the nature of regulation in a general context, there is a section that identifies the various forms that regulation that can take, including discussion of the role of the state in regulation. Having established the generalities of regulation, the next section goes to the specifics of health care regulation by analysing the reasons for the regulation of HCPs.

The chapter proceeds with an analysis of what is being regulated and by whom, providing the definitions of regulation that will be utilised throughout the thesis - the wide and narrow definitions of regulation. The rationale for the choice of the narrow definition of regulation as the main definition of the thesis is provided. Following this, the phenomena that can be regulated to achieve the aims of regulation are considered. Five fundamental elements of regulation are identified and explored. Finally, the chapter concludes with a discussion of regulation as being enabling as well as controlling, which is a key feature of regulation for this thesis. For regulation to be fit for purpose both these two aspects of regulation, controlling and enabling HCPs, have to be present.

Chapter 1

The nature and purpose of regulation

Introduction to chapter 1

It is difficult to be able to examine an entity or subject and communicate that examination with others without first establishing what that entity or subject is. The boundaries of the entity or subject need to be established so that the examination that occurs is meaningful for all the parties involved. Without establishing boundaries, parameters and definitions, the parties involved may be examining different versions of the entity or an altogether separate entity.

Therefore this chapter addresses the hypothesis of this thesis, that of whether the current regulation of Health Care Professionals (HCPs) is fit for purpose, by examining the nature of regulation and posing the questions, what is regulation and what is its purpose in a health care context? In addressing the nature and purpose of regulation and answering the questions posed, the chapter is structured as follows: an examination of regulation, including its role within society; identification of the various forms that regulation can take, together with a determination of the prevailing form that exists within the health care context, this also includes discussion of the involvement of the State in regulation and the political dimensions of regulation; a discussion of the reasons for regulation in a health care context, with the identification of the primary objective for regulating HCPs; a determination of both the wide and narrow definitions of regulation utilised in the thesis; an analysis of what needs to be regulated in order to achieve the stated purpose of regulation, identifying five key elements which will be used in later chapters of this thesis to test the hypothesis of whether the regulation of HCPs is fit for purpose; and finally an exploration of regulation that enables HCPs.

Later chapters will address the questions of who it is we regulate and how we regulate them.

1. What is regulation?

In addressing the question what is regulation, it may be useful to first consider the dictionary definition of the words regulate and regulation. This will at least provide a starting place from which to make a more detailed analysis of the question.

The verb regulate means *'to control, govern or direct by rule or regulations; to subject to guidance or restrictions ... to bring or reduce a person or class of persons to order'*;¹ whilst the noun regulation is defined as *'the act of regulating, or the state of being regulated. A rule prescribed for the management of some matter, or the regulating of conduct; a governing precept or direction'*.²

Therefore, at its simplest, regulation may be seen as the act of regulating; that is, the act of controlling and keeping in order through the use of rules.

The way that regulation is seen in society, and in particular within health care, needs further exploration. Indeed it may be said that regulation is one of the key features of societies. Regulation as a pervasive feature of society is implicit in the following: *'regulation is virtually a defining feature of any system of social organization, for we recognize the existence of a social order by the presence of rules, and by the attempt to enforce those rules'*.³

However, as to the nature of that regulation, there are a number of differing definitions of regulation around, even though it is often referred to as if it is a singular identified entity.⁴ Some commentators see regulation being divided between that which serves public interests and

¹ Onions C T (ed) (1984) *The Shorter Oxford English Dictionary* Clarendon Press, Oxford.

² Ibid.

³ Hancher L & Moran M (1998) 'Organizing regulatory space' chapter 3 in Baldwin R, Scott C & Hood C (eds) (1998) *A reader on regulation* Oxford University Press, Oxford, at page 148.

⁴ Allsop J & Mulcahy L (1996) *Regulating Medical Work: formal and informal controls* Open University Press, Buckingham, in particular chapter 1; Baldwin R & Cave M (1999) *Understanding Regulation* Oxford University Press, Oxford, in particular chapter 1; Ogus A (1994) *Regulation: legal form and economic theory* Clarendon Press, Oxford, chapter 1.

that which has an economic function.⁵ For instance, Ogus is one of those authors who distinguish between social regulation and economic regulation. He notes that economic regulation more readily '*applies primarily to industries with monopolistic tendencies*', as it is a substitute for the lack of competition that is said to act in the best interests of the consumer.⁶ For Moran and Wood regulation is '*the foundation of social life ... the activity by which the rules governing the exchange of goods and services are made and implemented ... [that] every kind of market has to be regulated*'.⁷ Social regulation is the mechanism whereby consumers, patients in the case of this thesis, have the information they need to make an informed choice. Although it is possible to categorise health care as a monopolistic institution within England, it is the social form of regulation that more readily applies to health and health care, where the need for regulation '*arises from information inequalities between individuals and organizations*'.⁸

Returning to the dictionary definitions of regulation provided at the beginning of this section, and the quotation by Hancher & Moran above, one of the key features of regulation is that of control. Baldwin et al confirm this when they state that, '*at its simplest, regulation refers to the promulgation of an authoritative set of rules, accompanied by some mechanism, typically a public agency, for monitoring and promoting compliance with these rules*'.⁹ This can be further developed so that regulation is seen as '*applying rules to manage, control or restrict behaviour ... a function both of the statutory framework that governs social care provision and of the internal procedural framework used by*

⁵ For instance see Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford.

⁶ Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at page 5.

⁷ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 17.

⁸ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 10.

⁹ Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 3.

agencies to standardize their practice'.¹⁰ Indeed there are those who describe regulation 'as any form of behavioural control',¹¹ a definition that is also used by Allsop and Mulcahy;¹² whilst others see it as 'as all forms of social control or influence'.¹³

What is commonplace, about these ways of seeing regulation, is that each indicates an element of control, restriction and constraint by another agency. With regard to the subject matter of this thesis, the HCP, this suggests a loss of freedom of the HCP to perform their role unchallenged, with an agency external to the HCP undertaking this control.

How this control occurs is also a feature of regulation. Whether there are rewards for undertaking certain activities and behaving in certain ways or whether there is punishment for not undertaking certain activities and not behaving in a certain way. Both may achieve the same result that of a certain form of behaviour and the undertaking of certain activities, yet the person to whom the regulation applies may have a distinct preference over which model of regulation, the reward or punishment method, applies to them.

It is fair to say that the reward or punishment models of regulation do not appear in isolation within health care and that, as shall be seen in Part 3, both models are integrated in a regulatory framework.

The next section examines the forms that regulation can take within society and within specific contexts.

¹⁰ Braye S & Preston-Shoot M (1999) 'Accountability, administrative law and social work practice: redressing or reinforcing the power imbalance?' Journal of Social Welfare and Family Law vol. 21 no. 3 p. 235 – 256, at page 238. Although discussing regulation in relation to social work, the same point can be made in relation to health care.

¹¹ Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at page 1.

¹² Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 8.

¹³ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 2.

2. Forms of regulation

Most commentators would agree that there are three main ways in which regulation can be organised. These are: self-regulation; State sanctioned self-regulation; and State administrated regulation.¹⁴

It is the attributes and differences between these three ways of organising regulation that is the focus of this section.

2.1 Self-regulation

Self-regulation refers to regulation that is undertaken by those involved in the activity being regulated, independently of any external influence, for the purposes of health care it would be undertaken by HCPs themselves, either collectively or as separate professions e.g. doctors, nurses etc. Grubb believes that *'self-regulation has often been seen as the hallmark of professional status'*.¹⁵ Abel appears to be in agreement with Grubb noting that *'if functionalism had to identify professions by a single characteristic, self-regulation would be near the top of the list'*.¹⁶ Additionally Allsop states that *'the prototype for self-regulation is based on medicine. In the mid-nineteenth century, medical practitioners obtained the statutory right to regulate their own occupational practice ... [and this] ... gave the profession a large degree of autonomy in determining what the content of medical practice should be, how medical work should be carried out, and protection from both the market and the State'*.¹⁷

It should be noted that genuine self-regulation is undertaken independently of any external influence, including that of the State. It is

¹⁴ For instance see Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, and Moran M & Hood D (1993) States, regulation and the medical profession Open University Press, Buckingham.

¹⁵ Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford, at page 83.

¹⁶ Abel R (1988) The legal profession in England and Wales Basil Blackwell Ltd, Oxford, at page 29. For further discussion on the functionalist view of professions see Chapter 3 section 1.

¹⁷ Allsop J (2002) 'Regulation and the medical profession' chapter 6 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 79.

undertaken as a means of the profession or group regulating itself on various matters, as a voluntary obligation. In this form, the self-regulatory body would set the rules of the profession, enforce these rules, and impose sanctions on those who infringe the rules; any mechanism of accountability is to the members of the profession.

Self-regulation is said to have the element of expertise in its favour.¹⁸ Those who are to be regulated are the ones with the necessary knowledge, technical and operational expertise and experience, and professional judgment to be able to determine the boundaries of the scope of regulation and the practices that need to be regulated in the first place, as well as the acceptable practices of undertaking the roles that are to be regulated, and the appropriate and effective remedies that can be applied. In addition, there may be cost benefits in having self-regulation as the form of regulation. The cost of defining standards is reduced because the regulatory body has the available expertise. The costs of monitoring and enforcing agreed standards are also reduced, both due to the expertise available and to an atmosphere of mutual trust that may exist as a result of the profession having control over its own regulation.¹⁹

If the regulation is voluntary, it has to be accepted by those being regulated. If the regulatory system is not approved by those being regulated, they are less likely to comply with the rules and regulations. Indeed, there has to be some incentive to encourage membership and observance of the rules and codes of practice. In relation to health care this has been through the use of having a register of those HCPs able to practise that have been issued and controlled by the regulatory bodies. In the case of the General Medical Council (GMC), if the individuals are not on the register, they are not been able to use the title 'registered medical practitioner' to describe themselves or their practice. As shall be seen in

¹⁸ For instance see Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at page 105, and Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 22.

¹⁹ For further discussion of the cost benefits see Ogus A (1998) 'Rethinking self-regulation' chapter 12 in Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 375.

Part 3, the GMC has the responsibility of maintaining a register of those entitled to practise, and also has the power to remove HCPs from the register.

There are those who believe that *'self-regulation is felt to improve compliance because the regime is seen as more reasonable and acceptable to those being regulated. This is supposed to produce higher levels of trust between the regulated and the regulatory bodies than is the case with direct [either State sanctioned or State administered] regulation'*.²⁰

An element of this higher level of trust may be exhibited because, through self-regulation, the actual process of regulation is removed from the State and thus those being regulated believe that they are independent and thus effectively in control of their own regulation. However Abel does not agree with this assessment noting that the profession who undertakes self-regulation is not autonomous as *'the profession necessarily derives its regulatory power from the State'*.²¹ Although this view may be more in line with State sanctioned self-regulation than pure self-regulation where there is no State involvement.

Ogus believes that *'self-regulation remains as the principal controlling device for a wide range of activities including...the practice of a large variety of professional occupations'*.²² However, it should be noted that pure independent self-regulation *'is actually quite rare in any important sector of the economy, simply because the modern State is seldom content to leave regulation totally in private hands'*.²³ This may be said to be

²⁰ Baggott R (2002) 'Regulatory politics, health professionals and the public interest' chapter 2 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 34.

²¹ Abel R (1988) The legal profession in England and Wales Basil Blackwell Ltd, Oxford, at page 29.

²² Ogus A (1998) 'Rethinking self-regulation' chapter 12 in Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 374.

²³ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 21. See also, Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at chapter 1.

equally so in the health sector and, as will be seen in Part 3, the State has both increased the amount of regulation through a regulatory framework and also provided the direction that regulation had to take so that the involvement of the State may be said to preclude HCPs from the pure form of self-regulation.

Others are of the opinion that self-regulatory bodies have a delicate balancing act to undertake as they have '*to handle three main constituencies. The first is their own rank-and-file membership, whose fees pay for regulation and whose interests are represented by other institutions within the professional world. The second is the public, which sees the regulatory body as responsible for setting appropriate standards. The final constituency is that of government and Parliament with whom ultimate responsibility lies*'.²⁴ It is open to debate as to whether the 'rank-and-file' has its interests met by 'other institutions' such as professional bodies; as membership of the regulatory body is mandatory in order to practise their profession, whilst membership of other professional bodies is voluntary.

Self-regulation is not considered to be the most efficient and effective form of regulation by everyone. There are those who see self-regulation as: lacking in accountability, openness and transparency, both to those it aims to protect and to society in general; open to misuse by those in positions of power within the regulatory body; and, lacking the distinction between rule-making and enforcement. That is, the regulatory body not only sets the standards and rules to which its registrants must adhere, but also sets and decides upon the appropriate sanctions for those who breach these standards and rules.²⁵ Baldwin et al see this as '*the classical model of regulation ... called command and control regulation*'.²⁶ This 'command

²⁴ For instance see Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 13.

²⁵ For instance see Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at page 108 and Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 40.

²⁶ Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 24.

and control' aspect of self-regulation may lead to abuse of power if there are not adequate checks and balances within the processes of the regulatory body to prevent any misuse of the body's powers. Another disadvantage of self-regulation as the method of regulation is that it lacks *'legitimacy in a number of ways. The public may be cynical about their effectiveness and it is easy for the media to accuse them of bias and 'protecting their own'.*²⁷

The advantages and disadvantages of any one particular form of regulation are different depending upon which viewpoint is taken, for instance that of those being protected, the public and patients, or those being regulated, the HCPs. Whether one sees self-regulation as an effective method of regulation or not, true independent self-regulation does remove one important factor in regulation, that of political interference; instead of having regulation that is open to political misuse and manipulation, a longer-term view may be taken that leads to a more coherent regulatory process.²⁸

However, as Baggott notes, self-regulation *'can be highly formalized and may even be underpinned by statute'*,²⁹ whilst for Baldwin and Cave *'the process of self-regulation may be constrained governmentally in a number of ways'*.³⁰ These authors see these constraints as being oversight of the self-regulatory body by government agencies or Parliament itself; the imposition of statutory rules on the processes of regulation; the need for approval by government ministers of the self-regulatory body's rules and processes; and, the imposition of accountability procedures, including reporting and publication procedures, and the need for lay representation on conduct committees. Thus even though the process of regulation is

²⁷ Baggott R (2002) 'Regulatory politics, health professionals and the public interest' chapter 2 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 35.

²⁸ For instance see Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at pages 105 - 6.

²⁹ Baggott R (2002) 'Regulatory politics, health professionals and the public interest' chapter 2 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 33.

³⁰ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 126.

thought to be undertaken by a self-regulatory body, it is possible for there to be informal, or even formal, *'influences from government that are exerted in the shadow of threatened State regulation'*.³¹

In addition to the above, there is also the issue of the underlying authority of the self-regulatory body. From where does the regulating body derive its power to 'police' and sanction its members? This moves the discussion onto the next form that regulation can take.

2.2 State sanctioned self-regulation

State sanctioned self-regulation is a form of regulation that has been delegated or sanctioned to be undertaken by the profession on behalf of the public. Here *'the rules, and the institutions concerned with their formulation and implementation, exist with the consent and support of the State and ... are operated with the support of State sanctions'*.³²

State sanctioned self-regulation may be said to be a mid-point on the continuum from independent self-regulation to State administered regulation. There may be many reasons why regulation moves from the independent to the State sanctioned variety of self-regulation. Some of these include the State establishing overall control of the regulatory process, without incurring financial cost; as well as overcoming the inability of the professional regulatory body to impose sanctions upon members who do not maintain standards in a voluntary led regulatory process.

Additionally it may be that the professions have been unable to effectively perform pure self-regulation and there needs to be a move toward State sanctioned self-regulation so that the regulation's purpose is effectively achieved. Abel is of the opinion that the professions are not able to *'perform their regulatory functions very well'* and that their *'self-interest*

³¹ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 130.

³² Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 22.

*frequently dampens their ardour for reform*³³ resulting in the need for the State to intervene in the regulatory process.

With regard to Allsop's³⁴ point above about the GMC being the prototype for self-regulation, for Moran and Woods, although '*statutorily created, the GMC was – and remains - a prime example of State-licensed self-regulation*'.³⁵ Whilst they believe that '*the historical significance of the [self-regulatory status of the] GMC is ... [that] ... unlike some countries where direct regulation by the State prevails, in the UK a tradition of a government-profession contract creating a legal regulatory body and hence legitimizing self-regulation was, and still is, the preferred approach. Certainly the privilege of self-regulation has for many decades been much cherished by the UK medical profession. This formal legitimacy makes the GMC that much more authoritative than would be a non-statutory body*'.³⁶

As Baldwin states, '*for governments there are many good reasons for regulating at arms-length. Agency regulation may, inter alia, be preferred to departmental control so as to facilitate the development of a technical expertise, to set up a non-civil-service system of bureaucracy, to hive-off a political "hot potato" or to make it clear that control is independent of political taint*'.³⁷

Having the support of the State in regulating HCPs permits the regulatory bodies to have the necessary power to compel registration and to enforce the sanctions available. However, being State sanctioned also helps to

³³ Abel R (1988) The legal profession in England and Wales Basil Blackwell Ltd, Oxford, at page 29.

³⁴ Allsop J (2002) 'Regulation and the medical profession' chapter 6 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London. Ibid this

³⁵ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 36.

³⁶ Ibid, at page 37.

³⁷ Baldwin R (1985) Regulating the airlines Clarendon Press, Oxford, at page 4.

ensure that the regulatory processes are compatible with other regulatory bodies and with general societal objectives.³⁸

As Moran and Wood state, *'genuinely independent self-regulation often faces serious problems of control, because it is difficult for voluntary associations to wield sanctions against those who break the rules. Putting State power behind the system can supply the necessary authority. At the same time, by delegating to private bodies the detailed tasks of regulation, States are saving the considerable financial and administrative burden of doing the jobs themselves'*.³⁹ For Allsop and Mulcahy *'the benefit of State-sanctioned regulation is that it operates with the support of the State. At the same time, by delegating the task of regulation, the government can make huge savings in cost'*.⁴⁰ Whilst Baldwin and Cave see low governmental costs; rule making that is comprehensive, well-informed and acceptable to those being regulated; and *'greater effectiveness in detecting violations and in securing convictions where prosecution is necessary'* as the strengths of State sanctioned self-regulation.⁴¹

However, State sanctioned self-regulation is not problem free for the State concerned. The State has to give power and authority to the regulatory body to allow it to undertake the regulatory function in the name of the State. This is mainly through devolved or delegated power. In providing this authority and power, the State has to ensure that there is a recognised chain of accountability from the regulatory body back to the State, so that the correct degree of scrutiny may be applied to decisions of the regulatory body and that periodic reviews are undertaken to ensure that the regulatory body is meeting its objectives and not abusing its power or failing to fulfil its legal obligations. Where the State has devolved powers

³⁸ For instance see Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at page 106.

³⁹ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 22.

⁴⁰ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 221.

⁴¹ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 40.

of sanction and discipline to the regulatory body, this is particularly important.⁴² It can be queried that if the State has devolved regulation to another body, giving them discretion as to how to perform the actual regulation, how can the State control that regulation?⁴³

This control may be exerted through the setting of boundaries of the area being regulated and the requirement that the body undertaking regulation be answerable to the State, whether this is in the form of reports on their activities or through attendance at scrutiny meetings.

Therefore, being State sanctioned means that the regulatory body will be subject to external scrutiny, if not control of some form, to an aspect of the machinery of State, for instance a Government Minister, a Parliamentary Committee or maybe an independent body created by Parliament for the purpose.

2.3 The State and regulation - State administered regulation

This section examines the final form of regulation discussed above, that of State administered regulation. It also addresses the role of the State in regulation in general, and specifically in the regulation of HCPs.

State administered regulation or direct State regulation has several features that distinguish it from independent or State sanctioned self-regulation. For Moran and Woods *'the identifying features of ... [State administered regulation] are as follows. Authority to regulate rests on legislation. Regulation may be carried out by a specialized public institution, or by a group of civil servants in a central department of government. The principles of the system are that those who make the rules, and those who implement them, are public servants: they are employees of the State, are subject to the rules of public accountability and their actions can be reviewed and challenged in the courts. In*

⁴² For further discussion of this point see Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at pages 22 - 23.

⁴³ See Baldwin R (1985) Regulating the airlines Clarendon Press, Oxford, at page 1.

principle, direct State regulation ensures public accountability; how far it does so in practice is a matter for investigation of particular cases'.⁴⁴

Ogus questions whether regulation and its associated rule-making should be left to those who are '*independent of government*'.⁴⁵ This may be taken to follow the argument that if the regulation is important enough to be needed by society, then society should have the full protection available and this includes government scrutiny and rule-making as and when necessary. Indeed, Ogus would seem to be actually arguing for State involvement in regulation, whether as State-sanctioned or State-administered, when he states that '*since the principle of regulatory regimes are normally promulgated by Parliament, the membership of which is determined by the electorate, it might seem appropriate that the institution itself should exercise some form of control*'.⁴⁶ The reasoning behind this is that Ministers are answerable to Parliament; thus regulatory rules may be subject to Parliamentary scrutiny and regulatory processes may be subject to select committee oversight. This may lead to disclosure of relevant information that would not otherwise occur, possibly leading to public debate of the regulation in question. However does state that '*increased Parliamentary scrutiny may encourage greater governmental interference, which itself may attempt to capture short-term political gains*'.⁴⁷

Given that State administered regulation does not necessarily involve HCP's in the process of regulation, as opposed to self-regulation or State sanctioned self-regulation where HCP's would be key architects of the regulation, as may be expected, it is State administered regulation that is the least autonomous for the HCP and professionals as a whole.

⁴⁴ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 23.

⁴⁵ Ogus A (1994) Regulation: legal form & economic theory Clarendon Press, Oxford, at page 105.

⁴⁶ *Ibid*, at page 112.

⁴⁷ *Ibid*, at page 113.

It can be argued that State administered regulation may be said to be reserved for those areas of society where the risk to society and its members from poor or substandard practice is greater than from those areas where poor practice poses less risk to society or individual members of society, and can be left to self-regulation.

However, it can also be argued that health care can pose a threat to society if not regulated and that this regulation should be of the State administered form for the public to be fully protected. Although at present this is not the case.

2.4 The politics of regulation

The three different ways of organizing regulation, discussed above, reflect the way that the State may be involved in regulation. When examining regulation and the form it takes, it is important to realise that *'regulation takes place in particular places and in particular times, and these two factors have an immense influence on the shape of regulatory space'*.⁴⁸ Regulation is a product of its time; it is not an apolitical issue, rather the form that regulation takes, whether it is self-regulation, State sanctioned self-regulation or State administered regulation, has its roots in contemporary politics and is dependent upon the political landscape of the time, the nature of the provision of health care and the values of the society in which it exists.

This view would appear to be supported by Moran and Wood who state that *'politics lies at the heart of regulation. The regulation of medicine is not just a technical matter of setting standards. It is a political process, involving the exercise of power and authority in struggles between competing interests; and it is a process in which the struggle for control of State power is central'*.⁴⁹ They go on to suggest that *'the institutions that develop, and the rules that those institutions enforce, are produced*

⁴⁸ Hancher L & Moran M (1998) 'Organizing regulatory space' chapter 3 in Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 161.

⁴⁹ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 26.

by the exercise of power. Relations of power are influenced by many factors, so regulation itself is determined by many factors. Out of a multitude of influences, however, three are especially important: the place where regulation is conducted; the time when it is conducted; and the nature of the job that is being regulated'.⁵⁰

Indeed, it is the outcome of this political process and the competing tensions that produces the form that regulation takes. Therefore, *'the system of professional regulation in the United Kingdom is marked by the distinctive imprint of the country's historical development'* and that, because at the time of the development of regulation of the medical profession the State lacked bureaucratic resources, this allowed a form of professional regulation to develop that kept *'State power firmly in the background, although it involved it as the guardian of the authority of professional institutions'.⁵¹*

For instance, the interventionist State could not conceive of true independent self-regulation as an effective method of regulation and because of its ideology has to put in place State oversight in some form. As Hancher & Moran note, *'regulation is embedded in the practices of the interventionist State. The aims of regulation are commonly only explicable by reference to the wider structures and more general aims of the interventionist State'.⁵²*

Moran and Wood advance the argument that regulation is a product of its time, by stating that *'the regulation of doctors, like the regulation of other groups and interests, is undoubtedly influenced by the national setting in which regulation is conducted and by the historical period when the system of regulation was originally constructed. But regulation is also a*

⁵⁰ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 27.

⁵¹ Moran M (2002) 'The health professions in international perspective' chapter 1 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 22.

⁵² Hancher L & Moran M (1998) 'Organizing regulatory space' chapter 3 in Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 149.

product of more immediate forces that are special to the profession itself: in other words ... the nature of the job is important. In part this is a matter of the distinct demands of the professional task: because a doctor and an architect need different skills, this is going to affect the way the two professions are regulated'.⁵³

Whilst recognising that politics and power have an effect upon regulation, it is not a wholly negative or unproductive element in that regulation. Regulation that arises out of the political sphere can be as effective and efficient as any other form of regulation. However, the point to be made is that any particular form or aspect of regulation has to be put into its historical and political context and that changes in regulation may arise for purely political purposes. It is when this occurs that there needs to be careful scrutiny of the effectiveness and efficiency of the regulation.

2.5 The current form of regulation of health care professionals

Whilst Part 3 will provide detailed examination of the regulation to which HCPs are subject, the overall form that this regulation takes is discussed here.

There has been a move, over time, away from pure self-regulation of the HCPs to the State sanctioned form of self-regulation. As Moran and Wood state '*in recent decades State sanctioning has increasingly displaced pure independent self-regulation. In many cases existing regulatory institutions have been brought under State supervision, while retaining the function of carrying out the detailed tasks of regulation*', noting that the reason for the change has been '*when failures in the old arrangements led to reform and State supervision*'.⁵⁴ At the present time, it is this State sanctioned self-regulation that is the prevailing form of regulation for HCPs,⁵⁵ although, given the amount of regulation that will be presented in

⁵³ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 29.

⁵⁴ Ibid, at page 22.

⁵⁵ For instance see Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford, at chapter 2 section A2.

Part 3, it may be thought that this has metamorphosed into direct State administered regulation.

The current regulatory bodies that regulate HCPs have been '*established by statute and carry out their self-regulatory functions within a legal framework ... [and] operate within a broader framework of regulation*'.⁵⁶ Regulation is governed by, and results in, rules.⁵⁷ As Allsop and Mulcahy state '*the source of these rules varies. Parliament, government departments, specialized agencies, the judicial system, professional associations, and educational institutions, through their curriculum and socialization processes, all play a part in generating and implementing rules*'.⁵⁸ Whilst for Baldwin et al, regulation in the United Kingdom is split into two elements with the rule-making powers being '*retained by central government and legislature ... [with] ... monitoring and enforcement powers devolved to ... central agencies*'.⁵⁹ Thus the notion of the HCPs self-regulating independently of the State appears to be a misnomer.

It would appear that the State sanctioned form of self-regulation is the preferred form for the current government and, by extension, society. In setting out the reforms for the new NHS in a White Paper, the then Secretary of State for Health, Alan Milburn, put forward the view that '*the Government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice*' and that '*professional self-regulation must remain an essential element in the delivery of quality patient services ... the government will continue to work with the professions, the regulatory bodies, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation by ensuring they are open, responsive and publicly accountable*'. Although the White Paper discusses 'professional self-

⁵⁶ Baggott R (2002) 'Regulatory politics, health professionals and the public interest' chapter 2 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 33.

⁵⁷ See section 1 above.

⁵⁸ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 1.

⁵⁹ Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 3.

regulation', it is clear from a detailed reading that what is being discussed is a form of State sanctioned self-regulation where standards are nationally set and responsive to changes in both the NHS and the expectations of the public.⁶⁰

Although, for Baldwin, the difference between self-regulation and State sanctioned self-regulation, with regard to State involvement, is not as great as may be initially considered, he states that '*in the end, though, such notions of independence are illusory and agencies are inevitably subject to a variety of ministerial controls. Those controls provide the thread that connects Parliament and [the] agency*'.⁶¹

It is worth noting that, although it was discussed above that State involvement in regulation results in legislation for the regulatory process, '*legislators ... may deliberately avoid setting down precise objectives because they want regulators to have the freedom to cope with problems as they arise in the future*'.⁶²

However, although it is State-sanctioned self regulation that is the current regulatory form of HCP regulation, this does not necessarily mean that the situation will always remain so. As Allsop and Mulcahy state, '*government can always threaten to introduce direct regulation if self-regulation does not work*';⁶³ whilst for Baldwin and Cave, '*self-regulation may appear to lack any State involvement but in reality it may constitute a response to threats by government that if nothing is done State action will follow*'.⁶⁴

⁶⁰ Secretary of State for Health (1997) The New NHS. Modern. Dependable. Cm 3807 The Stationery Office, London, quotation from paragraph 7.15 but see chapter 7 as a whole.

⁶¹ Baldwin R (1985) Regulating the airlines Clarendon Press, Oxford at page 253. Although Baldwin made this point in relation to the regulation of airlines, it is equally valid to all forms of regulation.

⁶² Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 78.

⁶³ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 21.

⁶⁴ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, at page 126.

Having defined and examined the nature of regulation and considered the forms that regulation can exist, as well as identifying the current form of regulation of HCPs, the next section will examine the reason for the regulation of HCPs within society.

3. Reasons for regulation of health care professionals

This section builds upon the previous by identifying the purpose of regulation in the health care context, specifically by addressing the reasons for the regulation of HCPs. It advances the thesis by providing the reason that HCPs are regulated and hence provides a starting point for assessing if that regulation is fit for purpose.

Some commentators see a case for distinguishing the regulation of HCPs from other forms of regulation. As Baldwin and Cave suggest, the regulation of HCPs is necessary for the public good and to avoid '*moral hazard*', thereby ensuring that the service is available and at the desired level.⁶⁵ This is not the only reason, as it can be argued that the public need HCPs to be regulated in order to ensure that they are competent in their professional duties, with patients needing protection from the bogus and those who are not competent or safe to practise. As Allsop and Mulcahy state, the reason for regulation of HCPs is '*the need to protect the safety of patients; to promote best practice; to minimise risk; to manage error; and to make the best use of resources in the care of patients*';⁶⁶ whilst for Moran and Woods, '*the regulation of doctors is part of a wider process of regulation that takes place in society. Medicine has its own special needs, and the medical arena has its own special interests and power structures*'.⁶⁷

Fiduciary relationships are open to abuse of power, whether intentional or not. In the health care setting, the power more usually resides with the

⁶⁵ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, see chapter 2.

⁶⁶ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 1.

⁶⁷ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 32.

HCP. They are the ones with the knowledge and skills and it is the patients requiring their services who are in a position of 'vulnerability'. Thus, regulation of HCPs exists, in part, to ensure that they do not abuse their position to their patients' disadvantage.

The particular issue relating to HCPs that does not relate to other professionals in quite the same way is that HCPs are involved in people's lives and health. The old adage is that doctors bury their mistakes. This is not as facile as it may seem. Mistakes by HCPs can, and do, result in harm to patients and ultimately their death; HCPs do not always have a second attempt to rectify an initial error. Indeed for Brazier, it is this possible chance of failure that results in HCPs being subject to the highest standards of practice and regulation, in an attempt to reduce the incidence of error,⁶⁸ whilst Allsop and Mulcahy state that, from a consumers viewpoint, *'the intimacy of the doctor-patient relationship, the potential for exploitation and the serious consequences of medical mistakes have all been given as justifications for regulation from a consumer perspective'*.⁶⁹

As Lord Cohen noted, in 1959, it is *'the protection of the public by the provision of skilled trained nurses'* that is the primary role of the General Nursing Council, a precursor of the current nursing regulatory body the Nursing and Midwifery Council (NMC), and thus, by analogy, the role of all HCP regulatory bodies.⁷⁰

Indeed, this is echoed and expanded by the House of Lords who see that *'the principal purpose of regulation of any healthcare profession is to protect the public from unqualified or inadequately trained practitioners. The effective regulation of a therapy thus allows the public to understand where to look in order to get safe treatment from well-trained*

⁶⁸ Brazier M (2003) *Medicine, patients and the law* 3rd edition Penguin Books, London, see pages 6 to 10.

⁶⁹ Allsop J & Mulcahy L (1996) *Regulating Medical Work: formal and informal controls* Open University Press, Buckingham, at page 12.

⁷⁰ *General Nursing Council for England & Wales v St Marylebone Borough Council* [1959] AC 540.

practitioners in an environment where their rights are protected. It also underpins the healthcare professions' confidence in a therapy's practitioners and is therefore fundamental in the development of all healthcare professions'.⁷¹

Confirmation that public protection, in particular patient protection, is the basis for HCP regulation is provided by the Department of Health. Indeed they cite this as the reason for the expansion of regulation to cover complementary therapies and the regulation of unqualified health care workers.⁷²

With regard to the reason for regulation, the Kennedy Report states that it is *'for assuring and improving the safety and quality of healthcare'*.⁷³ Remembering that the Kennedy Report⁷⁴ arose out a Public Inquiry into what was perceived as a failure in the NHS, it is worth noting Hancher and Moran's opinion that *'regulation almost always happens because some sense of crisis is precipitated'*.⁷⁵ The regulation that is then put in place aims to avoid similar crises in the future. This then links to the main reason that is put forward for regulation, that of pursuing or protecting public interest and thus ultimately society itself.⁷⁶

However, how to achieve this and what needs to be regulated to achieve this is open to debate. This debate and competition, regarding the nature of public interest and therefore the form of regulation needed to protect it,

⁷¹ House of Lords Select Committee on Science and Technology (2000) Report on complementary and alternative medicine The Stationery Office, London, at paragraph 5.1.

⁷² Department of Health (2004) Press release 2004/0086 'New package of regulation puts patient safety at heart of all health packages' 2nd March 2004.

⁷³ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 261.

⁷⁴ Ibid.

⁷⁵ Hancher L & Moran M (1998) 'Organizing regulatory space' chapter 3 in Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford, at page 160.

⁷⁶ For instance see Van den Bergh R (1993) 'Self-regulation in the medical and legal professions and the European internal market in progress' in Faure et al (1993) Regulation of professions Maklu, Antwerp.

can result in the failure to protect the public interest.⁷⁷ It is therefore important that there is consensus in the objective of the regulation and the manner in which it is to be achieved. From the above, it can be seen that the primary objective of regulation of HCPs is patient safety, and hence public safety, and regulation is primarily aimed at achieving this - the '*assuring and improving the safety and quality of healthcare*' of the Kennedy Report.⁷⁸ However, there are a number of different elements of the mechanism of HCP regulation that could be considered to protect patients and the public.

The precise regulatory elements that will be utilised to achieve the overall aim of regulation will be considered in section 4 below. This further examination of the elements needed within the regulatory process will provide focus in determining whether the regulation that is currently in place fulfils its objective and whether the hypothesis of this thesis is borne out.

3.1 Summary – reasons for the regulation of HCPs

The above discussion has outlined various reasons why HCPs are regulated. To clarify, it may be useful to consider the situation that would exist for the public if regulation were not in place.

It can be argued, as discussed above, that the regulation that exists is there for both public protection and patient safety. That regulation is the framework within which safe practice occurs. Therefore if this regulation did not exist there would be either no public protection and patient safety, or a severely reduced form of protection.

If the regulation were not in place there would be no nationally agreed minimum standards for HCP conduct, no opportunity to check whether

⁷⁷ Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, see chapter 3.

⁷⁸ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 261.

HCPs were competent and if the adverse event occurs the patient's only recourse would be through the civil system of the courts.

Regulation may be said to exist to form a balancing act between the needs of HCPs to undertake their clinical practice with autonomy and the ability to advance their practice and the protection of the public and patient safety through minimum standards and safe practice protocols, and through the knowledge that the HCP is competent within their speciality. It is this that is meant when the term 'fit for purpose' is used throughout this thesis; that the regulation does provide public protection and patient safety, but also that the regulation provides for the clinical autonomy of the HCP that it is regulating.

4. What is being regulated

Whilst the above has addressed the issues of the nature of regulation and the reasons for regulation, in particular the reason for the regulation of health care and HCPs, this does not answer the question regarding what is being regulated. The protection of the public and patient safety are laudable aims for the regulation of HCPs, and indeed are ones that the regulatory bodies of the HCPs see themselves as addressing.

The websites of the various HCP regulatory bodies all have brief 'mission statements' on their home pages that address these to one degree or another. For instance the GMC statement is '*Regulating doctors. Ensuring good medical practice*';⁷⁹ the NMC's states '*Protecting the public through professional standards*';⁸⁰ whilst the Health Professions Council states '*We are a regulator and our job is to protect the health and wellbeing of people who use the services of the health professionals registered with us. At the moment, we register members of 13*

⁷⁹ General Medical Council website homepage at <http://www.gmc-uk.org/> accessed on 2nd December 2007.

⁸⁰ Nursing & Midwifery Council website homepage at <http://www.nmc-uk.org/> accessed on 2nd December 2007.

professions. We only register people who meet our standards for their professional skills, behaviour and health'.⁸¹

However, the actual specific elements of regulation are not that easily determined and it is difficult to see how one could regulate specifically for the overall aims without identifying specific phenomenon as the subject of the regulation. The precise issue being, what exactly will affect public protection and patient safety, and be capable of being subject to regulation?

It is this question, of what exactly is being regulated in order to protect the public and promote patient safety that this section examines.

This thesis addresses the question of whether the current regulation of HCPs is fit for purpose, that is, does it present an effective and efficient means of regulation without restricting the clinical autonomy of the HCPs that it is regulating?

The research for this thesis commenced against a background of a loss of public confidence in, at least, some HCP groups. There were public inquiries being undertaken in to the events that had occurred at the Bristol Royal Infirmary,⁸² as well as the scandal of the Shipman affair and the subsequent public inquiry.⁸³

Against this background it was initially envisaged that the Kennedy Report⁸⁴ would prove to be an ideal starting point as a focus for professional regulation as it made a number of conclusions and recommendations with regard to the framework within which HCPs

⁸¹ Health Professions Council website homepage at <http://www.hpc-uk.org/> accessed on 2nd December 2007.

⁸² See the Bristol Royal Infirmary Inquiry website at <http://www.bristol-inquiry.org.uk/index.htm> accessed on 10th May 2008.

⁸³ See The Shipman Inquiry website at <http://www.the-shipman-inquiry.org.uk/> accessed on 10th May 2008.

⁸⁴ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

should be regulated. In addition, the definition of regulation provided within the Kennedy Report⁸⁵ acknowledges the points made above, for instance that regulation ‘*is a broad term*’,⁸⁶ and can be either economic or social in its outlook. This is best summarized through the statement ‘*by regulation, we do not refer to the various economic approaches, such as through the market. Instead, we mean the totality of the processes and systems for assuring and improving the safety and quality of healthcare, including the regulation of healthcare professionals and the regulation of the institutions in which they work*’.⁸⁷ It is important to note that this thesis is concerned with only the first of the two categories mentioned, that of the health care professional, and not health care institutions.

There is also tacit acknowledgement that regulation can comprise anything that controls an activity. A feature of the definition from the Kennedy Report⁸⁸ is that any process or any system that has been put in place can be seen as a type of regulation.

As well as fulfilling the definitions of regulation provided above, the definition provided by the Kennedy Report⁸⁹ was also being utilised because it was contemporaneous - having been published in 2001, it arrived as the research for this thesis was in its infancy; it has a legal perspective, in that it sees regulation as being based upon a system of rules; it remains applicable as a working definition; and, it is a definition that may be said to have the same contextual basis as this thesis, regulation within the health care arena, in particular how HCPs are regulated and controlled.

However, as will be seen in Chapter 4, this is not a valid definition for examining regulation of HCPs as it is too broad in its scope. It covers too

⁸⁵ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

⁸⁶ Ibid, at page 314.

⁸⁷ Ibid, at page 261.

⁸⁸ Ibid.

⁸⁹ Ibid.

much, seeing regulation as the sum of all *'the processes and systems for assuring and improving the safety and quality of healthcare'*.⁹⁰ Thus, any and all activities that limit, restrict, control or enable a HCP may be said to be a form of regulation. Within this thesis, this definition of regulation will be known as the wide definition or approach to regulation.

Ultimately this wide definition of regulation could lead to an analysis of regulation that does not have a clear focus or one that is lacking in analytical rigor. Rather the analysis that would be presented would be one that has superficiality as its key feature.

4.1 The definition of regulation adopted by this thesis

Rather than utilise the wide definition of regulation, for the reasons made above, this thesis will utilise what it terms the narrow definition of regulation. As the name suggests, the narrow definition does not see regulation as being all encompassing, instead it sees regulation in terms of those bodies or organisations that have been enacted for the specific purpose of regulation of a specified and defined group; a group who they oversee and control. This is distinct from professional bodies, such as the British Medical Association and the Royal College of Nursing, which do not have a statutory mandate to undertake this function, rather they provide support and guidance for their members.

Within this thesis the narrow definition refers to those bodies which have been formed through statutory provision and have specified functions with regard to their respective health care professions; for the medical profession this is the GMC,⁹¹ whilst for the nursing profession this is the NMC.⁹²

In analysing whether the regulation of HCPs is fit for purpose, this thesis will undertake an examination of the GMC and NMC to determine whether

⁹⁰ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 261.

⁹¹ Medical Act (1983) (consolidated version with amendments).

⁹² The Nursing and Midwifery Order 2001 (SI 2002/253).

the regulation that they exert upon their respective professions is effective and efficient in achieving its primary aim of public protection and patient safety, as well as having both a controlling and enabling aspect for the HCPs themselves.

4.2 The five elements of regulation

In order to achieve their regulatory purpose and aim, the two professional regulatory bodies, the GMC and the NMC, must undertake specific activities with regard to the HCPs they regulate. This section will examine the specifics of the regulatory process.

It was noted above that the wide definition of regulation put forward by the Kennedy Report⁹³ may be said to lack a clear focus in terms of analysing regulation and its effectiveness.

However, the Kennedy Report⁹⁴ does provide pertinent guidance on some of the elements that need to be regulated to ensure and maintain *'the safety and quality of healthcare'*,⁹⁵ that is public protection and patients safety in the health care arena, the purpose of regulation for this thesis. *'The regulation of healthcare professionals, historically largely associated only with discipline, involves all matters affecting the performance of the professional. It covers, therefore, initial education, training, appraisal, continuing professional development and, where relevant, disciplinary action'*.⁹⁶ Other elements are said to include: *'competence of healthcare professionals'*;⁹⁷ *'revalidation'*;⁹⁸ *'the capacity to deal with poor performance and misconduct'*;⁹⁹ being able *'to identify and act on failing or poor performance'*¹⁰⁰; and, *'registration'*.¹⁰¹

⁹³ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

⁹⁴ Ibid.

⁹⁵ Ibid, at page 261.

⁹⁶ Ibid, at page 314 - 315.

⁹⁷ Ibid, at page 332.

⁹⁸ Ibid, at page 332.

⁹⁹ Ibid, at page 333.

¹⁰⁰ Ibid, at page 333.

¹⁰¹ Ibid, at page 446.

It was stated above that regulation is the framework within which safe practice can occur. Thus there has to be an agreed safe standard that HCPs can work to, the minimum standard that they have to achieve in order to be able to provide care to the patient that advances the patient's treatment and progress and not hinder it. This could be established through the setting of rules, for instance through the use of protocols which have to be followed for specific treatment, or through guidelines that allows the HCP to use their clinical judgment provided that they act within the parameters which are considered to reflect safe competent practice, or a combination of the two.

The public and, specifically, patients are entitled to know that the person who is treating them, the HCP, has undertaken appropriate training and education that allows them to undertake that treatment competently; whether this be through the establishment of training and education that is directly under the direct control of the regulating body or through the establishment of competencies for practice, or the establishment of competencies for entering the profession.

There also needs to be a way of ensuring that HCPs are kept up-to-date and undertake practice that is contemporary

There also needs to be some form of control over those HCPs who do not comply with the agreed standards or whose practice leads to complaints from those who they treat.

From the above, five elements of regulation are advanced as being key in achieving the primary objection of regulation: the protection of the public and patient safety. These five elements are: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practise. These five elements will be known within this thesis as the narrow definition or approach to regulation. It is this narrow definition of regulation that will form the

focus of analysis and examination within this thesis. The five elements will be revisited in Part 3 where the regulation that currently exists will be assessed against them to determine whether it is fit for purpose.

5. Regulation as enabling

In section 1 above, it was noted that regulation was based upon an element of control, restriction and constraint by another agency; with regard to the subject matter of this thesis, the HCP, this suggests a loss of freedom of the HCP to perform their role unchallenged, with an agency external to the HCP undertaking this control.

In this sense regulation is perceived as a negative, indeed the very words that are used in its definition.¹⁰² Words such as control, govern, direct, rule, reduce, restrict and prescribe may be said to be negative words and the antithesis of the culture of those who are being regulated in health care, the HCPs, who have their emphasis on fostering the therapeutic relationship with their patients and clients.

However, regulation does not have to be a negative phenomenon or all one-sided. For regulation can be a positive aspect of health care; it can be a phenomenon that is enabling as well as restricting.¹⁰³ It enables the HCP to undertake their role without interference so long as certain procedures are followed, and is restricting in that if these are not followed then the freedom of the HCP will be reduced. In addition, regulation can be based either upon sanctions for breach or on incentives to follow the agreed principles, the so-called punishment or reward models noted in section 1.¹⁰⁴

¹⁰² Onions C T (ed) (1984) The Shorter Oxford English Dictionary Clarendon Press, Oxford.

¹⁰³ For instance see Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford, especially the introduction, and Harris P (1997) An introduction to law Butterworths, London, especially chapter 12.

¹⁰⁴ Baldwin R, Scott C & Hood C (eds) (1998) A Reader on regulation Oxford University Press, Oxford.

The positive aspects of regulation encompass the fact that it is the regulatory framework that provides the HCP with the ability to practise their clinical ability; that, if it were not for the registration that is required by the GMC and the NMC, they would not be able to practise. It is the registers of the GMC and the NMC that enable their respective HCPs to register their competence and allow them to undertake their professional practice. The regulatory framework provides safe, effective and competent practitioners with status and power, through clinical autonomy. It also allows the professional groups to have an agreed understanding of what is meant by clinical competence and the standards that are required for them to maintain their registration. It supports those HCPs who are hampered in their ability to undertake competent practice so that they can rely upon their regulatory body's rules to insist upon their right to practise competently.¹⁰⁵

In essence, regulation is a trade-off between the negative aspects of having to be regulated and perform certain obligations, for instance clinical updating, in return for the positive aspects of clinical autonomy.

It was stated above, in section 3, that the reason for, and primary objective of, regulation of HCPs was the protection of the public and patient safety. Yet, should the protection of the public and safety of patients be the sole consideration in the regulation of HCPs? Should the advancement of the health care professions also be a consideration? Should the protection of HCPs from interference, for instance in the form of restriction of clinical judgment, not also be an aim of regulation?

Protecting the public and promoting the professional interest of HCPs should not have to be mutually exclusive in terms of the regulation of HCPs.

¹⁰⁵ For instance those HCPs who are requested to undertake activities that conflict with their codes of conduct can refer their employers to their codes of conduct when refusing to comply with such requests.

As will be seen in Chapter 3, the status accorded to the profession and thus by extension to individual HCPs is beneficial to those HCPs. By virtue of their professional status, HCPs are given clinical autonomy to undertake their practice. It would be an absurd situation for that autonomy and clinical judgment to be removed by the regulation to which they were exposed. Were society to impose, through the use of the regulatory framework, a system that prevented the development of the professions and innovation in health care it would be harmful for society as well as restricting for HCPs. Whilst regulation should provide guidance for HCPs, it should not be so restricting that it removes the ability of the HCP to perform their clinical function autonomously provided that they are practising safely and effectively.

Therefore it is a contention of this thesis that the objective of regulation is both the protection of the public and patients safety, but also the protection and advancement of the profession through the protection of clinical judgment and autonomy.

Conclusion

This thesis proposes that regulation of HCPs is needed to protect the public in general and patients in particular.

Regulation is the framework within which safe clinical practice can occur. It does this through protecting the titles of HCPs and limiting their use to those who achieve registration with the appropriate regulatory body; providing rules and standards and a basis for the education structure that supports initial registration; outlining the minimum standard that must be achieved for clinical competence; agreeing the safe standard for performance; and establishing and implementing rules and procedures regarding a HCPs fitness to practise, including disciplinary processes and procedures.

The regulatory process is there to set and uphold the standards of professional practice. Those subject to its control need to know to whom

they are accountable, for what they are accountable, and any possible liabilities to which they are subject, and the process itself needs to be scrutinised against clear and readily available criteria.

Regulation should be led by the profession themselves, it should be the profession that agrees the standard that is required of all those who wish to practise within the sphere of that profession. Where the profession is unable or unwilling to regulate itself, the State needs to agree the way that the regulation is to be achieved.

Additionally regulation does not have to be an entirely control based entity, if it were, then it could be argued that the regulation as not fit for purpose as it only addressed one side of the regulation requirement, that of the control of HCPs and not the other side of enabling the HCP in their clinical roles. It is the interplay between the two sides of regulation, the controlling and the enabling that will be examined throughout this thesis in order to address the hypothesis that current regulation of HCPs is not fit for purpose.

Having examined the nature and purpose of regulation in Part 1, Part 2 of this thesis advances the hypothesis by providing the context within which the regulation of HCPs occurs, considering the environment within which this regulation occurs and who are being regulated. Following this context setting, Part 3 considers the actual ways in which HCPs are regulated.

Part 2

Setting the context of the thesis

Introduction to Part 2

Having examined the concept of regulation in Part 1, in order to determine whether the central hypothesis of this thesis, that the current regulation of health care professionals (HCPs) is not fit for purpose, is correct, it is vital to set the context in which HCPs operate.

Part 2 sets the context of this thesis in two ways. Chapter 2 examines the context within which HCPs undertake their roles and duties, that of the health services within which HCPs work. As the Kennedy Report observes, 'currently the State is virtually the monopoly provider of health services in this country'.¹ Therefore within this chapter the origins and structure of the National Health Service (NHS) are discussed, and the various reviews and reforms of the NHS are presented so that the changing context of health care can be examined to observe the changes and influences upon health policy that affect the working lives of HCPs. The nature of the current NHS is explored, including the size of the NHS, the introduction of non-NHS provision of health care, together with a discussion of treatment abroad within an NHS framework.

It is argued that it is the context in which the regulation occurs that has contributed to the regulatory framework that currently exists.

Chapter 3 analyses what it means to be a HCP. As Chapter 1 noted, the reasons for regulation within a health care context is that of public protection and patient safety when receiving health care. It is HCPs who deliver this health care.

Chapter 3 explores the notion of what it means to be a professional, and in particular a HCP. It presents the definition of HCP that will be used throughout the thesis. Following on from this it analyses the roles and functions of HCPs, utilising doctors and nurses as case studies as these are the most numerous and public of the HCP groups, from a traditional

¹ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 316.

viewpoint and then, following an investigation of the blurring of boundaries between HCPs, it analyses the contemporary view of HCPs roles and functions. The chapter concludes with a discussion of the roles of other health care workers.

It is further argued that the professional status and power differences of the various health care professions have contributed to the regulatory framework that currently exists. In addition, the changes in the roles of HCPs in recent years have contributed to the regulatory framework currently affecting HCPs.

This Part of the thesis therefore provides the context for this thesis by examining where regulation occurs and who is regulated.

For the purposes of this thesis, the definition of health care is taken to be that as defined within the Health and Social Care (Community Health and Standards) Act 2003 section 45(2): *'services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and the promotion and protection of public health'*.²

² Health and Social Care (Community Health and Standards) Act 2003 section 45(2).

Chapter 2

The context of health care

Introduction to chapter 2

There are two types of health care system, the private and the public. The private or independent system of health care is driven by the forces of the market, those of supply and demand. The public system is that of the National Health Service (NHS). It is one of the foundations of the welfare state. For most people, the NHS is the health care system. They will have no dealings with the private system of health care.¹ Since its inception, the NHS has been run by a Department of State, headed by a Secretary of State, and, as such, is a function of government. Therefore, this chapter will firstly examine the origins and structure of the NHS.

The NHS has continued to be overseen by a government minister, despite numerous reviews and reforms of the NHS structure since its establishment in 1948. All of these reviews and reforms have left their legacy on the current NHS and upon the current regulatory processes and framework to which health care professionals (HCPs) are subject. Writing in 1996, Allsop & Mulcahy stated that *'since the 1990 health service reforms, writing about the NHS is like shooting at a moving target. The changes which were introduced ... are still reverberating through the system. The provision of health care is now increasingly diverse and fragmented'*.² This is probably even more accurate, in today's changing climate of health care delivery and rolling targets of performance-led management, than when it was written.

Therefore, this thesis will consider the changing context of health care and some of the changes in health care policy, through the various NHS Reforms and the Committees that have examined and transformed the structure of the NHS, resulting in the present incarnation of the NHS. Several selected reviews and reforms will be examined and discussed to demonstrate the ways in which the NHS adapts to the changing demands of society and moves itself forward.

¹ See Ham C (2004) Health policy in Britain 5th edition Palgrave, Hampshire at page 37 - 38.

² Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham at page 1.

The chapter concludes with a discussion of the current NHS, including its current structure, its size and examples of the way in which the current NHS is unrecognisable from the original incarnation.

The concern of this thesis, that of the regulation and control of HCPs, does not occur within a vacuum. There is a contextual element to the regulatory framework that exists, even, if as hypothesised, this framework is not fit for purpose.

By examining the structure of the NHS, this chapter addresses the question of what health care is and where it occurs; thereby, presenting the contextual influences upon the regulation of HCPs from the viewpoint of the framework in which health care professionals work. As will be seen, most HCPs work within the NHS, which is directly under governmental influence. The structure of the NHS is consequently a major influence upon HCPs and their regulation.

Changes in the structure of health care and in health care delivery, whether within the NHS or not, have resultant changes upon the type of regulation of HCPs that is needed to ensure public safety.

1. Origins and structure of the NHS

In the last twenty years, it may be said that there have been more reforms and reviews of the NHS than at any other time in its history; although, since its inception, the NHS has undergone at least 17 major reorganisations in its structure.³ In addition, with the differences in health care provision across the four countries of the United Kingdom (UK), there has been an increasing complexity in the overall delivery of health care within the UK.⁴

³ Davis C (2002) 'Change Fatigue' *Nursing Times* vol. 98 no. 2 p. 23 – 24.

⁴ As noted earlier in the introduction to this thesis, the scope of the thesis concentrates upon England; although within this chapter, there will be general discussion that encompasses the other countries of the UK where relevant.

All this indicates the constantly changing world in which health care professionals are expected to perform; a world in which constancy and consistency are exchanged for the ever-driving processes of change and reform. However, prior to discussing the reforms that have taken place within the NHS, this thesis begins by looking at the formation of the NHS, examining the original premise and structure upon which the reforms have been imposed.

The NHS came into existence on 5th July 1948. It had not been an easy gestation, with a long period of debate and discussion. The NHS heralded a revolution in health care within the UK, as it resulted in the expansion of the then current health services, overseen by a new national co-ordination of these services, coupled with a social philosophy of health and social welfare.

1.1 Health Care before the NHS⁵

Although the NHS was created in the 1946 Act⁶, a health service of sorts has existed since the Poor Law Amendment Act 1834, which provided free medical treatment for the poor who were sick. The National Insurance Act 1911 provided primary health care through private insurance companies but no hospital services were provided under this Act and its provision did not extend to dependents, or to those who did not work. However, the services provided under the 1911 Act may be said to provide the basis for the general practitioner services in the National Health Service Act 1946, and compulsory national insurance. Thus, the situation before the NHS was one of free care for the destitute, although limited in its scope and availability, some provided by local authorities and others by charitable organisations; state insurance, that was available to workers only; and, mutual societies, friendly societies and private insurance schemes. A system that was as inadequate as it was baffling.

⁵ I am indebted to Rivett G (1997) From cradle to grave: fifty years of the NHS King's Fund, London, for background information in this section.

⁶ National Health Service Act 1946.

Prior to the NHS, the hospital service in the UK was one of two kinds, the voluntary and the municipal. The voluntary hospitals had their origins in the monasteries and were the early teaching hospitals. They provided most of the medical services and virtually all of the teaching facilities for training doctors and nurses. Although voluntary, patients would pay what they could for the services they required, trade unions helped pay for their members and, in the case of the teaching hospitals, the poor patients were subsidised by the wealthier private patients. The local authorities also subsidised the voluntary hospitals, as well as maintaining the municipal hospitals, which were required to take anyone requiring treatment.

The municipal hospitals emerged from the Victorian poor law system and the workhouses, until they came under the administration of the local authorities.

In 1938, a precursor of the NHS emerged in the form of the Emergency Medical Services, established in the anticipation of the vast number of casualties expected during the imminent war.

It was in 1942 that the 'Report on Social Insurance and Allied Services' (The Beveridge Report)⁷ was published. It provided the foundations of social legislation in the post-war period; the main emphasis of which was the notion of social welfare and health security for all, the so-called 'cradle to grave' approach to social welfare. The report identified five great 'evils': idleness, homelessness, want, ignorance and disease. Interestingly, the report took the view that the need for health care would diminish as the NHS treated the backlog of untreated illnesses that existed at its formation and individuals in the UK became healthier.

The formation of the NHS was no mean feat; it involved negotiations with competing professional groups and with groups whose interests clashed with the notion of a national health service for all, such as The Royal

⁷ Beveridge W (Chair) (1942) Report on Social Insurance and Allied Services Cmd 6404 HMSO, London.

Colleges and the British Medical Association. Beveridge was forced to compromise with doctors and their representatives, such that they were able to place themselves in the favourable, and powerful, position of being able to influence policy-making in both the formation of the NHS and in future reforms. In the first instance, they were able to obtain concessions for the retention of private beds, merit (financial) awards for doctors, independence of teaching hospitals, and an assurance that doctors (General Practitioners especially), unlike nurses, would not be salaried employees of the State.

The guiding principles and aims of the NHS were that access to health services was to be comprehensive, encompassing the ‘*cradle to grave*’ approach to care⁸, and it was to be ‘*free of charge*’⁹. The cost of providing the health services was to be financed mainly through taxation.¹⁰

1.2 Structure of the NHS at its inception

At its inception, the NHS was a different entity to the one in existence today. It was certainly simpler in overall structure of provision and had a more straightforward management system, as will be demonstrated.

Whilst it may be said that there was a nationalisation of the voluntary and municipal hospitals; it may be equally said that a true unification of health care was not achieved as there was a tripartite system put in place; this consisted of Local Authorities, the General Practitioner Services that controlled access to specialist services and hospital services.

The reporting/accountability structure had the Ministry of Health, which was established in 1919, at the top with the Minister of Health having responsibility for the provision of services. Aneurin Bevan, who has been

⁸ Lim J M E (1998) ‘The importance of social context’ British Medical Journal vol. 317 p. 51 – 52.

⁹ National Health Service Act 1946 section 1(2). Although it should be noted that the Act allowed for charges to be made (section 1(2)) e.g. section 44 for dental and ophthalmic services in certain circumstances.

¹⁰ So although the use of services was to be paid for through the taxation system, it would be free at the point of use, thereby encouraging the populace to seek the health care assistance they needed without the need for consideration of the cost of that service.

described as ‘*the founding Father of the NHS*’¹¹, was the first Minister of Health in the UK.

Below the Minister of Health, the provision of health services was separated into three distinct areas. These were hospital services, local health authority services, and family practitioner services which included general medical services (commonly known as general practitioners), dentists, ophthalmic and pharmaceutical services.

The following diagram shows the structure in place at the start of the NHS and relationships between the three divisions of the NHS.

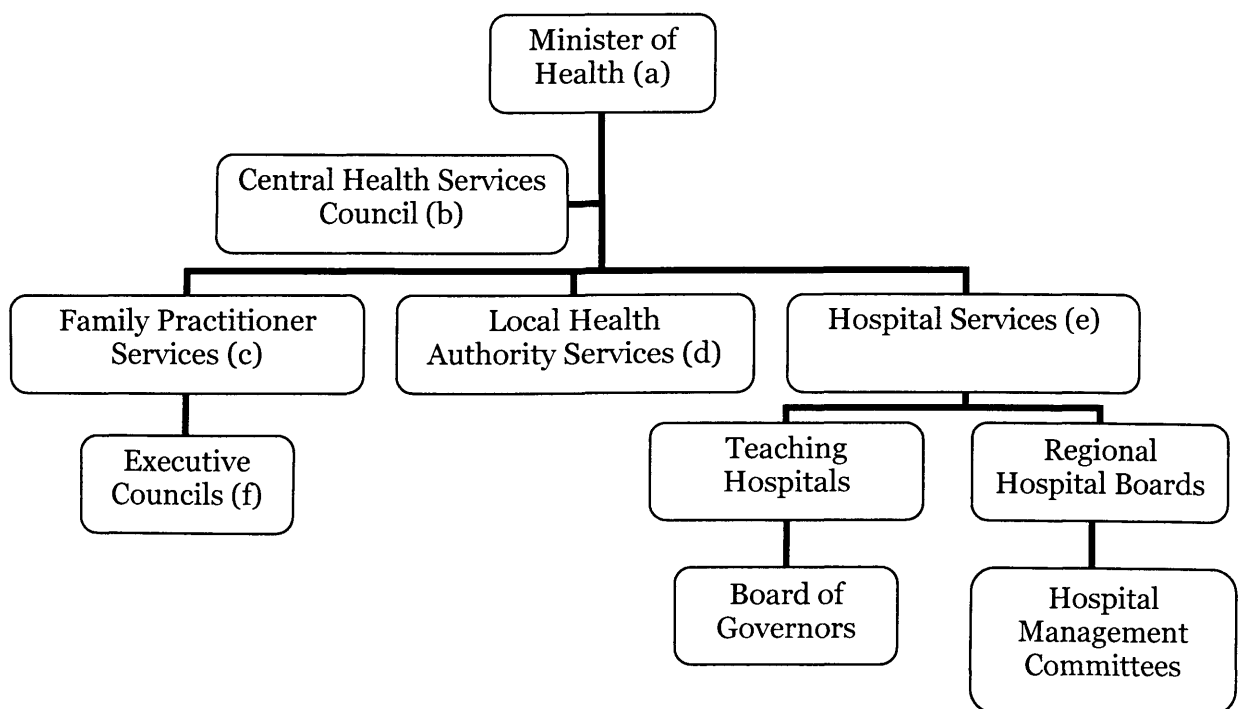


Diagram 1 Structure of the National Health Service 1948¹²

¹¹ Pierce A (2004) ‘Ward where NHS began faces closure’ *The Times* News Section 17 July 2004 p. 7.

¹² Notes to diagram 1:

a – the duties of the Minister of Health are detailed in National Health Service Act 1946 section 1

The NHS has essentially two sides: a policy side and a clinical side. Although both will be examined, it may be helpful at this point, before looking at the changes in the NHS structure, below, to describe the three parts to the clinical side of the NHS. These are the Primary, Secondary and Tertiary care settings. Primary care refers to the initial form of health care, what may be called the 'front-line' of health care. It is that part of health care that patients are able to access themselves: including general practitioners, dentists, opticians, pharmacists, health centres and minor injury centres. Secondary care refers to that which takes place in hospitals and patients are unable to access these services without first being referred by a general practitioner (GPs) or another member of the primary health care team; an exception to this is the Accident and Emergency Department. Tertiary care is the specialised form of secondary care, for instance oncology centres or trauma centres.

Diagram 1 clearly shows the structural separation of the three clinical elements of the NHS at its inception. The boundaries between primary/secondary care can be seen to have been set up in the original NHS structure. It has been said that this separation has resulted in a lack of integration in the delivery of health care and has continued ever since in all NHS reforms.¹³

b – the Central health Services Council was an advisory body that advised on any aspect of the National Health Service Act 1946 to the Minister of Health as detailed in National Health Service Act 1946 section 2

c & d represent primary care with e representing secondary care.

d – Local Health Authority Services are constituted under National Health Service Act 1946 Part III; they are responsible for health centres (section 21), maternal and child welfare (section 22), midwifery services (section 23), health visiting (section 24), home visiting (section 25), vaccination and immunisation (section 26), ambulance services (section 27), prevention of illness (section 28) and domestic help (section 29).

e – the provision of hospital services are detailed in National Health Service Act 1946 section 3. They are separated into teaching hospitals (g on diagram, administered by a Board of Governors (National Health Service Act 1946 sections 11 and 15)) and non-teaching hospitals (h on diagram, administered by a Hospital Management Committee (National Health Service Act 1946 sections 11, 12 and 13))

f – Executive Councils are constituted under National Health Service Act 1946 Part IV; they are responsible for GPs, Dentists, Pharmacists and Ophthalmic services.

¹³ *'Bevan's decision to take all the hospitals, voluntary and municipal, under government control also had the effect of creating a health service in three parts: hospitals, general practitioners, and community health. Since then these three have existed in separate columns like silos that have nothing to connect them...the NHS has*

It was not just the fragmentation of health care that has existed since the inception of the NHS, the relationships between the various health care professionals may be said to be affected by the initial structure of the NHS and the process by which the NHS was established. Management processes and regulation, in its widest sense, may also be said to be directly affected by the negotiation processes that led to the inception of the NHS and by the structure of the NHS at its inception.

Although these points will be addressed later in this thesis, the following examples will highlight how the status given to various health care professionals in today's NHS can be seen in the fledgling NHS.

Consultants had high prestige in the new NHS system, they were able to undertake private practice;¹⁴ indeed the NHS may be described as a consultant-led service. Portillo believes that this was because Bevan '*was convinced that he needed the hospital consultants on his side and so gave them the right to have private patients and allowed pay beds in NHS hospitals*'.¹⁵ The status enjoyed by general practitioners was unique in the new NHS. They were independent of local authorities and, instead of being civil servants, were self-employed.¹⁶ Thus, the medical profession may be said to have been treated differently, given extra prestige and status, from others in the NHS. Indeed it may be said that the medical profession was able to exert a power relationship over other HCPs that exists to this day because of the political power they exerted in being able to delay or prevent the commencement of the NHS. The relationship between parts of the NHS management structure was also not on an even keel. Teaching hospitals gained extra prestige from their independent

lived with this lack of integration ever since' Portillo M (1998) 'The Bevan Legacy' British Medical Journal vol. 317 p. 37 – 40 at page 39. Also, '*the old NHS was a fragmented financial and organisational structure with deep divides between primary care, consultants and hospitals*' Feachem R & Sekhri N (2005) 'Moving toward true integration' British Medical Journal vol. 330 p. 787 – 788 at page 787.

¹⁴ National Health Service Act 1946 section 5(2).

¹⁵ Portillo M (1998) 'The Bevan Legacy' British Medical Journal vol. 317 p. 37 – 40, at page 38.

¹⁶ '*to general practitioners he conceded ... their self-employed status, with payment mainly through capitation fees*'. Ibid, at page 38.

status as opposed to other hospitals which were taken over in their entirety and subject to central management.

2. Reviews and reforms of the NHS following its inception

Throughout its history, the NHS has not been an entity that stands still, one that does not respond to changing demands, rather it has been a creature of change, and has been subject to numerous reviews and reforms. Since the formation of the NHS, successive governments have developed initiatives that have transformed the NHS for a variety of reasons. Some of these have been ideological, whilst others have been financial, others still have been to adapt the NHS to changing demands and allow it to perform its original function of providing health care to those who need it in a modern society with different views and demands. Whatever the reason for the initiatives that have resulted in reform, reform has occurred. The modern NHS is, in many ways, unrecognisable to that introduced in 1948.

This section of the thesis will highlight the types of review and reform that the NHS has been subject to in its history, as well as identifying key reviews, reforms and some of the numerous changes that have occurred in the NHS resulting in significant changes, arguably moving it forward. The reason for discussing previous reform of the NHS is that, it is argued, change in the NHS affects the regulation of health care professionals. Not all NHS reforms, reports or legislation will be considered here, such is the nature and number of reviews and reforms it could take a whole thesis to examine these alone. However, where appropriate, reports and legislation will be considered in later chapters.

2.1 Changes in NHS structure

The NHS was able to survive mainly intact, in the same structure as at its inception, until its first major reorganisation that occurred in 1974.¹⁷ Prior to this, any reorganisation was of a part of the NHS and not of the whole. For instance, the Briggs Committee undertook a review of British nursing

¹⁷ Hart C (1997) 'The market leader' *Nursing Times* vol. 93 no. 28 p. 42 – 44.

in 1970s, recommending that nursing should become research-based and that training would be more effective if undertaken in a clinical setting.¹⁸

As stated earlier there have been numerous changes to the NHS since its inception, one of the first changes to affect the NHS was that of the introduction of charges for some of its services. Although, the National Health Service Act 1946 made provision for charges to be levied²⁰, it wasn't until 1951 that NHS charges were introduced for spectacles and dentures, with prescription charges being introduced in 1952.²¹ Prescription charges were abolished in 1965 and reintroduced in 1968 and stayed ever since, at least in England.²² Thus, one of the founding principles of the NHS, that of health care free at the point of use, can be said to have lasted in its totality, for only 4 years, though it must be stated that most health care was, and is still, free at the point of use.

The financial state of the NHS was examined further in the Guillebaud Report of 1956 which concluded that the NHS was efficient and in need of more resources and not less, as was thought to be the case at the time.²³

The tripartite structure of the NHS with its division of clinical services has been the subject of much debate and resulted in a number of reviews²⁴ to

¹⁸ Briggs A (Chair) (1972) Report of the Committee on Nursing Cmdnd 5115 HMSO, London.

²⁰ National Health Service Act 1946 section 1. Although it should be noted that the Act allowed for charges to be made (section 1(2)) e.g. section 44 for dental and ophthalmic services in certain circumstances.

²¹ Rivett G (1997) From cradle to grave: fifty years of the NHS King's Fund, London see page 112.

²² Eversley J (2001) 'The history of NHS charges' Contemporary British History 15 (2) p. 53 – 75, particularly page 56. In comparison in Wales, since April 2007 prescriptions are free for all.

²³ Guillebaud C (Chair) (1956) Report of the Committee of enquiry into the cost of the national health service Cmd 9663 HMSO, London.

²⁴ These reviews included British Medical Association (1962) Report of the Medical Services Review Committee (The Porritt Committee) British Medical Association, London which called for unification of the three of the three parts of the NHS; Ministry of Health (1968) The National Health Service: the administrative structure of the medical and related services in England and Wales (The Robinson Report) HMSO, London, proposed the abolition of regional hospital boards, executive councils, boards of governors and hospital management committees and the introduction of area boards acting as a single authority for the three services; Department of Health and Social Security (1970) National Health Service: the future structure of the National Health Service in England. (The Crossman Report) HMSO, London, recommended a unified system of health service

examine the current structure and recommend improvements, throughout the history of the NHS. These reviews led to the National Health Service Reorganisation Act 1973, which provided the legislation for the first major reorganisation of the NHS since its inception.²⁵ On 1st April 1974, the reorganised structure of the NHS became operational. The reorganisation created management structures, in England, at regional and area level with fourteen Regional Health Authorities and ninety Area Health Authorities being created.²⁶

In 1980, further restructuring of the NHS in the UK occurred with the Health Services Act that abolished the ninety Area Health Authorities created in 1974 and created one hundred and ninety-two District Health Authorities.²⁷ The District Health Authorities were operational on 1st April 1982 and had direct management of hospitals. Then, in 1995, the fourteen Regional Health Authorities were replaced by eight Regional NHS Executive Offices, whilst District Health Authorities and Family Health Service Authorities were merged to form one hundred Health Authorities.²⁸ Further structural reform will be discussed below in section 3.

The primary-secondary care divide that was created in the original 1948 NHS structure has been the subject of various reports and reforms which have aimed to remove the artificial divide between the two. Access to hospital services, apart from accident and emergency departments, is controlled by the general practitioner who, as well as providing primary care, makes the necessary referral. Recent reforms will be discussed in section 3, below.

administration as well as making recommendations regarding the bringing together of primary and secondary care; Parliament (1972) National Health Service reorganisation: England Cmnd 5055 HMSO, London, set out the Government's proposals for reorganisation of the NHS.

²⁵ National Health Service Reorganisation Act 1973 was repealed, subject to a saving relating to section 44, by the Health Authorities Act 1995.

²⁶ National Health Service Reorganisation Act 1973 section 5.

²⁷ Health Services Act 1980 sections 1 and 2.

²⁸ Health Authorities Act 1995 section 1.

A major reform in the primary versus secondary care area of health care was that of the 'internal market'. In essence, this meant that money should follow the patient and therefore there was a split between those who purchased the service and those who provided it. General practitioners would be fund-holders with a budget, with which they could purchase health care for their patients direct from NHS hospitals or other providers. The legislative provision was in the National Health Service and Community Care Act 1990, having previously been proposed in the White Paper 'Working for Patients'.³⁰

The National Health Service and Community Care Act 1990 also provided for the introduction of NHS Trusts.³¹ These were to be self-governing bodies that provided essential services to the NHS and contracted with GPs and other purchasers of care to provide health care.

The National Health Service (Primary Care) Act 1997 allowed a new form of primary health care to be developed. Instead of general practitioners being paid under a standard contract that was based upon size of their patient list and then fees and allowances for certain services and facilities being added to this, it was possible to enter into locally negotiated agreements. Thus, health authorities were able to make local agreements for personal medical services with a range of providers, including nurses.³²

3. The current NHS in England³³

The NHS is a policy driven organisation whose direction can be changed by the policies of successive governments. This section of the thesis will examine selected policies and agendas that have resulted in the current incarnation of the NHS. In particular, it will examine the changes in NHS structure as demonstrated by NHS Foundation Trusts, the role of the

³⁰ Parliament (1989) *Working for Patients* Cm 555 HMSO, London.

³¹ National Health Service and Community Care Act 1990 sections 5 to 11.

³² National Health Service (Primary Care) Act 1997 sections 1 and 2.

³³ It should be noted that the information within this section only relates to the NHS in England.

private/independent sector in the NHS and recent changes in the delivery of health care, such as treatment abroad.

It is worth noting that with all the reforms that have occurred, and are occurring with the NHS, it is the HCPs who provide the health care that have to work with these changes and with the resultant new structures and policies. As the NHS undergoes change, this results in changes to the delivery of health care provided to patients, the roles of HCPs,³⁴ the tasks and duties they undertake, and to the regulation of HCPs.

The current reforms in the NHS may be said to have started in 1997 with a change in government. Significantly, in 1999, fund-holding was repealed³⁵ and Primary Care Trusts (PCTs) were introduced, with the first being operational from 1st April 2000.³⁶ PCTs were to have similar roles as Primary Care Groups that had been originated in April 1999 to act as commissioning bodies under the remit of health authorities, developing the primary and community care in an area and improving health locally. The introduction of PCTs provided an NHS that was primary care led, with funding following the purchasing of services by PCTs. PCTs are the main purchasers of services from NHS hospitals and treatment centres. In addition, PCTs were to develop links with other agencies and social services. There was also provision within the Health Act 1999 to improve and strengthen the partnership between the NHS and local authorities.³⁷

In July 2000, the Government published the NHS Plan.³⁹ This was the government blueprint for the NHS; relevant aspects of it will be discussed in future chapters. However, for now, the NHS Plan introduced the notion

³⁴ See Chapter 3 for further examination of the changes in HCPs roles that have occurred.

³⁵ Health Act 1999 section 1.

³⁶ *Ibid*, section 2.

³⁷ *Ibid*, sections 26 to 31 which describe mechanism for payments to/from local authorities; give a statement that it is the duty of NHS bodies and local authorities to cooperate in undertaking their functions; and, provide for strategic planning for improving health and local services.

³⁹ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London.

of new roles for health care professionals and the breaking down of traditional barriers to role extension and development;⁴⁰ introduced new forms of clinical regulation;⁴¹ and launched the concordat with the private sector (see below).⁴²

Regarding the structure of the NHS, as can be expected, further changes have occurred. Health Authorities were replaced by twenty eight Strategic Health Authorities (SHAs) in April 2002,⁴³ and in July 2006 these were reduced to ten SHAs. PCTs became the lead NHS bodies in the planning and organisation of primary care, whilst NHS Trusts provided secondary care through hospital services. Strategic Health Authorities, which were in effect larger Health Authorities, oversaw the functions of both PCTs and NHS Trusts. Further, new regulatory mechanisms were introduced that will be discussed in Part 3.⁴⁴

In April 2003, the regional tier of the Department of Health was reconstituted; the eight NHS regional offices were closed and replaced by four regional directors of health and social care, who would oversee both NHS and social care development and provide the link between Government and the NHS.⁴⁵

There has been no change to the fact that it is the Secretary of State for Health who ultimately runs the NHS, on behalf of the government, and all management structures within the NHS are accountable to him and he, in turn, is accountable to Parliament.

⁴⁰ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-1 The Stationery Office, London, see sections 8 and 9.

⁴¹ *Ibid*, see section 6.

⁴² *Ibid*, see section 11.

⁴³ National Health Service Reform and Health Care Professions Act 2002 section 1.

⁴⁴ For instance the creation of The Council for the Regulation of Health Care Professionals, National Health Service Reform and Health Care Professions Act 2002 section 25.

⁴⁵ The changes in the regional tier of the NHS were announced in Department of Health (2001) Shifting the Balance of Power within the NHS: securing delivery Department of Health, London at paragraphs 38 to 49.

As well as altering the structure of the NHS itself, since 1997 there have been policy changes that have affected the clinical provision of care to patients. For instance, within the primary care setting, NHS Direct and walk-in centres have been introduced. NHS Direct is a twenty-four hour telephone and internet service that individuals can access for advice and information; whilst walk-in centres treat minor illnesses/injuries and are staffed by nurses in the main.⁴⁶

The changes that have occurred within the NHS, both structural and those in policy management of the NHS, coupled with the different ways of providing health care have led to the need for different approaches by HCPs. New roles and opportunities have been created for some HCPs, these will be explored in the next chapter.

3.1 NHS Foundation Trusts

NHS Foundation Trusts may be seen as an example of a government agenda moving the NHS forward in a way that will result in it being a fundamentally different organisation to the one that it was beforehand. The introduction of NHS Foundation Trusts is a major reform in the structure and internal relationships of the NHS. NHS Foundation Trusts will be explored here to demonstrate how the NHS undergoes reform and thereby moves forward and changes, whilst also providing a basis for highlighting how regulation develops in this new style NHS. NHS Foundation Trusts represent a change in the relationship between the centre of the organisation, represented by the Department of Health, and the periphery, represented by individual hospitals and medical centres.⁴⁷

NHS Foundation Trusts were announced by the then Health Secretary, Alan Milburn, on 15th January 2002, as a means of reducing central financial and management control of hospitals and of providing innovation and improvements in patient care. They were stated to be part of the

⁴⁶ NHS Direct was announced in Secretary of State for Health (1997) The New NHS. Modern. Dependable. Cm 3807 The Stationery Office, London at paragraph 1.11 and pilot services began on 1st March 1998.

⁴⁷ Klein R (2003) 'Governance for NHS Foundation Trusts' British Medical Journal vol. 326 p. 174 – 175.

redefinition of the NHS away from a *'monolithic, centrally run provider of services to a values-based system'*.⁴⁸ Legislative provision for the establishment of NHS Foundation Trusts was in the Health and Social Care (Community Health and Standards) Act 2003,⁴⁹ where they are known as *'public benefit corporations'*.⁵⁰

The first ten NHS Foundation Trusts were created in April 2004.⁵¹ A further eighty six NHS Trusts gained the special status of becoming an NHS Foundation Trust between April 2004 and April 2008, with further applications for Foundation Trust status being considered.⁵² It is the independent regulator who authorises the establishment of NHS Foundation Trusts.⁵³ Any NHS acute or mental health Trust is able to submit an application,⁵⁴ provided that it has achieved three star status.⁵⁵ The Government's aim is for all NHS Trusts to have *'the opportunity to become NHS Foundation Trusts'*.⁵⁶ Thus, Klein's observation that *'the first generation of Foundation Trusts is seen as preparing the way for their status becoming the norm in the NHS in time'*, would appear to have validity.⁵⁷ However, not all applications to become Foundation Trusts are successful, for instance, in the second wave of applications, the Nuffield

⁴⁸ Department of Health (2002) Press release 2002/0022 'Milburn announces radical decentralisation of NHS control' 15th January 2002.

⁴⁹ Which for Pollock A, Price D, Talbot-Smith A & Mohan J (2003) 'NHS and the Health and Social Care Bill: end of Bevan's vision?' *British Medical Journal* vol. 327 p. 982 – 985 *'is the most controversial piece of legislation to come out of the government's 10 year strategy for the NHS in England'* at page 982.

⁵⁰ Health and Social Care (Community Health and Standards) Act 2003 section 1(1) and 5(5).

⁵¹ Department of Health (2004a) Independent regulator authorises first NHS Foundation Trusts Press Release ref: 2004/0126 Department of Health, London.

⁵² Monitor – the Independent Regulator of NHS Foundation Trusts webpage 'NHS Foundation Trusts' available at http://www.monitor-nhsft.gov.uk/register_nhsft.php accessed on 30th April 2008.

⁵³ Health and Social Care (Community Health and Standards) Act 2003 section 6.

⁵⁴ *Ibid*, section 4(1).

⁵⁵ Department of Health (2002a) A guide to NHS Foundation Trusts Department of Health, London at paragraph 1.42.

⁵⁶ Department of Health (2003) Appointment of Independent Regulator for NHS Foundation Trusts Press Release ref: 2003/0494 Department of Health, London at page 1.

⁵⁷ Klein R (2003) 'Governance for NHS Foundation Trusts' *British Medical Journal* vol. 326 p. 174 – 175 at page 174.

Orthopaedic Centre NHS Trust did not succeed in becoming a Foundation Trust.⁵⁸

The introduction of NHS Foundation Trusts was not an easy passage. This was largely because of the fear that the introduction of Foundation hospitals would lead to the break up of the NHS as a single service. Foundation Trusts are a move away from the traditional NHS structure as they are not controlled by the centre, unlike the rest of the NHS. Thus, there is a fear that their introduction could result in back door privatisation of the NHS,⁵⁹ or a two-tier NHS with Foundation Trusts forming a super league of hospitals able to undertake management, clinical and financial decisions that other NHS Trusts would be unable to make.⁶⁰

For instance, regarding financial management, NHS Foundation Trusts may borrow money,⁶¹ make investments,⁶² and dispose of property⁶³ to further their objectives, unlike other NHS Trusts. Additionally, Foundation Trusts can set their own pay rates, disregarding negotiated deals by paying their staff in excess of the national agreed pay scales; and they can alter national terms and conditions of service, and would therefore be in a position to poach staff from other NHS hospitals that do not have Foundation status and are required to comply with nationally agreed terms and conditions and pay deals.⁶⁴

A further fear is that Foundation hospitals will concentrate on the financial side of their responsibilities at the expense of the clinical, that they will concentrate on profits rather than patients, and that they may take on

⁵⁸ Monitor (2004) Ten more NHS Foundation Trusts established Press Release ref: IRPR 09/04 Monitor, London. Interestingly the reason that the application failed was lack of reassurance re financial viability.

⁵⁹ See Lewis R (2005) 'NHS Foundation Trusts' British Medical Journal vol. 331 p. 59 – 60.

⁶⁰ House of Commons Health Committee (2003) Foundation Trusts Second Report of Session 2002–03 Volume I HC395-I The Stationery Office, London at paragraphs 133 and 157.

⁶¹ Health and Social Care (Community Health and Standards) Act 2003 section 17(1).

⁶² *Ibid*, section 17(4).

⁶³ *Ibid*, section 18(2).

⁶⁴ House of Commons Health Committee (2003) Foundation Trusts Second Report of Session 2002–03 Volume I HC395-I The Stationery Office, London at paragraphs 138 to 139.

more private patients, at the expense of NHS patients, to fund their borrowing.⁶⁵

Due to the imbalance between the freedoms of Foundation versus non-Foundation Trusts, it was felt that Foundation Trusts would be at an advantage and this would lead to the introduction of competition into the NHS again, with Trusts competing for staff and patients.⁶⁶

The Department of Health sees the benefits of NHS Foundation Trusts as being: the reduction in central control resulting in increased local responsiveness to local health needs; the increased accountability to the local community through Board of Governors which will include members of the public;⁶⁷ the preservation of a service that is '*free of charge*';⁶⁸ the rewarding of staff by being able to offer bonuses and pay above nationally agreed scales, as well as performance related awards; and the innovation in delivery of services and the use of resources, by reducing central bureaucracy.⁶⁹

Klein believes that NHS Foundation Trusts 'do not represent a backdoor form of privatisation. They will not be given a free hand to expend their facilities for treating fee paying patients: the percentage of income derived from this source is to be capped. They will be obliged to offer a set of "regulated services" to ensure that NHS commissioners, and eventually individual consumers, have an adequate menu of choice. And, of course, they will have to comply with national clinical and quality standards'.⁷⁰

⁶⁵ House of Commons Health Committee (2003) Foundation Trusts Second Report of Session 2002-03 Volume I HC395-I The Stationery Office, London at paragraph 26.

⁶⁶ Ibid, at paragraphs 4 and 127 and 128.

⁶⁷ Although NHS Trusts may involve the public and local representation through board membership and open meetings, Foundation Trusts take this one step further, with local accountability.

⁶⁸ The National Health Service Act 1946 section 1(2), providing the original foundation for this.

⁶⁹ Department of Health (2002a) A Guide to NHS Foundation Trusts Department of Health, London particularly Part 1 Introduction.

⁷⁰ Klein R (2003) 'Governance for NHS Foundation Trusts' British Medical Journal vol. 326 p. 174 - 175 at page 174.

The key distinction between Foundation and non-Foundation Trusts within the NHS is that of autonomy. According to the Department of Health, although the Foundation Trusts will remain part of the NHS they will not be subject to direction by the Secretary of State for Health and therefore will have greater freedom regarding their management, including more financial autonomy.⁷¹ However, they are subject to the scrutiny of an independent regulator,⁷² called Monitor,⁷³ who is free of Department of Health accountability but is accountable to Parliament through the Secretary of State for Health.⁷⁴

However, some are of the opinion that *'the problem [with NHS Foundation Trusts] is an excess of accountability. In the first place, Foundation Trusts will be accountable to the newly created independent regulator [Monitor] who will license them, monitor them, decide what services they should provide, and if necessary dissolve them. In the process, the regulator will be able to impose additional requirements on the Trusts, remove members of the management board, and order new elections. The regulator will ... be informed by the reviews carried out by the new Commission for Health Audit and Inspection [now known as the Healthcare Commission]. Foundation Trusts will also have to answer to the overview and scrutiny committee of the local authority ... Finally, Foundation Trusts will be accountable to Primary Care Trusts ... for fulfilling contracts. Overlapping accountabilities are likely to mean conflicting pressures'*.⁷⁵ There is also the obligation that NHS Foundation Trusts are required to have a board of governors and a board of directors,⁷⁶

⁷¹ Department of Health (2003) Appointment of Independent Regulator for NHS Foundation Trusts Press Release ref: 2003/0494 Department of Health, London at page 1.

⁷² Health and Social Care (Community Health and Standards) Act 2003 section 2.

⁷³ For information on Monitor – the Independent Regulator of NHS Foundation Trusts see their website at <http://www.monitor-nhsft.gov.uk>.

⁷⁴ Department of Health (2002a) A guide to NHS Foundation Trusts Department of Health, London at paragraph 3.28.

⁷⁵ Klein R (2003) 'Governance for NHS Foundation Trusts' British Medical Journal vol. 326 p. 174 – 175 at page 175.

⁷⁶ Health and Social Care (Community Health and Standards) Act 2003 section 6(2)(c).

with the board of governors being elected and the possibility of having members of the public sitting on it.⁷⁷

The point to be made about NHS Foundation Trusts is that they are essentially semi-independent hospitals that contribute to the NHS and are part of it, but are free of its central control i.e. that of the Department of Health. Instead, they are run locally by a board of governors and a management board. The Board of governors is selected through the membership of the NHS Foundation Trust. As Monitor states *'anyone who lives in the area, works for the trust, or, in some cases, who has recently been a patient there, can become a member of an NHS Foundation Trust. This gives staff and local people a real stake in the future of their hospital and enables them to elect representatives to serve on the Board of Governors. The Board of Governors will work with the Board of Directors – responsible for day-to-day running of the Trust – to ensure that the NHS Foundation Trust delivers NHS care and acts in a way that is consistent with the terms of its authorisation. In this way, the Board of Governors will play a role in helping to set the overall direction of the organisation'*.⁷⁸

Being free of central control therefore allows them more autonomy regarding financial, management and clinical freedom. Although, they have to achieve NHS national targets and standards, they are free to choose how they do this.⁷⁹ This is a fundamental change to the NHS of old which was centrally controlled, recently by the Secretary of State for Health through the Department of Health. As the then Secretary of State for Health himself stated: *'for the first time since 1948 the NHS will begin*

⁷⁷ Department of Health (2002a) A guide to NHS Foundation Trusts Department of Health, London at paragraphs 1.23 to 1.27.

⁷⁸ Monitor – the Independent Regulator of NHS Foundation Trusts webpage 'Patients and the public' available at http://www.monitor-nhsft.gov.uk/patients_involved.php accessed on 30th April 2008.

⁷⁹ See Lewis R (2005) 'NHS Foundation Trusts' British Medical Journal vol. 331 p. 59 – 60.

to move away from a monolithic centralised system towards greater local accountability and greater local control'.⁸⁰

3.2 Diagram of NHS structure in England in 2008

The following diagram highlights the current structure of the NHS in England in 2008, which can be contrasted with Diagram 1.

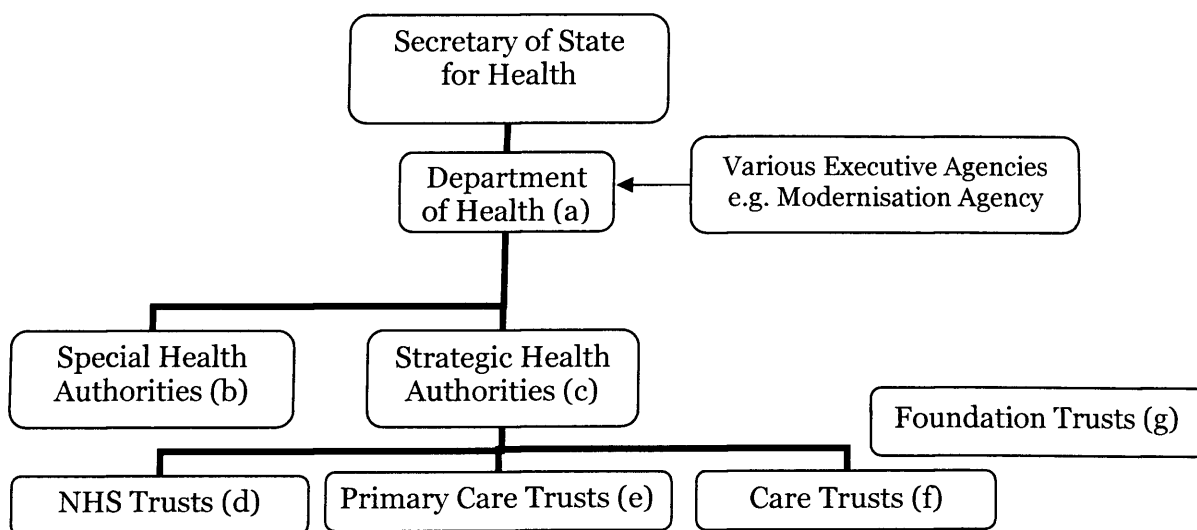


Diagram 2 Structure of the Current National Health Service in England 2008⁸¹

⁸⁰ Department of Health (2002a) A guide to NHS Foundation Trusts Department of Health, London at page 4.

⁸¹ Notes to diagram 2:

a - Department of Health sets the overall direction of the NHS, sets national standards and national priorities.

b - Special Health Authorities provide services that are national rather than local in outlook e.g. UK Transplant Service and National Blood Authority.

c - Strategic Health Authorities manage, monitor and develop local services through strategic planning of these local services and ensure that national priorities are developed locally.

d - NHS Trusts manage the hospitals of the NHS, some are specific Trusts e.g. ambulance Trusts that provide emergency ambulance provision.

e - Primary Care Trusts assess local health needs and undertake commissioning of services to meet these needs.

f - Care Trusts provide integrated health/social care services, also ambulance services that are not NHS Trusts in their own right etc.

g - NHS Foundation Trusts provide the problem of where they fit into the current structure. They are run locally and not under the direction of Strategic Health Authorities but do remain within the NHS as a whole.

3.3 Non-NHS health care provision

The Independent health care sector has been in existence for a long time and has quite a large market, especially in area such as care homes (see below). However, the Labour Government's reform of the NHS since 1997 has resulted in increased use of the independent sector in the provision of NHS health care. Indeed the NHS Plan (see above) stated that there would be a concordat between the NHS and private providers of health care.⁸²

Non-NHS health care provision is included here because it highlights that regulation of NHS provision of health care alone is not sufficient as it would not fulfil the primary aim of regulation of HCPs, that of public protection and patient safety, as there is already considerable non-NHS provision, and this provision is set to increase.

It has been suggested that £2 billion will be spent by the NHS in the independent sector, between 2004 and 2008, as part of providing treatment to NHS patients, with the aim being to have 15 percent of NHS elective work, or one million operations, to be undertaken by the independent health sector by 2008; currently elective work in the independent sector was estimated to be 2 to 5 percent in 2004 thus the proposed increase would in the region of threefold.⁸³ Part of this increase will be accomplished through the use of private or independent treatment centres to provide short stay inpatient care including day case surgery, and diagnostic procedures.⁸⁴ The use of such centres is part of the Government's plan to reduce waiting lists for a number of elective operations, where the General Practitioner can refer the patient to a

⁸² Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London see page 12 and section 11.

⁸³ See Editorial (2004) 'NHS Trusts hope to bid for 'private' contracts' The Times Public Agenda 7 December 2004 p. 6; Chand K (2004) 'NHS heading for privatisation' Doctor 15 October 2004 p. 17; and Lister S (2004) 'Labour wants private hospitals to perform 1m NHS operations' The Times 25 June 2004 p. 26.

⁸⁴ See Chand K (2004) 'NHS heading for privatisation' Doctor 15 October 2004 p. 17 and Lister S (2004) 'Labour wants private hospitals to perform 1m NHS operations' The Times 25 June 2004 p. 26.

treatment centre or an NHS hospital and the NHS pays for the operation regardless of where it is undertaken.⁸⁵

As the Chief Executive's report for the NHS in 2005 states 'the NHS is now using more services from the voluntary and independent sector'.⁸⁶ Between September 2003 and May 2005, 16,000 NHS patients were treated in Independent Sector Treatment Centres (ISTC) at NHS expense, with the aim being to have 34 ISTCs undertaking 250,000 procedures annually.⁸⁷

In a written statement to the House of Commons, the then Secretary of State for Health, Alan Johnson, stated that '*the Independent Sector is playing an important and increasing role within the NHS, providing high quality treatment and choice for patients, and innovation*' and provided the following information, '*in the first wave of the independent sector treatment centre (ISTC) programme we established 23 fixed site ISTCs, a mobile ophthalmology service, a mobile MRI scanning service, a Chlamydia screening service and six walk-in centres. This investment worth over £1.4 billion has provided nearly 800,000 elective procedures, diagnostic assessments and episodes of primary care to NHS patients*'.⁸⁸

As an example of this use of the independent health sector, Nuffield Hospitals were contracted to provide more than 17,000 operations for the NHS in 2005. The 35 Nuffield Hospitals were contracted to provide major operations, (ear, nose & throat, gynaecological and orthopaedic including hip replacements) for 20 strategic health authorities. Although local

⁸⁵ Hawkes N (2005) 'The giant of private care will bid for NHS work' The Times 10 January 2005 p. 21.

⁸⁶ Department of Health (2005) Chief Executive's Report to the NHS May 2005 Department of Health London at page 11.

⁸⁷ *Ibid*, see page 12.

⁸⁸ Hansard HC 15 November 2007 columns 78 to 79WS available at <http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm071115/wmstext/71115m0008.htm#0711150000015> accessed 4th May 2008.

⁹² Naish J (2004) 'Operating within a new market' The Times 18 May 2004 Public Agenda p. 5

arrangements and contracts for independent health providers to undertake operations for the NHS have occurred previously, this was the first time that a national contract had been established.⁹²

It is not just the secondary care element of the NHS that is subject to independent sector involvement in health care; the primary care sector is being opened up to the independent sector as well. PCTs are able to commission services from a variety of sources, including those from the independent sector, to assist where there is currently a deficit in NHS provision.⁹³

For some, the involvement of the private sector in providing traditional NHS services is seen as inevitable. The introduction of Foundation Trusts, long term contracting, and use of private finance initiatives to create new hospitals is seen as being one of the final steps along the path to having a market-led NHS that has both public and private sector elements to it;⁹⁴ one that is seen as ushering '*a pending revolution in NHS care delivery*'.⁹⁵ As Richard Smith states, '*the private sector has certain competencies and the public sector has others, and to improve a problem like healthcare that is below par everywhere, you are more likely to succeed by finding a way to employ both*'.⁹⁶ Although some advocate that the independent sector has been complementary to the NHS since its inception,⁹⁷ others fear that private sector involvement in the NHS will mean that independent providers will opt to treat those patients who are easiest to treat. Thus, NHS providers will be at a distinct disadvantage of being left to treat those patients whose more difficult conditions are more costly.⁹⁸

⁹³ Ham C (2005) 'Alternative providers' *MedEconomics* February 2005 p. 38 – 43.

⁹⁴ Coombes R (2004) 'US healthcare industry sees NHS as "unopened oyster," BMA conference told' *British Medical Journal* vol. 329 p. 1305.

⁹⁵ Naish J (2004) 'Operating within a new market' *The Times* 18 May 2004 Public Agenda p. 5

⁹⁶ Tyndale-Biscoe J (2005) 'Why the NHS needs US help' *Medeconomics* January 2005 p. 54 – 55 interview with Dr Richard Smith former editor BMJ and now Head of UK operations for UnitedHealth.

⁹⁷ For instance see Doyle Y & Bull A (2000) 'Role of private sector in United Kingdom healthcare system' *British Medical Journal* vol. 321 p. 563 – 565.

⁹⁸ For example see Coombes R (2005) 'Private providers must be stopped from skinning off easy cases' *British Medical Journal* vol. 330 p. 691, where Coombes discusses the

There is concern that the NHS will '*be exploited*' by private health care providers and that the NHS will be '*privatised by stealth*'.⁹⁹ Additionally, there are fears that the use of the independent sector will lead to destabilisation in the NHS, with NHS centres closing due to a lack of patients and hence funding, or even to the end of the NHS as a whole.¹⁰⁰

It is not only organisations that can engage in private health care, individual HCPs can undertake 'private practice'. As discussed above, hospital consultants were left with the ability to undertake private practice in the original 1948 NHS negotiations and agreement. Following relaxation of the General Medical Council's regulations on advertising in the 1990s,¹⁰¹ doctors can directly advertise their private services to the general public provided that they do not breach General Medical Council guidance on advertising and follow the Advertising Standards Authority guidelines.¹⁰² This further demonstrates that regulation needs to be of HCPs as well of organisations. Through the mechanisms of regulation of HCPs, those HCPs that undertake private practice, whether solely or in conjunction with NHS work, can be regulated as well as those who work within the NHS, thereby furthering the aim of public protection.

Interestingly, it is not only politicians and health care professionals who are engaged in reforming the relationship between the NHS and the independent health sector. The procedure for obtaining an operation in the NHS is that first a GP must refer the patient to a consultant in the relevant speciality. The consultant sees the patient and then places them on an appropriate waiting list for the operation. Both these elements, the consultant appointment and the actual operation have a waiting period

BMA's evidence to a House of Commons Public Administration Select Committee Inquiry into choice in public services.

⁹⁹ Lister S (2005) 'NHS cash to pay private GPs' *The Times* 31 May 2005 p. 4.

¹⁰⁰ See Eaton L (2005) 'Treatment centres are undermining patient choice, warns BMA' *British Medical Journal* vol. 330 p. 1350 and Arie S (2005) 'Writers join experts to campaign to save NHS from privatisation' *British Medical Journal* vol. 331 p. 713.

¹⁰¹ General Medical Council (1992) *Professional Conduct and Discipline: Fitness to Practise* General Medical Council, London. This severely restricted advertising by doctors and limited it to general practitioners.

¹⁰² Sladden J (2005) 'Ethics at the interface – private practice and the NHS' *BMJ Careers* 28 May 2005 p. 215 – 216.

attached to them. It is reported that some patients are by-passing the first element of the procedure by paying privately for an appointment with a consultant and then going on an NHS waiting list for an operation.¹⁰³ Thus the patient lessens the first period of waiting and could be said to be queue-jumping in the strict sense; alternatively the patients may be said to be engaging in their own private-public initiative.

Grubb raises the question of who is liable should an incident occur to a NHS patient treated in a non-NHS facility.¹⁰⁴ This is addressed in section 3.5 below.

3.4 Treatment abroad by the NHS

The reason for including discussion of treatment abroad is that the changes in the setting of where NHS patients may be treated demonstrate how the NHS has been transformed since its inception. At the beginning of the NHS, patients were treated at the hospital nearest to them. Now they can choose one hospital over another and even have the option of being treated abroad, all at the expense of the NHS. This raises the issue of clinical responsibility and the regulation of those HCPs involved in the treatment of these NHS patients.

Notwithstanding that UK citizens have been entitled to free care and treatment in the European Union, by virtue of the European Health Insurance Card (EHIC) reciprocal health care arrangements, and in various other countries throughout the world, through other reciprocal arrangements, although generally only for emergencies, it is now possible for NHS patients to receive treatment abroad rather than at an NHS facility.¹⁰⁵

¹⁰³ Rogers L (2003) 'Private patient ruse gets round NHS queues' The Sunday Times 9 March 2003 News Section p. 25.

¹⁰⁴ Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford.

¹⁰⁵ The European Health Insurance Card replaced the E111 form on 31st December 2005 and provides the same entitlement to emergency medical treatment in European countries as the E111. See Department of Health (2002b) Health Advice for Travellers Department of Health, London for information on the old E111; and, Department of Health (2005a) The European Health Insurance Card Department of Health, London for information on the new EHIC.

The mechanism that allows for NHS patients to be treated abroad at NHS expense has had a slow gestation. It had always been believed that Article 49 of the EC Treaty¹⁰⁶ which covers the freedom to provide services, excluded health care as a service and therefore this could not be relied upon to provide cross-border health care for citizens of one member State in another member State.¹⁰⁷ However, a number of cases have questioned this assumption.

In April 1998, the European Court of Justice gave rulings on two cases¹⁰⁸ that examined national rules on reimbursement of medical expenses incurred in another country, and the requirement for prior authorisation of medical expenses and purchase of medical products. Specifically in the Kohll case,¹⁰⁹ the Court ruled that health care was not excluded as a service under Article 49 of the EC Treaty.

Following this, in July 2001, the European Court of Justice clarified the situations under which patients could receive treatment abroad and claim reimbursement from their own health system, when it gave rulings on two further cases.¹¹⁰ The rulings effectively mean that patients would be able to seek medical treatment abroad and claim reimbursement from the NHS following their return, without prior authorisation of the treatment, so long as the cost involved would not be more than the treatment would cost in the home country. Further, the patient is entitled to seek medical

¹⁰⁶ Treaty establishing the European Community (previously known as the Treaty of Rome 1957 but retitled after the Maastricht Treaty (Treaty on European Union) 1992).

¹⁰⁷ For instance see Newdick C (2005) Who should we treat? 2nd edition Oxford University Press, Oxford at pages 239 to 241, where he discusses the concept of health as a service within the meaning of Article 49.

¹⁰⁸ The two cases were Nicolas Decker v Caisse de maladie des employés privés (Case C-120/95) & Raymond Kohll v Union des caisses de maladie (Case C-158/96).

¹⁰⁹ Raymond Kohll v Union des caisses de maladie (Case C-158/96) at paragraphs 46 to 54, where the court examines the notion of freedom to provide services across member States.

¹¹⁰ The two cases were BSM Geraets-Smits v Stichting Ziekenfonds VGZ and HTM Peerbooms v Stichting CZ Groep Zorgverzekeringen (Case C-157/99) and Abdon Vanbraekel and Others v Allinace nationale des mutualités chrétiennes (ANMC) (Case C-368/98).

treatment abroad where there would be undue delay in waiting for the same or equally effective treatment to be provided by the NHS.¹¹¹

This is a significant improvement upon the E112 mechanism for obtaining non-emergency treatment abroad. Patients, who needed medical treatment that was not available in the NHS, would obtain the support of their consultant, who would write to the local health authority who would approve the request and pass it on to the Department of Health who would decide whether to issue the E112 form. The E112 form entitles the patient to receive treatment in the country providing the service.¹¹² The European Court of Justice rulings mean that patients do not have to prove that the treatment they require is unavailable in the NHS, just that it is subject to undue delay.

Following the rulings by the European Court of Justice, the Department of Health undertook a pilot study to '*address the clinical, legal and quality issues involved in sending patients to other EU countries for treatment*'.¹¹³ One hundred and ninety patients from four health authorities were treated under contract at health care facilities in France and Germany.

In March 2004, the Department of Health issued general guidance on the commissioning of treatment in the EU by the NHS¹¹⁴ as well as specific guidance for patients¹¹⁵, NHS Trusts¹¹⁶ and Overseas Providers¹¹⁷. The guidance stated that for a patient to receive treatment abroad they had to use the E112 scheme, with its prior authorisation, or be directly referred by

¹¹¹ BSM Geraets-Smits v Stichting Ziekenfonds VGZ and HTM Peerbooms v Stichting CZ Groep Zorgverzekeringen (Case C-157/99) at paragraph 108, although the definition of undue delay is not provided by the European Court of Justice in their ruling.

¹¹² Department of Health (2004b) Commissioning treatment in the EU: patient information Department of Health, London.

¹¹³ Lowson K, West P, Chaplin S & O'Reilly J (2002) Evaluation of Treating Patients Overseas York Health Economics Consortium, York at page 1.

¹¹⁴ Department of Health (2004c) Commissioning treatment in the EU Department of Health, London.

¹¹⁵ Department of Health (2004b) Commissioning treatment in the EU: patient information Department of Health, London.

¹¹⁶ Department of Health (2004d) Commissioning treatment in the EU: NHS Trust/PCTs information Department of Health, London.

¹¹⁷ Department of Health (2004e) Commissioning treatment in the EU: information for Overseas providers Department of Health, London.

their NHS Trust and that the NHS would not reimburse those who undertook treatment privately and sought to claim back their fees and expenses.¹¹⁸

However, this last point of prior approval has been challenged in the courts, in a case where a patient had treatment abroad but did not have prior authorisation for the treatment and was therefore seeking reimbursement for their costs.¹¹⁹ In the initial court case, Munby J found that the claimant was not entitled to have her costs reimbursed because she did not suffer undue delay.¹²⁰

Because of comments made by the Judge in the initial case regarding the interpretation of law regarding the funding of treatment abroad, and the fact that authorisation can only be refused where treatment is not established practice, or if it is, cannot be received without undue delay in an NHS establishment, even if the delay is within NHS waiting times guidelines, the Secretary of State for Health challenged the judgment on appeal.¹²¹ As Blythe notes, the judgment confirms that the Department of Health's policy on the need for prior approval is consistent with European law but is critical of the way in which the policy is applied in practice.¹²²

The appeal was heard in February 2004 and raised questions regarding when a non-insurance based health service, such as the NHS, has to pay for a patient's treatment in another member state, or whether, being non-insurance based, the NHS is outside of the EU rules on this.¹²³ In order to answer this question, the Court of Appeal referred questions to the European Court of Justice. In May 2006, the European Court of Justice ruled that the Court of Appeal in deciding the case must consider whether

¹¹⁸ Department of Health (2004c) Commissioning treatment in the EU Department of Health, London.

¹¹⁹ R (on the application of Watts) v Bedford Primary Care Trust and Another [2003] EWHC 2228.

¹²⁰ *Ibid*, at paragraphs 182 to 195.

¹²¹ for instance see R (on the application of Watts) v Bedford Primary Care Trust and Another [2003] EWHC 2228 at paragraphs 175 to 179 and 196 to 199.

¹²² Blythe T (2003) 'Seeking treatment overseas' New Law Journal vol. 153 p. 1658 – 1659.

¹²³ R (on the application of Watts) v Secretary of State for Health [2004] EWCA CIV 166.

there had been any undue delay in Mrs Watts receiving NHS treatment which would mean that she would be eligible to receive the reimbursement she was seeking.¹²⁴

The result of this is that NHS Providers are being allowed to commission services from abroad and sign contracts with foreign health care providers to provide treatment either in England or abroad. This characterizes a fundamental change in the delivery of NHS provision.

3.5 Regulatory issues raised by non-NHS provision of treatment including treatment abroad

As noted above, Grubb¹²⁵ raises the question of who is liable should an incident occur to a NHS patient treated in a non-NHS facility. In addition to the use of non-NHS facilities in the UK to treat NHS patients, the use of overseas facilities raises similar issues.

These issues are related to the need to have the clinical responsibility for the patients to be clearly defined; will the clinical responsibility reside with the NHS or will it pass to the treating centre? Related to this is the regulation of the health care professionals involved in the treatment of NHS patients. Will those involved in the treatment of NHS patients in institutions abroad be held to the same regulatory framework as those within the UK? How will those working abroad be accountable, will it be a contractual issue, will it be via the regulatory processes in the country where treatment takes place, or will the NHS assume overall accountability? If there is a case for the patient to make a complaint, or even bring a case of negligence, will the patient sue the NHS or the institution that treated them, whether in the UK or abroad; if the latter, will the NHS help them to sue?

¹²⁴ The European Court of Justice case is The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust, Secretary of State for Health (C-372/04) 2006 ECJ CELEX LEXIS 394.

¹²⁵ Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford.

It would appear as though, with regard to claims for negligence, the Department of Health is of the opinion that the patients would be able to sue in the English courts as the NHS, and its associated organisations, would have a non-delegable duty of care to the patient, with regard to the use of third-party facilities.¹²⁶ However, this view may be said to be contrary to that held in A v Ministry of Defence and Guy's and St Thomas' Hospital NHS Trust by Bell J.¹²⁷ In this case it was held that provided there had been reasonable care exercised in the selection of overseas hospitals and the management of contracts with these facilities, then there is no further duty to ensure that the care the patient receives is subject to reasonable care and skill.¹²⁸ Thus, this is an issue that requires further clarification.

4. Size of the Health Service in the United Kingdom

In order to give some idea of the scale of regulation that has to be undertaken in the health care arena, the following information is provided.¹²⁹

4.1 Size of the NHS

Despite of, or perhaps because of, the changes and reforms of the NHS, it remains one of the largest organisations within the United Kingdom and one of the largest employers, employing some 1,336,030 individuals in 2005.¹³⁰ The annual budget for the NHS in 2007-08 is approximately £86.8 billion and is set to reach £92.6 billion in 2008-09.¹³¹

¹²⁶ Department of Health (2002c) Treating more patients and extending choice: overseas treatment for NHS patients Department of Health, London, in particular see paragraphs 6.1 to 6.3.

¹²⁷ A v Ministry of Defence and Guy's and St Thomas' Hospital NHS Trust [2003] Lloyd's Rep Med 339.

¹²⁸ *Ibid*, at paragraph 110.

¹²⁹ Unless otherwise specified the figures relate to the 2005/06 accounting year.

¹³⁰ Department of Health (2006) Chief Executive's Report to the NHS: statistical supplement June 2006 Department of Health, London, at page 34.

¹³¹ Hansard HC 17 January 2008 column 1456W available at <http://www.parliament.the-stationery-office.co.uk/pa/cm200708/cmhansrd/cm080117/text/80117w0016.htm> accessed 4th May 2008.

In June 2006, there were 303 PCTs, 29 NHS Ambulance Trusts and 234 NHS Trusts providing health care in the NHS.¹³² Of these, 155 NHS Trusts provide 24 hour accident and emergency services, whilst an additional 114 NHS Trusts and PCTs provide walk in/minor injury centres, resulting in 17,775,000 accident and emergency attendances.¹³³ The total number of recorded general and acute (i.e. not mental health, learning disability or maternity) in-patient admissions to hospital was 10,369,000, of which 4,4678,000 were emergency admissions.¹³⁴ This was provided through 136,123 overnight beds, out of a total of 181,784 overnight beds (which includes mental health, learning disability and maternity overnight beds) available to the NHS.¹³⁵

Of all those employed by the NHS in 2005, 1,144,570 were considered frontline staff¹³⁶. Qualified health care professionals comprised 587,590 individuals: of which 122,350 were doctors including 31,990 consultants and 32,7400 general practitioners (GPs); 404,160 were qualified nurses, midwives and health visitors; and 61,080 were qualified allied HCPs, for example physiotherapists and radiographers.¹³⁷

Within the primary care field there were 223,000,000 general practitioner consultations in the 2004 accounting period and approximately 91,000,000 with practice nurses.¹³⁸ In the 2005-06 year the general practice consultations resulted in 9,567,000 GP referrals to secondary care on an outpatient basis.¹³⁹ Additionally, there were 720,300,000 prescriptions dispensed in the community in England.¹⁴⁰

¹³² Department of Health (2006) Chief Executive's Report to the NHS: statistical supplement June 2006 Department of Health, London, at page 32.

¹³³ Ibid, at page 14.

¹³⁴ Ibid, at page 25.

¹³⁵ Ibid, at page 33, figures relate to the average number of beds available daily.

¹³⁶ Ibid, at page 34.

¹³⁷ Ibid, at page 34.

¹³⁸ Ibid, at page 6.

¹³⁹ Ibid, at page 12.

¹⁴⁰ Ibid, at page 7.

4.2 Size of the independent sector

The independent sector is not a single entity like the NHS. However, there were some 249 acute hospitals in the independent sector in 2004, with a further 79 private patient units in NHS hospitals.¹⁴¹ There are approximately 15,000 private and voluntary care homes, with the market for private sector care homes being some £6.9 billion.¹⁴²

The independent sector employs approximately 70,000 qualified nursing staff who work outside the NHS in private hospitals, care homes, and clinics.¹⁴³ The independent health and social care sector provides approximately 440,000 beds, with the independent acute elective surgery sector having some 800 critical care beds, including 150 ICU beds. It also provides 80 percent of all neuro-rehabilitation beds.¹⁴⁴

In 2004/05, there were over 8,000,000 NHS funded operative procedures in non-NHS settings.¹⁴⁵ The independent sector in 2004 provided 20 percent of all elective surgery, delivering 30 percent of all hip replacements, 14 percent of all cardiac work, and 44 percent of all vein removals. In addition, it provided 55 percent of medium secure mental health care, and 85 percent of all residential community care.¹⁴⁶ Some 7,550,000 individuals have private medical insurance, whether paid for privately or through their employers.¹⁴⁷

Thus, the independent health care sector is a significant part of health provision within England and Wales in general and within the NHS in particular.

¹⁴¹ Information from Laing's Healthcare Market Review 2005 (Acute Hospitals) available on <http://www.laingbuisson.co.uk/AcuteHospitals.htm> accessed on 16th September 2005.

¹⁴² Information from Laing's Healthcare Market Review 2005 (Long term care) available on <http://www.laingbuisson.co.uk/Longtermcare.htm> accessed on 16th September 2005.

¹⁴³ Hoban V (2004) 'Nursing outside the NHS' *Nursing Times* vol. 100 no. 23 p. 20 – 22 at page 22.

¹⁴⁴ *Ibid*, at page 22.

¹⁴⁵ Department of Health (2005b) *Chief Executive's Report to the NHS: statistical supplement May 2005* Department of Health, London at page 22.

¹⁴⁶ Hoban V (2004) 'Nursing outside the NHS' *Nursing Times* vol. 100 no. 23 p. 20 – 22 at page 22.

¹⁴⁷ Information from Laing's Healthcare Market Review 2005 (Private Medical Insurance) available on <http://www.laingbuisson.co.uk/PMI.htm> accessed on 16th September 2005.

Conclusion

What is considered to be the health care arena has changed radically since the NHS was introduced in 1948, becoming more complicated as a result. The influences upon the NHS have been constantly changing, as well as increasing. These influences include: technology, changing the face of health care; delivery of care, with different roles for health care professionals as well as differences in the place of care, for instance, more primary care treatment centres; high profile investigations, e.g. Bristol Inquiry;¹⁴⁸ the rising cost of health care and an overall search for value for money; and, at the same time, the public is better educated about their 'rights' as a result of the NHS plan,¹⁴⁹ the patients charter¹⁵⁰ etc, and their expectations have risen.

Additionally, health and health care has become increasingly political. Pressure groups, interest groups and lobby groups¹⁵¹ are becoming the norm rather than the exception and their influence is significant upon both NHS policy and NHS reform. These groups include those representing patients both generally and those with particular conditions; those representing HCPs, industries and businesses, political organisations, employers, and trade unions. Governments are now more inclined to set out their political aspirations for the NHS as consultative documents before implementing reforms.

The politicisation of the NHS, together with the associated additional groups involved in the reform and direction of the NHS, may be said to

¹⁴⁸ For further information see Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

¹⁴⁹ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London.

¹⁵⁰ Department of Health (1992) The Patient's Charter Department of Health, London.

¹⁵¹ Stuttaford cites Healy & Robinson who define interest groups as '*organisations within civil society which attempt to influence the direction of government policy without necessarily seeking political office. They are treated as a mechanism by which a diverse range of views can be absorbed into the democratic process*' – Stuttaford M (2004) 'Balancing collective and individual rights to health and health care' LGD – Law, Social Justice & Global Development Issue 1 2004 at paragraph 3.2, available from <http://elj.warwick.ac.uk/global/issue/2004-1/stuttaford.html> accessed on 24th November 2004.

have had influence upon the regulation of HCPs. As will be seen in Part 3, regulatory reform may occur for political reasons as well as to meet the changes in the NHS and health care discussed above.

As the NHS and health care in general has changed and become more complex, so the regulation needed to ensure public protection and patient safety has had to undergo change. Indeed, it is argued within this thesis that in order to take account of the changes in health care delivery, regulation has had to become more encompassing. This in part has led to the current situation, which is the hypothesis of this thesis, that the regulation that HCPs are currently subject to is not fit for purpose, and is controlling rather than enabling.

The NHS has been controlled from the centre since its inception and this has not changed greatly in the ensuing years. As can be seen above, the Department of Health is at the top of the structure and is responsible for policy and standards through the strategic health authorities, implementing national policies to develop local policies, which are implemented in turn by PCTs and NHS Trusts and delivered by individual hospitals, general practices and other treatment centres. It will be interesting to see how Foundation Trusts, with their greater autonomy, and the use of independent providers will change this. However, the centre, in the form of the Department of Health, still sets the accountability and regulatory framework that applies to all NHS providers. As well as ensuring that regulation is put in place to protect the public and provide for patient safety.

A major change that has occurred within the NHS is the nature of the service it provides. The NHS may now be said to be fragmented in terms of its role as it is a purchaser of health care for its clients, the patients, and not a provider, in the sense of actually providing all the care itself, as it was at its inception. The various NHS bodies that provide the health care may be likened to franchises, with the number and type of franchisee extending

to include NHS Trusts, NHS Direct, private/independent organisations and providers abroad. The NHS does not even have a monopoly in providing health care for the UK as private care is always available to those willing to pay; although it does provide the majority of health care in the UK.

The new NHS bodies and those in the independent sector may not readily comply with the existing regulatory structures. Therefore, as the NHS changes and new providers of health care are encompassed within the NHS framework, new forms of regulation may be needed to ensure that public protection remains a paramount objective.

The NHS is now not even so 'national' as one would previously have believed; its boundaries now extend beyond those of the United Kingdom, at least with regard to the provision of certain treatments. The structure of the NHS has been radically altered as a consequence of it being legally obliged to pay for treatment abroad in certain circumstances. Allied with this fundamental change in the delivery of NHS health care are questions regarding accountability, quality and regulation mechanisms.

As the NHS has changed, as discussed above, to be unrecognisable from the NHS that was 'born' in 1948, in terms of having increasing utilisation of non-NHS providers in the delivery of health care to NHS patients, including the use of overseas health care centres, it has also increased in size. The number of NHS bodies, employees and clinical events has increased phenomenally since 1948. This increase in size of the NHS and the number of both staff involved in delivering health care and patients receiving that health care have meant that the regulatory structures, that were sufficient to meet the aim of public protection in previous decades, may be inadequate to achieve the same aim in the modern era of health care delivery. It is important to remember that it is not just in the NHS that health care is delivered and the independent delivery of health care has increased too, both that which delivers health care for the NHS and that which provides health care outside the NHS. Simply put, there are a

considerable number of HCPs to regulate and a large number of clinical events for which protection must be provided.

The form of the NHS is a fast changing one that has to adapt to new initiatives and policies. For the HCPs that work within its structure, this means new working practices, with the development of new roles for some and the reduction of boundaries between different HCP groups. Whilst Chapter 3 will examine this further, it is sufficient to note here that changes in the roles of HCPs, and the development of new roles to meet the changes in health care, necessitate changes in the existing regulation to ensure that the regulation can provide the objectives it has been set.

There is no mistaking that the NHS is again at another crossroads. Whatever the shape of the NHS in the future, it will be radically different from that which we know today. This change is essential for the NHS to survive in any form which will continue the principles upon which it was founded, of creating a welfare system that cares for all based upon a universal national insurance system, free at the point of delivery. As will be seen in chapter 3, medicine, nursing and the other professions that provide the health service are providing new techniques and ways of providing that treatment and care. Society too is developing and, as it does so, its requirements upon the NHS change accordingly. At the present time, the emphasis of the NHS appears to be shifting from being a system based upon 'cure' to one that focuses on prevention of illness and the promotion of 'good health'. The NHS, to date, has been an organic organisation that has adapted to change in a flexible and progressive manner. It will need to continue to do so. However the NHS emerges, there will be a need to regulate it and to regulate the professionals that work within it.

Chapter 3

Health Care Professionals

Introduction to chapter 3

In order to regulate a specific entity, such as a Health Care Professional (HCP), it is necessary to know the nature of this entity; to know who it is that is being regulated. Therefore, before examining the actual regulation of health care professionals in Part 3, it is appropriate, and necessary, to firstly explore the theoretical concept of a profession; to discover what it is that distinguishes a professional from a non-professional, and in particular a HCP from other professional groups and from health care workers; and to establish the definition of HCP for the purpose of this thesis.

The chapter investigates why individuals and occupational groupings wish to consider themselves as professionals within the health care sphere and assess the benefits to be gained from being recognised as a professional. This includes an examination of the question, whether being seen as a professional gives any advantage to the individual and/or professional group.

The main emphasis of this chapter is therefore, what do we mean by profession and professionals? The first part of this chapter will address this question. This will be followed by a section examining what a health care professional is, followed by an analysis of the roles and functions of the two HCP groups upon which this thesis is focusing. This will, in turn, be followed by an exploration of the boundaries within which HCPs work and will consider the blurring that has occurred in these boundaries in recent years. Finally, the role of health care workers will be addressed.

1. What is a profession?

There are various ways of approaching the distinction between professional and non-professional. Indeed, there is nothing new about the study of professions and professionals, and the ways in which they are distinguished from other occupational groups and workers. In the 1960's and 1970's, there was increased interest in the work on distinguishing

professionals from other workers.¹ Historically, professions have existed and been recognised as such since the eighteenth century.² The occupations that have been accepted as being professional have been those of divinity, law and medicine. Other occupational groups have laid claim to being professional and, over time, many have been accepted by society as such. However, whether society sees an occupational group as being a profession, or not, depends upon the dominant viewpoint within that society as what constitutes a profession. Some of the more common traditional models and theoretical concepts, that have been used to distinguish between professionals and non-professionals, will be considered here.

The first approach to be examined is that of the taxonomic, an approach which according to Saks '*rests on the tenet that professions both possess some unique characteristics which set them apart from other occupations and play a positive and important role in the division of labour in society*'.³

There are two variations to the taxonomic approach to professions, the trait and the functionalist. The first to be considered is that of the 'trait' view. For Saks, this consists of '*the formulation of a list of attributes which are not theoretically related but which are held to represent the core features of professional occupations*'.⁴ There is a wide degree of variation between the traits that can be included as representative of a profession. For instance Millerson⁵ notes that there are some twenty three distinct traits associated with professions. However, amongst these variations the following are typically represented: a body of theoretical knowledge; the setting of standards of education and training; education

¹ For instance see Witz A (1992) Professions and Patriarchy Routledge, London.

² Macdonald K. (1995) The sociology of professions Sage, London.

³ Saks M (1983) 'Removing the blinkers? A critique of recent contributions to the sociology of professions' The Sociological Review 31 (1) at page 2.

⁴ Ibid, at page 2.

⁵ Millerson G (1964) 'The qualifying associations: a study in professionalisation' Routledge & Kegan Paul in Hughes M (2000) Professionals and the management of organisations Chapter 1 in Hall L & Marsh K eds.(2000) Professionalism, policies and values Greenwich University Press, Greenwich.

and training of a set duration; a code of ethics that is set and maintained by the profession; independent or autonomous practice; a controlled entry to the profession, usually through a form of competence testing and granting of a licence to practise; and, the profession runs its own licensing and admission boards.

Because some occupations may not possess all the traits that are considered to be vital for a profession, there is a continuum between those occupations that are considered full professions possessing all the necessary traits, those that are full occupations and not possessing any of the traits, and those that are considered to be semi-professions possessing some of the necessary traits. These latter occupations are considered to be progressing along a path that may eventually see them emerging as a full profession.

According to Etzioni⁶, the semi-professions are a group of new professions whose claim to the status of traditional professions is not fully established. He makes the claim that these newer professions have a less legitimate claim to the status of a profession, because they do not meet the criteria established for professional status. Typical characteristics of a semi-profession, when compared to a profession, include: shorter training; a less specialized body of knowledge; less autonomy, as they are subject to more supervision (that is, they are supervised by, and accountable to, a senior in their organisation) or bureaucratic control (administrative authority) than the professions, they may even be subject to the authority of members of another profession (note medical historical dominance of nursing); client trust in the semi-professional is not so crucial, which can be seen when comparing that of the doctor and nurse; and, membership of many of the semi-professions is predominately female.

The functionalist view of the taxonomic approach is that professions have a central role within society and that this relates to the values of the

⁶ Etzioni A (1969) The Semi-professions and their organization Free Press / Prentice Hall, New York.

society. The central tenet of the functionalist approach asks, what is the distinctive role of the profession in maintaining the interests of society? Thus, health would be seen as a central value within society and something that is so important for society, and the social groups that comprise the society, that without it society would not be able to function. The work undertaken by the members of the profession requires a high level of theoretical knowledge, expertise and skill that the client would not possess. A possible disadvantage of this approach is that the client may be at risk of exploitation by the professional. This, in turn, results in the profession taking steps to prevent this exploitation; this is usually in the form of accepted practices and professional standards. This may take the form of entry criteria, ethical principles, concern for social interest rather than self-interest, measuring the competence of practitioners, adherence to a disciplinary framework and adoption of codes of practice.

Although the profession adopts the standards and practices to protect the client, the profession also confer on its members certain privileges and standing. There is a form of social contract between society and the profession. In exchange for high status and income, the profession guarantees a high standard of service through the adoption of the professional standards and accepted practices discussed above. In the words of Schröck, *'the autonomy and control granted to the professions over their members by the wider society and their general activities are part of a contract or bargain by which the professions guarantee to the community an expert service of high standard'*.⁷

Another approach to assessment of professions to be considered is that of the neo-Weberian view of social closure. This refers to the profession's ability to close their occupation to 'outsiders' and thus increase their own value within society. For Saks, professions *'regulate market conditions in their favour, in the face of actual or potential competition from outsiders, by restricting access to specific opportunities to a limited group of*

⁷ Schröck R (1987) 'Professionalism - a critical examination' Recent Advances in Nursing vol. 18 p. 12 - 24 at page 12.

eligibles'.⁸ Macdonald, writing in 1995⁹, echoes this view, seeing professional groups attempting to close the economic and social opportunities of the profession to outsiders through monopoly of the profession. Therefore, social closure may be seen as a form of occupational monopoly that seeks to maintain privileges and benefits for those who are members of the profession.

More recently, there has been an evolution of these previous approaches to professions. Some of this re-evaluation has arisen as a result of changes in society and, therefore, the changes in beliefs and values held by society.¹⁰

Schröck considers that neither the trait nor functionalist view of the taxonomic approach is an appropriate manner in which to assess professional status in contemporary society. The taxonomic approach is seen as failing because of the inaccurate notion that recognition is accorded by society when in essence the status of profession is accorded to a social elite who have been '*persuaded that there is some special value in the work of an occupational group which is aspiring to professional status*'.¹¹ The traits that are needed to determine professional status are not determined by society, neither is the central value accorded to professions within the functionalist approach.

For Beaty, '*the term professional describes an attitude to work and not merely a type of job. To take a professional approach means acting in a professional way. It involves an approach to life and work which includes taking responsibility, being creative and critically questioning our own individual practice*'.¹² She goes further to state that this approach centres upon personal professional growth and the ability to

⁸ Saks M (1983) 'Removing the blinkers? A critique of recent contributions to the sociology of professions' *The Sociological Review* 31 (1) at pages 5 - 6.

⁹ Macdonald K. (1995) *The sociology of professions* Sage, London.

¹⁰ Taylor S & Field D (eds) (1997) *Sociology of Health and Health Care* Blackwell Science, Oxford.

¹¹ Schröck R (1987) 'Professionalism - a critical examination' *Recent Advances in Nursing* vol. 18 p. 12 - 24 at page 15.

¹² Beaty L (2000) 'Becoming a professional teacher' Chapter 3 in Hall L & Marsh K eds. (2000) *Professionalism, policies and values* Greenwich University Press, Greenwich at page 17.

undertake effective practice that is focused upon this growth. Additionally, professionals learn and develop from their experiences, and their reflections on the way that they have interacted with these experiences. She sees the professional as continuously developing along a continuum from novice to expert, and that this development is never complete.

Other approaches to the re-evaluation of the concept of professions and professionalism have arisen as a result of the rise of the feminist perspective. For instance, Davies¹³ argues that we should transcend the traditional views of professions, which she argues are based on outdated views of masculinity and its associated traits. She advocates a new vision of professions that is less gender dominated and views each professional as having equal value within the professions. In her view, the specialist was seen as having higher status than the general practitioner in any professional field because of the gender biased beliefs and values held by those who defined professions, in particular that of mastery of knowledge.

The new vision of professions that Davies puts forward is based upon a reflective approach to practise, with collective responsibility and interdependent decision making involving patients and colleagues as appropriate, as opposed to a traditional view of professions that she believes emphasises a mastery of knowledge, unilateral decision making, autonomous practice and individual accountability.

In contemporary society, being a professional goes beyond the classical neo-Weberian concept of social closure; though elements of the approach can be applied to the professional concept in contemporary society. Likewise the traditional taxonomic approach is not an acceptable means of identifying what is and is not a profession. However, this does not imply that there are not traits or functions that can be applied to a profession. Rather, it means that one must go beyond the purely taxonomic approach to identify the concept of professions in a modern society. One must apply

¹³ Davies C (1996) 'A new vision of professionalism' *Nursing Times* vol. 92 no. 45 p. 54 – 56.

the traditional approaches to that of the newer viewpoints on professions and professionals. This in turn produces a viewpoint that is applicable and pertinent to the professions that exist in modern society. It is this hybrid viewpoint that will be utilised in this thesis.

The characteristics that may be said to exist in all modern professions include those of expertise, autonomy and credentialism.¹⁴ Expertise relates to the knowledge, skills and application of judgment and discretion that the professional uses to determine how best to perform their services, rather than merely following a set of rules for a particular state of affairs. The expertise of any given profession is self-contained and independent. Autonomy being the ability of the professional to work within their field of expertise with the capability and discretion to determine what is within their area of competence and what they would need to refer for assistance. Freidson's concept of credentialism refers to the credentials that a professional has as evidence of their competence within the profession.¹⁵

Credentialism may be said to exist where *'professions ... have an element of control over recruitment and training, together with control over standards of performance, an expectation of Continuing Professional Development (CPD) and, frequently, a code of ethics. Normally there is a long training process, often with incremental stages clearly delineated from novice to expert, and often a clear career progression route'*.¹⁶ In addition, the profession functions as gatekeeper through the use of entry qualifications to the profession and/or a licence to practise.

Freidson's three characteristics of a profession enable the profession to have its own area of jurisdiction, or self-contained field, over which it has influence. As Freidson notes, a profession is *'an occupation that controls*

¹⁴ Freidson E (1994) Professionalism Reborn: Theory, Prophecy and Policy Polity Press, Oxford.

¹⁵ Ibid.

¹⁶ Brown S, Bucklow C & Clark P (2002) 'Professionalising teaching' ILT Newsletter No. 9 p. 6 - 9 at page 6.



*its own work, organised by a special set of institutions, sustained, in part, by a particular ideology of expertise and service’.*¹⁷

Thus, although the characteristics of being a profession can be identified, there are additional elements within the definition. It is these additional elements that render the definition of use in modern society, for professions and professionals are not static entities; they are organic and evolve over time and with the society.

In modern society, being a professional means more than membership of a particular guild or organisation that has certain traits or characteristics that make it stand apart from others. It means more than merely becoming a member of a particular group. To be a modern professional, one has to continue to develop one’s skills, abilities and knowledge; in essence one’s competence must be maintained and continue to advance.

Beatty suggests a model of professional behaviour that can be seen to demonstrate this adaptation; a model that may be described as a continuum that exists from the novice to the expert. She writes that *‘in this model, skill is acquired through routine practice and decision making. Thus, for the novice, experiential knowledge is small and decisions will be tentative and rule bound to avoid mistakes. After some experience the application of rules becomes more automatic and there are fewer surprises in practice. Thus longer-term goals become visible and procedures are applied routinely and with less anxiety. The expert moves beyond rules to more ‘intuitive’ action where a deep understanding of context informs a view of what is routine and what is novel’.*¹⁸

The professional is treated differently from non-professionals, or what this thesis will term workers. One of the key features of a professional is that they are allowed a degree of autonomy or discretionary judgment that is

¹⁷ Freidson E (1994) Professionalism Reborn: Theory, Prophecy and Policy Polity Press, Oxford at page 10.

¹⁸ Beatty L (2000) ‘Becoming a professional teacher’ Chapter 3 in Hall L & Marsh K eds. (2000) Professionalism, policies and values Greenwich University Press, Greenwich at page 18.

not open to their worker colleagues.¹⁹ It is the professional who determines their sphere of expertise and whether they are competent to undertake a particular role or not. There are also differences in the way that society views the relationship it has with both professions and worker groups. The member of the occupational group performs their role according to a form of master-servant relationship; their expertise is given on request. To the professions, it gives a mandate, the ability to tell society how an aspect of societal life should be governed, what is right and what is wrong; the professional has the responsibility to inform society of how it needs to operate for the good of society. For instance, medicine informs society of the importance of diet and exercise in leading a healthy life.

This interplay between society and the professional is key to the aim and hypothesis of this thesis. As noted in Chapter 1 section 5, regulation should be enabling for the HCP as well as being controlling. This results in the trade-off between society and the HCP; as noted above the HCP has the autonomy to undertake their professional role (the enabling element of regulation) whilst at the same time being subject to regulatory control (the control element of regulation, for the HCP this would relate to the five elements of regulation introduced in Chapter 1 section 4)²⁰.

2. What is a Health Care Professional?

From section 1 above, the professional is seen as being someone with a degree of discretion in their activity, expertise and competence in their field, autonomy, and, a continuum of education throughout their career from the novice to expert. This section will develop this in relation to the concept of the HCP through examination of: competence; autonomy; the difference between HCPs and other professionals; and legal definitions of the HCP. This will set up the definitions of HCP and health care worker that will be used throughout this thesis.

¹⁹ Autonomy is discussed in more detail below in section 2.2

²⁰ The five elements being: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practise.

2.1 Competence

Competence, as mentioned above, refers to the capabilities of the HCP, their skills, abilities, knowledge and judgment. It is related to, but distinct from, performance; it is possible for a HCP to perform well but in a very limited area, to do one thing very well, but when the circumstances are changed the performance deteriorates. Thus the performance is not universal, and it may be said that the HCP does not have the necessary skills, abilities and knowledge to be competent in undertaking these tasks, the performance is good but in a restricted or limited area of practice.

Competence is thus more than having a skill or performing a task; it involves the judgment and discretion to be able to choose how to perform a particular task, which technique to utilise, when to undertake it and in what manner it should be used. The professional is able to judge when a particular task is outside of their level of competence and when to refer to another professional, or to decline the task altogether. This may be referred to as clinical autonomy in the case of the HCP.

Thus, the competent HCP does not need supervision as they can effectively supervise themselves. As the Nursing and Midwifery Council (NMC) note competence is '*possessing the skills and abilities required for lawful, safe and effective professional practice without direct supervision*'.²¹ The HCPs professional practice is effective because they are aware of both their abilities and limitations, when to intervene and, of equal importance, when to request assistance. Expertise is linked to competence, as competence increases so does expertise.

The aim of regulation is therefore to ensure that the HCP is only able to practise in the areas in which they were competent and not those where their competence was limited, unless they were practising under the supervision of another HCP who is competent to provide that supervision. This aspect of regulation may be said to be connected to the HCP's own

²¹ Nursing and Midwifery Council (2004) The NMC code of professional conduct: standards for conduct, performance and ethics Nursing and Midwifery Council, London, at section 6.2.

accountability in that, by having the status of a professional, the HCP has to exercise their own judgment and discretion in accepting and undertaking roles and tasks.

It is the initial preparation of all professionals that should enable them to be able to determine their own competence, and to know when they are and are not able to undertake a specific task and what to do when they are not able to achieve something, for example to make a referral to another professional, or how to gain the competence that they lack. The initial education of all professionals should include preparation in the concept of professional work and the responsibilities that go along with the role. This would include achieving competence in decision making and problem solving.

In order to achieve registration, the HCP has to demonstrate that they are competent to practise. However, competence should not be seen as a static achievement that is achieved at the point of registration; there is a need to maintain and develop competence. Within the health field, the development of HCPs' competence has been addressed through the notion of continuing professional development (CPD). CPD can be said to be *'the process by which health professionals keep updated to meet the needs of their patients, the health service, and their own professional development. It includes the continuous acquisition of new knowledge, skills, and attitudes to enable competent practice'*.²³

Various commentators have postulated a number of incentives for professionals to undertake CPD. These include: the financial, where there is an increase in salary or bonus payable on completion of the required amount of hours or credits; the use of penalties for those who do not complete the CPD requirements, which can be financial; mandatory

²³ Peck C, McCall M, McLaren B & Rotem T (2000) 'Continuing medical education and continuing professional development: international comparisons' British Medical Journal vol. 320 p. 432 - 435 at page 432.

requirement to enable professional to undertake a contract with, for example, insurers or hospitals; and status based incentives, where those who have completed the requirement for CPD have their names on published lists of professional bodies.²⁴ However, there has been suggestion that the main drivers for CPD are '*legislated revalidation and recertification of practitioners*'.²⁵

Any system of regulation has to ensure that the correct incentive, whether through the use of reward or retribution, is in place to guarantee that HCPs undertake CPD to maintain and further their competence.

2.2 Autonomy and accountability

Autonomy is a key feature of being a HCP and is related to competence. As can be seen above, to be autonomous the HCP has to have reached a standard of practice, i.e. be competent. Integral to autonomy, and the notion of being a professional, is accountability.

HCPs are accountable; they may be removed from their respective registers because their accountability is monitored by statute through a statutory body. This statutory body, as shall be seen in Part 3, governs the education and training and hence entry to the profession through the use of the register. Removal from the register removes ones right to practise. Workers may have a form of government list or a trade body that maintains a list of those holding certain qualifications; however, not being on the list will not necessarily prevent someone from offering their services in the particular trade.

Indeed, Freidson has stated that '*the only truly important and uniform criterion for distinguishing professions from other occupations is the fact of autonomy*'.²⁶ If Freidson is correct in this assertion, then the regulatory framework that HCPs are currently working within should provide for

²⁴ For instance see Peck C, McCall M, McLaren B & Rotem T (2000) 'Continuing medical education and continuing professional development: international comparisons' British Medical Journal vol. 320 p. 432 - 435.

²⁵ Ibid, at page 435.

²⁶ Freidson E (1970) Profession of Medicine Dodd Mead, New York at page 82.

their autonomous practice. In particular, as noted within the hypothesis, any regulation that exists should not interfere with the legitimate exercise of autonomy, for instance clinical discretion in the treatment of a patient, but rather have a framework in place that supports the HCP in their clinical discretion.²⁷

2.3 Comparisons with other professionals

In many ways the HCPs are no different to other professionals. However, as Sritharan et al²⁸ note, almost fifty percent of British medical students and ninety eight percent of American medical students swear some form of oath during their medical education. This is either on entry to medical school or on graduation, that is, during their entry into the profession. Not everyone agrees with oath-taking by medical students. It can be seen as a bid for respectability, a form of paternalism or an indicator of inflated self-importance. However, for Sritharan et al, the oath, or declaration, allows the medical student to pronounce '*their commitment to assume the responsibilities and obligations of the medical profession*'.²⁹ In addition, the principles, virtues and values that '*guide modern medical practice*'³⁰ are all encompassed within the oath or declaration.

The swearing or affirmation of an oath or declaration is a practice that is not common amongst non-medical professionals; indeed it is not even common amongst other health care professionals. However, where it is utilised, and some authors are reporting a '*resurgence of professional interest in medical oaths and codes of conduct*',³¹ it does mark a difference to other professionals.

The legitimacy of medicine as a profession is recognised '*symbolically by the very head of state. Here there are Royal Colleges of surgeons, of*

²⁷ Freidson's assertion regarding autonomy is the enabling aspect of regulation examined in Chapter 1 section 5.

²⁸ Sritharan K, Russell G, Fritz Z, Wong D, Rollin M, Dunning J, Morgan P & Sheehan C (2001) 'Medical oaths and declaration' British Medical Journal vol. 323 p. 1440 - 1441.

²⁹ Ibid, at page 1440.

³⁰ Ibid, at page 141.

³¹ Hurwitz B & Richardson R (1997) 'Swearing to care: the resurgence in medical oaths' British Medical Journal vol. 315 p. 1671 - 1674 at page 1671.

*physicians, and of general practitioners. To this has been added parliamentary recognition of the virtues of professional self-regulation, and legislation creating a General Medical Council (GMC) to determine whether or not a “doctor” should obtain registration’.*³² To this should be added the nurse, who also has a Royal College and whose registration is protected.

Another difference between the HCP and other professionals is that the State, in the form of the National Health Service (NHS), provides employment as well as defining HCPs’ activities.³³ However, it is important to note the significant contribution made by non-NHS providers of health care to both NHS patients and those patients in the independent sector.³⁴ Therefore any system of regulation needs to be able to regulate those HCPs within the NHS and those without as well.

2.4 Boundaries between health care professionals

So far this thesis has explored the notion of the HCP as a group distinct from other professional groups. This clearly raises the issue of whether HCPs can be seen as a single entity. The more ‘professions’ there are in the health care field, the more boundaries between the different professional groups will need to be clearly demarcated. If there are no differences between the various HCP groups then the question has to be asked, are they distinct professionals or not?

The individual professional groups in the health care arena would not see themselves as a single entity. Rather, they would point to the distinct differences between their roles. However, as will be discussed below, the boundaries between the various HCP groupings is becoming blurred and, it may be argued, that there are more similarities between some than there are differences. However, although HCPs may be classified as a group that is distinct in some ways from other professional groups, within the

³² Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham at page 2.

³³ Macdonald K (1995) The sociology of professions Sage, London.

³⁴ This was discussed further in Chapter 2.

classification of those seen as HCPs there are still distinctions between what one professional group, for example doctors, may do that another professional group, for example nurses, may not do. Thus although, as will be seen, there is a blurring between the traditional boundaries and some overlap between the roles of the various health care professional groups, there are still differences between the main roles and tasks that each of the individual groups perform. This will be explored in greater detail below,³⁵ but is raised here to acknowledge that all HCPs are not the same.

2.5 Legal definition of health care professional

Several Acts of Parliament make reference to HCPs.³⁷ What is interesting, about the references they make, is that they define a HCP as someone who is registered with one of a list of regulatory bodies.³⁸ The regulatory bodies being those bodies that are under the remit of the Council for Healthcare Regulatory Excellence: the General Medical Council, the General Dental Council, the General Optical Council, the General Osteopathic Council, the General Chiropractic Council, the Royal Pharmaceutical Society of Great Britain, the Nursing and Midwifery Council, and the Health Professions Council.³⁹ There are some anomalies within the legislation regarding the nature of a HCP, for instance some Acts of Parliament take the view that a HCP is someone other than a medical practitioner, implying that somehow

³⁵ See section 5 below.

³⁷ For instance: Fatal Accidents Act 1976; National Health Service Act 1977; Police and Criminal Evidence Act 1984; Road Traffic Act 1988; Road Traffic Offenders Act 1988; Access to Health Records Act 1990; Transport and Works Act 1992; Data Protection Act 1998; Health Act 1999; Freedom of Information Act 2000; National Health Service Reform and Health Care Professions Act 2002; Police Reform Act 2002; and, Health and Social Care (Community Health and Standards) Act 2003.

³⁸ As an example, the Health and Social Care (Community Health and Standards) Act 2003, section 172, states a '*health care professional means a person who is a member of a profession regulated by a body mentioned ... in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002*'.

³⁹ National Health Service Reform and Health Care Professions Act 2002, section 25(3),

a medical practitioner is different to a HCP.⁴⁰ However, it is the wider view of the definition of HCP that will be adopted for this thesis.⁴¹

Therefore it may be said that the legal definition of a HCP has to include with it some element of registration with a regulatory body, so fulfilling one of the criteria of a profession as discussed above in section 1. The health care worker⁴² is unregistered and so fails on that criterion.

However, it is argued by this thesis that being registered with a regulatory body does not, in itself, make someone a HCP. There are other essential characteristics, such as those discussed above, that are also needed.

2.6 Definition of health care professional

The definition that one applies to the HCP is important as it will affect who should be under the auspices of the various types of regulation that affect HCPs and their practice.

In the discussion above in section 2.2, it was stated that autonomy is the key factor in determining whether an occupational group could be considered a profession, or not. Given this definition, nursing may not be considered a profession as it does not have full autonomy. There may be many reasons put forward for this but Liaschenko & Peter believe that the most significant is the '*complex hierarchies [that nurses work in] where they are subordinate to organizational structures, professional agendas, and the culturally-endorsed cognitive authority of medicine*'.⁴³

⁴⁰ For instance see Transport and Works Act 1992, section 38 at 2A and Police Reform Act 2002, section 55 at 4A(a and b).

⁴¹ It is interesting to note that there are some that may be seen as HCPs, such as psychologists that currently are not under the remit of a regulatory body. Although it has been proposed that psychologists be regulated by the Health Professions Council, this is not currently the case as the British Psychological Society is of the opinion that not all psychologists work within the health care field. For instance see British Psychological Society (2008) 'Psychologists still await news on regulation' available via [http://www.bps.org.uk/media-centre/press-releases/releases\\$/statutory-regulation/await.cfm](http://www.bps.org.uk/media-centre/press-releases/releases$/statutory-regulation/await.cfm) accessed on 10th May 2008.

⁴² See section 7 below.

⁴³ Liaschenko J & Peter E (2004) 'Nursing ethics and conceptualizations of nursing: profession, practice and work' *Journal of Advanced Nursing* vol. 46 no. 5 p. 488 – 495 at page 489.

Etzioni, above, puts forward the proposition of professions and semi-professions; one of the distinctions between the two is the degree of autonomy that of occupational group.⁴⁴

Autonomy has been considered above, specifically in section 2.2; however, it is worth noting the point made in Chapter 2 regarding the power relationship between medicine and nursing.⁴⁵ It is true that '*medicine as a profession continues to enjoy power and influence*' whilst nursing has a '*subordinate position in relation to medicine*'.⁴⁶ This is because medicine has a degree of control over the actions of nurses and hence may be said to be the dominant actor in the relationship between the two. Thus, in the relationship between the two, it is nursing that has less autonomy. Whether this means that they lack autonomy altogether is debateable as they have autonomy in the way that they perform the order and instruction of doctors.

Although nursing may not be seen as being a profession using the criteria established by Etzioni, as it is a semi-profession that has an element of autonomy, it will be considered a profession as opposed to an occupation for the purpose for this thesis.

Therefore, for the purposes of this thesis, a health care professional will be taken to mean someone working within health care who has a clinical role with patient contact: has a nationally recognised qualification validated by one of the regulatory bodies; is registered with a regulatory body; has elements of accountability and competence; and has an aspect of independent practice or autonomy. The other individuals who work in health care will, for the purposes of this thesis, be termed health care workers.

⁴⁴ Etzioni A (1969) The Semi-professions and their organization Free Press / Prentice Hall, New York.

⁴⁵ See Chapter 2, specifically sections 1.1 and 1.2.

⁴⁶ Williams A (2000) Nursing, medicine and primary care Open University Press, Buckingham.

Therefore the two HCP groups that are the subject matter of this thesis,⁴⁷ doctors and nurses, are both HCP groups for the purposes of this thesis.

3. Preparation of health care professionals

Entry to the various health care professions is controlled by the regulatory bodies, which have a say in core curricula, to a greater or lesser extent depending upon the particular profession.⁴⁸ The Departments of Health and Education also have an interest, and a voice, in the various training programmes. Thus, one of the propositions of this thesis is that the training and education leading to entry to professional registers is an aspect of the regulation of HCPs. Indeed, as seen in Chapter 1, it encompasses two of the elements that need to be regulated to achieve the regulatory aims of public protection and patient safety; those of protection of titles and registration and, education for initial registration. As such, the main discussion will occur in Part 3, where the types of regulation to which HCPs are subject are the focus. For the present, it is sufficient to highlight a few points of relevance to this chapter's subject matter.

The purpose of training and education for entry to the regulatory body of the HCP is that it prepares the HCP for their autonomous practice.

In the 2005/06 academic year, there were 6,298 students admitted to medical school, whilst in the 2004/05 academic year there were 25,016 pre-registration nursing and midwifery places.⁴⁹

There is no one set national curriculum for medical students or students of nursing or midwifery. Whilst the various interested bodies may make suggestions and recommendations and the regulatory bodies present core elements that must be delivered, the educational establishments are free to develop their own curricula, subject to receiving approval from a regulatory body. Thus, parity between the various curricula cannot be

⁴⁷ See introduction section 3.1.

⁴⁸ Chapter 7 provides further information on the educational requirements for entry to the professional registers.

⁴⁹ Department of Health (2006) Chief Executive's Report to the NHS: statistical supplement June 2006 Department of Health, London, at page 35.

guaranteed; at best, one can only say that a minimum standard is achieved.

It may be surprising to note that HCPs as a whole do not have a single standard of educational level for entry to their professional registers. Indeed, for nursing, there is not even a national educational standard that has to be achieved. Some pre-registration training programmes are at diploma level, whilst others are at bachelor's degree level, with many institutions offering both levels of training to prospective students. Although Northern Ireland, Scotland and Wales have moved to an all-graduate entry to the nursing profession, England has not. Therefore any system of regulation will have to provide for the differences in the preparation of the HCP, even though they achieve the same registration.

4. Traditional roles, functions and responsibilities of health care professionals

This section of the thesis examines the traditional roles of HCPs, the doctor and nurse, before exploring, in later sections, the ways in which boundaries between roles have been blurred or broken, and new roles have emerged and developed.

The aim of all HCPs is the health of the patient and, ultimately, that of society as a whole. However, within this aim are differing approaches, strategies and philosophies as to the focus of the HCP's intervention. There have been many attempts to define the actual role of the doctor and of the nurse.⁵⁰

Nursing duties were those that were taught during basic nurse training, training that led to registration or entry onto the nursing roll. Anyone who had met the requirements for entry to the nursing register or nursing roll was expected to be able to competently undertake these roles and tasks. Until relatively recently, it may be said that nursing had a task orientated

⁵⁰ For instance see Clarke A (1991) 'Nurses as role models and health educators' Journal of Advanced Nursing vol. 16 no. 10 p. 1178 - 1184.

mentality.⁵¹ Clarification of the position of the nurse with regard to basic and extended roles was obtained with the publication of a circular from the Department of Health & Social Security,⁵² which was supported by a joint document from the Royal College of Nursing and British Medical Association.⁵³

Both documents clearly spelt out that anything which was not covered in the nurse's basic training was considered to be an extended role⁵⁴ and could only be undertaken under the supervision of doctors, once the nurse had followed an approved course to achieve competence.⁵⁵

This had important connotations for the regulation of both these groups as it meant that the doctor had an increased level of accountability in relation to the nurse, and was in fact accountable for some of the nurse's actions in relation to roles and tasks that the doctor had delegated. This relates to the medical dominance of nursing examined in section 2.6 above.

There may appear to be a dichotomy between the roles of the doctor and nurse in that the doctor's role is concerned with diagnosis and curing the patient of their ailment whilst the nurse's role is to care for the patient whilst they are awaiting this cure. Yet this is not a dichotomy, but the focus of the interplay between the role of the doctor and that of the nurse and how both contribute to the overall benefit of the patient.

Cure relates to the resolution of a health problem. It may mean that the problem is in remission or being managed rather than the problem has

⁵¹ Naughton M & Nolan M (1998) 'Developing nursing's future role: a challenge for the millennium: 1' *British journal of Nursing* vol. 7 no. 6 p. 983 – 986.

⁵² Department of Health and Social Security (1977) Extended role for the nurse HC (77) 22 Department of Health and Social Security, London.

⁵³ Royal College of Nursing & British Medical Association (1978) The duties and position of the nurse Royal College of Nursing & British Medical Association, London.

⁵⁴ Extended role is used in this thesis to mean a role or task that is not in the HCP's initial training or education that leads to registration, whilst expanded roles are those that were previously undertaken by the HCP but are now undertaken to a higher level of competence.

⁵⁵ See section 6 below for further discussion of extended roles.

been totally resolved and no longer exists; whereas care relates to the activity of supporting someone through an illness.

Clarke's⁵⁶ viewpoint is that caring is connected with empowering patients, that to empower the patient to achieve their own health goals is the ultimate form of caring. That care, rather than cure, is associated with nursing is for some commentators a strength of nursing as it allows the nurse to focus on people, and the way that individuals live, work and feel; that the ability of the nurse to perceive the uniqueness of the individual patient is a distinction that moves from the notion that the body is a machine that is in need of repair.⁵⁷

If there were only one aspect to the health of the patient, either care or cure, the patient's experience of the health process would be limited and in many cases incomplete. The patient would not receive the treatment that they needed; and the HCPs looking after the patient would not meet all the patients' needs. When care and cure are undertaken together, a more holistic approach to the health needs of the patient is possible. Both the doctor and the nurse need to be involved in meeting the health needs of the patient. Both need to fulfil their roles, yet what is the interplay between these roles and who, if anyone, is in overall charge?

If one were to ask a member of the general public for their view it is most likely that they would see a nurse, at best, as someone who administers treatment on the orders of a doctor or, at worse, the doctor's handmaiden or helper. Yet, was this the case?

In a case that predates the NHS, the power relationship between the doctor and the nurses was clearly laid bare. According to Goddard LJ *'it is part of the nurses' duty as servants of the hospital, to attend the surgeons*

⁵⁶ Clarke A (1991) 'Nurses as role models and health educators' Journal of Advanced Nursing vol. 16 no. 10 p. 1178 - 1184.

⁵⁷ Department of Health (1993) The challenges for nursing and midwifery in the 21st century: the Heathrow debate HMSO, London.

and physicians and carry out their orders'.⁵⁸ Later, when discussing operations, he states, *'I would suppose that the first thing required of a nurse would be an unhesitating obedience to the orders of the surgeon'*.⁵⁹ There can be no doubt where the courts believed the power lay.

Therefore, as discussed above, the doctor would have the increased accountability over the nurse and therefore be regulated accordingly, with the nurse being accountable to the doctor.

Following the formation of the NHS, this relationship continued. As seen in Chapter 2,⁶⁰ doctors were given a powerful position in the structure of the newly formed NHS which, may be argued, continues to this day. As Field and Taylor state *'the final agreement between the government and the medical profession guaranteed the professional autonomy and clinical freedom of doctors ... the NHS thus confirmed the power of the medical profession, especially the medical hierarchy, over other health professionals, including nurses'*.⁶¹

In 1981, the House of Lords, by a majority, held that where nurses undertook the instructions of a registered medical practitioner for treatment that was prescribed and initiated by that practitioner, the treatment, in this case termination of pregnancy, was deemed to have been undertaken by the registered medical practitioner.⁶² The logical extrapolation of this is that the doctor accepts responsibility for ordering the treatment but that the nurse has responsibility for following the doctor's instructions.

It is not only the courts who see nurses as being subservient to doctors. In the first international code for nurses published in 1953, one of the tenets

⁵⁸ Gold and Others v Essex County Council [1942] 2 All ER 237 at page 249.

⁵⁹ *Ibid*, at page 250.

⁶⁰ See Chapter 2, section 1.2.

⁶¹ Field D & Taylor S (1997) 'Health and health Care in modern Britain Chapter 2 in Taylor S & Field D (eds) (1997) Sociology of Health and Health Care Blackwell Science, Oxford at page 33.

⁶² Royal College of Nursing of the United Kingdom v Department of Health and Social Security [1981] AC 800.

was *'the nurse is under the obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures'*.⁶³

Henderson, in a seminal and oft quoted work on the essence of nursing,⁶⁴ believed that the role of the nurse encompassed a unique and a collaborative element. The unique element consists of those aspects of work which the nurse initiates and controls as an independent practitioner; it involves decision making to arrive at a prescription for nursing care. Its purpose is to assist the patient in the activities they would undertake themselves, if they could, that contribute to health and recovery. The nurse assists the patient in such way as to promote independence in the patient. The collaborative element of the nurse's role occurs when nurses work with other health care professionals and workers. For Henderson, nurses work in a cooperative manner when working in a multidisciplinary team. An example of this would be the administration of drugs: the doctor prescribes the drugs, the pharmacist dispenses them, but the nurse gives the drugs to the patient. In Henderson's view, the nurse is dependent upon the doctor to prescribe the drugs and the doctor is dependent upon the nurse to ensure that the correct patient receives the correct drug at the correct time.

Thus, for the beginning of the NHS, it was the doctors who made decisions regarding diagnosis and treatment. It was they who prescribed medication. Nurses would follow doctors' treatment orders, give the medication that was prescribed and add in nursing care, as appropriate to the patient's regime, so as to be able to achieve the doctors' instructions. The nurse was clearly the doctor's assistant or, in some cases, their handmaiden. As the NHS progressed so did the relationship between the two professions. Such that, in 1992, the nurses governing body issued a code of professional conduct that stated nurses should *'work in a*

⁶³ International Council of Nurses (1953) International Code of Nursing Ethics available from the International Council of Nurses website http://www.icn.ch/regnetbul2_99.htm accessed on 8th October 2005.

⁶⁴ Henderson V (1966) The Nature of Nursing MacMillan, New York.

collaborative and cooperative manner with health-care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team'.⁶⁵

The relationships between the health care professions have continued to evolve, as have the individual roles of the professions. The rest of this chapter will examine the ways in which the boundaries within which HCPs work are being blurred and the ways in which their traditional roles, functions and responsibilities are changing.

5. Changes to health care professionals' boundaries

In the last twenty years or so, the roles of HCPs have changed dramatically. The aim of this section is to explain some of the reasons why the boundaries that previously existed between doctors and nurses have become blurred and, in some cases, broken.

There are numerous influences that have affected the boundaries between the various health care professions. Some of these may be categorised as internal factors and others as external. Internal influences are taken to mean those influences that arise within the health care profession itself. Whilst external influences are those that arise from sources that are not within the control or remit of the health care profession. This section will use these two categories to address the blurring and breaking of boundaries that have occurred.

5.1 Internal challenges to health care profession boundaries

One of the ways in which professional boundaries are broken is when one group of HCPs wishes to strengthen their case for being deemed a profession.⁶⁶ This has happened to nurses, who have willingly taken on roles and tasks from other professions in an effort to strengthen their

⁶⁵ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) Code of professional conduct 3rd edition United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London at clause 6.

⁶⁶ For discussion on the basis of being a profession see section 1 above in particular Freidson E (1994) Professionalism Reborn: Theory, Prophecy and Policy Polity Press, Oxford.

professional standing.⁶⁷ At the same time another profession has to be willing to devolve itself of certain roles and tasks; in the case of nursing, this other profession has invariably been that of medicine.

In 1997, the then General Secretary of the Royal College of Nursing (RCN), Christine Hancock, stated that '*nurses are continuously pushing at the boundaries of care. We are creating new and expanding roles, based on our skills and experience. As a result, we are raising standards of patient care*'.⁶⁸

Prior to 1992, when the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) published 'The Scope of Professional Practice',⁶⁹ nurses were constrained by what they could and could not do. Nurses were directly, or more usually, indirectly supervised by medical staff for extended roles, that is those roles and tasks that were not part of their basic training, for example intravenous medication. They had to have undertaken training courses which increased their competence and receive a certificate confirming the fact before they could undertake these extended roles and the tasks had to be authorised by their employer. Even when the employer had authorised the task and the nurse had their certificate of competence, the task was usually undertaken according to a rigid protocol. Often these certificates had to be retaken when moving from job to job, and employer to employer, as one employer would not recognise the certificate of another.

When the UKCC published 'The Scope of Professional Practice'⁷⁰ in 1992, it was a landmark position paper for the development of nursing practice. The UKCC effectively removed the need for nurses, midwives and health visitors to achieve extended training certificates issued on the completion

⁶⁷ Beardshaw V & Robinson R (1990) 'The New Nursing' Chapter 3 in New for Old? Prospects for nursing in the 1990s The King's Fund, London.

⁶⁸ Royal College of Nursing (1997) Continuing Professional Development : an RCN Guide Royal College of Nursing, London at page 2.

⁶⁹ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992a) Scope of professional practice United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

⁷⁰ Ibid.

of study days before being able to perform a particular procedure. Instead, the nurse was able to decide, using their professional judgment, whether they had the necessary skills knowledge and ability to undertake any procedure that was necessary for the care of their patients, and to decide what skills and knowledge they needed to develop their practice. Where the nurse was confident of their competence they were able to undertake that procedure, where they were not confident of their competence they were to gain assistance from a professional colleague, nurse or doctor, in performing the procedure, or to request that individual to undertake the procedure for them.

The Scope of Professional Practice position paper⁷¹ provided a framework that encouraged nurses to be flexible in their approach to care delivery and to adapt to the changing health care environment by extending the boundaries of their practice whilst keeping the patient as the focus of their efforts. It encouraged nurses, midwives and health visitors to consider how their practice could meet patient needs; whilst at the same time emphasising that accountability for their practice rested with the individual nurses, midwives and health visitors and that they needed to ensure that their practice was based upon knowledge, skills and competence and that they needed to attain, maintain and develop these. As a result, there has been an abolition of the term extended role, nurses can perform any task, procedure or role, not restricted by legislation,⁷² that they feel competent to undertake, thus liberating nurses from the previous bureaucratic process of developing roles and resulting in the removing of boundaries to the development of nursing practice. As the UKCC stated, '*it is the Council's principles for practice rather than certificates for tasks which should form the basis for adjustments to the scope of practice*'.⁷³

⁷¹ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992a) Scope of professional practice United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

⁷² For further discussion on this point see section 6 below.

⁷³ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992a) Scope of professional practice United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London, at page 8.

It may be said that the removal of the need for certificates of training in extended roles was one of the biggest changes in health care professions' boundaries and led to the development of Nurse Specialists, Nurse Practitioners and, ultimately, the Nurse Consultant.⁷⁴

The medical profession has also been instrumental in the blurring of boundaries between HCPs. As well as consenting to nurses undertaking tasks previously defined as being medical, in 1993, the General Medical Council (GMC) published its recommendations on undergraduate medical education,⁷⁵ where they stated that there was a blurring of boundaries between health care professions with several professions overlapped in terms of skills and responsibilities. They went on to recommend there be a redistribution of tasks and roles between the various professions.

5.2 External challenges to health care profession boundaries

As discussed in the conclusion to Chapter 2, the NHS has been subject to various influences that have affected its development. Some of these influences have resulted in changes in the roles of HCPs and thus affected the boundaries between the health care professions. Doyal & Cameron believe that 'since the 1970s there have been irresistible pressures towards collaborative working across traditional boundaries'.⁷⁶ Whilst Dowling et al stated that '*the boundaries between the clinical work of doctors and that of nurses in the acute sector are being redrawn owing to a complex mixture of pressures coming from new technologies and treatments, changing patterns of health care delivery, and the processes by which services are purchased and provided*'.⁷⁷

Whilst this still applies today, other changes have occurred as a result of the strategy for health care and reform of the NHS pursued by

⁷⁴ For more these roles see section 6.1 below.

⁷⁵ General Medical Council (1993) Tomorrow's Doctors: recommendations on undergraduates medical education General Medical Council, London.

⁷⁶ Doyal L & Cameron A (2000) 'Reshaping the NHS workforce' British Medical Journal vol. 320 p. 1023 – 1204 at page 1023.

⁷⁷ Dowling S, Barrett S & West R (1995) 'With nurse practitioners, who needs house officers?' British Medical Journal vol. 311 p. 309 – 313 at page 309.

Government.⁷⁸ For instance, NHS Direct, announced in 1997,⁷⁹ has resulted in the employment of nurses who do not have direct hands-on patient contact. Instead they follow protocols and assessment/treatment algorithms, and provide a form of advanced triage and advice service to the general public.⁸⁰ Previously, in 1994, the English National Board for Nursing, Midwifery and Health Visiting (ENB) produced guidelines⁸¹ as a response to the developments occurring in the NHS that were changing the focus of nursing and the skills needed to meet the change. The guidelines were aimed to provide managers with a benchmark to measure '*clinical excellence*' and to ensure that the '*right skill mix*' was achieved in clinical practice.⁸²

Additionally, NHS Trusts have examined the skill mix of their staff to achieve cost savings, reorganise patient care and provide a more efficient service, resulting in role changes.

However, it is the more recent reforms that have had the greatest impact upon the boundaries between HCPs. The publication of 'Making a difference'⁸³ prepared the way for nurses to work in innovative ways that allowed them to push at the traditional boundaries, as it promoted the increased contribution of nurses to health care in the modern NHS. The document also saw a need for modernisation of the education of nurses to

⁷⁸ For instance: advances in technology that have resulted in shorter patient hospital stays; changes in NHS organisation meaning nurses are in more senior roles; patient and society's expectations of the NHS and health care, requiring quicker access to health care and thus introduction of nurse-led clinics; and, financial considerations, nurses are cheaper than doctors.

⁷⁹ NHS Direct was announced in Secretary of State for Health (1997) The New NHS. Modern. Dependable. Cm 3807 The Stationery Office, London at paragraph 1.11 and pilot services began on 1st March 1998.

⁸⁰ Shamash J (1998) 'Between the lines' Nursing Standard vol. 12, no. 28, p. 22 - 23.

⁸¹ English National Board for Nursing, Midwifery and Health Visiting (1994) Reframing the framework: A manager's perspective English National Board for Nursing, Midwifery and Health Visiting, London.

⁸² *Ibid*, at pages 3 - 4.

⁸³ Department of Health (1999a) Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare Department of Health, London.

⁸⁶ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London, in particular see sections 8 and 9.

enable them to undertake these increased roles with the appropriate skills and knowledge in a flexible and creative manner that benefits patients.

Introduced in 2000, the NHS Plan advanced the notion of new roles for health care professionals and the removing of traditional barriers between HCPs, thereby allowing role extension and development.⁸⁶ Indeed it is a specific tenet of the NHS Plan that the traditional boundaries between HCPs have held back clinical reform in the NHS.⁸⁷ This develops the approach taken in the strategy for nursing and midwifery published in 1999,⁸⁸ where it was stated that *'developing roles and improving services go hand in hand. Using nursing, midwifery and health visiting expertise more effectively as part of multidisciplinary team development is good for patients ... We support and want to encourage these developments. We expect NHS organisations to support the role developments we have proposed and to continue to support, monitor and evaluate those now taking place'*.⁸⁹

Within the NHS Plan is a list of ten key roles that the Chief Nursing Officer believes nurses should be able to undertake.⁹⁰ Undertaking these roles

⁸⁷ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London, at paragraph 9.5 which states *'the new approach will shatter the old demarcations which have held back staff and slowed down care. NHS employers will be required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs'*.

⁸⁸ Department of Health (1999a) Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare Department of Health, London.

⁸⁹ *Ibid*, at paragraphs 10.46 and 10.47.

⁹⁰ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London, at paragraph 9.5, the ten key roles are: *'to order diagnostic investigations such as pathology tests and x-rays; to admit and receive referrals direct, say, to a therapist or a pain consultant; to admit and discharge patients for specified conditions and within agreed protocols; to manage patient caseloads, say for diabetes or rheumatology; to run clinics, say, for ophthalmology or dermatology; to prescribe medicines and treatments; to carry out a wide range of resuscitation procedures including defibrillation; to perform minor surgery and outpatient procedures; to triage patients using the latest IT to the most appropriate health professional; and, to take the lead in the way health services are organised and in the way that they are run'*.

⁹² The NHS plan (Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London) outlines key new roles for nurses, see section 6 below for discussion of these new roles.

will certainly blur the boundary between medicine and nursing as many of these roles were the domain of doctors.⁹²

If there is any doubt as to the commitment of the Department of Health, and thus the NHS, to the removal of boundaries between HCPs, then the statement released in 2001 should clarify the position.⁹³ In a section entitled 'new ways of working' the following statement is made: *'over the last few years many doctors, and the clinical teams in which they work, have identified new ways of delivering care which have made their services more responsive to patients, more effective and more efficient ... an ethos of multi-professional team-based practice is becoming the dominant way of delivering services'*.⁹⁴

The above statement should also clarify that, where nurses take on extra roles, it is because the medical profession has allowed them to do so.⁹⁵

In order to modernise the various pay systems and conditions of service that existed within the NHS, 'Agenda for Change' was introduced.⁹⁶ It affects all NHS staff except those HCPs covered by the doctors and dentists pay review body and senior managers and is based upon job evaluation. As well as being a pay system, 'Agenda for Change' is also a system of rewarding staff for the skills they use in their jobs.⁹⁷ There is a job evaluation element to it that encompasses an annual appraisal for all staff that is linked to a knowledge and skills framework. Initially all staff will have their position attached to a job profile that will determine their

⁹³ Department of Health (2001a) A Commitment to Quality, A Quest for Excellence - A statement on behalf of the Government, the medical profession and the NHS Department of Health, London was a position paper that outlined the commitment to the NHS of the Government and medical profession.

⁹⁴ Ibid, at page 4,

⁹⁵ The statement was signed by the Secretary of State for Health, the Chief Medical Officer and the Chairs or Presidents of the medical Royal Colleges and Committees but by no other health care professional body.

⁹⁶ Department of Health (1999b) Agenda for change: modernising the NHS pay system Department of Health, London.

⁹⁷ Agenda for Change is a national system of pay review and includes harmonisation of terms and conditions across all staff included within its remit; it also includes standardisation of on-call allowances, working hours, overtime, London weighting payments, annual leave, and unsocial hours payments. It commenced on 1st December 2004 with pay and conditions backdated to 1st October 2004.

position on the pay bands. Following this, it is the annual job evaluation and appraisal that will determine how individuals progress through the pay scheme to higher bands.⁹⁸

This affects the boundaries between HCPs because it is a scheme that rewards staff for the skills they have and not their job title; therefore it encourages HCPs to develop their skills and knowledge in order to increase their position within their pay band and to progress to the next band. Thus, a HCP who develops their practice, gaining extra skills and responsibilities, thereby extending their role, will be rewarded through the pay scheme.

Arguably one of the major challenges to professional boundaries has been the need to counter the effect of the reduction in junior doctors' hours.⁹⁹ The agreement between the government and junior doctors in 1991 meant that no junior doctor should work more than 72 hours per week.¹⁰⁰ This would be further reduced to 48 hours, from 2009, under the Working Time Directive.¹⁰¹ Coupled with the recommendations on specialist training for doctors from the 1990s,¹⁰² this has effectively resulted in a reduction in the number of junior doctors working in the NHS, with a further effective decrease when the requirements of the Working Time Directive¹⁰³ are met in full in 2009.¹⁰⁴

⁹⁸ Information on Agenda for Change available from Department of Health 'Agenda for change' webpage available at <http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaForChange/fs/en> and Royal College of Nursing 'Agenda for change' webpage available at <http://www.rcn.org.uk/agendaforchange/>.

⁹⁹ It was the National Health Service Management Executive (1991) *Junior Doctors: The New Deal* The Stationery Office, London that initiated the reduction of junior doctors' hours.

¹⁰⁰ Ibid.

¹⁰¹ The Working Time Directive is Council Directive 93/104/EC which was incorporated into English law through the Working Time Regulations 1998 (SI 1998/1833) and subsequently amended by the Working Time Regulations 1999 (SI 1999/372). Although initially junior doctors were excluded from the Working Time Directive, an amendment to the original Directive (Council Directive 2000/34/EC) included them within it.

¹⁰² Department of Health (1993a) *Hospital doctors: training for the future. The report of the working group on specialist medical training* (Chairman: Kenneth Calman - The Calman Report) Department of Health, London recommended shortening specialist training for doctors.

¹⁰³ Council Directive 2000/34/EC

The reduction in junior doctors' hours and change in medical training¹⁰⁵ has created many opportunities for nurses. There has been a need to examine workloads and skill mix with the result that new clinical roles for HCPs are being developed to replace the roles previously undertaken by junior doctors. As a consequence, the boundary between medicine and nursing is becoming blurred. Nurses have been effective in pushing the professional boundaries because they have had the support of the medical profession, who have recognised the need for nurses to assume the roles that they are unable to continue to perform. This is interesting because traditionally medicine has been the area which provided the most opposition to the change in the boundary between nurses and doctors.

5.3 Boundaries in health care

It is important to emphasise the dynamic nature of health care because, as health care changes and the NHS is reorganised, the roles of the HCPs that provide the clinical aspect of care delivery have to adapt to that which results. For instance, Manley believes that '*the interface between nursing and other professions will always have to be considered if nursing is to remain responsive to changing health care needs within a dynamic society*'.¹⁰⁶

In recent years, the roles of HCPs have become increasingly fluid to accommodate the many drivers of change that are occurring. The reasons for change are varied and some of these drivers are internal to the professions, but have become increasingly external recently. Thus, the drivers may be said to originate from the political and the health care arenas as well as from the health care professions themselves.

¹⁰⁴ MacDonald R (2004) 'How protective is the working time directive?' British Medical Journal vol. 329 p. 301 – 302, calculates that United Kingdom will require an extra 12,550 doctors as a consequence of the Working Time Directive.

¹⁰⁵ This is explored further in Chapter 8, section 3.1.

¹⁰⁶ Manley K (1996) 'Advancing practice is not about medicalising nursing roles' Nursing in Critical Care vol. 1 no. 2 p. 56 - 57 at page 56.

Boundaries between the health care professions are less clear than they used to be and may be said to be blurred. The result of this is that the traditional roles of HCPs have evolved so that the modern HCP is undertaking a different role to that of their predecessors. As the HCP advances its own role, it comes up against a boundary with another HCP, one whose role is being encroached upon. This will result in a boundary change and an evolutionary change in both medicine and nursing. It is this change in role that will be the focus of the next section in this chapter.

6. Contemporary Health Care Professionals' roles

HCPs' roles and responsibilities are affected by the changes in society and the changes in the NHS. The roles and responsibilities of all health care professionals need to be examined in the context of the change and development of the health care within the UK. The NHS has not been a static organisation since its inception in 1948.¹⁰⁷ Rather it has metamorphosed and undergone both evolutionary and radical reorganisation to become the NHS that is recognisable today. As the NHS has changed, so has the role and function of the various health care professionals that it employs.

The aim of this section is to explore the changes that have occurred in the roles of the various HCPs, from the traditional role discussed in section 4 above, now that boundaries between the various health care professions have blurred and, in some cases, broken, as discussed in section 5 above. The outcome of this section will be a description of the HCPs who are the subject of this thesis, the contemporary doctor and nurse who is affected by the regulation that will be examined in Part 3.

6.1 Extension of nurses' roles

The traditional nurse, discussed in section 4 above, is well and truly gone. In recent years, the nurse's role has extended into many other health care professions, especially that of the doctor, so that they are unrecognisable from the nurse of twenty or thirty years ago. Indeed, it may be said that it

¹⁰⁷ See Chapter 2.

is nurses who have benefited the most from the changes in boundaries between the health care professions, and the reasons for these changes have been discussed above.¹⁰⁸

As well as extending their remit into areas that were the traditional preserve of the doctor, there have been moves within nursing to extend and promote nursing knowledge. For the most part this has been seen as advanced nursing practice, that is, nurses who work at a level of practice that exceeds that expected of, or undertaken by, the average nurse. This is not a new phenomenon and has been debated within nursing for some time. In the past few years, several new roles have been created for nurses¹⁰⁹: for instance, specialist practitioners,¹¹⁰ modern matrons,¹¹¹ advanced practitioners,¹¹² and nurse consultants.¹¹³

¹⁰⁸ See section 5 above.

¹⁰⁹ Department of Health (1999a) Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare Department of Health, London, stated that there was to be development of a modern career framework for nurses.

¹¹⁰ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) The future of professional practice – the Council's standards for education and practice following registration United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London. The UKCC proposed that beyond initial registration there be an additional specialist level of practice and registration.

¹¹¹ Although the traditional matrons were phased out of the NHS after Ministry of Health and Scottish Home and Health Department (1966) Report of the committee on senior nursing staff structure (The Salmon Report) HMSO, London and seen as obsolete by Department of Health and Social Security (1983) NHS Management Inquiry Report (The Griffiths Report) HMSO, London, they were reintroduced as Modern Matrons in Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London. In National Health Service Executive (2001) Health Service Circular 2001/010 Implementing The NHS Plan - Modern Matrons Department of Health, London '*modern matrons are seen as being accountable for a group of wards and in control of the resources necessary to sort out the fundamentals of care, backed up by appropriate administrative support*', at paragraph 2.

¹¹² Advanced practitioners are known by a variety of titles and the term advanced practice or practitioner needs further clarification. However, one accepted term for an advanced practitioner is that of the clinical nurse specialist who, according to Dickson, combines '*in-depth medical knowledge with an expertise in dealing with the impact of illness and disability on the lives of their patient*' (Dickson N (1998) 'Blurring professional boundaries' BMA News Review May 1998 p. 30). Advanced practitioners go beyond specialist practice to become an expert and leader in their field.

¹¹³ Initially announced as a consultation by the National Health Service Executive (1998) Health Service Circular 1998/161 Nurse Consultants Department of Health, Leeds; the posts were established by National Health Service Executive (1999) Health Service Circular 1999/217 Nurse, midwife and health visitor consultants Department of Health, London, where the establishment of the positions was said to '*provide better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity to help retain experienced and expert nurses, midwives and health visitors in practice*' at page 5. In 2003, there were said to be 1,000 nurse

The important point of these changes in roles for both regulation in general and for this thesis is that all of these new roles have to be regulated along with those that have previously existed. The framework of regulation that exists for HCPs has to be able to regulate new roles; otherwise additional types of regulation will need to be put in place to provide the necessary public protection and patient safety. Whether it is feasible to have a single regulatory framework that regulates both the previously existing roles of HCPs, as well as the new roles that have been, and are being, developed will be explored later in this thesis.

In addition to the extension in roles discussed above, nurses are also progressing through the management structure, and being appointed to the management boards of NHS Trusts. Within the Department of Health there is a nursing position, Chief Nursing Officer, who provides professional advice on nursing to the department and ministers and reports directly to the NHS Chief Executive. Thus, the regulation that is in place needs to provide a framework that extends from the novice HCP through to the highest levels of HCP practice.

Even where today's nurses do not actually have a new role, they are taking on tasks that would have been unthinkable twenty years ago.

6.1.1 Role extension

There are many examples that could be presented to demonstrate the myriad ways in which nurses have extended their practice into areas traditionally the preserve of other HCPs. However, the following will serve to illustrate this point.

consultants according to Carr-Brown J (2003) 'Super-nurses set to earn £65,000' The Sunday Times News Section p. 8. The nurse consultant position is based around four functions: expert practice; professional leadership; education and training of others; and, practice development and research.

Some of the tasks previously undertaken by doctors that are becoming extended roles for nurses include: cardioversion;¹¹⁴ coronary angiography;¹¹⁵ discharging patients from day surgery units;¹¹⁶ inserting central catheters;¹¹⁷ administering thrombolysis;¹¹⁸ performing minor surgery, ordering electrocardiograms and x-rays, and running minor injury clinics;¹¹⁹ and, venous cannulation, venepuncture, suturing, and verifying of death.¹²⁰

Various commentators have described the extension in nurse's roles. For instance, Radcliffe notes that nurses are '*developing increasingly technical skills in various specialities. In some assisted conception units, for example, nurses are reimplanting embryos as well as looking to train in harvesting eggs*'.¹²¹

Akid describes how four nurse practitioners have joined consultant teams working in obstetrics and gynaecology to take on many of the roles that junior doctors traditionally undertook. These roles include pre-assessment before admission, management of the elective surgery diary, undertaking ward rounds with senior doctors and arranging discharge summaries.¹²² Pollard describes the introduction of a nurse led percutaneous endoscopic gastrostomy service, a service that is normally undertaken by doctors, detailing how the nurses who were chosen to undertake this role underwent a training programme that introduced them to a protocol devised by senior medical and nursing staff, and that each

¹¹⁴ Currie M, Karwatowski S, Perera J & Langford E (2004) 'Introduction of nurse led DC cardioversion service in day surgery unit: prospective audit' British Medical Journal vol. 329 p. 892 – 894.

¹¹⁵ Smy J (2005) 'In the doctors' domain' Nursing Times vol. 101 no. 22 p. 24 – 25.

¹¹⁶ Fessey E (2005) 'Implementing nurse-led discharge from day surgery' Nursing Times vol. 101 no. 16 p. 32 – 34.

¹¹⁷ Hartley J (2005) 'Children have faster service as nurses take on central catheter insertion role' Nursing Times vol. 101 no. 24 p. 9.

¹¹⁸ Armstrong L (2003) 'Clot busters' Nursing Times vol. 99 no. 5 p. 41 - 42.

¹¹⁹ Department of Health (2004f) Developing key roles for nurses and midwives: a guide for managers Department of Health, London.

¹²⁰ Furlong S & Glover D (1998) 'Confusion surrounds piecemeal changes in nurses' roles' Nursing Times vol. 94 no. 37 p. 54 – 55.

¹²¹ Radcliffe M (2003) 'Forward Role' BMA News Review 1 Feb 2003 p. 13 - 14 at p. 13.

¹²² Akid M (2001) 'Is there a nurse in the house?' Nursing Times vol. 97 no. 14 p. 13.

nurse was trained by a doctor specialised in the procedure and supervised by a specialised consultant surgeon.¹²³

Laurance writes of a nurse who claimed to have performed than 200 operations. He reports that a theatre nurse was undertaking minor surgical procedures and received backing from the BMA, who were reported as saying '*why shouldn't nurses carry out simple operative techniques? ... simple procedures can quite simply be carried out by nurses*'.¹²⁴ The nurse was reported to draw up her own surgery list and assist in the training of junior doctors, albeit informally. Leifer,¹²⁵ writing about the same nurse, states that there had been opposition to the nurse performing surgical procedures and that her employing NHS Trust ensured that there was always a doctor available for her to call on for assistance.

Strachan-Bennett discusses the forming of a nurse-led orthopaedic unit where nurses undertake the role of junior doctors in its entirety as, although there are consultant surgeons and anaesthetists, there are no junior doctors.¹²⁶

6.1.2 Protocols

In relation to role extension, it is interesting to note that when undertaking these roles nurses usually work under agreed protocols, with these protocols being decided and written by doctors, or as least agreed by doctors, usually the consultant in charge of that particular area.¹²⁷ The protocols are used as a reference guide for the nurse. They provide guidance including what to do in various circumstances, outline treatments and procedures that the nurses may and may not undertake,

¹²³ Pollard C (2000) 'A PEG service with nurses at its heart' *Nursing Times* vol. 96 no. 39 p. 39 - 41.

¹²⁴ Laurance J (1996) 'BMA backs nurse who performed 200 operations' *The Times* 24th June 1996 p. 4.

¹²⁵ Leifer D (1996) 'The future of nursing?' *Nursing Standard* vol. 10 no. 41 p. 13.

¹²⁶ Strachan-Bennett S (2004) 'Nurses lead the way' *Nursing Times* vol. 100 no. 8 p. 20 - 21.

¹²⁷ For instance see Marshall J (1997) 'Protocols and emergency nurse practitioners' *Nursing Times* vol. 93 no. 14 p. 58 - 59.

and give authorization of agreed procedures and treatments. They be said to limit the HCPs discretion because the protocol is quite rigid with regard to its outcomes. This relates to the points made above that nurses work under the direction of doctors and thus may not have full autonomy in their clinical practice.¹²⁸

Protocols can be useful in obtaining a consensus from all the HCPs involved; those that used to undertake the role and those that intend to undertake the role. All can agree as to the circumstances when the procedure should be undertaken; the training that is necessary; the method of undertaking the procedure; the level of supervision required; and any review that is necessary.

The protocols can be quite detailed and give the nurse little or no opportunity for autonomous practice, thus nurses can have little or no freedom to use their own clinical and professional judgment. Legge describes a computer based protocol system used for nurse screening of out-of-hours calls for general practitioner services managed by nurses from a minor injury centre. The system prompts the nurse with questions to ask based upon responses to previous questions.¹²⁹

Thus, the expansion of the nurse's role may not be as groundbreaking as previously stated and could be said to be merely an extension of their traditional role that requires the permission and supervision of doctors.

6.1.3 Support, or lack of support, for nurses' role extension

As can be imagined, the extension of nurses' roles has its supporters and those who believe it is not a positive move. Those in the former camp believe that nurses can undertake roles previously undertaken by doctors

¹²⁸For example, see section 2.6 above.

¹²⁹ Legge A (1998) 'Nurse-led hospital service takes on GPs' night calls' Nursing Times vol. 94 no. 2 p. 57.

at least as well as doctors did, if not better, and to the satisfaction of the patients.¹³⁰

Those who are less supportive of additional roles for nurses have a number of reasons for their stance. Some believe that *'no matter how you dress it up, extended roles exist mainly to cover the cracks in the NHS'* and that this is not advantageous for HCPs.¹³¹ Some see the extension of roles as taking on doctors' cast-off roles or filling in to help reduce junior doctors' hours;¹³² whilst Williams is of the opinion that *'too many doctors are devolving too many major responsibilities to nurses, not because they think nurses can do it better, but because they don't like doing it and it's easier to get the nurse to do it'*.¹³³ There are those who do not see nurses as being as effective as doctors in undertaking the tasks in question.¹³⁴ Others believe that taking on junior doctors roles will have a negative impact both for nursing and for patients; that if the nurse takes on roles from other HCPs, then who will be left to undertake the nurse's role? It is suggested that the deficit will be filled with untrained health care workers.¹³⁵ However, not everyone sees this as being a negative aspect, Caines, former personnel director for the health service, wrote in 1998 that *'nurses should ... take over some of the work traditionally done by doctors while shedding a range of menial tasks that could be done just as well by staff with lesser qualifications'*.¹³⁶

There are those who believe that, by extending their roles, nurses are effectively fragmenting the essence of nursing; that they are creating another level of nurse, an elitist super-nurse or medical assistant, a half-

¹³⁰ For instance see Salvage J (2000) 'Jointly and severally' *Nursing Times* vol. 96 no. 27 p. 26 and Horrocks S, Anderson E & Salisbury C (2002) 'Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors' *British Medical Journal* vol. 324 p. 819 – 823.

¹³¹ Radcliffe M (2001) 'All work and no say' *Nursing Times* vol. 97 no. 34 p. 180.

¹³² For instance see Brignall J (1997) 'Hidden agenda behind push to increase nursing's role' *Nursing Times* vol. 93 no. 20 p. 20.

¹³³ Williams K (1996) 'Tell it like it is' *Nursing Standard* vol. 11 no. 2 p. 12.

¹³⁴ Cressey D (2005) 'Warning over errors in nurse spirometry' *Pulse* 10 September 2005 p. 10.

¹³⁵ For instance see Caines E (1998) 'A hole of your own' *Nursing Times* vol. 94 no. 38 p. 40 - 41. For an exploration of the role of the health care assistant see section 7.1 below.

¹³⁶ Caines E (1998) 'A hole of your own' *Nursing Times* vol. 94 no. 38 p. 40 - 41 at page 40.

breed doctor-nurse. They feel that these nurses are so far removed from the traditional nurse that they have more in common with doctors than with nurses. Phillips appears to be of this view when she stated that *'nurses no longer know what they are for. Are they to be managers of staff and writers of care plans; or quasi-doctors administering intravenous fluids or diagnosing illness in NHS Direct; or people who actually look after the sick? In recent years, they have become too grand for caring. Tasks such as washing patients, feeding them or settling them comfortably in bed are seen as too demeaning and are often given to untrained care assistants. The nurse has been reconstructed as the professional equal of the doctor, shaking off the gender and class bias that used to treat her as the doctor's skivvy'*.¹³⁷ There are those such as Shepherd who believes that nurses who wish to abandon the traditional role of the nurse and *'wish to sacrifice control over essential care to become physicians' assistants ... should forgo the right to be called nurses'*.¹³⁸ Whilst a further view against nurses taking on extended roles from doctors is that the government should be more concerned that nurses give quality nursing care rather than medical care.

It is important to note that not all nurses are currently undertaking the new roles described here. However, the changing role of nurses, and specialisation within nursing, has led in some cases to nurses having greater clinical autonomy. Along with this autonomy has come an ever changing landscape of nursing roles and responsibilities, as more and more nurses adapt to a new way of working.

The regulatory effect of nurses adopting new roles and extending the roles that they have traditionally encompassed is that it needs to be seen whether a single regulatory framework can provide the necessary regulation for both those nurses who extend and expand their professional

¹³⁷ Phillips M (2000) 'How they teach the nurses not to care' *The Sunday Times News Review* 27 February 2000 p. 6.

¹³⁸ Shepherd E & Cassidy A (1999) 'Bring back the EN: for and against' *Nursing Times* vol. 95 no. 13 p. 26 - 27.

practice along with those that do not; or, whether there should be different regulation for each of the two groups.

6.2 Boundary changes and the doctor

Although almost all HCPs have extended their role boundaries, it is the medical profession that has given up its roles to these other HCPs. The result is that whilst doctors have not changed in terms of their traditional role, many other HCPs now undertake elements of these roles and tasks. This has resulted in a more team-based approach to health care with complementary roles for the various HCPs, and the demise of the nurse as the doctors' handmaiden.

It used to be that the GP was the main gatekeeper to the NHS services,¹⁴⁸ the patient either went to see their GP or to an A & E department. Now there are walk-in clinics, NHS direct, minor injury centres etc that all provide direct patient access to the NHS. As noted in Chapter 2, these changes in the delivery of health care have an effect upon the regulation that is needed to provide public protection and patient safety. If the role of the doctor is being assumed by other HCP groups, then it may be assumed that all these groups may be regulated along the same framework as that of the doctor.

However, despite the fact that there appears to be no limit to the roles or tasks that HCPs will take on from doctors, there are still some roles or tasks that remain the exclusive legal preserve of the doctor and cannot be undertaken by other HCPs.¹⁴⁹

¹⁴⁸ See Chapter 2 section 2.

¹⁴⁹ For the purposes of clarity, it should be stated the legislation that follows uses the terms 'registered medical practitioner' and not doctor. The term doctor is used here as a shorthand and because it is a familiar title.

Only doctors can authorise and supervise termination of pregnancy;¹⁵⁰ it is an '*offence to tattoo a person under the age of eighteen except when the tattoo is performed for medical reasons by a duly qualified medical practitioner or by a person working under his direction*';¹⁵¹ whilst nurses and midwives etc may verify that death has occurred, only doctors may certify death;¹⁵² only doctors may perform female genital mutilation, where it is necessary for her physical or mental health, except where it is connected with labour or birth, where it may be undertaken by a midwife;¹⁵³ only doctors may sign statutory certificates, e.g. sick certificates for statutory sick pay purposes, the so-called Med 3;¹⁵⁴ and interestingly, until it was repealed in November 1998, the venereal disease act made it a criminal offence for anyone other than a doctor to treat venereal disease.¹⁵⁵

Additionally, although the NHS Plan introduced the 10 key roles for nurses, ¹⁵⁶ it stopped short of allowing nurses to make a diagnosis outside agreed protocols. For Bucknall and Thomas, the reason for this curtailing of nurses' ability to undertake diagnosis is because doctors have the legal authority to undertake diagnosis and treatment decisions.¹⁵⁷

Despite the various boundaries that have become blurred and broken over the last few years, there is still a unique role for doctors. However, it remains to be seen, in later parts of this thesis, whether there is a need to differentiate between the different HCP groups in terms of the regulatory framework that should be in place.

¹⁵⁰ Abortion Act 1967, section 1. However in Royal College of Nursing of the United Kingdom v Department of Health and Social Security [1981] AC 800, it was held that nurses and midwives can work under the order and supervision of doctors regarding the performance of abortion.

¹⁵¹ Tattooing of Minors Act 1969, section 1.

¹⁵² Births and Deaths Registration Act 1953, section 22.

¹⁵³ Female Genital Mutilation Act 2003, Enactment Clause 1.

¹⁵⁴ Social Security (Medical Evidence) Regulations 1976 (SI 1976/615).

¹⁵⁵ Venereal Disease Act 1917, section 1, repealed by Statute Law (Repeals) Act 1998, Schedule 1 Section 1(1).

¹⁵⁶ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London at paragraph 9.5.

¹⁵⁷ Bucknall T & Thomas S (1995) 'Clinical decision making in critical care' Australian Journal of Advanced Nursing vol. 13 no. 2 p. 10 – 17.

6.3 Prescribing as an example of role extension

In section 4 above, it was noted that, traditionally, prescribing was a medical function. However, this has been one of the areas that has undergone significant change as a result of the external changes to boundaries discussed in section 5.2 above. It is presented here as an example of how a change to one aspect of one professional group can have far reaching effects for other HCPs.

Nurse prescribing had been initially considered by the Department of Health as long ago as 1986;¹⁵⁸ when, in a review of non-hospital based nursing services, a recommendation was made that nurses should be able to prescribe from a limited list of items.¹⁵⁹ In a review of this and other recommendations from the 1986 report, the Crown Report¹⁶⁰ recommended that only district nurses or health visitors be able to prescribe from a limited list of items in a defined range of circumstances. As a result of this, primary legislation¹⁶¹ was passed in 1992 with subsequent secondary legislation¹⁶² coming into effect in October 1994.

This legalisation resulted in nurses undertaking prescribing subject to the limitations mentioned above. Subsequent reports from the Department of Health¹⁶³ have extended the range of nurses being able to prescribe, and have extended the range of items they can prescribe into a separate nurse's formulary.

¹⁵⁸ Department of Health & Social Security (1986) Neighbourhood nursing – a focus for care (The Cumberlege Report) HMSO, London.

¹⁵⁹ Ibid, at page 33.

¹⁶⁰ Department of Health (1989) Report of the Advisory Group on Nurse Prescribing (The Crown Report) Department of Health, London.

¹⁶¹ Medicinal Products: Prescription by Nurses etc. Act 1992.

¹⁶² The Medicinal Products: Prescription by Nurses etc. Act 1992 (Commencement No. 1) Order 1994.

¹⁶³ For instance, Department of Health (1999c) Review of Prescribing, Supply and Administration of Medicine. Final Report (The Crown II Report) Department of Health, London.

The Health and Social Care Act 2001 included provision for Ministers to be able to introduce new types of prescriber.¹⁶⁴ This has resulted in prescribing being extended to a wider range of HCPs for a wider range of conditions and for a wider range of medicinal items.

The changes to the type of HCPs who were able to prescribe resulted in two classes of prescriber: independent and supplementary. Independent prescribers have the responsibility for the assessment of the patient and for clinical management decisions which includes prescribing; whilst supplementary prescribers have responsibility for the continued care of a patient once they have been diagnosed, any prescribing is undertaken according to guidelines and treatment plans that have been agreed with the lead clinician who would be an independent prescriber, for example a GP.¹⁶⁵

Elliott stated that, as of June 2005, there were approximately 4,000 independent nurse prescribers who are able to prescribe from an extended nurse formulary of around 240 medicinal items, 3,000 supplementary nurse prescribers and a further 28,000 community nurses who are able to prescribe from a limited list of 100 medicinal products.¹⁶⁶

In November 2005, the Department of Health announced further reform of prescribing with the result that certain groups of nurses '*will be able to prescribe any licensed medicine for any medical condition – with the exception of controlled drugs*'.¹⁶⁷

This is a fundamental example of a role extension. As can be imagined it has not been universally welcomed by HCPs.

¹⁶⁴ Section 63 Health and Social Care Act 2001 extended prescribing rights to a much wider range of HCP including section 63(3) '*persons who are registered by any board established under the Professions Supplementary to Medicine Act 1960*'.

¹⁶⁵ Department of Health (2005c) Supplementary prescribing by nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers within the NHS in England Department of Health, London.

¹⁶⁶ Elliott R (2005) 'Should nurse prescribing expand?' GP 3 June 2005 p. 40-41.

¹⁶⁷ Department of Health (2005d) Press release 2005/0395 'Nurse and pharmacist prescribing powers extended' 10th November 2005.

Whilst doctors undertake a minimum of five years undergraduate education and further postgraduate specialist training, nurses will be able to have full prescribing powers after they have been qualified for three years, having undertaken three years of training to diploma level to become qualified, and a further thirty eight days¹⁶⁸ of specific training for their new role.

It is this training, or rather lack of it, which appears to be at the forefront of most fears regarding the prospect of these new prescribing powers.¹⁶⁹ However, the BMA reports that nurses under the new prescribing rules would not be prescribing for any condition but would be limited to their specialist areas of work.¹⁷⁰

From a position of being unable to prescribe any medicinal product, nurses now have the right to prescribe in limited situations from a limited number of medicinal products, with some nurses, notably extended nurse formulary prescribers, being able to prescribe virtually any medicinal product in any situation. This raises the issue of whether the regulation of this group of HCPs needs to be increased above that which affect those HCPs who cannot perform this extended task or do not have this particular role within their professional practice.

¹⁶⁸ O'Dowd A (2005) 'Nurses gain power to prescribe' Nursing Times vol. 101 no. 46 p. 2.

¹⁶⁹ In the three weeks following the Department of Health announcement, the various professional health journals all reported the new role with many medical journals highlighting nurses lack of education and lack of diagnostic ability as being potential problems with the new proposals. For instance, see Day M (2005) 'UK doctors protest at extension to nurses' prescribing powers' British Medical Journal vol. 331 p. 1159 and Editorial (2005) 'Nurses given full prescribing rights' Doctor 15th November 2005 p. 1.

¹⁷⁰ Editorial (2005a) 'BMA assured over controls on prescribing' BMAnews 26th November 2005 p. 1, where it is reported that the Department of Health have confirmed that '*although nurses would have a prescribing licence for the whole formulary, they would be prescribing within specialist areas in which they had received validated training*'.

¹⁸⁴ For exploration of these issues see Dowling S (1997) 'Life can be tough for the inbetweens' Nursing Times vol. 93 no. 10 p. 27 - 28.

6.4 Implications of extension and changes in roles

New roles have to be regulated, whether within the existing regulatory framework or through the use of additional types of regulation instituted particularly for these new HCPs.

The nurses who take on the roles at the edge of, or past, the traditional boundaries of nursing and medical roles can find themselves in a difficult position. They may not fit into either professional camp of nurse or doctor; they may find that they suffer from role confusion as their new role does not fit with their own philosophy of nursing and they question to what extent they are still nurses. There is also the difficulty of to whom they are responsible. There is a traditional management structure of nurses and doctors that dictates that doctors are managed by doctors and nurses by nurses. It remains to be seen whether the nurses, who have pushed past the traditional boundary to undertake roles that were the preserve of the doctor, will have a nurse as their manager or a doctor, or both.

Equally with regard to the regulatory framework, the new nurse could continue to be regulated through the traditional framework for nurses, that of the NMC, or they could be regulated by the GMC, or it is possible that there would need to be a separate regulatory body established specifically for this new group of HCPs.

If the existing regulatory framework is kept and no new bodies established, it may be difficult for the HCP to appreciate which professional guidance they should follow, that from the NMC or the GMC.¹⁸⁴

The Department of Health has attempted to clarify the legal situation, where nursing roles are being extended, in two recent publications. The first,¹⁸⁵ which states that nurses must act within the law, borders on the facile; it redeems itself by stating the minimum standard that must be

¹⁸⁵ Department of Health (2002d) Developing key roles for nurses and midwives: a guide for managers Department of Health, London, particularly section 4.

achieved, when taking on a role or task from a doctor, is the standard of a doctor undertaking the role or task. It then provides the general statement that nurses taking on extended roles need to be aware '*of the legal boundaries relating to the role*' and '*that they have sufficient training and preparation to ensure that they can perform the role to the required standard*'.¹⁸⁶ Yet, it does not provide the information regarding the legal boundaries! The second publication¹⁸⁷ merely repeats the information in the first, agreeing that nurses must follow their regulatory body's standards and suggesting that they have professional indemnity insurance.

The information, from the professional bodies and the Department of Health, is that HCPs can undertake any role that is not expressly prohibited by legislation,¹⁸⁸ provided that they believe themselves to be competent to undertake the role to the required standard, although this does not directly address the regulatory framework's issues raised above.

One solution would be that the HCP is judged against the person who normally undertakes the role. For instance, this will depend upon whether the role is still considered to be a medical one or is accepted as a nursing role. For the former, the acceptable standard will be that of the reasonable medical practitioner professing to have that particular skill, whilst for the latter it will be the reasonable nursing practitioner.¹⁸⁹

6.5 Contemporary roles of health care professionals

It is the patient that should be at the heart of any decision, for the aim of health care is to provide the best possible care for the patient. In order to meet the health needs of the patient, delivery of health care should be from the most appropriate individual able to undertake that need, and not confined to practise within traditional professional boundaries. When

¹⁸⁶ Department of Health (2002d) Developing key roles for nurses and midwives: a guide for managers Department of Health, London, at page 18.

¹⁸⁷ Department of Health and Royal College of Nursing (2003) Freedom to practise: dispelling the myths Department of Health, London.

¹⁸⁸ See section 6.3 above.

¹⁸⁹ That is applying the 'Bolam Standard', from Bolam v Friern Hospital Management Committee [1957] 2 All ER 118.

taking on new roles, HCPs need to question whether they are doing so because they wish to be seen as doctors, or in the same esteem as doctors; because they wish to advance their professional status; because they wish to work for doctors or with doctors to provide a quality patient-centred service that forms part of a total approach to caring for the patient;¹⁹⁰ and not because others no longer wish to, or are no longer able to, undertake them.

Any role extension taken on by HCPs should be one that meets a patient's needs and fits in with the HCP's other roles and duties. Personal experience suggests that it is doubtful whether the patient is concerned with who provides the various elements of their health needs, so long as these needs are met.

All HCPs play a vital role in health care and they are interdependent upon each other, although they are trained differently and their roles require different 'aptitudes'. HCPs, like any other professional, undertake work according to their ability to achieve the task. As their skills, knowledge, experience and competence develop, they take on more challenging tasks thereby extending the boundaries of their role, developing new practices for their roles and formulating new techniques for these tasks. The HCP remains accountable for the tasks they take on; along with the responsibility to keep themselves updated with regard their competence and ability to perform their role.

The introduction and evolution of new roles may be said to be one of the contributing factors in the blurring of traditional boundaries that existed between the various HCP groups. With regard to doctors and nurses, although the traditional role of the nurse as the doctor's handmaiden has disappeared, the traditional boundary between the doctor and nurse, described above, still exists for most nurses.

¹⁹⁰ For instance see Scott S (1996) 'Doctors' assistant or a Trojan horse' Nursing Standard vol.10 no. 33 p. 17.

The doctor still provides the diagnosis and the treatment plan, with the nurse providing the caring element of the patient's health care needs. There are nurses who have crossed the boundary into part of the doctor's traditional role, but these nurses are presently in the minority. The tasks and roles that these nurses have assumed belonged to the junior doctors and not to the specialist doctors or consultants. The emergence of the nurse who is able to take on the full role of the doctor remains a long way off, if it were ever to occur. The roles that doctors and nurses now have are still complementary. The nurse may be able to do more than they used to but there is still a clear demarcation between the role of the doctor and the nurse. The doctor has overall responsibility for the patient, and control over the admission and discharge of patients.¹⁹¹ In the main, the doctor still aims for cure with the nurse providing the care.

As nurses move into medical roles and tasks, it is necessary to examine what impact will this have on the delivery of health care, that is, who will do the work that nurses no longer have the time to do? The next section examines the rise of the support worker in health care.

7. Other health care workers

How does the health care worker differ from the HCP? Apart from the fact that HCPs are registered and health care workers are not, Boylan¹⁹² supports the notion made above that it is the ability to use judgment. The individual requires a knowledge base to be able to draw upon the necessary knowledge to make the judgment and the ability to change the way in which a task is undertaken to meet the situation with which the HCP is confronted. A health care worker is able to perform tasks but it is the HCP who will be able to use their judgement to decide when the task is appropriate, or inappropriate, and when it is necessary to modify the way

¹⁹¹ For instance see Department of Health (2004g) Achieving timely 'simple' discharge from hospital Department of Health, London, which discusses the legal responsibility of the consultant for the patient.

¹⁹² Boylan A (1982) 'Nursing at the crossroads 1' Nursing Times 18th August 1982 p. 1387 - 1389.

in which the task is undertaken to meet the specific needs of the patient at that specific time.

This section examines two groups of workers who are not HCPs because, as will be seen, they lack the necessary autonomy in performing their clinical role. Also, neither is subject to the regulation to which their professional counterparts, nurses and doctors respectively, are required to adhere.

7.1 Health care assistants

Health Care Assistants (HCAs) will be used to refer to unqualified health care workers otherwise known as support workers.¹⁹³ The following discussion will focus on the nursing HCA, although HCAs operate within all the health care professions and the same issues are relevant.

In 1986 the HCA role was proposed by the Department of Health and Social Security¹⁹⁴. The main reason for this was that a new form of nurse training was being introduced that would remove student nurses from the wards. This new form of training, commonly known as Project 2000, would make student nurses supernumerary to the nursing establishment and college based; previously they had been part of the nursing establishment and ward based. The aim of the introduction of the HCA was to provide support for qualified nurses, following the removal of student nurses from the workforce. The UKCC saw the HCA as being able to free qualified nurses to provide skilled nursing care, by assisting them in the more basic or non-specialist elements of nursing practice.¹⁹⁵

Since their introduction, later in 1986, the HCA role has mushroomed and now encompasses many tasks that would have been unthinkable at the

¹⁹³ Within nursing this would include nursing assistants and nursing auxiliaries, it also includes clinical support workers and health visitor assistants etc.

¹⁹⁴ Department of Health and Social Security (1986a) Mix and match: A review of nursing skill mix DHSS, London.

¹⁹⁵ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) A new preparation for practice United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

time of their conception. Indeed, many wards and departments would not be able to function without the HCA. Such is the influence of the HCA on nursing that there are many who believe that the HCA undertakes the actual essence of nursing, whilst the qualified nurses merely direct or supervise them.

O'Dowd estimates that there are 300,000 HCAs in the UK, and that 117,000 of these work within the NHS.¹⁹⁶ However, there is no formal, national training programme for HCAs, no minimum standard for their training, and they are not subject to any form of national regulation; that is, they do not need to be on a register to practise.¹⁹⁷

Just as nursing has expanded the boundaries of its professional practice and taken on roles that were traditionally the preserve of other health care groups (see section 6 above), so health care assistants are beginning to expand the range of duties that they undertake. Presently HCAs can, under the supervision of nurses, undertake a wide range of tasks and skills. HCAs are performing tasks that were the remit of the qualified nurse and, for some, should continue to be undertaken by qualified nurses.¹⁹⁸ For instance, Poole writes of HCAs who have been trained to perform venepuncture,¹⁹⁹ whilst Kenny describes a HCA who is able to '*put cannulas in*', and '*often scrubbed up to assist the surgeon in theatre*'.²⁰⁰ For Poole²⁰¹, the difference between a qualified nurse and a HCA is that the HCA does not prescribe care, but supports the nurse. As the HCA's

¹⁹⁶ O'Dowd A (2004) 'Developing the HCA role' Nursing Times vol. 100 no. 25 p 22 - 24.

¹⁹⁷ Although there have been plans to introduce regulation of health care assistants, no regulatory structure has been put in place. For instance, see Department of Health (2004h) Press release 2004/0086 'New package of regulation puts patient safety at heart of all health packages' 2nd March 2004, and Department of Health (2004i) Regulation of health care staff in England and Wales: a consultation document Department of Health, London.

¹⁹⁸ For instance see Doult B (1998) 'Concerns over HCA's role in caring for children at home' Nursing Standard vol. 12 no. 24 p. 5.

¹⁹⁹ Poole J (1998) 'A role change for auxiliaries' Nursing Times vol. 94 no. 44 p. 61.

²⁰⁰ Kenny C (2002) 'HCA dropped from role after nurses protest' Nursing Times vol. 98 no. 38 p. 7.

²⁰¹ Poole J (1998) 'A role change for auxiliaries' Nursing Times vol. 94 no. 44 p. 61.

work remains under the qualified nurse's supervision and direction, the qualified nurse is accountable and responsible for the patient's care.²⁰²

Within nursing there is a considerable amount of hostility to HCAs.²⁰³ This hostility can be seen in the frequent debates that occur in the nursing press.²⁰⁴ There has been opposition to HCAs joining a professional nursing organisation.²⁰⁵ However, in 2001, HCAs were admitted to the Royal College of Nursing.²⁰⁶

Many nurses see the HCA role as developing along the same route as that of the nursing auxiliary, who in the 1940s suddenly became enrolled or second level nurses.²⁰⁷ They are worried that the HCA will become the new non-nurse equivalent of the State Enrolled Nurse, a second level nurse who will actually undertake the nursing element of their role, leaving them, the first level or registered nurse, to manage, supervise and undertake the roles that they have assumed as a result of the blurring of boundaries that has occurred.²⁰⁸ As the boundaries between HCPs are blurring, then that between HCPs and HCAs is also blurring and the HCAs are taking on roles that were traditionally the preserve of the HCP.

²⁰² In part this is because the HCA is not regulated in their own right as HCPs are, but also because it is perceived that they do not have the training and education to allow them to work autonomously.

²⁰³ For instance, see Lambert T & Eaton A (2001) 'Should HCAs be allowed to call themselves nurses?' *Nursing Times* vol. 97 no. 15 p. 17.

²⁰⁴ For instance, see Chapman P & Glover D (2001) 'Should health care assistants be called nurses?' *Nursing Times* vol. 97 no. 45 p. 16 and, Baxter H & Radcliffe M (2002) 'Should nurses retake control of essential nursing care from HCAs?' *Nursing Times* vol. 98 no. 11 p. 16.

²⁰⁵ For instance see Kenny C (1997) 'RCN rejects health care assistants...' *Nursing Times* vol. 93 no. 17 p. 5.

²⁰⁶ HCAs working in the nursing field are now admitted into the RCN (since 2001) as associate members if they hold a national vocational qualification at level 3.

²⁰⁷ According to Dingwall R, Rafferty A & Webster C (1998) *An Introduction to the social history of nursing* Routledge, London, the Nurses Act 1943 allowed the General Nursing Council (the nurse's regulatory body at the time) to create a new 'roll' of assistant nurses. This gave legal status to the assistant nurses and created a system for their admission to and removal from the 'roll'. Assistant nurses in post at the time became enrolled. They subsequently became a second level of qualified nurse known as the State Enrolled Nurse (SEN). Those wishing to join the 'roll' in the future had to undergo two-year training. The effect was that unqualified nurse's assistants achieved qualified status.

²⁰⁸ See sections 5 and 6 above on the blurring of professional boundaries and the new roles that HCPs have assumed.

Others are concerned because they see the HCA being used to plug the gap of the shortage of qualified nurses, or even to replace the more expensive qualified nurses. Ramdhanie believes that the role of HCAs should be *'to assist professionals, not to replace them'*.²⁰⁹ The comments that have been made by, and on behalf of the government, only reinforce the views of nurses. In 2001, at a fringe meeting of the Labour Party Conference, the then Health Secretary, Alan Milburn, was quoted as stating that *'I think we fall into a trap if we assume that the only people who can care are nurses. I want to see a greater role for nursing auxiliaries [HCAs] ... just as there is a job to do to break down the demarcation between doctors and nurses, it is also time to break down barriers between nurses and auxiliary staff'*.²¹⁰ This suggests that traditional nursing roles may not necessarily be held by registered nurses, that more clinical tasks could be delegated to support workers, and that expansion of HCAs roles is very much part of the government's agenda.²¹¹

However, in order to fulfil the aim of public protection and patient safety, where tasks that have been the traditional preserve of HCPs are assumed by health care workers there would need to be a review of the regulation of health care workers. It may be that in such circumstances the health care worker needs to be subject a level of regulation that is not dissimilar to the HCP group whose roles and tasks they are assuming. Alternatively, it may be that as health care workers are only able to work under the direct supervision of a HCP, even where they assume additional roles and tasks, it is the regulatory framework of the HCP that provides the public protection and patient safety.

²⁰⁹ Ramdhanie P (2002) 'Beware: stealth care assistance' *Nursing Times* vol. 98 no. 8 p. 33.

²¹⁰ Mulholland H (2001) 'Milburn: HCAs must have 'greater role'' *Nursing Times* vol. 97 no. 41 p. 8.

²¹¹ See also, Department of Health (1999a) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare* Department of Health, London, particularly paragraph 3.13, and Secretary of State for Health (2000) *The NHS Plan: a plan for investment, a plan for reform* Cm 4818-I The Stationery Office, London, in particular section 9.13.

7.2 Medical assistants

This new role²¹² is designed, as the name suggests, to assist doctors in performing their role. They will work under the direction of a doctor, usually a GP or consultant, and be able to: prescribe; undertake one-to-one consultations including taking medical histories and making a diagnosis; manage emergencies according to their competence; request diagnostic tests; discharge patients; manage chronic conditions; provide treatment for acute conditions; make referrals to other HCPs; provide patient education; and, where they work with a GP, undertake home visits independent of their supervising doctor. They will not be able to work without supervision, even if this is indirect, and will make use of protocols to aid their work.²¹³

It is anticipated that they will undergo a two-year training programme at degree level.²¹⁴ Once qualified, they will be able to work in either primary or secondary care settings. They are essentially an anglicised version of the American physician assistants who work as '*interdependent semi-autonomous clinicians practising in partnership with physicians*'.²¹⁵

Whilst the medical profession appears to be equally split between supporting and opposing the new role, with the BMA being opposed to them,²¹⁶ it seems that the nursing profession has come out against them; one might suggest that this is because the new role will conflict with advancements being made by nurses in their own roles.²¹⁷

²¹² There are a variety of titles being put forward for this role including medical care practitioners; physicians' assistant; and, assistant practitioner.

²¹³ Hartley J (2003) 'Nurse-led practice pioneers new doctor role to assist GPs' Nursing Times vol. 99 no. 3 p. 5; Pepper D (2005) 'US-style roles 'to ease workload' Pulse 12th November 2005 p. 7; and, Cameron I (2005) 'Physician assistants 'can do majority of GPs' work' Pulse 14th May 2005 p. 8.

²¹⁴ Snow T (2005) 'Are physician's assistants worthwhile?' GP 18th November 2005 p. 16 – 17.

²¹⁵ Mittman D, Cawley J & Fenn W (2002) 'Physician assistants in the United States' British Medical Journal vol. 325 p. 485 – 487 at page 485.

²¹⁶ Newton P (2005) 'Care practitioner plan 'poses safety threat' BMANews 12th November 2005 p. 1.

²¹⁷ See the Nursing Standard and Nursing Times journals during November 2005 for a flavour of nursing opposition to the new roles.

Although this is a new role, it is interesting to note that the concept is not new and the armed forces have been using '*medical assistants to help take some of the workload from doctors*' for some time, although '*this is as much for practical purposes as anything else*'.²¹⁸

However, their regulation needs to be considered. For instance, they could fall into a category similar to the HCA where the fact that they work under the direction of a HCP means that it is the HCP who provides the public protection through their regulation and not the support worker themselves. Alternatively, the medical assistant could be regulated separately; if this was to be the case, the mechanism and framework by which this will be achieved needs to be explored. Will they be regulated alongside doctors by the General Medical Council or will there be a separate form of regulation for them? It could be that all support workers are regulated together as they provide the supporting role to HCPs and that they do not have clinical autonomy but work under the direct orders and supervision of a regulated HCP.

Conclusion

This chapter has explored the concept of the HCP, differentiated the HCP from the health care worker, and provided a definition of the HCP that will be used throughout the thesis.

The roles of HCPs have been examined, both from a traditional perspective and from the contemporary. It has been noted that, with the changes that have occurred within the health care environment in recent years, there have been resulting changes in the roles of HCPs, as well as in the boundaries between the different HCP health care groups.

²¹⁸ Clews G (2001) 'Mixed blessings' BMA News Review 1 December 2001 p. 13 – 14 at page 13.

²²⁶ See Chapter 2.

It is apparent that the roles and tasks undertaken by HCPs have undergone tremendous change in recent years; such that the role of the nurse now encompasses tasks that would have been unthinkable to those who were practising some twenty years ago. Some of these new tasks have occurred as a result of the role extension of the nurse, others have been entirely new tasks assumed from doctors, for instance prescribing. It is suggested that because of the blurring of boundaries between the different HCP groups, there are more similarities between the different HCP groups than there are differences.

With regard to the regulatory framework, these changes have an immense impact. Where the traditional HCP existed, with clearly defined roles for the various HCP professional groups, for instance the doctor providing the instruction that the nurse would follow, it was appropriate to have different regulatory bodies for the different HCP groups. However, with the blurring of boundaries that has occurred in recent years, this separation of regulation needs to be revisited to analyse whether it is still the most effective form of regulation to achieve public protection and patient safety. Where separate regulation exists for the different HCP groups, there needs to be consensus on which regulatory body and which professional guidance those who practise at the edge of health care should follow; whether it is that of their original professional regulatory body, or that of the regulatory body which undertook the regulation of HCPs who previously carried out the particular role or task.

As the changes in the delivery of health care, and in particular in the NHS,²²⁶ have not ceased but are continuing, the regulatory framework and types of regulation imposed must permit further development in the roles of HCPs.

Additionally, any type of regulation that is put in place must take account of the difference between the HCP and the health care worker. For instance, it is proposed that any form of regulation has to take account of

the need for the HCP to maintain their professional competence, as well as ensuring that their professional autonomy can be established and protected, for these are seen as being elements in the hallmark of separating the HCP from the health care worker.

Part 3

**The regulation of health care
professionals:
applying the wide definition**

Introduction to Part 3

Having provided the framework with which to analyse and evaluate the regulation of health care professionals (HCPs) in Part 1, including a discussion of the reasons for regulation and the five elements that need to be regulated to achieve the aim of public protection and patient safety. The five elements were identified in Chapter 1, section 4 as protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practise.

The contextual basis for the thesis was supplied in Part 2 with an examination of the health care arena, in Chapter 2, and an exploration of the notion of professionalism and what it means to be a HCP, including the underlying changes that have occurred in recent years, in Chapter 3, this thesis now addresses the current regulation to which HCPs are subject.

There is only one chapter in this part of the thesis. Chapter 4 presents an overview of the regulation of HCPs utilising the wide definition of regulation identified in Chapter 1. The wide definition of regulation utilised by this thesis, as found in Chapter 1, section 4, is '*the totality of the processes and systems for assuring and improving the safety and quality of healthcare*'.¹ Although the wide definition was criticised as lacking in focus and being superficial, it does have the advantage of presenting an overview of the regulation of HCPs and places the regulatory bodies, that will form the focus of the subsequent five chapters, in context. Chapter 4 identifies the types of regulation that will be considered and introduces the classification system that will be used. It then classifies each of the types of regulation into one of the four classifications. Following this, it analyses how each of the types of regulation identified affects the five elements of regulation deemed to be necessary for public protection and patient safety.

The chapters in Part 4 of this thesis will then consider the five elements of regulation from the perspective of the professional regulatory bodies

¹ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 261.

themselves, the General Medical Council and the Nursing and Midwifery Council.

Chapter 4

Applying the wide definition of regulation to health care professionals

Introduction to chapter 4

Although the main focus of this thesis is upon what it has termed the narrow definition of regulation,¹ this chapter examines the regulation to which health care professionals (HCPs) are subject using the wide definition supplied in Chapter 1, that regulation is '*the totality of the processes and systems [affecting HCPs] for assuring and improving the safety and quality of healthcare*';² that is, anything that restricts or controls the HCP in the performance of their role, to use the widest sense of the definition. This therefore goes beyond what Chapter 1 presented as the more narrow sense of regulation that this thesis is using to test its hypothesis that the regulation of HCPs is not fit for purpose.

As stated in the introduction to Part 3 the reason for including examination of the wide definition of regulation is to provide the regulatory context within which the professional regulatory bodies operate. Discussing regulation of HCPs in the context of the wide definition of regulation allows the five elements of regulation to be considered from perspectives that would not be possible if just the narrow definition was examined.

The narrow definition of regulation will be returned to in Chapters 6 to 10 where the five elements necessary for the aim of regulation to be achieved will be individually examined with regard to the professional regulatory bodies, the General Medical Council (GMC) and Nursing and Midwifery Council (NMC).

Identifying the many agencies and factors that regulate HCPs has been a complex task. The wide definition of regulation for the purposes of this thesis encompasses rules and procedures, whether of specific regulatory bodies or not, that are founded in legislation or some other authority, that are enforceable, and that may be used to prohibit an activity, to force an

¹ See chapter 1, in particular section 4.

² Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London at page 216.

activity to be undertaken or to impose standards in the undertaking of an activity.³ This, as Chapter 1 notes,⁴ means that any and all activities that limit, restrict, control or enable a HCP may be said to be a form of regulation and need to be examined. This results in a large number of types of regulation.

Indeed as identified in Part 2, there are a large number of stakeholders involved in health care, and this thesis suggests that this has resulted in an equally large number of interested parties who all desire to exert their influence upon the regulation of HCPs. Indeed, this thesis would contend that regulation has increased significantly in recent years so that there are a multitude of agencies attempting to regulate HCPs in the wide sense of the term. As Montgomery notes, professionals are subject to the same general laws and rules as non-professionals but are also subject to '*more onerous rules of behaviour*' than non-professionals.⁵

However, what has been more problematic, than identifying the types of regulation, is developing a method of categorising the different types of regulation so that they can be suitably analysed. The purpose of the next two sections of this chapter are to provide a method of categorising that regulation, followed by section 3 that highlights the various types of regulation to which HCPs are subject to in the wide sense so that the five elements of regulation may be examined and analysed from the perspective of the wide definition in the sections that follow.

1. Classification of regulatory influences

Chapter 1, section 2 provided three distinct methods of classifying regulation according to the amount of external influence and control on that regulation. However, in order to provide effective examination and analysis of the regulatory influences on HCPs, a more detailed method of

³ See Chapter 1, at page 41.

⁴ See Chapter 1, in particular section 4.

⁵ Montgomery J (2003) Health Care Law 2nd edition Oxford University Press, Oxford at page 14.

classifying these regulatory influences is needed, in addition to the categories of regulation discussed in Chapter 1.

One method of providing a more detailed category of classifying the regulation influences on HCPs, initially used in this thesis, was the compilation of a list of all those to which the HCP is deemed to be accountable. The HCP is professionally accountable in several different ways and thus a number of areas of accountability can be identified. This is because, as with any professional, there are different aspects of the HCP's role, as examined in Chapter 3, and these aspects of the role relate to different lines of professional accountability. Utilising this approach several areas of accountability may be identified, including:

- Colleagues and other professionals
- Employers
- National Health Service
- Patients
- Professions
- The public/society in general

It is then possible to utilise these lines of accountability to classify the types of regulation to which HCPs are currently subject. So that, for instance, under 'patient' there may be the NHS Ombudsman, civil law, in particular negligence, patient complaints and patient forums; whilst the 'society' category may include coroner's courts, public inquiries, criminal law, formal regulatory bodies, government organisations and QUANGOs,⁶ for example the National Institute for Clinical Excellence and the National Patient Safety Agency.

⁶ "Quango" is an abbreviation of the phrase 'quasi autonomous non-governmental organisation'. It is used to describe a public body that has responsibility for developing, managing and delivering public policy objectives at an 'arm's length' from Ministers'. Macleavy J & Gay O (2005) House of Commons Research Paper 05-030 - The QUANGO Debate at page 3, available from <http://www.parliament.uk> accessed on 16th June 2005.

However, there are differing views as to whom the HCP is accountable⁷ and so whilst this approach does allow for the identification of areas of accountability, it is open to debate as to whether a comprehensive and exhaustive list may be produced. There is also an inherent disadvantage in classifying the types of regulation to which HCPs are currently subject using these lines of accountability as categories. For instance, many of the regulatory influences can overlap into more than one category, for instance the GMC and the NMC may be seen as part of the professions influence or as being related to society in general, depending on whether one sees it as being self-regulating or state-sanctioned regulation.

A further problem with the form of classification discussed above is that it does not address the form of influence that the regulation has upon the HCP. Some regulation achieves its regulatory effect through an informal mechanism. For example, public opinion may be said to have an informal effect upon HCPs, whilst other types of regulation exert their effect through a more formal mechanism, for example the professional regulatory bodies such as the GMC and the NMC. In order to address this difference in influence, the classification of regulation needs to be explicit about the effect it has upon the HCP.

In addition, regulation and regulatory influences may be said to arise from an internal or an external perspective. For example, the court system may be said to be an external influence, whilst the Royal Colleges may be said to be internal to the professions and thus exert their effect internally.

2. Regulatory dichotomies

From section 1 above, it can be seen that a further way of distinguishing between various types of regulation, not utilised earlier, is that of the dichotomy in regulation between internal and external mechanisms and

⁷ For instance, for a comparison of different views, see: Baldwin R & Cave M (1999) Understanding Regulation Oxford University Press, Oxford; and Stewart J 'Accountability and empowerment in welfare services' in Gladstone D (1995) (ed) British Welfare: Past, Present and Future UCL Press London cited in Gladstone D (2000) (ed) Regulating Doctors Institute for the Study of Civil Society London.

also those between the informal and formal method of regulating. Indeed this is the method of categorising social control that Bosk has expounded.⁸

Bosk believes that four distinct categories of control emerge from the interplay between the two dichotomies. There is tension between the informal and formal control mechanisms and between the internal and external methods of controlling and regulating HCPs, and these tensions result in categories of regulation that are '*analytically distinct modalities*'.⁹

However, it may also be said that taken together, the four distinct methods of control form a coherent regulatory framework. The categories that Bosk proposes are the: informal-internal; informal-external; formal-internal; and formal-external.¹⁰

Moran and Wood can be said to support this division in the form of regulation at least in terms of the dichotomy between formal and informal methods of regulation. They do not go as far as Bosk in seeing the internal and external dichotomy as well. They state that '*by formal we mean based on established, published rules. These rules may be found in laws, approved by and only changeable by the legislature ... This is the most formal of all regulation. Or the rules may be drawn up and approved by the regulatory institution which makes it quite clear that all its decisions on particular cases will be based on its rules. Less formally, there can be codes of conduct, guidelines or recommendations which indicate the general thinking of the institution but do not bind it or the regulated. Finally, decisions can be entirely informal, based neither on written rules or guidelines nor on any precedents created by previous decisions*'.¹¹

⁸ Bosk C (1979) Forgive and remember: managing medical failure The University of Chicago Press, Chicago.

⁹ Ibid, at page 18.

¹⁰ Ibid, at pages 18 – 19.

¹¹ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham at page 90.

Moran & Wood go on to suggest that because of the nature of what is being regulated in health care, the informal method is less likely to be the more dominant method of regulation. Indeed, when discussing the regulatory institutions and organisations, they state that *'if rules have not been imposed upon them, they will generate bureaucratic methods of operating and will be inclined to produce their own written rules'*.¹² Indicating that they believe the formal method of regulation will always come to the fore and be the more dominant.

However, Allsop and Mulcahy do seem to be in agreement with Bosk regarding the four categories of regulation. They too suggest that regulation may be seen as being divided between formal and informal and between internal and external, resulting in the same four distinct categories of regulation that control the HCPs practice.

For Allsop and Mulcahy, *'formal is taken as an activity which is structured by written rules and procedures, while informal controls occur through day-to-day social interaction. Internal controls are those exercised within the work group ... while external controls are those exercised by those outside of it'*.¹³

This too is in keeping with Bosk's definitions of the two dichotomies that exist in regulatory structures. He too sees the external as that which is exercised by those who are not members of the group being regulated, whilst the internal is exemplified by the *'work group that disciplines its own members'*.¹⁴ It is clear that formal regulation has an element of process to it, which relates to Moran and Woods notion of rules discussed above, and informal regulation relates to that which is not set in rules, but through the ad hoc day-to-day processes of interaction.

¹² Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham, at page 90.

¹³ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham at page 4.

¹⁴ Bosk C (1979) Forgive and remember: managing medical failure The University of Chicago Press, Chicago, at page 18.

For the purposes of this thesis, the four categories are defined as follows:

- Informal-internal – this is the least regulatory of the four categories. It refers to those processes that are not based on rules and procedures but more on social interaction within the health professions themselves;
- Informal-external – refers to regulation that is not based upon rules and procedures, and is also outside of the control of the health professions;
- Formal-internal – this is a form of regulation that is based upon rules and procedures, usually written, that are within the control of the health professions;
- Formal-external – this is the most regulatory of the four categories as it relates to those types of regulation that are based upon rules and procedures that are outside the health professions control.

By the phrase ‘within the control of the health profession’, this thesis means that the members of the health professions can, individually or collectively, exert influence or control on the type of regulation in some way. For example, with regard to the professional bodies, such as the GMC and NMC, individual HCPs can currently vote for the membership of their respective councils.

The following section will identify the types of regulation that will be examined and analysed in this thesis as being those that restrict or control the HCP in the performance of their role.¹⁵ Once the types of regulation have been identified, the subsequent section will allow the various types of regulation to be placed within the framework above, thus providing the basis for the sections that follow.

¹⁵ See Chapter 1, specifically section 3 and the conclusion, for the full definition of regulation utilised within this thesis.

3. Identification of types of regulation

As noted above in Chapter 1, section 2, regulation is not a static entity and neither is it an apolitical issue; it very much has its roots in the politics of the day and this has an effect on both the nature of that regulation and the regulatory bodies that exist.

However, elements of the regulation that currently affect HCPs can be seen to have their roots in the professional dominance of the past and also with the introduction of the National Health Service, as discussed in Part 2. Indeed for Moran and Woods, writing in 1993, '*in the UK many of the regulatory processes and institutions pre-date the NHS*'.¹⁶ Whilst many of the earlier forms of regulation still exist, a number of those discussed in sections 5.3 and 5.4, below, are relatively new, having been established in the last ten years or so.

It might be expected that with regulation of such an important nature, that the regulation would arise as a result of legislation. However, as will be seen, whilst many of the regulatory agencies and bodies that impact upon the HCP are statutory in origin, there are also a considerable number that are not.

Due to the way that regulation has been introduced and built upon, it is possible to state that there does not appear to be a coherent overall framework of regulation. For instance, Allsop & Mulcahy are of the opinion that '*in the context of the NHS, rules have appeared in a variety of guises, such as British or European Union (EU) legislation, departmental circulars, judicial pronouncements, ethical guidelines, contracts and clinical protocols*'.¹⁷

¹⁶ Moran M & Wood D (1993) States, regulation and the medical profession Open University Press Buckingham at page 97.

¹⁷ Allsop J & Mulcahy L (1996) Regulating Medical Work: formal and informal controls Open University Press, Buckingham, at page 14.

3.1 Method of identifying regulation

Taking the wide definition of regulation proposed within this thesis that regulation is '*the totality of the processes and systems [affecting HCPs] for assuring and improving the safety and quality of healthcare*',¹⁸ as a starting point, it is possible to state that regulation encompasses anything that restricts or controls the HCP in the performance of their role. This will include rules and procedures, whether of specific regulatory bodies or not; that are founded in legislation or some other authority; that are enforceable; and that may be used to prohibit an activity, to force an activity to be undertaken or to impose standards in the undertaking of an activity, for example, in their clinical practice or decision-making. This specifically includes the five elements of regulation: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and fitness to practise.

Thus, in essence, any agency, organisation, factor, or process, which in the opinion of this thesis could be considered to have an impact, both controlling and enabling, on the performance of HCPs has been included.

3.2 Methodology utilised

As noted at the beginning of this chapter, the identification of the myriad forms of regulation that has an impact upon the professional practice of HCPs has not been an easy task.

Various methods were employed to identify possible types of regulation and to determine structures and organisations that may have a regulatory effect upon HCPs. These included:

- identification of case reports and detailed examination of any types of regulatory factors within;
- internet search engines, through the use of keyword searching. It was found that the initial use of the term regulation yielded other keywords that widened the original search and provided increased

¹⁸ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 261.

results in most of the methods employed. Key terms used therefore included regulation, accountability, liability, responsibility, probity, governance, health care professional and their various derivatives;

- keyword searching of LexisNexis and Westlaw, to identify legislation that may have provided a statutory basis for regulatory bodies, case reports used as described above, and journal articles;
- a modified form of documentary analysis was undertaken to search for key terms and themes relevant to regulation of HCPs. This included journal articles, newspapers, Inquiry reports and key text books, both in the legal field and those offering a social history of health care and HCPs;
- once a regulatory body was identified as being relevant for the purposes of this thesis, an analysis was undertaken of its literature and website, if applicable, to determine any related regulatory bodies; and,
- personal experience and discussion with other HCPs was also utilised.

The methods described resulted in a wealth of information that was compared against the definition of regulation put forward by this thesis. This culminated in the list of regulation and regulatory influences that currently affect HCPs in their professional practice provided in the next section.

3.3 Types of regulation identified

The following list, in alphabetical order, is the regulation that has been identified as currently affecting HCPs in their professional practice:

- Appraisal – both job related and for revalidation
- Chief Health Officers – to include their reports and recommendations
- Clinical audit
- Clinical governance

- Clinical supervision
- Colleagues and peers – including those from other health care professions
- Commission for Healthcare Audit and Inspection, now known as the Healthcare Commission
- Complaints
- Continuing Professional Development (CPD)
- Council for Healthcare Regulatory Excellence (CHRE)
- Courts – civil, coroners’ and criminal
- Department of Health - to include QUANGOS, central guidance, NHS bodies not specifically mentioned in this list, performance indicators etc
- Education and training – including for initial registration
- Employers
- European influence
- External audit – to include the Audit Commission
- Health Service Commissioner for England (HSC), also known as the Health Service Ombudsman
- Inquiries - hospital, public, inquests etc
- Legislation
- The media
- Medical Defence Organisations
- National Institute for Health and Clinical Excellence (NICE)
- National Patient Safety Agency (NPSA) – including the National Clinical Assessment Service (NCAS)
- Parliament - MPs, select committees etc.
- Public – to include patient groups, lay forums etc.
- Police - police checks and police investigations
- Professional bodies e.g. BMA and RCN
- Professional regulatory bodies e.g. GMC and NMC, including revalidation requirements
- Royal Colleges – e.g. Royal College of Anaesthetists

- Standards – whether these be guidelines, policies, protocols, they can be classified as being local e.g. hospital based or national e.g. National Service Frameworks.
- Whistleblowing

4. Application of classification to the regulation identified

The purpose of this section is to identify which of the four categories of regulation discussed in section 2 is the appropriate category for each of the types of regulation identified in section 3, based upon whether the type of regulation has formal rules and procedures or not and if the regulation is influenced by the HCPs themselves or not. Thus the following table may be produced.

	Internal	External
Informal	Colleagues and peers Local standards Medical Defence Organisations Professional bodies	Chief Health Officers The media Public
Formal	Appraisal Clinical Audit Clinical supervision Continuing Professional Development Professional regulatory bodies Royal Colleges	Clinical governance Complaints Council for Healthcare Regulatory Excellence Courts Department of Health Education and training Employers European influence External Audit Healthcare Commission Health Service Commissioner for England Inquiries Legislation National Institute for Health and Clinical Excellence National Patient Safety Agency National standards Parliament Police Whistleblowing

Table 1: Categories of types of regulation

At this stage, the only points to note are the discrepancies in size between the informal and formal and between the internal and external categories. As can probably be expected it is the formal that has the larger share of the regulatory field, as is the case with the external categories of regulation, making the formal-external category the largest of the four, by far.

5. Analysis and commentary on the four categories of regulation

The following sections in this chapter will examine and analyse how the various types of regulation identified above affect the five elements of regulation identified as being necessary to achieve the regulatory aim of public protection and patient safety.¹⁹

The ordering of the sections will move from that considered to be least regulatory to that which is most regulatory,²⁰ that is informal-internal, informal-external, formal-internal and formal-external.

Each of the four sections that follow will concentrate on one of the four categories of regulation identified above and the types of regulation it comprises. Following an examination of the category of regulation upon the HCP, within each section there will be a commentary that includes an analysis of the category of regulation in relation to the five elements of regulation identified as being necessary to achieve the regulatory aim of public protection and patient safety.²¹

5.1 Commentary on informal-internal regulation

The first observation that can be made about the informal-internal category of regulation is how few forms of regulation it encompasses. Only four are identified in section 4 above.

The reasons for this paucity of regulation within this category can be summarised as the need for regulation to have a formal and external

¹⁹ See Chapter 1, section 3 for further information on each of these five elements.

²⁰ See section 2 above.

²¹ See Chapter 1, section 3 for further information on each of these five elements.

element to it so that the HCP's accountability can be seen to be addressed. As noted above the informal-internal category is the least regulatory of the four categories. This is because it relies more on social interaction between HCPs than on rules and procedures that can be used to make HCPs accountable; it may be said to be an anachronism in a society where there are calls for more formal and external regulation of HCPs to exist, and for more external bodies to enforce that regulation.²²

The disadvantages with the informal-internal category of regulation from the viewpoint of public protection and patient safety, is that there is no obligation upon the HCP to follow any of the guidance offered to them. They are free to choose which aspects of the received guidance they follow and which aspects they do not wish to follow. There is no guarantee that the HCP's practice will change as a result of any of the interventions and guidance they receive.

However, the main advantage of the informal-internal category of regulation is that it allows the HCP to seek advice, assistance or guidance, without the fear that doing so, and possibility admitting a deficit in their practice, will affect their future career or employment prospects, or their perception that doing so might jeopardise their professional practice.

In Chapter 1, section 4, the question of what is being regulated to ensure the protection of the public and safety of patients was addressed. Five elements were introduced and explored, these being: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practise.

With regard to the regulation within the informal-internal category, the protection of titles and registration is not covered as a regulatory effect;

²² Various reports of Inquiries that have emerged in recent years have made recommendations for increased regulation and for external bodies to be established to oversee and/or enforce that regulation, for instance see, amongst others, the recommendations in Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

neither is education for initial registration, apart from the professional bodies who make their views known through the publication of reports and consultation documents on the requirements for pre-registration education and the qualities needed for registrants.

It is the final three elements that are addressed through the regulatory effect of the informal-internal approach. All four types of regulation included within this category may be said to have a regulatory effect to the extent that they promote good practice, either through presenting what is the acceptable standard of competence and clinical practice, as with local standards, or through highlighting what is unacceptable practice. In the same way this addresses the HCP's fitness to practise, although the first type of regulation, colleagues and peers, concerned as it is with raising issues with the HCP and other relevant authorities, may be seen to have a greater effect on the HCP. Additionally, the medical defence organisations, who will provide advice and support for those HCPs whose fitness to practise has been called into question, have a significant influence.

Thus, as a single category of regulation it does not fulfil the aim of regulation of HCPs, that of public protection and patient safety. In Chapter 1 it was held that all the five elements need to be addressed to achieve this aim. Not addressing two of them means that there are other categories of regulation required to provide the necessary regulation in these two elements.

Therefore, as noted above, although the informal-internal approach to regulation does have a place, that place is limited. What may have been thought of as being within the informal-internal category in the past has now moved into the other three categories, as will be seen. For instance, the influence of colleagues and peers is being more and more formalised, through the whistleblowing process and the requirement of professional regulatory bodies that HCPs report instances of poor practice to them, with the implied threat of sanctions if they do not. This could be said to

make the HCP less likely to adopt the ‘chat over coffee’ approach in an effort to protect their own registration.

Between the four types of regulation that make up this category of regulation there is overlap between the regulation that each provides for HCPs. As an example, both the medical defence organisations and professional support bodies provide education and training for their respective members. Although there is overlap between the types of regulation presented there does not appear to be any overall regulatory framework discernable within this category of regulation. Additionally there appears to be a lack of co-ordination as each organisation strives to provide services for its members, irrespective of the service already on offer.

5.2 Commentary on informal-external regulation

As with the informal-internal category of regulation discussed in section 5.1 above, one notable feature is the lack of regulation that falls within it. There are only three types of informal-external regulation identified in section 4 above.

As noted in section 5.1, the reason for the scarcity of regulation within this category can be summarised as the need for regulation to have a formal element to it so that the HCP’s accountability can be directly addressed. The disadvantage of this category of regulation, and with the types of regulation within, is that it has no direct influence over HCPs. It cannot compel them to alter their activities. Their influence, and therefore their regulatory effect, is through their ability to raise matters of concern and is largely confined to their influence on other forms of regulation.

An advantage of the types of regulation raised within this category, particularly of the media and the public, is that they are not constrained by socialisation into the health care professions. Thus, they are able to raise issues that may not be apparent as issues to those within the health care sphere. For instance, the retention of body parts after post-mortem was

not identified with the health care professions as needing consent, and retaining them without consent was a common practice that became the subject of an Inquiry²³ and a report by the Chief Medical Officer;²⁴ subsequently leading to changes in the practice of HCPs and in legislation.²⁵

In Chapter 1, section 4, the question of what is being regulated to ensure the protection of the public and safety of patients was addressed. Five elements were introduced and explored, these being: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practice.²⁶

With regard to the regulation within the informal-internal category, the Chief Health Officers, through their advisory capacity to the Department of Health and other Government agencies, may be said to exert a regulatory influence upon all five elements. They can produce reports, consultation and discussion documents on any aspect of HCP regulation and these are then treated with the appropriate respect by the regulatory body concerned. Consultations from the Chief Health Officers can, and do, result in recommendations that then result in regulatory change for the HCP.

With regard to the media and the public, they tend not to comment upon protection of titles and registration or education for initial registration. However, the media does publish stories of bogus doctors and nurses and then make calls for the registration of HCPs to be tightened so that these bogus professionals can be identified and removed from public contact.

²³ Redfern M (Chair) (2001) Royal Liverpool Children's Inquiry House of Commons, London.

²⁴ Chief Medical Officer (2001) The removal, retention and use of human organs and tissue from post-mortem examinations Department of Health, London.

²⁵ Certain provisions within the Human Tissue Act 2004 may be said to have originated as result of the public outrage regarding this issue and the subsequent CMO report and Inquiry.

²⁶ See Chapter 1, section 3 for further information on each of these five elements.

In the main, it may be said that effect of the three types of regulation in this chapter is upon the final three elements, although not directly, and, for the media, it is usually with regard to the competence, performance or fitness to practice of individual HCPs. As such this, category does not fulfil the regulatory aim of public protection and patient safety. There is a need for additional regulation in achieving this aim.

With regard to a framework of regulation, apart from the Chief Health Officers, the types of regulation raised here do not appear to fit within an overall framework. Although the public do have a necessary role within regulation as a whole, it is through their involvement with the other types of regulation and not as a force upon their own. Likewise the role of the media appears to be in highlighting deficiencies to the existing regulatory bodies and not as a force of regulation on their own.

As may be expected, there is no co-ordination between the types of regulation presented here.

5.3 Commentary on formal-internal regulation

In Chapter 1, section 4, the question of what is being regulated to ensure the protection of the public and safety of patients was addressed. Five elements were introduced and explored, these being: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practice.²⁷ These five elements will be used to examine how the formal-internal category of regulation affects HCPs.

One of the first comments that can be made about the formal-internal category of regulation is that it contains the professional regulatory bodies and that they have the ultimate regulatory sanction of removing the HCP from the professional register thereby removing their right to practice. However, given that they form the narrow definition of regulation utilised in this thesis, and are therefore discussed in later chapters, they will not be

²⁷ See Chapter 1, section 3 for further information on each of these five elements.

fully explored within this section. Rather the use of the professional regulatory bodies within this section will be to illustrate points about the formal-internal category of regulation.

The five types of regulation, other than the professional regulatory bodies, within this chapter all have a regulatory effect upon some of the elements discussed. However, it is through the last three elements that they exert their regulatory effect. All the types of regulation within this regulatory category have a regulatory effect upon clinical competence and standards for performance; whether this be through identifying with the HCP the accepted standard for practice as with appraisal, clinical audit and clinical supervision, or through the provision of education via CPD and the Royal Colleges.

The element of fitness to practise is one that can be regulated through the use of appraisal and clinical audit whereby poor practice is identified, clinical supervision where the HCP whose practice provides grounds for concern is allowed to work with a colleague who can demonstrate the correct procedures and standards whilst also assessing the HCP in their practice environment, and through the Royal Colleges who can remove from the specialist register those HCPs who are not performing adequately or who have not undertaken the required CPD element.

It is the professional regulatory bodies that may be said to provide the main regulatory effect within this category of regulation as it is they who have a regulatory effect on each of the five elements of regulation identified in Chapter 1, section 4 as being necessary to achieve the aim of public protection and patient safety. However, it is open to debate as to whether the professional regulatory bodies should be one of the internal categories of regulation or whether their constitution should be such that they form part of the external-formal category of regulation.

Although this category has the advantage of having a formal nature to the types of regulation within, it may still be argued that it is weakened by virtue of the internal nature of its regulation.

There is a lack of a regulatory framework within this category of regulation at present, although it can be seen that there is scope for a framework to be developed, for instance between appraisal, CPD, clinical supervision and Royal Colleges, linked to the revalidation requirements of the professional regulatory bodies. This would also address the question of co-ordination between the types of regulation represented within this category. At present this appears to be lacking in general, although co-ordination can be seen between some of the types of regulation represented, for instance between the professional regulatory bodies and Royal Colleges with regard to revalidation requirements and the shared agreement on the need for CPD.

Thus, it can be seen that the formal-internal category of regulation is a strong one that provides a regulatory influence and effect upon all the five elements that are considered necessary for public protection and patient safety, provided that the regulatory bodies function efficiently. This last point is one that will be explored more thoroughly in the following chapters.

5.4 Commentary on formal-external regulation

It is no coincidence that this category of regulation has the highest number of types of regulation. Nineteen types of regulation have been presented within this category, which is more than the other three categories combined. As was noted in section 2 above, the formal-external category of regulation is the most controlling of the four categories, as it relates to those types of regulation that are based upon rules and procedures that are outside the health professions control.

In Chapter 1, section 4, the question of what is being regulated to ensure the protection of the public and safety of patients was addressed. Five

elements were introduced and explored, these being: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practice.²⁸

Several of the types of regulation discussed above, Department of Health, the European influence, Inquiries, legislation and Parliament, can affect all the five elements just mentioned, to a greater or lesser effect, through their wide remit and the power they have to change the way that health care is delivered in England. They can also change the roles of HCPs, and have the ability to influence, revoke or amend relevant legislation.

With regard to protection of titles and registration and education for initial registration, this is only further affected by the education and training type of regulation as it affects whether HCPs meet the initial requirements for registration.

It is clinical competence and standards for performance which are most affected by the other types of regulation discussed in the formal-external category of regulation. This is largely due to the quality assurance and clinical governance agenda which has resulted in the production of standards for various aspects of practice and the resultant bodies established to measure these standards. Standards affect the HCP's clinical competence because they can reduce their autonomy to make decisions based solely upon the clinical need of the patient in front of them. However, it is questionable whether it is necessary to have as many types of regulation regulating for this element.

It would appear that the HCP's fitness to practise is an element of regulation that is particularly affected by repetition and overlap between the types of regulation presented. This element can now be reviewed through many of the types of regulation discussed: from the courts and the employer; through the NPSA and NCAS, who can undertake assessment of the HCPs fitness to practice; complaints which raise questions about an

²⁸ See Chapter 1, section 3 for further information on each of these five elements.

individual HCP's fitness to practise; the clinical governance bodies who measure the HCPs achievement of standards; to the CHRE, who can refer lenient decisions from the professional regulatory bodies to the High Court for what may be seen as a second attempt to question the HCP's fitness to practise. Although there is much repetition in the regulation of HCPs' fitness to practice, it is vital that there is communication between employers regarding disciplinary action taken on specific HCPs, so that HCPs cannot move from employer to employer without declaring previous disciplinary action taken against them.

As has been discussed in section 5.3, there is scope for a framework to be established regarding appraisal, CPD and clinical supervision, that should involve the Royal Colleges, it can be argued that employers are in the ideal position to oversee and implement this framework.

The role of CHRE may be said to expose HCPs to double jeopardy with regard to having their disciplinary cases retried by the courts. Further, the existence of CHRE weakens the roles of the professional regulatory bodies as their decisions may be challenged on two grounds, those of leniency of sanction and a finding of not guilty, thereby questioning their role with regard to disciplinary matters.

Several of the types of regulation presented within this category of regulation can be said to have been established on top of those already in existence. For instance, CHRE has been established to have an overarching role above that of the professional regulatory bodies.

Both of these last two points will be explored further in the chapters that follow.

A structure can be identified between some of the types of regulation presented within category of regulation. With regard to the handling of complaints, the complaints system along with the involvement of the Healthcare Commission and HSC can be seen to form a vital part of the

overall process of dealing with complaints and have a statutory basis regarding their respective functions within that process. However, whilst the types of regulation work together on the complaints system and a framework can be identified for clinical complaints, there is not a single complaints portal; for example, there are those to the professional regulatory bodies and those with concerns relating to negligence.

However, too many of the types of regulation are in need of co-ordination, with many of the types of regulation having overlap between their functions. All of the following are aspects of the clinical governance agenda: NHS complaints process, CHRE, external audit, Healthcare Commission, NICE, national standards and NPSA, yet there is no single framework overseeing their functioning and ensuring that they are not repeating elements of regulation. Clinical governance is ideally suited to provide a framework for those elements of regulation that encompass a clinical dimension, and also to include types from other categories, such as CPD and clinical supervision. Yet, at present this has not occurred and clinical governance itself would require strengthening to provide this framework.

Although aspects of a structure can be identified with regard to some of the elements of regulation, and it is possible to identify areas where some of the types of regulation can provide a co-ordinated approach to elements of regulation, there is no discernable single coordinated framework of regulation within this category of regulation. Overlap between the types of regulation regulating for specific elements is present and it can be argued that the existence of so many types of regulation, regulating for the same elements, is repetitive and burdensome for the HCP who has to contend with them all.

The formal-external category of regulation may be seen as the strongest form of regulation upon HCPs, both in terms of the number of types of regulation it contains and in terms of the regulatory influence it has upon HCPs. That this is so is considered right by this thesis in order to provide

effective regulation. Indeed, it can be queried whether the professional regulatory bodies should be one of the internal categories of regulation or whether their constitution should be such that they form part of the external-formal category of regulation, in order to achieve the regulatory aim of public protection and patient safety.

However, there remains the problem of a lack of an overall coherent framework, and thus the regulation that does exist within this category may be said to be overlapping, over-complex and repetitive on the HCP.

Conclusion

Although it is the narrow definition of regulation that is being used to test the hypothesis of this thesis, if the wide definition were to be used, the types of regulation discussed above would be encompassed, and the above is a summary of how they would achieve the five elements of regulation in order to achieve the regulatory aim of public protection and patient safety.

The comment made in Chapter 1, section 4, regarding the wide definition of regulation adopted in this thesis as being too broad in scope can be seen to be borne out in the analysis and discussion above, as many of the types of regulation identified are outwith the scope of regulation in the narrow sense of the definition, as HCPs have no degree of control over them.

As stated in the introduction to this chapter, the reason for including an examination of the wide definition of regulation was to provide the context within the narrow definition of regulation operates. The analysis of the five elements of regulation undertaken above demonstrates the lack of coordination with the wide definition of regulation, with no overall framework for the regulation of HCPs, as well as highlighting the overlap that occurs between the various types of regulation within the wide definition.

All the regulation that has been presented as being within the confines of the wide definition of regulation within this chapter can be said to have

varying degrees of control over HCPs as well as being enabling for HCPs to a greater or lesser extent. Yet it has to be questioned whether it is necessary for the types of regulation within the wide definition to exert their control over HCPs if the narrow definition of regulation, the GMC and the NMC, are effective in their roles and functions, as the five elements used to discuss the regulation within the wide definition are what the GMC and the NMC are enacted to undertake.

Having analysed the regulation of HCPs from the perspective of the wide definition of regulation, this thesis will now proceed to analyse HCP regulation from the narrow definition to determine whether it is fit for purpose.

Part 4

The regulation of health care professionals: applying the narrow definition

Introduction to Part 4

The emphasis in this part of the thesis is on who or what regulates. It advances the thesis by detailing the ways in which health care professionals are regulated, using the five elements of regulation highlighted in Chapter 1 as a framework for discussion; thereby allowing analysis of whether the regulation of HCPs is fit for purpose. In dealing with these issues this part of the thesis provides the basis for the hypothesis of this thesis, that the regulation of HCPs is not fit for purpose as it is more controlling than enabling.

The narrow definition of regulation utilised by this thesis, as found in Chapter 1, section 4, is those bodies which have been formed through statutory provision and have specified functions with regard to their respective health care professions; for the medical profession this is the General Medical Council (GMC),¹ whilst for the nursing profession this is the Nursing and Midwifery Council (NMC).²

There are six chapters within this part of the thesis.

The first chapter in this part of the thesis, Chapter 5, is a brief overview of the history of the two professional regulatory bodies which form the narrow definition of regulation within this thesis, the GMC and the NMC. Relevant aspects of the history of each of the two professional regulatory bodies will be highlighted to inform the examination of the five elements of regulation that occur in the subsequent chapters.

Each of the following chapters presents one of the elements that are deemed to be necessary for regulation to achieve its aim, and explores how that particular element is regulated by the professional regulatory bodies, that is the GMC and the NMC.

¹ Medical Act (1983) (consolidated version with amendments).

² The Nursing and Midwifery Order 2001 (SI 2002/253).

Chapter 5

**The professional regulatory
bodies:
the General Medical Council
and the Nursing and
Midwifery Council**

Introduction to chapter 5

The aim of this chapter is to provide the background and context to the current incarnations of the bodies contained within the narrow definition of regulation utilised in this thesis. The narrow definition of regulation is discussed in Chapter 1 at section 4.1, where it is noted that it is the professional regulatory bodies which comprise the narrow definition of regulation for the purposes of this thesis. The professional regulatory bodies are held to be those institutions that are created by legislation specifically for the regulation of a defined group of Health Care Professionals (HCPs): for this thesis, these are the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

In the chapters that follow this part of the thesis, the differences and similarities in the way that the two professional regulatory bodies perform their various roles and duties will be explored through an examination of the five elements of regulation. These five elements of regulation identified in Chapter 1, section 4.2, being: protection of titles and registration; education for initial registration; clinical competence; standards for performance; and, fitness to practise.

This chapter will discuss some of the historical aspects of the professional regulatory bodies in order to highlight some key changes which have occurred in their development that relate to points or comments made in subsequent chapters. This is so that when examining characteristics of the current manifestations of the two professional regulatory bodies in subsequent chapters, the context of these will be apparent. What this chapter does not do is present a full history of the development of the GMC or the NMC.

There have been various proposals for reforms and actual reforms that have occurred, both to the professional regulatory bodies and to regulation of HCPs as a whole, over the period of the existence of the professional regulatory bodies. Those that have occurred have been incorporated into the relevant chapters and sections and discussed as appropriate. Those

reforms that are ‘outstanding’, that is they have yet to be incorporated into the regulatory framework or integrated into the processes of regulation, will have their proposed regulatory impact upon the regulation of HCPs examined in the appropriate chapters and sections that follow.

Of the two professional regulatory bodies, one is able to celebrate its one hundred and fiftieth anniversary this year, whilst the other has only been in existence in its present form for less than a decade. It is the GMC which is the more senior of the two professional regulatory bodies in terms of continued existence since inception, whilst it is the NMC which is the newer professional regulatory body.

Although this thesis is concerned with the GMC and the NMC with regard to examining if the regulation of HCPs is fit for purpose,¹ it is worth noting at this point, in order to paint a complete picture of the professional regulatory bodies, that there are other professional regulatory bodies which regulate HCPs within the United Kingdom (UK).

The complete list of professional regulatory bodies is: the General Chiropractic Council (GCC) regulating chiropractors;² the General Dental Council (GDC) regulating dentists, dental therapists, dental hygienists, and, from 31st July 2006, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists;³ the General Medical Council (GMC) regulating doctors;⁴ the General Optical Council (GOC) regulating opticians;⁵ the General Osteopathic Council (GOsC) regulating osteopaths;⁶ the Health Professions Council (HPC) regulating arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and

¹ See Introduction to the thesis at section 2.1.

² Website at www.gcc-uk.org.

³ Website at www.gdc-uk.org.

⁴ Website at www.gmc-uk.org.

⁵ Website at www.optical.org.

⁶ Website at www.osteopathy.org.uk.

orthotists, radiographers, and speech and language therapists;⁷ the Nursing and Midwifery Council (NMC) regulating nurses and midwives;⁸ and the Royal Pharmaceutical Society of Great Britain (RPSGB) regulating pharmacists and pharmacy technicians (currently voluntarily), and also pharmacy premises.⁹

However, prior to the establishment of the professional regulatory bodies, or their predecessors, there was no national body undertaking regulation of any of the predecessors of today's HCPs.

1. Role of the professional regulatory bodies

The professional regulatory bodies are established by legislation and responsible to, and under supervision of, the Secretary of State for Health and hence ultimately to Parliament. Their main role is to serve the public interest and protect the public.¹⁰ They aim to undertake this through setting and maintaining standards in education, conduct, training and ultimately performance. They maintain a register of HCPs who meet the requirements for registration in that particular health care field and provide a mechanism for the control of those HCPs who are considered to be unfit to practice, whether through their health or conduct, including the ultimate regulatory sanction of removing the HCP's ability to undertake clinical practice by removing them from the professional register. It should be noted that the accountability of the professional regulatory bodies is firstly to the public and secondly, if at all, to the profession that funds it.

It is the professional regulatory bodies that, within this thesis, undertake the regulation of HCPs through the narrow definition of regulation, that is

⁷ Website at www.hpc-uk.org .

⁸ Website at www.nmc-uk.org .

⁹ Website at www.rpsgb.org .

¹⁰ With regard to nursing, the Nursing and Midwifery Order 2001 (SI 2002/253) article 3(4) states that '*the main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants*'.

the five elements of regulation identified in Chapter 1, section 4 as being necessary to achieve the aim of public protection and patient safety.

Chapter 4 identified the professional regulatory bodies as being in the internal-formal category of regulation; however, it is open to debate as to whether the professional regulatory bodies should be one of the internal categories of regulation or whether their constitution is or should be such that they form part of the external-formal category of regulation.

The next two sections examine the GMC and NMC respectively.

2. The General Medical Council

The GMC has existed in one form or another since 1858 when it was established under the Medical Act 1858 as the General Medical Education and Registration Council of the United Kingdom; a title which may be said to have neatly summed up its primary purpose.

However, the GMC was established largely as a result of the demands of the profession itself and established in part to protect those that it 'regulated', as much as for the protection of the public.¹¹ This is because prior to the establishment of the GMC, medical practitioners were 'regulated' regionally or locally through councils and committees that maintained a register of those they deemed fit to practise in the specific locality, thus preventing those from outside a particular area from practising without registering locally.

Indeed these committees and councils issued both medical qualifications and licences that enabled medical practitioners to practise within a defined area. In addition to those medical practitioners who held a licence to practise through their local medical committee or council, there were a vast array of unqualified practitioners of medicine who were undertaking medical practice.

¹¹ For further discussion on the inception of the GMC see Stacey M (1992) Regulating British medicine: the General Medical Council Wiley, Chichester.

The formation of the GMC in 1858 allowed for a nationally recognised register of medical practitioners, who were able to practise their profession anywhere within the UK. Additionally, it became an offence for someone to hold themselves out as being a registered medical practitioner if they did not hold registration with the GMC.

Thus it may be said that the creation of the GMC with its national register of medical practitioners served the interests of the profession itself by creating a boundary between those who were registered to undertake medical practice and those who were not; a form of professional closure.¹² It also opened the potential area within which a registered medical practitioner was able to practise their profession.

The original council of the GMC was comprised of twenty four members, with six being nominated by the Privy Council and the rest being the heads or representatives of the organisations that had previously undertaken medical education and licensing within the UK.

The first major change to the GMC may be said to have occurred with the Medical Act 1886¹³ which provided for the membership of the council to include five members of the profession, who were to be voted onto the council through a postal ballot. The 1886 Act¹⁴ also provided that any individual who wished to achieve registration with the GMC had to undertake examinations in stipulated areas of medical practice, medicine, surgery and midwifery, rather than in any one area as was previously the case.

The 1886 Act¹⁵ also stipulated that inspectors were to be appointed to oversee the conduct of the examinations which were held.

¹² For discussion on the nature of professions and professional closure see Chapter 3, particularly section 1.

¹³ The Medical Act 1886 was repealed by the Statute Law (Repeals) Act 1986.

¹⁴ The Medical Act 1886 (repealed).

¹⁵ The Medical Act 1886 (repealed).

Lay members of the council were first introduced to the GMC in 1926.

The Medical Act 1950¹⁶ made a fundamental change in that it introduced the pre-registration year for doctors, so that they had to apply for provisional registration with the GMC, and complete a successful internship, before they were able to achieve full registration.

The Medical Act 1969¹⁷ provided for annual retention fees to be charged by the GMC. Until this provision, the GMC had charged a one-off registration fee which entitled the HCP to be registered with the GMC for life.

Various other changes were made to the composition and constitution of the GMC over the years since its inception until the Medical Act 1983, which consolidated the Medical Acts of 1956, 1969 and 1978. It is the Medical Act 1983¹⁸ which remains the principle statutory provision for the GMC and the regulation of medical practitioners.

Although there have been changes to the GMC since its inception, some fundamental, others less so, including the changing of its name to its present shortened version in 1951, it has essentially remained the same body. As will be seen in the next section the same cannot be said of the professional regulatory body which regulates nursing and midwifery. Section 4 below provides an analysis of the more recent reforms and changes to the role and constitution of the GMC.

3. Nursing and Midwifery Council

Nursing and midwifery has not always been regulated under a single professional regulatory body. Indeed there was a seventeen year gap between the first statutory provision for midwifery and that for nursing.

¹⁶ The Medical Act 1950 was repealed, with savings, by the Medical Act 1978.

¹⁷ The Medical Act 1969 was repealed by the Medical Act 1983.

¹⁸ The Medical Act (1983) (consolidated version with amendments).

It was 1902 that saw the passing of the Midwives Act,¹⁹ however this only applied to England and Wales. The main provision of the act was the establishment of a statutory body overseeing the work of midwives. Midwives were required to undergo supervised training and were required to be on the 'roll of midwives' established by the Central Midwives Board under the Midwives Act 1902. There was also a statutory system of supervision of midwives with medical supervision being one aspect of this.

The Midwives Act 1902 provided for the protection of certified midwifery status with the first clause reading *'from and after the first day of April one thousand nine hundred and five, any woman who not being certified under the Act shall take or use the name or title of midwife (either alone or in combination with any other word or words), or any name, title, addition or description implying that she is certified under this Act, or is a person specially qualified to practise midwifery, or recognised by law as a midwife, shall be liable on summary conviction to a fine not exceeding five pounds'*.

The passing of the Nurses Registration Act did not occur until 1919.²⁰ This was the first legislation concerning the registration of nurses and resulted in the establishment of the General Nursing Council for England and Wales in 1921. Separate legislation created Councils for nursing in Scotland and in Ireland.

In 1920, the Central Midwives Board was given the power to suspend midwives from practice; the provision in the 1902 Act²¹ only allowed removal of midwives from the roll.

It was in 1951 that midwives were required to attend statutory post-graduate courses to maintain their competencies.²²

¹⁹ The Midwives Act 1902 received royal assent on the 31st July 1902, it was repealed by the Midwives Act 1951.

²⁰ The Nurses Registration Act 1919 was repealed by the Nurses Act 1957.

²¹ The Midwives Act 1902.

²² Midwives Act 1951, subsequently repealed by the Nurses, Midwives and Health Visitors Act 1979 .

Teachers of nursing were admitted to a register of nurse teachers, if they were also registered nurses, under the Teachers of Nurses Act 1967.²³

The Nurses, Midwives and Health Visitors Act 1979 provided the legislation for the creation of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and four national boards of Nursing, one for each of the four countries of the United Kingdom, in 1983. For the first time in the UK, midwifery and nursing would be regulated under one professional regulatory body, and so prevent the inconsistencies in the regulation of nurses and midwives that occurred with separate national regulatory bodies.

The UKCC was a two-tier regulatory structure that replaced the General Nursing Council, the Central Midwives Board and their associated bodies. The Nurses, Midwives and Health Visitors Act 1979 Act abolished the medical supervisor with regard to midwives and required that all supervisors of midwives be practising midwives.

The two tier structure for the regulation of nurses, midwives and health visitors was arranged so that the UKCC and National Boards had different function in the regulation of its registrant HCPs. It was the UKCC that had responsibility for maintaining the register of HCPs and setting the standards for education leading to initial registration and for determining fitness to practise regulations and procedures; whilst the four National Boards were responsible for ensuring that the UKCC's standards for education were implemented and for either providing or approving, where appropriate, training courses for both pre and post-registration. Initially the four National Boards were also able, by legislative provision, to undertake investigation of misconduct cases. As the Central Midwives Board was abolished in 1983, the four National Boards were required to advise and guide on midwifery matters.

²³ The Teachers of Nurses Act 1967 was repealed by the Nurses, Midwives and Health Visitors Act 1979 .

In 1987, the UKCC introduced periodic registration for all its HCPs. Prior to this, as with the GMC initially, there had been a system of registering for life upon payment of the appropriate once only fee.

The constitution and function of both the UKCC and the four National Boards were amended significantly by the Nurses, Midwives and Health Visitors Act 1992. The UKCC was able for the first time, following the implementation of the 1992 Act,²⁴ to suspend a HCP's registration; prior to this it had to remove a HCP from the professional register. The 1992 Act²⁵ also gave the UKCC the power to issue a caution against a HCP and to enter this on the professional register. For the first time there was provision direct election for places on the Council, with forty out of the sixty available places being directly elected by registrants. With regard to the four National Boards, the 1992 Act²⁶, as well as altering their constitution, notably removed their ability to undertake investigation of alleged misconduct against a HCP.

In 1997 a consolidation act was passed drawing together the Nurses, Midwives and Health Visitors Act 1979 and the subsequent enactments amending it.²⁷ The 1997 Act²⁸ also made changes to the constitution of the UKCC.

It was also in 1997 that a review was commissioned of the way in which the regulation of nurses, midwives and health visitors was undertaken.²⁹ The review had some quite damning conclusions and recommendations with regard to the existing regulatory processes and the legislation that was in place at the time. The main conclusion being that the regulatory processes

²⁴ Nurses, Midwives and Health Visitors Act 1992.

²⁵ Ibid.

²⁶ Ibid.

²⁷ This was the Nurses, Midwives and Health Visitors Act 1997, which was subsequently repealed by the Health Act 1999.

²⁸ Nurses, Midwives and Health Visitors Act 1997.

²⁹ The final report of the review was published in 1998. JM Consulting (1998) The regulation of nurses, midwives and health visitors: report on a review of the Nurses, Midwives and Health Visitors Act 1997 JM Consulting, London.

and legislation did not have public protection as its primary purpose and that they did not accommodate the changes occurring within nursing and midwifery. Also the UKCC had '*restricted and inflexible powers in the area of conduct and discipline*' and was '*poorly constituted for the role it needs to play*'.³⁰

As a result the NMC replaced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, although not until 2002.³¹ It is the role and constitution of the NMC that will be analysed and discussed in the remaining chapters of this part of the thesis.

The following section provides an analysis of the more recent reforms and changes in the regulation of both doctors, and nurses and midwives.

4. Changes to the constitution and functions of the GMC and NMC

The introduction to this thesis explained the contemporary events that were occurring that led to the origination of the research underpinning this thesis. Several events, that were highlighted within the introduction, may be said to have led to questions being asked about the fundamental basis of professional regulation of HCPs. These questions have been asked within the media, within the professions and within parliament and have led to the production of various position papers, and ultimately to changes being made in the constitution and functions of the professional regulatory bodies.

Some of the more notable recent events which have led to questions being asked about the role of the professional regulatory bodies and the nature of professional self-regulation as the mechanism for the protection of the public and patient safety include:

³⁰ JM Consulting (1998) The regulation of nurses, midwives and health visitors: report on a review of the Nurses, Midwives and Health Visitors Act 1997 JM Consulting, London, at page 3.

³¹ The Nursing and Midwifery Council was created under the Nursing and Midwifery Order 2001 (SI 2002/253).

- the Public Inquiry in to the Shipman case³²
- the Bristol Royal Infirmary Heart Surgery Inquiry ³³
- the Ledward Inquiry³⁴

The effect of an inquiry is related to two separate aspects of that inquiry. The first is that the inquiry draws attention to the issue; this inevitably raises the interest of the media unless they have already been reporting the issue.

As the Consumer Association stated in a consultation document released during the Bristol Royal Infirmary Heart Surgery Inquiry, *'there are frequent stories in the media of incompetent doctors who have been allowed to continue to practise without proper investigation and action by the regulatory bodies. As a result the public has lost confidence in the ability of professionals to regulate themselves'*.³⁵

However, arguably more important are the terms of reference of the inquiry and its recommendations. For instance, the terms of reference of the Bristol Inquiry included the reference *'to reach conclusions from these events [at the Bristol Royal Infirmary] and to make recommendations which could help to secure high quality care across the NHS'*.³⁶ Recommendations from inquiries have to be seen to be acted upon by governments; otherwise there is little point of having the inquiry at all. The more high profile the inquiry, the more emphasis is placed upon the recommendations that emerge. Something has to be seen to be done to

³² Secretary of State for the Home Department and the Secretary of State for Health (2004) Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future (Chair Dame Janet Smith DBE) Cm 6394 The Stationery Office, London.

³³ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

³⁴ Department of Health (2000a) Report of the inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward (Chair Jean Ritchie – the Ritchie Report) Department of Health, London

³⁵ Consumers Association (2000) Professional self-regulation: a patient-centred approach Consumers Association, London, at page 1.

³⁶ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London, at page 26.

prevent the situation occurring again. Implementing some, or all of, the recommendations of an expert inquiry is one way of achieving this. It is no falsehood to say that high profile inquiries change the nature of HCP regulation through their recommendations.

The recommendations from two inquiries alone, those of the Bristol Inquiry³⁷ and the Shipman Inquiry,³⁸ have resulted in changes to the professional regulatory bodies and thus to the regulation which HCPs are subject. In response to the recommendations following the Bristol Inquiry,³⁹ the then Secretary of State for Health (Alan Milburn) announced that the government would be developing proposals to reform the GMC.⁴⁰

Following on from this various consultation papers were published and consultations undertaken.⁴¹ However in 2006 two major reviews were undertaken whose outcome has had considerable effect upon the regulation of HCPs. One concerned the regulation of the medical profession, and the other that of the regulation of non-medical health care professions. The reviews occurred as a direct result of the recent Inquiries and were designed to respond to the criticism and recommendations regarding the regulation of HCPs.⁴²

³⁷ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

³⁸ Secretary of State for the Home Department and the Secretary of State for Health (2004) Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future (Chair Dame Janet Smith DBE) Cm 6394 The Stationery Office, London.

³⁹ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

⁴⁰ Hansard House of Commons vol. 372 column 292 (debates 18 July 2001 The Secretary of State for Health).

⁴¹ An example of a consultation undertaken in the aftermath of the Inquires is Department of Health (2002e) Reform of the General Medical Council – paper for consultation Department of Health, London.

⁴² For the background on the reviews see Department of Health (2006a) The regulation of the non-medical healthcare professions Department of Health, London, in particular see pages 3 to 5.

The outcome of the reviews were that two consultations were undertaken in 2006 regarding the future professional regulation of HCPs.⁴³ These consultations along with government responses to the recommendation of Inquiries, such as those listed above, resulted in the publication of a White Paper in 2007.⁴⁴ This White Paper outlined the reforms that would be undertaken to the regulation of HCPs that would enable it to achieve its primary aim of public protection and patient safety.

As a result of the White Paper in 2007,⁴⁵ there have been legislative changes that have amended and altered the constitution of both the GMC and the NMC, as well as the roles and functions they undertake and the processes by which they achieve these.

The reforms that have occurred within recent years to the GMC and the NMC are now part of the mechanism of professional regulation. These include a reduction in the size of the Councils of the professional regulatory bodies; more lay representation and a reduced proportion of HCP representatives on the Councils; more lay member involvement in fitness to practise committees and panels; lay members to be appointed by the Appointments Commission; changes in the definition of impaired fitness to practise, and the use of sanctions; and the establishment of the Council for Regulation of Health Care Professionals (CHRE).⁴⁶

Where appropriate, the changes to the professional regulatory bodies will be examined and discussed in the chapters that follow within this part of the thesis. Where the change or reform is so new that it is not yet known how this will effect the regulation of HCPs, where appropriate, comment will be made regarding this.

⁴³ These consultations were Department of Health (2006b) Good doctors, safer patients: a report by the Chief Medical Officer Department of Health, London; and Department of Health (2006a) The regulation of the non-medical healthcare professions Department of Health, London.

⁴⁴ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London.

⁴⁵ Ibid.

⁴⁶ See section 5 below for a discussion on CHRE and its role.

Proposed reforms and changes to the GMC and NMC that have not yet been implemented will be discussed in the relevant chapters that follow, where it is felt that the proposed reform or change will have a particular impact upon the regulation of HCPs

4.1 Process of change

The legislation that established both the GMC and NMC has been explored above; however, subsequent legislation is able to change or amend the originating legislation and therefore can change the constitution of the professional regulatory bodies or their processes and procedures. For instance, the National Health Service Reform and Health Care Professions Act 2002 made changes to the rules around fitness to practise and appeals procedures of several health care professions,⁴⁷ including moving the hearing of appeals from the Privy Council to the High Court.⁴⁸ It was this Act that also established the Council for Healthcare Regulatory Excellence in 2003, an overarching regulator which, in effect, regulates the professional regulatory bodies and has a major impact upon the regulation of HCPs.⁴⁹ Its role will be examined in later chapters, where appropriate.

An interesting and far-reaching result of legislation is the so called 'section 60 order' provision. The passage of Acts of Parliament can be both time-consuming and difficult, in terms of the provisions of the act remaining unchanged during their passage through both Houses of Parliament. However, Orders in Council allow the government to make legislation through the use of the Privy Council. This means that the government can enact legislation without having to go through the full process of Parliament, meaning that the process can be quicker and less subject to change; as well as ensuring that the regulatory framework is responsive to the changes in society and within health care.

⁴⁷ For example it is the National Health Service Reform and Health Care Professions Act 2002, at section 30 which affects medical practitioners.

⁴⁸ Ibid, section 30(2c).

⁴⁹ Ibid, sections 25 to 29.

The Health Act 1999 provided that the regulation of health care professions could be changed through the use of Order in Council in section 60, hence the use of the term ‘section 60 order’. Section 60 allows for the modification of *‘the regulation of any profession to which subsection (2) applies, so far as it appears to Her [Majesty] to be necessary or expedient for the purpose of securing or improving the regulation of the profession or the services which the profession provides or to which it contributes’*.⁵⁰ This applies to both the medical and nursing and midwifery professions.⁵¹

The result of ‘section 60 orders’ is that the Government no longer has to pass primary legislation to amend the professional regulatory bodies, modification to the legislation affecting HCPs can be made without full parliamentary debate or approval each time it is changed. The use of the ‘section 60 order’ by government makes the process of change both quicker and easier. The introduction of the NMC was made by the use of ‘section 60 orders’, rather than primary legislation.⁵²

As well as legislative changes to the composition, structure and roles of the GMC and the NMC, there are changes that the professional regulatory bodies themselves can make; for instance, the GMC and the NMC are able to make changes to the fees they charge. However, some of the changes that can be made by the two professional regulatory bodies are far-reaching; for instance, the change to the standard of proof requirements in fitness to practise hearings from the criminal standard to the civil standard was made by the Council of the GMC in response to external calls for reform.⁵³

⁵⁰ Health Act 1999 at section 60(1a).

⁵¹ Health Act 1999 at section 60(2a).

⁵² The Nursing and Midwifery Council was created under the Nursing and Midwifery Order 2001 (SI 2002/253).

⁵³ See Chapter 10 for further discussion on the change to the standard of proof.

5. The Council for Healthcare Regulatory Excellence

The Council for Regulation of Health Care Professionals⁵⁴ was originally envisaged in the NHS plan,⁵⁵ where it was described as a co-ordinating body for the existing professional regulatory bodies and as a forum where the adoption of common approaches to regulation could be developed. However, following the publication of the Kennedy Report,⁵⁶ the functions of the proposed Council changed, and it now includes an oversight role of the existing professional regulatory bodies.

CHRE is independent of both government and of the professions, and is accountable to Parliament.⁵⁷ It has authority over all professional regulatory bodies that are the subject of this thesis; as such, it is sometimes referred to as a 'super-regulator'.⁵⁸

The functions of CHRE include the promoting the interests of patients and the public; to promote best practice by the professional regulatory bodies, and to promote co-operation between the professional regulatory bodies.⁵⁹ To achieve these functions it has some far-reaching powers and duties. These include:

- Advising ministers on health care professions⁶⁰
- Developing principles of good regulation
- Directing the professional regulatory bodies to make or change rules to achieve a particular outcome⁶¹

⁵⁴ The Council for Regulation of Health Care Professionals was established under section 25 of the National Health Service Reform and Health Professions Act 2002. It commonly uses the name Council for Healthcare Regulatory Excellence (CHRE).

⁵⁵ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London. See paragraphs 10.13 - 16 in particular.

⁵⁶ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 - 1995 CM 5207(1) Stationery Office, London, in particular see Chapter 25, paragraph 75.

⁵⁷ Department of Health (2002f) Press release 2002/0114 'Better protection for the patient' 5th March 2002.

⁵⁸ For instance the professional health press often use the term as in the case of Editorial (2003) 'Super-regulator reviews nurse case' Nursing Times vol. 99 no. 26 p. 2.

⁵⁹ National Health Service Reform and Health Professions Act 2002, section 25.

⁶⁰ *Ibid*, section 26(7).

⁶¹ *Ibid*, section 27. This power is mediated by the fact that such direction must be approved by the Privy Council (subsection 3), and has to go before both Houses of Parliament (subsection 7).

- Ensuring that the professional regulatory bodies conform to good regulatory principles
- Overseeing the professional regulatory bodies rules, procedures and processes
- Preparing annual reports for Parliament
- Promoting consistency between the professional regulatory bodies, including communication and shared values
- Referring final decisions of the professional regulatory bodies' fitness to practice committees to the High Court, when CHRE considers that the decision or sanctions were too lenient, or to challenge a not guilty finding⁶²

In June 2008, CHRE issued a highly critical report on the working of the NMC to the Minister of State for Health Services.⁶³ This report is mainly concerned with the internal working of the NMC and finds that *'there are serious weaknesses in the NMC's governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders'*.⁶⁴ The report also makes recommendations to the Department of Health and the NMC itself on addressing its concerns.⁶⁵

This thesis is not concerned with the governance arrangements of the GMC nor the NMC specifically, rather its focus is on the regulation of HCPs and how the two professional regulatory bodies achieve this with regard to the five elements of regulation identified.⁶⁶ Where appropriate, this thesis will

⁶² National Health Service Reform and Health Professions Act 2002, section 29. It is interesting that the power of CHRE is phrased in such a way that it can appeal a decision that it considers too lenient, section 29(4a), however, there is no provision for it to do so where it considers that the decision is too harsh.

⁶³ Council for Healthcare Regulatory Excellence (2008) Special report to the Minister of State for Health Services on the Nursing and Midwifery Council Council for Healthcare Regulatory Excellence, London.

⁶⁴ Ibid, at page 2.

⁶⁵ Ibid, in particular see page 17.

⁶⁶ For discussion of the five elements of regulation see Chapter 1, section 4.2.

consider the recommendations of the report in the relevant chapters that follow.

Conclusion

Its interesting to see how the earlier incarnations of the professional regulatory bodies have left their mark on their current manifestation, for instance with regard to the establishment of professional registers and the setting of educational standards for admission to these registers, which was not a feature for the original GMC.

However, as Davies and Beach note '*practitioners and public alike tend to confuse the roles of regulatory bodies with those of professional associations*'.⁶⁷ Thus there is a danger that the professional regulatory bodies do not meet the needs of either of the public and patients they should protect, or the profession that they regulate. To the HCPs, they can appear to be overzealous in their pursuit of public protection, taking sanctions against those HCPs who appear to be performing adequately; whilst to the public, they can appear to be 'professional associations' whose interest in serving the HCPs and 'letting off' those who have transgressed. As Bowles states '*it has long been recognized that a policy of giving professions powers of self-regulation carries with it the danger that the professions will thereby be enabled to pursue the interests of their members to the detriment of public interest*.'⁶⁸

That is not to say that the professional regulatory bodies do not provide a vital function. When the processes work effectively and a poorly performing HCP is correctly identified and that HCP's practice is limited, or the HCP is removed from practice completely, the professional regulatory bodies perform a valuable policing service and provide assurance and confidence to the public regarding the standards by which

⁶⁷ Davies C & Beach A (2000) Interpreting professional self-regulation Routledge, London, at page xv.

⁶⁸ Bowles R (1993) 'Regulation of the medical profession in England and Wales in Faure M, Finsinger J, Siegers J & Van den Bergh R (eds) (1993) Regulation of professions: a law and economics approach to the regulation of attorneys and physicians in the US, Belgium, The Netherlands, Germany and the UK Maklu, Antwerp, at page 331.

HCPs undertake their professional practice. In addition, the professional regulatory bodies may be said to allow Parliament to satisfy its objective of public protection in the health care arena.

The following five chapters examine whether the current professional regulatory bodies provide regulation that is efficient, effective and therefore fit for purpose in protecting the public, providing for patient safety, yet also allowing HCPs autonomy in their clinical practice. This is undertaken through an examination of the GMC and NMC in relation to each of the five elements of regulation previously identified.

Chapter 6

Protection of titles and registration

Introduction to chapter 6

This chapter examines the protection of titles and registration element of regulation to determine whether this aspect of the regulation of health care professionals (HCPs) is fit for purpose. Therefore the question that this chapter addresses is, does this element of regulation contribute to the protection of the public and patient safety without restricting the clinical autonomy of HCPs?

In addressing this question, the chapter is structured as follows: an analysis of how protecting titles and maintaining a register of HCPs can provide public protection and patient safety; an examination of the maintenance of the registers by the professional regulatory bodies; a commentary on the issues raised; and a conclusion on whether this element of the regulation of HCPs is deemed to be fit for purpose, or not.

1. Protection of titles and the professional registers

There is a difference between the protection of titles and protection of function or role. The former refers to the actual title that the HCP uses and some of these, as will be seen below, are protected by legislation. However, protection of function or role refers to the situation where specified functions and roles are protected in legislation so that only specified individuals or groups who possess the required qualification, experience or competencies, or are registered with the correct formal body, are able to perform them: for instance with regard to health care this would be HCPs.

It is important to note that there is no legal restriction on the right to provide medical care and treatment to others in general;¹ *‘the common law right to practise medicine means that in the United Kingdom anyone can treat a sick person even if they have no training in any type of healthcare*

¹ See Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford, at chapter 2 section A2 and Montgomery J (2003) Health Care Law 2nd edition Oxford University Press, Oxford, at page 142.

whatsoever,² subject to certain provisos.³ This means that the public could be unwittingly treated by those who are not competent to do so, or are untrained, or who are not what the patient believes them to be; if it were not for these provisos. The provisos are that the person providing the treatment does not: hold themselves out as having qualifications that they don't have; use, or imply, any title protected by statute, for example registered medical practitioner, or registered nurse;⁴ or, state or imply, that they have registration with a HCP regulatory body that they do not possess; and that the person being treated provides valid consent to the treatment.

Thus, 'as long as they do not claim to be a medical practitioner registered under the Medical Act [or any other legally protected health care practitioner], then anyone can offer medical advice and treatment and can purport to treat a range of diseases, provided that they do not claim to cure or treat certain specified diseases as proscribed by law'.⁵

The reason for the provisos, detailed above, is that they allow the person seeking the treatment to know whether the person providing the treatment has achieved registration with, and is subject to the demands of, a regulatory body. If the patient believes the person providing the care or treatment to be qualified or registered when they are not, there may not be valid consent and the person providing the treatment could be liable to a criminal and civil action.

² House of Lords Select Committee on Science and Technology (2000) Report on complementary and alternative medicine The Stationery Office, London, at paragraph 5.9.

³ It must be stressed that certain medical procedures are limited to their performance by registered HCPs, for instance see Chapter 3 section 6.2 for a discussion on procedures that can only be performed by registered medical practitioners.

⁴ It is a criminal offence to use the titles Registered Medical Practitioner or Registered Nurse or Midwife without being on the respective professional register.

⁵ House of Lords Select Committee on Science and Technology (2000) Report on complementary and alternative medicine The Stationery Office, London, at paragraph 5.9. For a discussion on diseases proscribed by law see Chapter 3, section 6.2. Similarly, the Nursing and Midwifery Order 2001 (SI 2002/253) at article 44(1)(a), creates a criminal offence of falsely representing oneself to be on the nursing and midwifery register.

Therefore a system of regulation of HCPs has to have provision for the protection of certain titles and for the registration of those HCPs who have achieved the standard required of the regulatory body to undertake their function or role. The maintenance of a register is a key feature of HCP regulation.⁶

Both of the professional regulatory bodies, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), are charged with maintaining a register of those HCPs who are entitled to be registered, such registration allowing the HCP to practise their respective professions.

The maintenance of the registers of HCPs plays an important part in the protection of the public and patient safety within the health care arena. It may be queried as to how a register of those entitled to practise can promote public protection and patient safety. The answer lies in having knowledge about those individuals who are deemed to be competent to undertake their professional clinical roles and who are subject to the regulation of their professional practice through their respective professional regulatory bodies.

Additionally, by having a register of those who are entitled to practise within a defined area, it is possible to protect the titles that those individuals use. Thereby those individuals who use those protected titles may be said to fulfil the requirements necessary for registration and be competent in their professional practise. For the titles to be adequately protected, anyone who uses the titles without the appropriate authorisation has to have a suitable sanction applied against them that will act as a deterrent to others using the titles. Within the health care arena, it is a criminal offence to claim to be a registered medical practitioner⁷ or a registered nurse,⁸ when the individual is not entitled to use these titles.

⁶ For Grubb maintaining a professional register is the principal function of regulatory bodies. Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford, at page 84.

⁷ The Medical Act (1983) (consolidated version with amendments) section 49(1) makes it a criminal offence to imply or state that one has registration when one does not; it is also

Moran and Wood note that with the creation of the GMC and its register, 'some 60 per cent of those who claimed to be a doctor disappeared'.⁹

The register may be said to represent an assurance that those HCPs who are able to apply and maintain their registration meet the regulator's minimum standard. The assurance will only be valid if there is a mechanism for removal of those HCPs who do not meet the minimum standard. This entails the register being a 'live' list of those entitled to registration and not merely a list of those who have achieved registration at some point in the past. There is therefore a need for periodic checks on the HCP's continued entitlement to registration.

Therefore, in addition to the authority to maintain the register, the regulatory body has to have the ultimate sanction of being able to remove the HCP from the register, either temporarily or permanently, should their practice fall below the required standard. Thereby, any HCP who fails to maintain the minimum requirements for registration will have their name removed from the register and be unable to practise as a HCP. This provides protection for the public and patients, by ensuring that only those who continue to meet the requirements for registration are allowed to be registered and proclaim that registration.

However, it should be noted that there are some commentators who see the maintenance of a register as a form of '*certification and credentialism*', that results in a monopoly over the provision of health care.¹⁰ That by having a register of those who can perform a certain function or role or are allowed to use a particular title, the market in that particular professional

an offence under the section to use titles such as doctor of medicine, physician, surgeon or general practitioner.

⁸ The Nursing and Midwifery Order 2001 (SI 2002/253) at article 44(1)(b), creates a criminal offence of using a title that one is not entitled to, such as registered nurse or midwife.

⁹ Moran M & Wood D (1993) *States, regulation and the medical profession* Open University Press, Buckingham, at page 46.

¹⁰ For instance see Allsop J & Saks M (eds) (2002) *Regulating the health professions* Sage, London, at page 4.

sector is restricted to ‘outsiders’ who are not so registered. Yet as noted in Chapter 3,¹¹ this is the result of the contract between the profession and society, in which the profession agrees to a certain standard in its delivery of its functions in exchange for being able to limit entry to the profession.

Being on the register of the relevant professional regulatory body is an enabling aspect of regulation for the HCP as it allows them to prove their credentials through their registered status and allows them to hold certain positions that are not available to those who are not so registered. For instance, section 47(1) of the Medical Act 1983 states that: ‘*no person who is not fully registered shall hold any appointment as physician, surgeon or other medical officer –*

(a) in the naval, military or air service,

(b) in any hospital or other place for the reception of persons suffering from mental disorder, or in any other hospital, infirmary or dispensary not supported wholly by voluntary contributions,

(c) in any prison, or

(d) in any other public establishment, body or institution,

*or to any friendly or other society for providing mutual relief in sickness, infirmity or old age’.*¹²

However for the non-HCP it is restricting, in that it prevents them from claiming to be registered and so precludes them from certain functions and roles, although this is the very reason that the protection of titles and the professional registers exist.

In summary, the register can confirm the status of HCPs as having the necessary education and competencies to be admitted to the register, and that they are currently registered to practise within their specialist area.

¹¹ In particular see sections 1 and 2.

¹² The Medical Act (1983) (consolidated version with amendments).

2. Maintaining the registers

The provisions for the maintenance of the registers of HCPs are provided for in legislation. The provision for the GMC's register is within Section 2(1) of the Medical Act 1983, which states '*there shall continue to be kept by the registrar of the General Council ... a register of medical practitioners registered under this Act containing the names of those registered and the qualifications they are entitled to have registered under this Act*'.¹³ Whilst the provision for the NMC's is in article 5(1) of The Nursing and Midwifery Order 2001, which states '*in accordance with the provisions of this Order the Council shall establish and maintain a register of qualified nurses and midwives*'.¹⁴

The professional registers, although being provided for in legislation, are not static entities. Over the years of their operation they have been subject to various changes. However, before changes are made there are usually consultations on the proposed changes that are open to both the professions and the general public. Sometimes the consultation occurs first and this results in proposed amendments that are then provided for in legislation; at other times, the legislation is made and the consultation is concerned with how the legislation can be implemented into the existing procedures and rules of the professional regulatory body.

Whilst it is possible for the professional regulatory bodies to have only one register of HCPs, both the GMC and NMC have sub-divisions that allow them to categorise their registrants more accurately. The following two sections detail the registers that are maintained by the GMC and NMC respectively.

2.1 The General Medical Council Register

Prior to the 19th October 2007, the GMC had a part of the register which was known as 'limited registration'. Limited registration applied only to those qualifying doctors whose qualification was obtained in an overseas

¹³ The Medical Act (1983) (consolidated version with amendments).

¹⁴ The Nursing and Midwifery Order 2001 (SI 2002/253).

medical school.¹⁵ The registration was ‘limited’ in that the International Medical Graduate (IMG) was limited in their employment. In fact the IMG had to have an offer of employment before they would be considered for limited registration and the registration was then linked to this position, so that if the IMG moved employment they would have to notify the GMC of this fact.

Following review of the GMC registration process, in 2003 agreement was reached that this part of the register would be abolished and would be replaced by the provisional and full registration applying to all qualifying doctors regardless of their place of qualification.¹⁶

Limited registration was used to ensure that those HCPs coming from non-approved medical schools had the necessary education and competencies to be able to practise safely within the UK. It was designed to protect the public and promote public safety where the education and training of the HCP was not under control of the GMC. However, following the review in 2003, it was decided that the changes in registration which would be applied to UK medical school graduates would be an appropriate safeguard for public protection and patient safety if applied to all those applying for first registration with the GMC, along with additional criteria for IMGs which could be used within the proposed registration framework.

The change means that all medical graduates are treated equally through being subject to the same system of registration, regardless of the country of their medical education.

Therefore *‘IMGs applying for either provisional or full registration need to meet rigorous criteria. They are required to satisfy the GMC that:*

- *they hold an acceptable primary medical qualification*

¹⁵ For the purposes of this part of the medical register, overseas meant non UK and non European Economic Area medical school graduates. The GMC applies the term International Medical Graduate (IMG) to these individuals.

¹⁶ Abolition was provided for by Part 2 of the Medical Act 1983 (Amendment) and Miscellaneous Amendments Order 2006 (SI 2006/1914).

- *they have the requisite knowledge and skills for registration*
- *their fitness to practise is not impaired*
- *they have the necessary knowledge of English*

Doctors may demonstrate their medical knowledge and skills in one of the following ways:

- *a pass in the PLAB test¹⁷*
- *sponsorship by a medical Royal College or other sponsoring body for further postgraduate training*
- *an acceptable postgraduate qualification*
- *eligibility for entry in the Specialist or GP Register¹⁸.*

Following the changes to the GMC registration process and register on the 19th October 2007, the current GMC register has four parts to it. These are:

- Provisional registration
- Full registration
- Specialist registration
- GP registration

Provisional registration is provided to graduates of medical schools, that is newly qualified doctors, whilst they are in their first training posts. It is also provided for IMGs who are applying for first registration with the GMC and who do not meet the requirements for full registration. Doctors on this part of the register are not allowed to practise unsupervised and may only undertake training in certain designated programmes, the so-called 'Foundation Year' clinical training posts.

These clinical training posts are structured to provide the provisionally registered doctor with the education, training and competencies that they

¹⁷ The PLAB (Professional and Linguistic Assessment Board) test is an examination that is offered to IMGs who are not able to demonstrate their competence for registration with the GMC in any other way.

¹⁸ Information from 'New registration framework for doctors' available at http://www.gmc-uk.org/doctors/registration_news/new_framework.asp accessed on 31st May 2008.

need to achieve full registration. They are provided for within legislation, the Medical Act 1983¹⁹ at section 10A(1) states that an ‘ “*acceptable programme for provisionally registered doctors*” means a programme that is for the time being recognised by the Education Committee as providing a provisionally registered person with an acceptable foundation for future practice as a fully registered medical practitioner’.

Furthermore, the legislation provides the GMC with the authority to determine: the duration of such programmes;²⁰ who is able to provide the training programmes,²¹ including removing approval from a programme;²² the ‘*content and standard of programmes*’;²³ the activities that a doctor may undertake whilst provisionally registered;²⁴ and certification arrangements for completion of the programme.²⁵

It can be seen for the above arrangements that the GMC’s provisional registration arrangements are a robust and structured mechanism designed to protect the public and promote patient safety from those HCPs who are not yet at the required standard to undertake clinical practice unsupervised; whilst at the same time providing suitable opportunities for such HCPs to gain the necessary education and competencies to enable unsupervised clinical practice.

Full registration is accorded to those doctors who are deemed to be able to undertake unsupervised medical practice.

The specialist register is a register of all those who hold, or who are training for, consultant posts in the various medical or surgical specialties; whilst being on the GP register is a requirement for those doctors who wish to practise as general practitioners (GPs) within the UK and hold

¹⁹ The Medical Act (1983) (consolidated version with amendments).

²⁰ Ibid, at section 10A(2)(a)

²¹ Ibid, at section 10A(2)(b)

²² Ibid, at section 10A(8)(a)

²³ Ibid, at section 10A(2)(c)

²⁴ Ibid, at section 10A(2)(d)

²⁵ Ibid, at sections 10A(2)(e)(i) to (iii)

appropriate certification or are eligible by virtue of the length and time of their experience.²⁶

In order to achieve registration on the specialist or GP register, it is first necessary to hold full registration.

The division between those doctors on the provisional and full parts of the register has been in existence for a significant period of time. However the specialist register came into being on the 1st January 1997 and the GP register at midnight on the 31st March 2006.

All those on the GMC register, both those provisionally and fully registered, are subject to the rules and regulations of the GMC.

As of the 12th May 2008, the total number of registered medical practitioners on the GMC register was 244,256.²⁷

2.2 The Nursing and Midwifery Council Register

Until 1st August 2004, the NMC register had fifteen parts to it, rather than the three it currently has. These fifteen parts included some historical nursing roles, such as 'fever nurses' who constituted Part 9 of the old register, as well as separate parts for first (registered) and second (enrolled) level nurses undertaking one of the four nursing branches. Thus Part 1 was for first level nurses trained in general nursing, whilst Part 2 was for second level nurses trained in general nursing. Midwives constituted Part 10 of the register, whilst Health Visitors were on Part 11. Finally there were separate Parts depending upon the nature of the education received; that is whether the nurse was trained pre or post introduction of 'Project 2000' courses which allowed those who were trained under them to be supernumerary instead of the previous position of being an employee of the Hospital where the student trained.

²⁶ See GMC website 'Information on the GP register' available from http://www.gmc-uk.org/register/gp_register/index.asp, accessed on 29th May 2008.

²⁷ Information from 'List of Registered Medical Practitioners – Statistics' available at <http://www.gmc-uk.org/register/search/stats.asp> accessed on 28th May 2008.

Following its establishment on the 1st April 2002, the NMC was required by legislation to create a new register of the HCPs it had under its remit.²⁸ The review of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1998,²⁹ which proposed the establishment of the NMC, recommended that there be two parts to the new register, these being nursing and midwifery. This proposal was rejected by the Government which said that there should be three parts to the register; nursing, midwifery and health visiting.

However, following a consultation in the last quarter of 2002,³⁰ a three part register was established but this did not include health visiting but rather had parts for nursing, midwifery and specialist community public health nurses. This last category being able to be interpreted more widely than health visiting and deemed to be more indicative of the work carried out by those in the area. However, it is only open to those who are registered on one of the other two parts of the register. Therefore, in some ways, it is similar to the specialist and GP registers of the GMC. Interestingly, The Nursing and Midwifery Order 2001 allowed for a part of the register to be established for '*specialists in community and public health*'.³¹

The legislation establishing the NMC, The Nursing and Midwifery Order 2001, limited the register to a total of three parts. This was not explicitly stated. However, throughout the legislation, there are references to nurses and midwives as being the regulated professions; whilst, within Schedule 1 of the Order, the new Council is to consist of twelve registrant members³² and eleven lay members³³. Of the registrant members, one is to be elected

²⁸ The Nursing and Midwifery Order 2001 (SI 2002/253), at article 5(1).

²⁹ JM Consulting (1998) The regulation of nurses, midwives and health visitors: report on a review of the Nurses, Midwives and Health Visitors Act 1997 JM Consulting, London, at paragraph 62.

³⁰ Nursing and Midwifery Council (2002) NMC Consultation on the new register, Nursing and Midwifery Council, London.

³¹ The Nursing and Midwifery Order 2001 (SI 2002/253), at article 6(3)(g).

³² Ibid, at Schedule 1 paragraph 1(1)(a).

³³ Ibid, at Schedule 1 paragraph 1(1)(b).

for each of the four national constituencies for each part of the register,³⁴ therefore as there are twelve registrant members in total there can only be a maximum of three parts to the register.

The new three part register was opened on the 1st August 2004. The three parts of the NMC register are:

- Registered nurse – Part 1 (incorporates parts 1 – 9 and parts 12 - 15 of the old register)
- Registered midwife – Part 2 (formerly part 10 of the old register)
- Registered specialist community public health nurse – Part 3 (including part 11 of the old register)

The three part register has caused some controversy recently when it was realised that the NMC had been letting those HCPs who were registered on the third part of the register, that of registered specialist community public health nurse, to allow their registration on either part 1 or part 2 to lapse. As noted above, this part of the register is only supposed to be open to those already on parts 1 or 2 of the register. Approximately 3,500 HCPs were registered on the third part of the register only, but the NMC only has the legal authority to regulate nurses and midwives. Thus, it is a legal requirement for those on the third part of the register to also hold registration on either part 1 or 2 of the register as well.

Therefore these HCPs were actually practising illegally for two years because they were not correctly registered with the relevant professional regulatory body. Effectively this could have meant that the NMC would have had '*no jurisdiction to register [the HCP], charge them fees or carry out fitness to practise investigation or hearings*'.³⁵

The 'error' occurred because the NMC '*voted in 2005 to allow SCPHNs [Specialist Community Public Health Nurses] solely to join the third part*

³⁴ The Nursing and Midwifery Order 2001 (SI 2002/253), at Schedule 1 paragraph 2(2)(c).

³⁵ Tweddell L (2007) 'Error leaves nurse unregulated' *Nursing Times* vol. 103 no. 49 p. 2.

of the register'.³⁶ The outcome of this vote became effective in December 2006. The Department of Health pointed out the regulatory lapse to the NMC and has informed the NMC that it must reverse its earlier decision.

The outcome for those HCPs who were registered solely on part 3 of the NMC register is that they must achieve registration on parts 1 and/or 2 of the professional register in order for their registration to be legal. This may require them to undertake return to practise courses for the relevant part of the register that they are seeking to be registered on, in order for their part 3 registration to be effective.

Although only having three parts to the new register, the NMC is allowed to indicate whether a registrant is qualified in a particular branch of nursing or at a particular level of practice.³⁷ Therefore, the registered nurse part of the register has two sub-parts of level 1 and level 2, according to the HCP's level of qualification. Additionally, the NMC register is able to record certain additional qualifications held by nurses and midwives. This may be said to be equitable with the certificates nurses and midwives used to obtain for extending their roles.³⁸ Some of the currently recordable qualifications include prescribing and teaching.

However, the term 'registered nurse' does not in itself denote the level of the nurse. This is because since the 1st September 1992 the use of the title 'registered nurse' and its associated abbreviation 'RN' has been open to any nurse on what were then the first and second parts of the register, that is those nurses both registered and enrolled. The change was brought about to reflect the importance of the nurse being registered, rather than the educational level they had achieved, for achieving the aim of public protection and patient safety.³⁹

³⁶ Tweddell L (2007) 'Error leaves nurse unregulated' *Nursing Times* vol. 103 no. 49 p. 2.

³⁷ The Nursing and Midwifery Order 2001 (SI 2002/253), at article 6(3).

³⁸ This is discussed in Chapter 3 at section 5, in particular section 5.1

³⁹ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992b) *Registrar's letter of 23rd June 1992* United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

It is important to note that the current NMC register does not allow for provisional registration. All its registrants are fully registered and therefore able to undertake unsupervised clinical practise from the point of registration. There is no period of supported supervised practise required by the NMC on first registration to allow the newly qualified nurse or midwife become accustomed to their qualified role.

As of 31st March 2007, the number of registrants on the NMC register was 660,480, with 27,704 new registrants in the preceding twelve months.⁴⁰

2.3 Checking the registers

As part of the public protection and patient safety function of the professional regulatory bodies, they are required to allow the professional registers that they maintain to be searched. The Medical Act 1983 states that *'the Registrar shall cause to be published from time to time (electronically or otherwise) a list of all persons who, on a date specified by him at the time of publication, appear in the register'*.⁴¹ Whilst for nursing, this is required under The Nursing and Midwifery Order 2001 which states *'the Council shall make the register available for inspection by members of the public at all reasonable times'*.⁴²

The rationale behind searching for a HCP's registration status is that it allows a member of the public, or an employer, to confirm that the HCP is at that point in time registered with the relevant professional regulatory body and also allows the searcher to confirm the type of registration which the HCP holds. Thus, those who claim to have registered status when they do not, or to have additional registrations other than the most basic, can be readily checked and confirmed as being unregistered. This means that members of the public can go to HCPs, who have met minimum education and competence standards, and that they can therefore trust, as opposed to those who are bogus.

⁴⁰ Nursing and Midwifery Council (2007) Statistical analysis of the register: 1 April 2006 to 31 March 2007, Nursing and Midwifery Council, London.

⁴¹ The Medical Act (1983) (consolidated version with amendments), at section 34(1).

⁴² The Nursing and Midwifery Order 2001 (SI 2002/253), at article 8(1).

As the professional registers are now established electronically as forms of electronic databases, the searching can be performed by a member of the public through the professional regulatory body website without the member of the public having to make any other contact with the professional regulatory body.

Both the GMC and NMC have prominent, clearly signposted areas on the home pages of their respective websites for checking a HCP's registration status.⁴³ Searching for a HCP's status is simple on both websites and can be undertaken by entering the HCP's name, either in full or just surname, or by entering their reference number for the GMC or their PIN (Professional Identification Number) for the NMC. These last two items of information, the reference number and PIN, are the unique numbers assigned to HCPs by their respective professional regulatory bodies which they hold for the duration of their registration.

The information which the searcher receives is similar, but slightly different, for the two professional regulatory bodies. The GMC supplies the following:

- GMC reference number
- given name and surname
- gender
- registration status
- primary medical qualification, including date and university
- provisional registration date
- date of full registration, if achieved
- specialist register entry date, if applicable
- GP register entry date, if applicable
- any publicly available fitness to practise details⁴⁴

⁴³ The GMCs is in a section entitled 'Check a doctor's registration' on the front page of their website - <http://www.gmc-uk.org/>, the NMC's is also on the front page of their website, <http://www.nmc-uk.org/>, with a button entitled 'Search the register'.

⁴⁴ Although this only relates to information from 20th October 2005 onwards.

Each of the terms above is hyperlinked so that the searcher can click on the term to determine the GMC's use of the term, which is particularly useful in terms of fitness to practise details and any sanctions imposed as these use terms which may be unfamiliar to the general public.

The NMC supplies the following information:

- full name
- expiry date of registration
- register entry, that is which part of the register the HCP is on
- date of first registration
- recordable qualifications, if any, with date of entry on register
- geographical location of HCP
- any publicly available fitness to practise details

Both the GMC and NMC supply enough information on a general search available to any member of the public to allow them to determine if the HCP is registered with the professional regulatory body and whether the HCP has the qualification that they hold themselves out as having. In addition, both have a caveat on the registration search result area which states that the information is only valid for the date, and for the GMC the time, it was retrieved. However, the GMC's information is more comprehensive and captures fitness to practise information in one place; whereas, in relation to a NMC registrant, this information is available if the searcher knows where to search for it. The NMC registration service is therefore not as user friendly as the GMC is terms of fitness to practise results.

With regard to employer searching, the GMC supplies additional information to employers on the same page as the general search but which is accessed through an additional click button, although this does not require any special access codes. The information appears on clicking the relevant button if it is held. Examples of such information would be anything that the GMC is of the opinion that an employer needs to be aware regarding the HCP's registration status, such as conditions upon the

HCP's registration. An example would be if the HCP had been restricted in the classification of drugs they could prescribe or the clinical area in which they were allowed to work. Although this information is designed for employers, it is available to anyone who searches the register and clicks on the relevant button.

The NMC, however, has an additional electronic service for employers known as the 'employer confirmation service'. This is only available to those employers who have registered themselves with the NMC and received a code and pass number. The additional information available to the employer includes information on the specific parts of the register that the HCP is registered on, along with any additional recordable qualifications and fitness to practise information on the HCP. Again, it would appear that the GMC offers a more comprehensive facility for checking the register than the NMC as all the information is provided in one place without the need for passwords.

The information that is available to members of the public on searching the registers does not comprise all the information that the professional regulatory bodies hold about their respective registrant HCPs. However, some of the information that is held may be considered to be of a personal or sensitive nature that the HCP would not want divulged to the public or their patients, for instance home addresses, date of birth details, ethnicity and relationship data.

Thus it would appear that the HCPs' right under Article 8 of the Human Rights Act 1998 for respect for their private and family life is maintained, as the information that is available on a search of the registers is thought to be the minimum that is needed to be sufficient for the purpose of protecting the public and maintaining patient safety, without compromising the HCP's right to have their personal information protected. The information that is released is in accordance with Article 8(2) of the Human Rights Act 1998, as it is required for public safety.

2.4 Registration fees

It is the HCP who meets the cost of their registration, both through initial registration and each subsequent re-registration, and thus the cost of the professional regulatory bodies, as they are not funded by the NHS or from government.⁴⁵

As can be imagined the issue of the cost of registration is a thorny one with HCPs themselves. The issues include whether HCPs should pay for the cost of regulation or whether this should be borne by the NHS, employers or through general taxation.⁴⁶ However, regardless of one's stance on this, at present professional regulation is about registrants paying for protection of the public to be in place. However, some of the professional regulatory bodies are attempting to raise income and hence limit the cost to individual registrants.⁴⁷

Being financially independent is seen as being an aspect of maintaining professional standards by not having to rely upon government or other agencies for their income and thus they are not beholden to them.

Both the professional regulatory bodies require their registrants to re-register yearly, although it is worth noting that the NMC only went to annual re-registration on 1st January 2006 for registrants renewing their registration on or after this date. Prior to this the NMC had a three year

⁴⁵ Although some 'start up' costs of the newer professional regulatory bodies, for instance the NMC and HPC, are provided by the government. For instance see Akid M (2002) 'NMC appeals to DoH for more cash' Nursing Times vol. 98 no. 20 p. 9.

⁴⁶ The letters pages of many of the professional journals regularly, and consistently over the years, have comments relating to the cost of registration and who should be paying for it. For instance see Mulholland H (2003) 'Should nurses pay to protect the public?' Nursing Times vol. 99 no. 11 p. 10 – 11; Penny J (2005) 'Funding for GMC should come from taxpayers' British Medical Journal vol. 330 p. 540; Kmietowicz Z (2007) 'Doctors threaten to withdraw subscriptions to GMC' British Medical Journal vol. 335 p. 14; and Daniels S (2008) 'We're forced to pay for an organisation that does nothing of any real benefit for us' Nursing Times vol. 104 no. 2 p. 14. Additionally, Moran M & Wood D (1993) States, regulation and the medical profession Open University Press, Buckingham at page 55, are of the opinion that it was the introduction of an annual fee that led to the Merrison inquiry into the regulation of the medical profession (Merrison A (Chair) (1975) Report of the Committee of Inquiry into the regulation of the medical profession Cmnd 6018 HMSO, London).

⁴⁷ For instance see O'Dowd A (2002) 'NMC raps company over mailing claim' Nursing Times vol. 98 no. 27 p. 8, who writes of the NMC's attempt to raise income by including advertising mail shots in their communications with registrants.

renewal period, so that those who renewed their registration in December 2005 will not have an annual renewal until 2008.

Given that both the GMC and the NMC undertake the same statutory duties, what is surprising is the marked difference in the fees each charges HCPs for registration. In the debate concerning the rise in nurses and midwives fees that occurred in 2003, the Nursing and Midwifery Council (NMC) published details of the cost of registration as a percentage of the average salary for those on each register across all HCPs professions. These was 0.3% for nurses and midwives and 1.1% for those registered with the General Medical Council.⁴⁸

The current fees⁴⁹ are as follows:

GMC

- provisional registration - £135 (this fee covers a two year period and is effectively £67.50 per year);
- full registration - £390, this is only payable once, thereafter the annual retention fee is payable annually;
- annual retention- £390 per year, although only £195 if annual income is less than £21,391 ;
- restoration fee - £390, payable if the HCP has had their name removed from the register for whatever reason and wishes to have it restored;

NMC

- on first joining the register - £76;
- annual registration fee - £76;
- re-admission or restoration fee £76, payable if the HCP has had their name removed from the register for whatever reason and wishes to have it restored;
- recordable qualifications - £25 for each qualification;

⁴⁸ Nursing and Midwifery Council (2003) Registration fees: consultation background information Nursing and Midwifery Council, London, in particular see table 1 on page 12.

⁴⁹ The fees are as of 29th May 2008. Details of fees are available on the GMC website at <http://www.gmc-uk.org/doctors/fees/index.asp> and the NMC website at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=54>.

- registerable qualification - £23 for each subsequent qualification.

Both the GMC and the NMC have different fees for overseas applicants who apply for registration to reflect the cost of evaluating their applications.

2.5 Registration requirements

With regard to the actual requirements for initial registration, these will be examined in Chapter 7 which analyses the educational requirements for initial registration. It will suffice to note at this point that an applicant must meet various educational requirements, as well as requirements that prospective registrants have to be of good health and good character, in order to have their admission to the register accepted. This is required by both professional regulatory bodies for initial registration. Additionally, the NMC requires that a declaration is made once every three years.

The requirements for annual retention or registration will be examined in Chapter 8 which is concerned with clinical competence, and analyses the competence and continuing professional development requirements that HCPs have to maintain in order to be able to renew their registration with their professional regulatory body. At this point it is worth noting that with regard to renewal of registration, nurses are required to submit a notification of practice declaration, essentially a declaration of the speciality in which the HCP intends to practice, whilst doctors are not required to do this; and that nurses are required to have undertaken a minimum number of practice hours whilst doctors can remain on the register even if they are not currently practising.

3. Commentary on protection of titles and registration

This section of Chapter 6 is a commentary on whether the protection of titles and registration provides an adequate level of public protection and public safety and thereby leads to regulation of HCPs that is fit for purpose. Where there is thought to be an issue with regard to this element of regulation, this is analysed and a recommendation is put forward.

3.1 Protection of titles and registration

The protection of HCPs' titles is well established in the legislation,⁵⁰ with clear offences and penalties for those who falsely claim to be a registered HCP or inappropriately use a registered title. For instance, with regard to those who falsely claim to be a registered nurse or midwife, the Nursing and Midwifery Order 2001 (SI 2001/253) states that '*a person guilty of an offence under this article shall be liable on summary conviction to a fine not exceeding level 5 on the standard scale*'.⁵¹

Despite this, each time a 'bogus' HCP is identified, there are media outcries in both the professional and general media calling for stricter controls and greater punishments.⁵²

Additionally, both the GMC and the NMC are able to take action against HCPs who fraudulently have registrations or qualifications on the professional registers.⁵³

However, what is a cause for concern are the changes that have occurred in the traditional roles of doctors and nurses and how this has been transformed into the current roles that each has, which was examined in Chapter 3. Section 6, in particular, noted how it is the nurse's role that has changed significantly resulting not only in new roles but also new unprotected titles as well. Some of the new titles highlighted as now being used by nurses include nurse consultant, advanced nurse or practitioner, and specialist nurse or practitioner.

⁵⁰ See section 1 above.

⁵¹ Nursing and Midwifery Order 2001 (SI 2002/253) at article 44(5).

⁵² For instance see Coombes R (1998) 'A punishment to fit the crime?' Nursing Times vol. 94 no. 34 p. 17; Rogers L (1998) 'Fake nurses dodge NHS checks to infiltrate hospital wards' The Sunday Times 5 April 1998 p. 1; Editorial (2003a) 'Nurse impostor admits charges' Nursing Times vol. 99 no. 32 p. 3; and, Rogers L & Gadher D (2000) 'Finance manager 'posed as doctor for six months'' The Sunday Times 28 May 2000 News section p. 13.

⁵³ For the GMC this is governed by the Medical Act (1983) (consolidated version with amendments), at section 39; and for the NMC this is governed by the Nursing and Midwifery Order 2001 (SI 2002/253), at article 22(1)(b).

However, these new titles may be said to be meaningless in that there is no register of them, no regulation regarding who can use them and therefore no protection for the public from those who use the titles without appropriate qualifications and experience.

Such is the rapid emergence of these new titles that Thompson and Watson believe that they cause confusion in the public and ultimately undermine the term 'registered nurse'.⁵⁴ This is because the new terms are used instead of the more traditional 'registered nurse' and thus this becomes meaningless and devalued against the rise of the new titles.

Indeed, such is the confusion regarding the use of new titles, that in 2003 the NMC commissioned a report, part of whose remit was to analyse the range of titles that were emerging for the new roles nurses were adopting, as well as examining the extent that the use of titles other than 'registered nurse' affected public perception of nurses and the work they undertake.⁵⁵ At the time, it was widely reported within the professional media that the NMC was considering regulating nursing titles, essentially all titles which had 'nurse' or its derivatives in them, in order to make it easier for the public, and for other HCPs, to recognise which titles were protected and only available for use by those who were registered on the NMC register and suitably qualified, and thereby provide an enhanced degree of public protection.⁵⁶

The Government White Paper on the future regulation of health professionals has stated that it will '*consider extending statutory regulation to these roles [advanced nurse or practitioner etc as discussed above] when they are agreed as fit for purpose*'.⁵⁷

⁵⁴ Thompson D & Watson R (2003) 'Advanced nursing practice: what is it?' International Journal of Nursing Practice vol. 9 p. 129 – 130.

⁵⁵ Longley M, Magill J & Warner M (2004) Innovation and Protection Welsh Institute for Health and Social care, Pontypridd.

⁵⁶ For instance see Parker G (2004) 'NMC to regulate nursing titles' Nursing in Critical Care vol. 9 no. 5 p. 253

⁵⁷ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London.

However, no further action on the protection of titles has been forthcoming to date. So that the only titles that are protected in law are 'registered medical practitioner', 'registered midwife' and 'registered nurse'. This means that anyone, whether a registrant of the NMC or not, is able to call themselves, for example, a specialist nurse or nurse consultant with no redress against that person if they do not have the appropriate training or competencies for the role they perform.

An aside that can be made with regard to the protection of HCPs' titles is that of the difference in the status afforded to the titles doctor, midwife and nurse. All are occupational titles in that they describe the role and work that the HCP is undertaking. However, the difference is in the status that is accorded to the titles. The title 'Doctor' is awarded to medical school graduates as an honorary title, even before they hold full registration; they keep the title for life. Although it is worth noting that because of tradition those who enter the surgical specialties and achieve Fellowship of the relevant Royal Colleges refer to themselves as 'Mr' or 'Miss' and drop the 'Doctor' title; whilst those who enter the medical specialties retain the title 'Doctor' throughout their careers even on reaching the level of consultant.

The reason for the differences in the use of the title 'doctor' between the medical and surgical specialties goes back to the time when physicians were members of the Royal Colleges but surgeons had not yet been admitted to such a prestigious organisation, as they were considered to be tradesman and not professionals and therefore inferior to physicians and not worthy to be associated with them, and were instead members of a guild, that of the Company of Barber-Surgeons. So instead of receiving the title of 'Doctor' they were addressed as 'Mr', as an indication of their lower status to physicians. However, due to what may be termed inverted snobbery or a wish to distinguish themselves from physicians, surgeons never reverted to calling themselves 'doctor' and the term 'Mr' for a surgeon who has achieved their Fellowship has become a mark of prestige and achievement.

Therefore the doctor, who retires and removes themselves from the GMC register because they are no longer practising, may retain their title of 'Doctor'. They keep the mark of esteem that they earned earlier in life. Whereas midwives and nurses do not have such a title, the terms 'midwife' and 'nurse' are occupation related and job specific. On leaving the specific job they relinquish their title and indeed on leaving the profession as a whole are not able to refer to themselves as 'Midwife' or 'Nurse' X. Indeed midwives and nurses who reach higher positions in their organisations often have titles that do not refer to the HCP as a midwife or nurse but perhaps as a midwifery or nursing supervisor.

A further note of difference between the two professions is that medical HCPs do not have to remove themselves from the GMC register on retiring. Indeed, until May 2008, it was a feature of GMC registration that those registrants over the age of 65 did not have to pay the annual retention fee. In May 2008, the GMC received advice that its age exemption is unlawful,⁵⁸ as it is contrary to provisions contained in the Employment Equality (Age) Regulations 2006.⁵⁹ Therefore, from 30th June 2008, no further age exemptions will be given and all those on the professional register will be required to pay the appropriate registration fee.

However upon retiring, the registrant with the NMC is removed from the professional register. The difference between the two professional regulatory bodies is that the NMC require all registrants on renewing their registration to sign a 'Notification of Practice'⁶⁰ form which states that the registrant has undertaken 450 hours of registered practise in the preceding three years in either nursing, midwifery or specialist community public health nursing, that is in an activity covered by one of the three parts of the

⁵⁸ For more information on this see the 'Registration News' page of the GMC website at http://www.gmc-uk.org/doctors/registration_news/index.asp accessed on 20th June 2008.

⁵⁹ Employment Equality (Age) Regulations 2006 (SI 2006/1031).

⁶⁰ An example Notification of Practice form is available at <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=2214>.

register.⁶¹ Being unable to complete this 'Notification of Practice' form means that the registrant is not able to renew their registration. The GMC does not require such a declaration from its registrants.

Recommendation

It is recommended that they be further protection for the public with regard to the increasing number of titles that are being used, particularly with regard to nursing roles. Each title, for instance nurse consultant or specialist nurse, should be linked to a specific part of the register with the requirement that set competencies and educational attainments are required in order to achieve registration on that specific part of the register. Thus HCPs who work at a level that is in excess of the normal standard, that is advanced or specialist practitioners, can be registered on a separate part of the register that acknowledges this fact, and also allows for the public, and employers, to expect these HCPs to actually be able to perform their clinical practice at this level, as well as being able to check the register in this regard.

The title that a HCP uses should reflect their level of education and training and be protected from misuse by those who are not so educated.

3.2 Provisional registration

It is interesting that a rigorously applied structured system of provisional registration for those HCPs who qualify from their initial education preparation is not universal. So that on qualification from medical school, doctors will have a year of provisional registration with the GMC, whilst nurses are able to achieve full registration with the NMC at the point of qualification.

This means that on one day nurses will be wearing their striped student uniform and having their clinical practice overseen by a mentor or assessor; the next day they are wearing their blue uniforms as are nurses

⁶¹ Although, as noted in section 2.5, a notification of practise declaration only has to be completed once every three years.

with ten years or more experience and practising independently anywhere within the UK. More importantly, the nurse who has just qualified with their full registration is able to undertake the full range of nursing tasks without any direct supervision or mentorship.

The NMC has been aware of concerns about newly qualified nurses' fitness to practise at the point of registration. Indeed, it undertook a review of the issue in 2005,⁶² whilst in 2007 the NMC included a proposal on whether there should be a '*mandatory consolidation period*' in a consultation on pre-registration education. The final report of the 2007 consultation is still awaited and the NMC has not yet stated its position on the issue.⁶³ Furthermore since 2004,⁶⁴ it has had 'preceptorship' arrangements for newly qualified nurses on their first position after initial registration. According to the NMC '*preceptorship is about providing support and guidance enabling 'new registrants' to make the transition from student to accountable practitioner ... [who is able to:] practise in accordance with the NMC code of professional conduct: standards for conduct, performance and ethics; develop confidence in their competence as a nurse, midwife or specialist community public health nurse. To facilitate this the 'new registrant' should have: learning time protected in their first year of qualified practice; and have access to a preceptor with whom regular meetings are held*'.⁶⁵

This on first reading would appear to be similar to the GMC provisional registration requirements. However, preceptorship is only '*strongly recommended*'⁶⁶ for a formal period of about four months⁶⁷ and is not tied

⁶² Nursing and Midwifery Council (2005) Proposals arising from a review of fitness for practice at the point of registration Nursing and Midwifery Council, London.

⁶³ The consultation, which commenced in November 2007, closed on the 8th February 2008. Information relating to the consultation entitled 'The future of pre-registration nursing education' is available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2641> accessed on 10th May 2008.

⁶⁴ Nursing and Midwifery Council (2004a) Standards for the preparation of teachers of nurses, midwives and specialist community public health nurses Nursing and Midwifery Council, London.

⁶⁵ Nursing and Midwifery Council (2006) Preceptorship guidelines NMC Circular 21/2006 Nursing and Midwifery Council, London, at page 1.

⁶⁶ *Ibid*, at page 1.

⁶⁷ *Ibid*, at page 2.

to any limitations on the registration of the registrant who is receiving it. It is therefore a voluntary arrangement between the HCP and their employer; as can be imagined providing preceptorship has a cost implication for the employer and it is not widely provided. In addition, there are no specific educational outcomes for the preceptorship period. The role of the preceptor is left to agreement between the newly qualified HCP and the preceptor and can be best described as a facilitator role. Therefore the preceptorship arrangements of the NMC are not as robust, nor as formal, as the provisional registration arrangement of the GMC.

Recommendation

That all HCPs undergo at least a one year period of provisional registration before achieving full unrestricted registration. That, in order to achieve full registration, HCPs have to demonstrate that they meet the required standards that are set for full registration. The GMC model of 'Foundation year 1' of the two year foundation program, that all doctors are required to undertake before specialising, with set competencies to be achieved, is to be applauded and should be applied to the NMC system of registration.

The benefits of the provisional year of registration are that it is a transitional period for the HCP. It is a period of limited responsibility. Instead of the nursing system where suddenly the ropes of restraint and support are cut and the HCP is on their own, with provisional registration, the HCP does not take full responsibility, but has more than they did as a final year student.

It is a transitional period that allows the HCP to go from their student way of life to that of the practical application of clinical practice. Instead of being a supernumerary member of the health care team, the provisionally registered HCP is a full member of the team, but receives close supervision and further direct training in the specific area in which they are working and specialising.

There is a system of supervision in place for the provisionally registered HCP so that they do not have to make treatment decisions alone. Indeed within the medical system, it is rare for the 'Foundation year 1' doctor (previously know as the House Officer) to make treatment decisions or undertake the admission of a patient without their decisions being checked by a more senior colleague.

The provisional registration year acts as a safety net: for the HCP, who has a chance to increase their responsibility but with supervision; for their colleagues who are aware that the HCP has their basic educational qualification but not the practical experience, in this respect it may be seen as going from having red 'L' plates on one's car to having green ones (it informs other drivers that you have the qualification but are still learning and inexperienced); for the patients, it allows them to have their care overseen by more experienced and qualified HCPs, the supervisors.

3.3 Registration fees

The list of fees, above in section 2.4, highlights the discrepancy between the fees charged by the GMC and the NMC to their respective registrants. The NMC, which is the larger of the two professional regulatory bodies, is the cheaper of the two on the basis of fees charged to registrants. However the NMC does not offer a lower income discount and its annual registration fee is the same for all grades of nurses and midwives. In addition, the NMC charges registrants for recording and registering additional qualifications, whilst the GMC does not charge for placing a doctor on either the Specialist or GP register, possibly because it is a requirement of practising in those areas.

Given that each of the professional regulatory bodies has the same statutory functions it does not appear logical, fair or just, that there is such a wide variance in the fees charged to registrants for the same privilege of being registered. This is particularly noticeable when one considers that

the HCP at the top of their profession pays the same as someone entering the profession on full registration.⁶⁸

Recommendation

If the purpose of registration is to regulate those that enter the profession and, in being registered, enable the HCP to practise their chosen profession and so earn an income from doing so, it seems logical that the basis for the registration fee payable by HCPs would be the same for all. The just solution would be on a percentage of income, so that regardless of the HCP's income they pay the same amount proportionally.

Although this would result in different fees being paid by those in the same professional group, it would make the basis for payment of fees fair and comparable. At present, those who are part-time pay the same as those who are full-time and those in the early stages of their careers pay the same registration fee as those at the height of their career, unless they qualify for the GMC reduced income rate.

3.4 Health care workers

This thesis is concerned with the regulation of HCPs; however it is legitimate for it to consider health care workers⁶⁹ due to the boundary changes and changes in roles examined in Chapter 3, as it is the health care worker who is taking on the roles of those who are shedding tasks as part of their boundary changes.

Within the regulatory framework, there has to be recognition of the fact, that tasks that were once the traditional roles of doctors and nurses, are now being undertaken by those who are not as qualified as doctors and nurses and, further, workers who are not currently regulated. Therefore, if regulation of HCPs is for public protection then those who take on the roles that HCPs cast aside need to be regulated, as well as the HCPs themselves.

⁶⁸ It is noted that the GMC has a reduced fee for those on provisional registration.

⁶⁹ Health care workers were defined and examined in Chapter 3, section 7.

There is no national standard for health care worker training, rather this is organised by individual employers. With the increase in the use of health care workers, as first outlined in the 'NHS Plan',⁷⁰ the greater responsibility they have is increasing, as is the need for a recognised qualification and a mechanism of public protection.

It is recognised that many health care workers work under the direct supervision of HCPs. Indeed, both the GMC and the NMC make reference in their 'codes of conduct' to ensuring that anyone to whom work is delegated is adequately trained for the task and that the delegating HCP remains responsible for the overall care that is provided. However, there are health care workers who work without direct supervision and can perform many more tasks than the traditional nurse, who was deemed in need of regulation, could undertake.

As nurses take on more tasks and roles of doctors, it is the health care worker who will take on the tasks and roles that nurses can no longer perform. That the person who discards a task is regulated but the person who attains it is not is a ludicrous situation and not one that affords the public the highest protection that could be offered.

If health care workers are not registered, the whole basis of registration of HCPs, patient safety and protection of the public would appear to fail. Either all those involved in direct, 'hands on' health care provision are regulated and registered, or none are. Only having certain groups of those involved in health care provision registered would mean that full public protection is not in place.

Recommendation

It is recommended that all health care workers are 'registered' with a regulatory body. In making this recommendation it is noted, as stated in

⁷⁰ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London.

Chapter 3, section 7.1, that there have been consultations on their regulation; also that the Government appears to suggest that regulation is not necessary when it announced that it will '*consider whether there is sufficient demand for the introduction of statutory regulation*';⁷¹ and that, in late 2008, the NMC is to host a summit on the regulation of health care workers⁷² to attempt to clarify issues such as the role and function of health care workers as well as their regulatory status. However, to date, health care workers remain unregulated and unregistered.

Whether this regulation is with the same regulatory body as the HCPs whose roles that are assuming, albeit on a separate register to HCPs, or on the register of a separate regulatory body is immaterial to the fact that they should be registered.⁷³

There are several benefits to registration of health care workers. It would allow for a statutory definition of a health care worker within their specific occupational grouping, for example nursing or midwifery. This in turn could lead to a national standard for minimum competence, with associated training programmes which would form the basis for registration. This allows for greater public protection and patient safety as the training they undertake would have to conform to the national minimum standard as opposed to being organised to meet the employer's needs, as occurs at present.

It will allow for a mechanism to be put in place to manage the health care worker who undertakes unsafe practice that puts the patient at harm but

⁷¹ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraph 7.20.

⁷² As reported on the NMC Today section of the NMC website, available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2675> accessed on 25th October 2007.

⁷³ It is interesting that article 21(2) of the Nursing and Midwifery Order 2001 (SI 2002/253) states that '*the Council may also from time to time give guidance to registrants, employers and such other persons as it thinks appropriate in respect of standards for the education and training, supervision and performance of persons who provide services in connection with those provided by registrants*'. This would appear to suggest that the NMC may provide guidance to HCAs who work with registered nurses and midwives, and to their employers on their education and training. However, the NMC does not appear to be using this facility.

where no harm occurs. Currently this could not be dealt with as a negligence case as the patient suffered no harm, no criminal action would be forthcoming and the only mechanism would be through the health care worker's employer. The employer may take disciplinary action up to and including terminating the employment of the health care worker. However having a register of health care workers would remove the regulatory 'loopholes' whereby a health care worker who is deemed to be unsafe or unfit to practice is disciplined by their employer but then able to take up alternative employment with another employer without any checks on their status. The other 'loophole' is that, at present, HCPs who are removed from their professional register are able to return to clinical practice working as health care workers, possibly putting patients at risk from their practice. This happened in the case of Yuen How Choy, a convicted rapist who was removed from the nursing register in 1986 but subsequently took a position as a care assistant working with individuals with mental illness at a nursing home.⁷⁴ While protecting the public from inadequate care, it will also ensure that HCPs can delegate care to appropriately trained individuals.

Legislation will be needed to establish any regulation of health care workers.

3.5 Register of HCPs

Given the discussion in Chapter 3, especially that in sections 5 and 6, with regard to the blurring of boundaries between HCP groups, apart from the historical aspect of the professional registers and the 'power' exerted by some of the HCP groups, it is difficult to see why there is not one register for all HCPs.

Any HCP who takes on a role previously undertaken by another professional group will be expected to meet the standard of the original professional group, until a sufficient body of the adopting professional group profess to undertake the particular skill. For instance, where the

⁷⁴ See Duffin C (2006) 'Registered post' Nursing Standard vol. 21 no. 3 p. 18 – 20.

nurse undertakes the role of intravenous cannulation, a role previously only undertaken by doctors, they will be expected to meet the '*standard of the ordinary skilled man exercising and professing to have that special skill*',⁷⁵ the doctor. If the civil court does not differentiate between types of HCP, this would lend weight to the argument that there do not need to be separate registers for each professional group. In addition, the NMC already has a register that includes three professional groups; thus, it would not be unrealistic to have a single register.

However, although there are different registers for different groups of HCPs, not all of the professional registers have different parts for HCPs with 'higher' level qualifications. The fact that some of the registers⁷⁶ are able to differentiate between those with 'initial' and 'advanced' registration status would seem to indicate that it is feasible for all of the professional registers to undertake this form of registration of their respective HCPs.⁷⁷ Moving to a single register would enable this to be undertaken based upon the principles of the registers currently in place.

Coupled with this is the use of titles by HCPs. Chapter 3, section 6.1, discussed the creation of new roles for HCPs, most notably nurses and the increase in the use of titles used by this new form of nurse. At present nurses undertaking these new roles are using titles that are meaningless because there is no recognised format to the education or competences that must be undertaken to be able to use the title.⁷⁸

Recommendation

That there is a single register for all HCPs, irrespective of their professional group. That this register allows for specialist and advanced

⁷⁵ *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, at page 121.

⁷⁶ For instance the GMC, as discussed in section 2.1 above, maintains registers of those doctors who are on the GP or specialist register.

⁷⁷ The NMC has agreed that there should be a separate register of those working at an advanced level and is currently awaiting approval for the Privy Council on this. See NMC website 'Advanced nursing practice – update 4 May 2006' at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2038> accessed on 13th June 2006.

⁷⁸ See Thompson D & Watson R (2005) 'Editorial: the state of nursing in the United Kingdom' *Journal of Clinical Nursing* vol. 14 p. 1039 – 1040.

practice qualifications and titles to be registered, which is in line with the recommendation in section 3.1 above, with the setting of educational and practical competencies needed to achieve this additional registration, and the ability to remove this additional registration subject to fitness to practice procedures. This would allow the public to be assured of the education and competencies of those who hold themselves out as being specialists.

In addition, having one professional register would mean that removal from the register would not allow the HCP to join another profession by achieving registration with that professional regulatory body.

That there is a separate register for all other health care workers.

3.6 Notification of intent to practise

Not all HCPs who are registered with either the GMC or the NMC are actually undertaking clinical practice or working by virtue of their registration, that is, in a position of employment where their registration with the professional regulatory body is essential. Therefore it is necessary to query whether there should be a non-practising part of the professional registers for those who are not currently 'in practice'.

Allied to this concept of the non-practising part of the register is the fact that the NMC currently requires HCPs on one of the parts of its register, and only one, to notify the NMC of their intent to practise in the forthcoming year. The NMC require midwives to notify them of their intent to practise but do not require nurses or specialist community public health nurses to do the same. In fact, for a midwife to be able to legally provide midwifery care to women in the UK, it is a legal requirement that they are on the appropriate part of the NMC register and complete an 'Intention to Practise' form that they hand to their local supervising authority.⁷⁹

⁷⁹ The Nursing and Midwifery Order 2001 (SI 2002/253), at article 42(b).

Recommendation

It would seem to be logical that if there is a compelling need for a group of HCPs to be required to notify their professional regulatory body of their intent to practice in any given period, that this be extended to all HCPs. Therefore it is recommended that, each year, HCPs on professional registers are required to inform the regulatory body of their intent to practise by virtue of their qualification each year; that those who do not do so are moved to a non-practising part of the register. If the HCP has not returned to the practising part of the register within a given time period and subsequently wish to do so, that they are required to undertake a return to practise course, that is sanctioned by the professional regulatory body, to ensure that their competencies and knowledge are current.

Additionally, this would also provide a solution to the situation whereby HCPs may become out of date yet remain on the professional regulatory body registers. As noted above in section 3.1, HCPs registered on the NMC register only have to complete 450 hours of relevant practice in the preceding three years, whereas the GMC does not have any practice requirement for those wishing to register with it. Therefore it is entirely possible to have a situation where a HCP who has not undertaken any clinical practice for a significant periods of time to successfully register with either the GMC or the NMC. The NMC practice requirement is only twelve weeks of full-time employment, that is, thirty seven and a half hours per week. Therefore this could be fulfilled by a HCP who last undertook clinical practice some thirty three months prior to registering.

Conclusion

This chapter has analysed how the protection of titles and registration element of regulation contributes to the regulatory aim of public protection and patient safety, and whether this element of regulation is fit for purpose.

It has undertaken this analysis through a discussion of how the GMC and the NMC protect HCP titles and provide for the registration of HCPs, comparing and contrasting their approaches to these tasks.

The underlying philosophy of protecting the titles of HCPs and having a register of HCPs is that it protects the public because only those HCPs who have meet the initial requirements for registration, along with any subsequent requirements for re-registration are able to register.

In section one, above, it was noted that this element of regulation is both controlling and enabling for the HCP. Whilst it is not proposed to re-examine that discussion here, it is thought by this thesis that the protection of titles and registration as an element of regulation is generally fit for purpose in that it achieves the controlling effect on HCPs that provides public protection and patient safety. At the same time, it enables the HCP to undertake their clinical practice autonomously providing that they comply with the not too arduous requirements regarding registration and not holding themselves out as having qualifications, titles or registration that they do not have the right to claim. Effectively, this element of regulation provides the HCP with a 'licence to practise' that they retain so long as they maintain their registration with the professional regulatory bodies. This is seen, by this thesis, as being a positive aspect of the regulation of HCPs.

However, generally fit for purpose does not equate to being fit for purpose and there are some gaps in the regulatory processes which have been identified in the commentary above. If these gaps in the regulatory processes can be closed along the lines recommended, then this element of regulation would be fit for purpose and the regulatory aim achieved.

It is the provisional regulation of those HCPs regulated by the NMC that is of particular concern. Preceptorship is a voluntary arrangement and, having no nationally agreed standard, length of duration, or competencies to be achieved, and not being tied in any way to the registration of the HCP

receiving it, is not sufficient to ensure that regulation is fit for purpose. The provisional registration arrangements of the GMC are much more suited to achieving the regulatory aim.

Both the GMC and the NMC are affected by the lack of regulation of health care workers and the ability of HCPs to renew their registration each year even though they have not been undertaking clinical practice for some time.

Putting aside the benefit to public protection and patient safety for one moment, the recommendations put forward above are not seen as being controlling at the expense of removing the HCP's clinical autonomy in their clinical practice. The recommendations would sit alongside the regulatory framework already in place and support it rather than be an altogether new regulatory framework.

Protecting the titles used by HCPs, in particular nurses, is more enabling than controlling for those who are able to use the titles but controlling for those who would be excluded from using them, if the recommendation were accepted. However, it would enable those who are excluded from using the titles to know what competencies they need to acquire in order to gain that particular title.

Having a period of provisional registration for HCPs registered with the NMC is more enabling than controlling as it provides the individual HCPs with the skills and competencies they will need throughout their careers and may lead to some having more rapid career advancements as a result of their increased competencies.

The recommendation with regard to registration fees may be said to be controlling, if the HCP pays more as a result, or not, if they end up paying less.

Regulating and registering health care workers is seen as being enabling for HCPs, as it would result in health care workers who have achieved a set of national competences through a training programme that results in their registration. Thus the HCP would be able to delegate tasks and roles to the health care worker in the knowledge that they have the requisite skills and knowledge to undertake the specified tasks and roles.

The recommendation of a single register for all HCPs would not affect all HCPs but could have an enabling effect on those whom it would allow to progress to achieve more competencies and thus adopt more advanced roles within a framework that provides for their protection through the advisory role of the professional regulatory body. Unlike the situation where HCPs taking on advanced roles currently may feel that they are between the two professional regulatory bodies, rather than fitting in the remit of one in particular, and therefore not receiving the correct advice regarding their role.

Requiring the HCP to notify the professional regulatory body of their intent to practise in the year forthcoming is a controlling aspect of the recommendations put forth. However, for most HCPs it will not mean more than completing another part of the registration form. For those registered with the GMC, it will mean another form to complete with regard to their annual registration.

The professional regulatory bodies exert their effect through protecting the titles that HCPs use and the maintenance of the register. Taking the two professional regulatory bodies individually, the GMC would appear to currently have the more robust and fit for purpose regulatory framework with regard to this element of regulation, whilst it is the NMC that is the poorer of the two in this regard.

Chapter 7

Education for initial registration

Introduction to chapter 7

Although this chapter is entitled education for initial registration, as well as examining the education requirements of the two professional regulatory bodies for initial registration, it also examines the other criteria that it is necessary to fulfil to initially register as a health care professional (HCP) with either the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC). Within this thesis initial registration is taken to mean the first level of registration following qualification in the particular profession that allows autonomous practice,

The purpose of this chapter is to determine whether this aspect of the regulation of HCPs, that of education for initial registration, is fit for purpose. Therefore the question that this chapter addresses is, does this element of regulation contribute to the protection of the public and patient safety without restricting the clinical autonomy of HCPs?

In addressing this question, the chapter is structured as follows: an analysis of how education for initial registration can provide public protection and patient safety; an examination of process of pre-registration education, including quality assurance mechanisms; a discussion of other requirements for initial registration; a commentary on the issues raised; and a conclusion on whether this element of the regulation of HCPs is deemed to be fit for purpose, or not.

1. Education for initial registration

If HCPs are to be subject to registration before they are able to practice as a HCP, there needs to be consensus among the members of the particular HCP's profession regarding the requirements necessary to enable registration to be achieved. One criterion is that of entry to the register based upon educational achievement of a course leading to preparation for professional practice.

The regulatory effect of education and training occurs on several levels. There is the socialisation process involved undergoing a formal

educational programme. However, the importance of education and training as a regulatory function and the main regulatory effect comes from the fact that education and training control entry to the health care professions by setting the minimum standard that we can expect of a HCP. If an individual does not successfully undertake a prescribed programme of study, and achieve the minimum standards and competencies of the professional regulatory bodies, they will not be able to register with the appropriate professional regulatory body and hence will not become a HCP and so will be unable to practise.

It is worth noting that there is no single level of educational achievement for entry to the register required across all the health care professions. Medicine requires graduate status, whereas nursing admits those with diplomate status to their register. Likewise there is no national curriculum for each of the health care professions. Additionally, there is wide variation in the educational provision and assessment of students undertaking the various health care courses across the country. Therefore the educational requirements for initial registration are an important aspect of the regulation of HCPs, as each educational establishment is able to set its own curriculum, subject to receiving approval from the appropriate bodies.

By having supervisory authority over the education of student HCPs, through, for example, the approving of individual curricula, the regulatory body effectively sets the minimum educational requirements and, in turn, competencies that are necessary for achieving registration. This ensures that the professional regulatory body promotes public protection and patient safety through the use of education and training for purpose. It also guarantees that all HCPs registered with the particular body are educated to the same minimum standard, as opposed to a situation where HCPs from different parts of the country may have knowledge, skills and abilities idiosyncratic to that particular area or educational institution.

As Green states, '*the philosophy behind the GMC is to protect consumers by issuing a licence only to doctors who have undergone a standardised programme of education*'.¹ This is echoed by Montgomery when he writes that '*membership of the profession should indicate a level of training and expertise which enables the public to rely on the skill of the practitioner*'.² Indeed the original title of the GMC was the General Council of Medical Education and Registration of the United Kingdom, a title that, although cumbersome, reflected the link between education and subsequent registration.

With regard to nursing, it has been stated that '*effective education and training is the bedrock of professional practice which aims to provide the highest standards of care for patients and clients*'.³

2. The process of pre-registration education

For the purposes of this chapter, pre-registration is the term used to describe the education that occurs prior to initial registration with one of the professional regulatory bodies.

Both the GMC and the NMC essentially undertake the same roles and functions with regard to pre-registration education; however, the authority for their education function and the way in which they perform these roles and functions demonstrate the difference between the two professional regulatory bodies.

The statutory provision for the GMC's functions with regard to pre-registration education is within the Medical Act 1983.⁴ This creates a statutory committee known as the 'education committee',⁵ which has '*the*

¹ Green D (2000) in foreword to Gladstone D, Johnson J, Pickering W, Slater B & Stacey M Regulating doctors (2000) Institute for the Study of Civil Society, London, at page ix.

² Montgomery J (2003) Health Care Law 2nd edition Oxford University Press, Oxford, at page 133.

³ Moores Y & Jarold K (1994) foreword to Department of Health (1994) Nursing, midwifery and health visiting education: a statement of strategic intent Department of health, London, at page 3.

⁴ The Medical Act (1983) (consolidated version with amendments).

⁵ The Medical Act (1983) (consolidated version with amendments), section 1(3)(a).

general function of promoting high standards of medical education and co-ordinating all stages of medical education'.⁶

For the NMC it is the Nursing and Midwifery Order 2001⁷ that contains the relevant legislative provisions with regard to pre-registration education. The NMC has no statutory committee or body whose specific remit is that of oversight of education for nurses and midwives. Instead this function is undertaken as part of the quality assurance committee.⁸

The purpose of pre-registration education is that it shall enable the student to achieve a qualification that is recognised by the professional regulatory body as preparing the student for entry to the professional register, both in terms of having the education knowledge, skills and competencies to undertake their role as a HCP, as well as providing a grounding in the responsibilities of being a HCP and working within professional standards and ethical codes including the adoption of a professional attitude and behaviour.

Therefore, with regard to pre-registration education, in essence the GMC and the NMC:

- set the education standard necessary for the HCP to achieve the educational requirement with respect to initial registration;
- approve qualifications which may lead to initial registration;
- approve educational establishments to provide pre-registration education;
- provide a quality assurance mechanism with regard to the provision of pre-registration education.

2.1 Content of pre-registration programmes

As stated above, it is the professional regulatory bodies which set the overall standard required for successful completion of a pre-registration

⁶ The Medical Act (1983) (consolidated version with amendments), section 5(1).

⁷ The Nursing and Midwifery Order 2001 (SI 2002/253), in particular Part IV.

⁸ Although this is not a statutory committee either, see The Nursing and Midwifery Order 2001 (SI 2002/253), in particular articles 3(9) and 3(10).

programme and the award of a qualification which allows registration. The GMC and the NMC set the core outcomes for entry to the register. However, as to the detailed content of the curriculum which a student wishing to become a registered HCP will undertake, this is left to the educational institutions that provide the pre-registration programmes.

Thus, it is possible that two medical students studying in different areas of the United Kingdom (UK) may have different educational experience and have covered different syllabuses. Therefore, the outcome of the two pre-registration programmes they have undertaken will both have prepared them for registration with the GMC. However, this will only signify a minimum criteria and it is possible that, for example one student will have a more psychological focused education and the other a more physically focused one.

The same is true for nursing and midwifery students studying in different parts of the UK.

Therefore it is vital that the standards which are set by the GMC and the NMC are comprehensive in that they detail the specific outcomes, knowledge, skills, attitudes and competencies which a HCP is required to possess on registration.

The GMC provides its standards for pre-registration education within its publication '*Tomorrow's doctors*'.⁹ This publication is reviewed and revised at periodic intervals, currently the GMC is preparing for a consultation on a future education, as outlined on its website the consultation is due to begin in the latter part of 2008.¹⁰

⁹ General Medical Council (2003) *Tomorrow's doctors* General Medical Council, London.

¹⁰ See GMC 'review of tomorrow's doctors' page at http://www.gmc-uk.org/education/undergraduate/news_and_projects/review_of_undergraduate_education.asp accessed 30th May 2008.

*'Tomorrow's doctors'*¹¹ provides information on: the curriculum and content of pre-registration education, including learning outcomes; how the curriculum may be delivered, including principles of good educational practice; the assessment of students; health and conduct issues relating to students; and the background to pre-registration education.

Having, as it does, two professions within its remit, the NMC provides guidance on the standard of education required for initial registration within two separate documents. These are *'Standards of proficiency for pre-registration nursing education'*¹² and *'Standards of proficiency for pre-registration midwifery education'*.¹³ Both documents are similar to each other and cover the same range of information as the GMC's *'Tomorrow's doctors'*.¹⁴

Both professional regulatory bodies also issue guidance and other documentation on specific aspects of pre-registration education, for instance on the quality assurance mechanisms.

2.1.1 *European requirements for pre-registration programmes*

The standards set by the GMC and the NMC with regard to pre-registration education programmes have to take account of European directives in relation to their respective professions. Although the different professions have different Directives relating to their pre-registration programmes, in general the Directives have requirements as to the educational content of pre-registration programmes, including the outline content of the programmes; the length of programmes, including in some instances the number of hours that need to be undertaken before registration; the practice areas in which the student gain clinical experience; the balance between theory and practice within the

¹¹ General Medical Council (2003) *Tomorrow's doctors* General Medical Council, London.

¹² Nursing and Midwifery Council (2004b) *Standards of proficiency for pre-registration nursing education* Nursing and Midwifery Council, London.

¹³ Nursing and Midwifery Council (2004c) *Standards of proficiency for pre-registration midwifery education* Nursing and Midwifery Council, London.

¹⁴ General Medical Council (2003) *Tomorrow's doctors* General Medical Council, London.

programme; and, in some cases, specify where the programme has to be delivered, for example in a university for medical education.¹⁵

However, not all the Directives cover all of these requirements. Compliance with these Directives is necessary for the qualifications and registration within the UK to be recognised in other EU countries.

2.2 Provision of pre-registration education programmes

Another function of the professional regulatory bodies, in regard to education for initial registration, is to approve educational establishments to provide pre-registration education.

An interesting difference between the GMC and the NMC with regard to provision of pre-registration education is that of the approval of institutions and pre-registration programmes.

Although the legislative provisions of the GMC and the NMC are similar with regard to education for initial registration, there are differences. Article 15(6) of the Nursing and Midwifery Order 2001¹⁶ provides that the NMC itself can approve programmes of pre-registration education; qualifications leading to registration; and institutions which it '*considers to be properly organised and equipped for conducting the whole or part of an approved course of education or training.*'

¹⁵ For example, Directive 77/453/EEC is concerned with nurse education and registration and specifies, amongst other things, that for adult nursing the programme should entail 4,600 hours over a three year period. This means that the student's year has to be at least 45 weeks per year. It also details some of the content that has to be included in the programme, such as exposure to midwifery services. For medicine, the corresponding Directive is Directive 93/16/EEC, which specifies that the programme has to be delivered in a university setting or under the supervision of a university, be at least six years in length and contain at least 5,500 hours of theoretical and practical training. The relevant Directive for midwifery is 80/155/EEC which specifies areas of midwifery practice the student midwife has to undertake within their pre-registration programme.

¹⁶ The Nursing and Midwifery Order 2001 (SI 2002/253).

However, with regard to the GMC, it does not have this power directly itself but makes recommendation to the Privy Council, in order to approve a university awarding a UK medical degree.¹⁷

Whilst the NMC maintains a list of those institutions that are approved to offer pre-registration programmes, and the programmes that they are approved to provide, those institutions which are entitled to hold a qualifying examination in medicine are listed within the Medical Act.¹⁸

Therefore an amendment to the list of medical schools able to hold qualifying examinations requires an Act of Parliament, or possibly nowadays, a 'section 60 order'.¹⁹

2.3 Quality assurance mechanisms

Both professional regulatory bodies undertake quality assurance with regard to the education requirements for initial registration. The GMC's is called Quality Assurance of Basic Medical Education or QABME.²⁰ The NMC simply refers to its as quality assurance of education.²¹

These quality assurance mechanisms are in place to ensure that, as the education provision is not under the direct control of the GMC or the NMC, it is fit for purpose, that is, the educational provision achieves the standard that has been set by the professional regulatory bodies.

Both the GMC and the NMC operate a system of periodic review of educational institutions and programmes. This allows the professional regulatory bodies to set the review period depending upon the findings from the latest and previous reviews. Thus an educational institution, or a particular programme within an educational institution, could be subject

¹⁷ The Medical Act (1983) (consolidated version with amendments) at section 8.

¹⁸ The Medical Act (1983) (consolidated version with amendments) at section 4.

¹⁹ See Chapter 5, section 4, for a discussion on 'section 60 orders'.

²⁰ Information on the GMC quality assurance mechanism is available at: http://www.gmc-uk.org/education/undergraduate/undergraduate_qa/qabme_process.asp.

²¹ Information on the NMC quality assurance mechanism is available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2562>.

to more frequent review if there were concerns expressed about aspects of the provision; whereas an educational institute or programme that was deemed to be fulfilling all the required standards may have less frequent reviews.

The longest period between quality assurance visits is every five years for the NMC and two visits in a ten year period for the GMC. However, the professional regulatory bodies require educational institutions to provide regular reports to them various aspects of their educational provision. For instance the GMC require all education institutions to provide an annual return with regard to factors such as: significant changes in the curriculum or assessment; innovative practice; responses to external changes in medical education; or any areas of concern that have been raised previously. The GMC write to all educational institutions each year and inform them of the specific information that is required from them in their annual return.

Both professional regulatory bodies make use of ‘visitors’ in their quality assurance mechanisms. ‘Visitors’ are individuals who attend educational institutions to assess and report upon *‘the sufficiency of the instruction given in the places which they visit and as to any other matters relating to the instruction which may be specified by the Committee either generally or in any particular case’* for the GMC;²² or *‘on the nature and quality of the instruction given, or to be given, and the facilities provided or to be provided, at that place or by that institution; and on such other matters (if any) as ... [the Council] requires’* for the NMC.²³

The NMC has ‘outsourced’ its quality assurance processes to HLSP, a consultancy firm.²⁴ Whilst the GMC undertakes its own quality assurance processes.

²² The Medical Act (1983) (consolidated version with amendments) at section 7(2).

²³ The Nursing and Midwifery Order 2001 (SI 2002/253) at article 16(7).

²⁴ The HLSP webpage relating to its work with the NMC is available at: <http://www.hlsp.org/uk/nmc/> accessed on 9th June 2008.

Both the GMC and the NMC publish copies of the quality assurance reports they compile on the educational institutions which provide educational programmes that lead to initial registration with them.²⁵

In addition to the quality assurance mechanisms undertaken by the professional regulatory bodies, quality assurance is also undertaken by the Quality Assurance Agency for Higher Education (QAA).²⁶ The QAA is funded through the higher education sector and reviews the performance of higher education institutions and the standard of education being offered, this includes health care programmes of education for initial registration. In addition, the education institutions offering education programmes for initial registration are required to conduct their own audits of the clinical placements they use for their student's clinical experience. The reports of these audits form part of the information that they are required to provide in their reports to the GMC and the NMC.

Where the professional regulatory bodies have concerns with regard to the educational provision being offered at a particular institution, they are obliged under their legislative provision to take action.

For the GMC this consists of making recommendations to the Privy Council who have the power to revoke a medical school's power to award a qualifying medical degree.²⁷ Whilst for the NMC, it can itself '*refuse to approve, or withdraw approval from, as the case may be, any education, training, qualification or institution to which*' the concern relates.²⁸

This power to remove approval from those educational institutions that do not meet the educational standards set by the professional regulatory

²⁵ These quality assurance reports are made available on their respective websites. The NMC's are available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=1710>, whilst the GMC's are available at:

http://www.gmc-uk.org/education/undergraduate/undergraduate_qa/medical_school_reports.asp.

²⁶ For more information on the QAA see their website at: <http://www.qaa.ac.uk/> accessed on 10th May 2008.

²⁷ The Medical Act (1983) (consolidated version with amendments) at section 7.

²⁸ The Nursing and Midwifery Order 2001 (SI 2002/253) at article 18.

bodies in relation to education for initial registration is an important aspect of ensuring that this element of regulation is fit for purpose. If the GMC and the NMC were not able to remove approval from an educational institution once approval had been granted, public protection and patient safety would be potentially compromised with regard to those HCPs who are able to achieve registration from those institutions.

Thus the GMC and NMC provide a form of accreditation to those institutions offering pre-registration education programmes, that their programmes meet the educational standard necessary for their students to achieve registration with their respective professional regulatory body.

3. Other requirements for initial registration

In addition to meeting the educational requirements of the professional regulatory bodies, potential registrants also have to meet other requirements for initial registration. These additional requirements are concerned with the potential registrant's fitness to practise their chosen health profession.

As part of the process of initial registration with the GMC all potential registrants are required to complete a declaration of fitness to practise.²⁹ This is a series of questions to which the potential registrant is required to answer either yes or no as appropriate. The declaration of fitness to practise has to be completed within three months of the registration being approved, if it is older than three months, a new declaration will be required before the registration is effective.

The questions on the GMC's declaration of fitness to practise relate to applicants from medical schools as well as from those applicants who may already have practised within health care as a HCP. The declaration includes information relating to: criminal convictions, cautions or fixed penalty notices; suspension from duty whilst working as a HCP, or

²⁹ A declaration of fitness to practise is available at: http://www.gmc-uk.org/doctors/registration_applications/join_the_register/declaration_of ftp.asp accessed on 9th June 2008.

receiving a complaint; registration with another professional health care regulatory body; physical and mental health; personal conduct that may call the applicant's fitness to practise to be questioned; any disciplinary action in university, medical school or employment; and any current or future proceedings that have yet to be resolved.

Where the potential registrant has answered yes to any of the questions, the GMC may request further information from them in relation to that aspect of their declaration.

The NMC requires that all potential registrants provide an assurance with regard to their good health and good character. This is through a self-declaration process. The NMC states that the self-declaration confirms that the potential registrant: *'intend[s] to comply with the Code of professional conduct: standards for conduct, performance and ethics; ... [has] no relevant convictions or cautions; ... [has] not been found guilty of misconduct or lack of fitness to practise by another regulatory body, or the NMC, and are not subject to a judgement by a licensing body elsewhere that would prevent you from practising as a nurse or a midwife; ... [is] not currently suspended by another regulatory body or licensing body; and ... [has] good health sufficient to practise safely and effectively'*.³⁰

There is also a requirement that a potential registrant with the NMC only has five years from the end of their pre-registration education programme to undertake initial registration.

In addition to the self-declaration by the potential registrant, the NMC also asks for a supporting declaration. In relation to student applications, this is from a person leading the pre-registration education programme. The supporting declaration has to state to that *'to the best of their knowledge*

³⁰ Nursing & Midwifery Council Good character and good health, guidance for students and registrants available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2603> accessed on 9th June 2008.

... [the applicant is] *of sufficient good health and good character to practise safely and effectively without supervision*'.³¹

It is important to note that no Criminal Record Bureau (CRB) check is undertaken by the professional regulatory bodies at the point of initial registration. The CRB is an Executive Agency of the Home Office established in 2002. Its role is to assist employers in determining the suitability of applicants for positions. It does this though checking the police national computer for details of any police cautions, reprimands, warnings or convictions, whether spent or current, which it then notifies to prospective employers. This is known as the standard disclosure.

The CRB can also undertake an enhanced disclosure. This involves the information from the standard disclosure but also includes any other relevant information held by local police forces, for example concerns logged by the police that did not result in a caution or conviction.

Where the applicant is applying for a position that would involve working with children or vulnerable adults, other checks may be made.³² These are checks of the Protection of Children Act List,³³ the Protection of Vulnerable Adults List,³⁴ and a check of Information that is held under Section 142 of the Education Act 2002.

A further requirement for initial registration is proficiency in English. This is usually only required of those applicants who are requiring registration with a qualification from an overseas educational institution. However, within the Government's White Paper on the future regulation of health care professionals, it is stated that language testing is conducted after

³¹ Nursing and Midwifery Council Good character and good health, guidance for students and registrants available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2603> accessed on 9th June 2008.

³² See NHS Employers (2006) Safer recruitment – a guide for NHS employers NHS Employers, London.

³³ Protection of Children Act 1999.

³⁴ See Part 7 of the Care Standards Act 2000.

registration but before employment as language skills are not a prerequisite for registration.³⁵

4. Commentary on education for initial registration

Having provided an examination of the ways in which the professional regulatory bodies undertake their role and function with regard to education for initial registration above, this section provides an analysis and commentary on the issues that are raised with regard to this element of regulation. Where there is an issue with regard to this element's fitness for purpose recommendations are put forward to address this.

4.1 The GMC, the NMC and the provision of education

As stated above, the professional regulatory bodies do not provide the education for initial registration; rather as noted above, they set the standard for the education, approve institutions and programmes of education and undertake quality assurance mechanisms to ascertain that the programmes in existence are achieving the educational standard.

Therefore, it is the health education institutes that set the academic standards for their own institutions. Although they have to meet the standards and competencies required by the professional regulatory bodies, in order to get accreditation for their courses, how they do so is up to them, so long as they meet the overall standards required. This means that there can be vast difference in emphasis on these programmes across the country.

Thus, although the professional regulatory bodies set the competencies that students must achieve at the end of their educational programmes in order to be eligible for registration, there are no national curricula for the various HCP groups. A national curriculum would ensure that there was parity between all medical students studying medicine and nursing students studying nursing, with regard to the content of their programmes.

³⁵ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraphs 5.17 and 5.18.

The main criteria for regulation with regard to initial education are that of the outcomes of the educational programme. As long as all those emerging from initial education programmes have the same outcomes and competencies, within their HCP group, the issues of whether the curriculum is the same seems to be a redundant one. It can be argued that by setting the outcomes of programmes and the competencies required for initial registration nationally, in effect, a core curriculum is set nationally; this core curriculum setting the minimum standard for each professional group. Therefore the present arrangement would appear to fulfil its regulatory function.

In his review of the regulation of doctors and the GMC in 2006, the Chief Medical Officer recommended that the GMC lose its role with regard to setting the educational standard for pre-registration education and their right to approve medical schools and undertake quality assurance mechanisms with regard to medical schools.³⁶

It was proposed that these functions be transferred to the body undertaking this function with regard to education following registration. This would effectively divorce the standard for achieving initial registration from the body which was responsible from maintaining the register itself. Therefore the GMC and the NMC would be required to register HCPs whose education they had not set the standard for, nor would they be involved in the quality assurance of that educational provision.

However in the Government's White Paper³⁷ that responds to the Chief Medical Officer's 2006 report,³⁸ this recommendation was not accepted and the professional regulatory bodies, including the GMC, will continue

³⁶ Department of Health (2006b) Good doctors, safer patients: a report by the Chief Medical Officer Department of Health, London, recommendation 19.

³⁷ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London.

³⁸ Department of Health (2006b) Good doctors, safer patients: a report by the Chief Medical Officer Department of Health, London.

to set the educational standard for pre-registration education as well as undertaking quality assurance of the standard.

Recommendation

That the government's response to the Chief Medical Officer's report is the correct one; that the regulatory body that maintains the register continues to oversee education requirements and set the standards, objectives and competencies for educational provision for initial registration as well as overseeing that educational provision.

4.2 Provisional registration

One major difference between the two professional regulatory bodies is that the GMC see pre-registration education as covering not only the period up to initial registration but also the first foundation year, that is, the provisional registration year. As the GMC itself states, the '*GMC sets the standards and outcomes for basic medical education in the United Kingdom (UK). This covers undergraduate education and the first year of training after graduation*'.³⁹ For the NMC, its responsibilities with regard to pre-registration education cease at the point of initial registration.

Chapter 6, section 3.2, provided a detailed analysis and discussion regarding the need for a provisional registration year and it is not intended to repeat that discussion. Rather this section asks the question as to whether the HCP on initial registration is fit for purpose, or if there is a need for a period of adjustment following the point of initial registration?

This thesis would argue that there is a need for a period of adjustment for several reasons. As noted above there is no national curriculum for preparation of HCPs for initial registration. Although it was noted above that the HCP on initial registration is deemed to have achieved set competencies. However, during their education, students are largely supernumerary and are not mean to be treated as part of the workforce

³⁹ See <http://www.gmc-uk.org/education/index.asp> for the GMC's statement.

and therefore the transition from student to registered HCP may be an unsettling experience for some.

However, a more important issue is that of the adequacy of the pre-registration education does not produce registrants that are fit to practise. The General Secretary of the Royal College of Nursing (RCN), Peter Carter, recently expressed concern and criticism that there was inconsistency in the training that students of nursing were receiving and that some new registrants were not fit to practise at the point of registration.⁴⁰

Some of the concerns are that the achievement of skills is neglected at the expense of the academic side of training; and that education programmes are more concerned with the achievement of academic skills and ability rather than clinical skills. One way of dealing with this apparent dichotomy is that whilst they are undertaking their education for initial registration, students are seen as being within the confines of their academic training, yet once they have achieved their initial registration, as with doctors, they make a contribution to the service of health care and are salaried, but also still in training.

This two stage approach utilised by the GMC, the education for initial registration period and the one year clinical period may be likened to the academic and vocational aspects to the training of solicitors and barristers. The education for initial registration provides the basic building blocks of the doctor's future education, yet it is the clinical period of the provisional registration year that provides the opportunity for them to fully appreciate the role of a HCP, and for them to develop into this role.

Recommendation

It is for these reasons that the recommendation in Chapter 6, that the provisional registration year be extended to cover all HCPs, is reiterated here. Indeed the NMC itself has recently conducted a consultation on pre-

⁴⁰ See the professional nursing journals during January and February 2008 for further discussion on the RCN's General Secretary's comments. For instance Staines R (2008) 'College chief criticises training variation' *Nursing Times* vol. 104 no. 4 p. 8.

registration education that included a proposal on whether there should be a '*mandatory consolidation period*' following initial registration.⁴¹ Although the consultation has closed, it was conducted as the first of a two part consultation and the second has yet to commence. Therefore the final report is still awaited and the NMC has not stated its position.

4.3 Level of education programmes

The issue of the level of education that the HCP has on entry to the professional register is a contentious one. All health care professions, apart from nursing, have single levels of education; nursing currently has both degree and diploma level education providing entry to the professional register.⁴² This means that nursing is the only health care profession within the UK that does not require its registrants to be educated to graduate level.

Although this appears to be an anomaly, it is not as serious an issue as it first appears. The only difference in their education is the level of educational qualification that they achieve at the end. All nursing students undertake the same number of hours of theoretical and practical experience, all are exposed to the same forms of practice experience, and all undertake the same core subjects. Indeed all nursing students qualifying from their educational programmes achieve the same competencies as set by the NMC.

There have been various periodic debates calling for there to be a common educational entry to the nursing register, at graduate level, and an equal number resisting the change.⁴³ However, to date, the move to an all

⁴¹ The consultation, which commence in November 2007, closed on the 8th February 2008. Information relating to the consultation entitled 'The review of pre-registration nursing education' is available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2641> accessed on 10th May 2008.

⁴² See Chapter 3, section 3.

⁴³ For instance, see the nursing professional publications on the debate and the length of time it has been ongoing: Davis B & Burnard P (1992) 'Academic levels in nursing' *Journal of Advanced Nursing* vol. 17 p. 1395 – 1400; Glasper E & O'Connor S (1996) 'Nursing should be an all graduate profession' *British Journal of Nursing* vol. 5 no. 1 p. 5 – 6; O'Dowd A (1999) 'Employers prefer degree nurses to diplomates' *Nursing Times* vol. 95 no. 38 p. 6; Mulholland H (2003a) 'Do all nurses need to have a degree?' *Nursing*

graduate entry to the nursing and midwifery professional register has been resisted and it would appear that as long as the nurse on entering the professional register has achieved the outcomes and competencies set by their professional regulatory body, the dual level of educational provision is not an issue that affects the overall regulatory standard for public protection.

However, it is important to reiterate that there is no single set curriculum for HCP preparation for registration and that nursing has its preparation for registration set at two educational levels, completion of either entitling the individual to the same registration status.

4.4 Registration of students

The professional regulatory bodies do not select the students that are accepted for places on the pre-registration education programmes. They do have requirements that have to be satisfied with regard to those who are selected for such places. For instance the Nursing and Midwifery Order 2001 enables the NMC to establish '*the requirements to be satisfied for admission to, and continued participation in, such education and training which may include requirements as to good health and good character*'.⁴⁴

However, neither the GMC nor the NMC has any statutory role with regard to the conduct of students whilst they undertake their pre-registration education. Indeed the NMC has stated that until they are informed by educational institutions that a student has passed their pre-registration educational programme they have no prior knowledge of the existence of the student, and therefore no information about them at all.⁴⁵

Times vol. 99 no. 34 p. 10 – 11 and, Vere-Jones E (2008) 'Unions polarised on graduates' Nursing Times vol. 104 no. 7 p. 2.

⁴⁴ The Nursing and Midwifery Order 2001 (SI 2002/253) at article 15(1)(b).

⁴⁵ Nursing and Midwifery Council (2002a) Guidelines for higher education institutions in England and Northern Ireland on registration for newly qualified nurses and midwives Nursing and Midwifery Council, London.

It is noted that until recently *'the award of a medical degree automatically entitles the graduate to be provisionally registered by ... [the GMC] and to practise under supervision as a doctor'*.⁴⁶ However, the Medical Act 1983⁴⁷ has been amended so that this is not longer the case and the GMC is able to require all potential registrants to satisfy certain requirements.

As discussed in section 3 above, both the GMC and the NMC require all potential registrants to satisfy both good health and fitness to practise requirements before their initial registration is approved. Initial registration is taken to mean that the student has met the requirements of the professional regulatory body and is able to apply for registration as a HCP in their particular profession; therefore it occurs at the end of the pre-registration education process.

However, prior to being able to apply for initial registration, all potential HCPs in training will have to undertake clinical practice placements which will require them to interact with patients, practising their professional skills upon them, throughout their training and not just at end of courses when they are qualified. They are able to interact with patients in the full sphere of professional activities, albeit under the supervision of a fully registered member of their profession.

However, at present, there is no requirement or provision for students of the health care professions to be registered with the professional regulatory bodies. Any disciplinary investigation and action that is necessary is under the remit of the educational institutes. The question arises as to whether there should be a student category of registration for all those who are undertaking educational courses and training that prepare them for professional practice as a HCP.

⁴⁶ General Medical Council (2003) *Tomorrow's doctors* General Medical Council, London, at paragraph 75. This is the most recent version of the guidance on pre-registration education for doctors; although, as stated in section 2.1 above, it is scheduled for review in late 2008.

⁴⁷ The Medical Act (1983) (consolidated version with amendments).

If the purpose of regulation is to protect public, not registering students who come into contact with patients, and may affect their care as much as a fully registered HCP, is illogical. The usual response to such a suggestion is that the supervising HCP is responsible for the student HCP. Yet, this merely means that the fully registered will be subject to disciplinary procedures by their professional regulatory body and the student subject to disciplinary action by the educational institute. This does not safeguard the public and patients against students who are ill suited to working in health care.

Some education providers have contracts with their students which include the responsibilities of both the institution and the student and include an obligation on the student to behave in a professional manner.

Students may be professionally unsuitable because of incidents in the clinical area, where they would be under the supervision of a registered HCP, but equally they may be unsuitable because of a breach of conduct or failure to demonstrate appropriate standards of behaviour outside of the clinical area.

At present students are disciplined by their educational institute, and possibly have conditions placed upon them whilst continuing their course. If the student is forced to leave their course, there is nothing to prevent them applying to another educational institute. As there is no central record, they can continue to do this until they receive an offer of another place.

Both the GMC and the NMC have published guidance for educational providers on students' fitness to practise issues.⁴⁸ These outline the behaviour expected of students on pre-registration education programmes and the procedures to be taken with regard to fitness to practise panels

⁴⁸ The GMC guidance is General Medical Council (2007) Medical students: professional behaviour and fitness to practise General Medical Council, London. The NMC guidance is Nursing and Midwifery Council (2007a) Good health and good character Guidance for educational institutions Nursing and Midwifery Council, London.

that hear allegations of misconduct against students on such programmes. It has been a requirement since September 2007 that all educational institutions offering pre-registration education programmes have fitness to practise panels that can consider issues with regard to students' health or conduct.

Although the guidance is a welcomed addition to the protection of the public, the onus remains on the educational institution to take relevant disciplinary action against students and to prevent unsuitable candidates from entering pre-registration education programmes; whilst the professional regulatory bodies only take action when the potential registrant makes an application for initial registration. This thesis considers that there should be a system to prevent those who are deemed unsuitable from continuing to undertake clinical practice where they come into contact with patients. It should also allow those deemed unsuitable from being able to put patients at risk as a result of their impaired fitness to practise by applying for places at other educational institutions and for pre-registration education programmes in other professional areas of practise, for instance the medical student who is removed from medical school yet is able to secure a place on a pre-registration nursing or midwifery programme.

Recommendation

That all students on courses that lead to registration with a professional regulatory body are given student registration that can be revoked in the case of disciplinary action being instigated against them by the professional regulatory body. This is already the situation in the case of students studying courses leading to registration with the General Optical Council (GOC);⁴⁹ where the onus is upon course leaders to ensure that students do not enter clinical placements until their registration has been confirmed by the GOC.

⁴⁹ From September 2005, all students studying on courses leading to registration with the General Optical Council have to register annually with them, section 8 subsection 8A of the Opticians Act 1989 as amended by The Opticians Act 1989 (Amendment Order) 2005 (SI 2005/848), article 9.

Further, that if a pre-registration student is removed from the student register, they are unable to accept another place on a course leading to professional registration.

It is noted in making this recommendation that there have been proposals and consultation undertaken on the issue of student registration⁵⁰ and that the Government requested professional regulatory bodies to consider the issue of student registration but had no clear preference itself.⁵¹ However, to date, no firm proposals have emerged from either the GMC or the NMC for student registration.

Although the provision of guidance by the GMC and the NMC is welcomed by this thesis and is thought that it will lead to some commonality with regard to fitness to practise procedures used with educational institutions, there are still a number of issues that remain with regard to having educational institutions undertaking the fitness to practise part of regulation of students on pre-registration programmes as opposed to the professional regulatory bodies.

Educational institutions are not professional regulatory bodies nor an offshoot of them. They have their own agendas that include making money through the provision of education and are not experts in dealing with fitness to practise issues. By leaving fitness to practise issues to be dealt with by the educational institutions, there may be inconsistency issues regarding how different institutions deal with the same problem and, where medicine and nursing are within different departments of the same educational institution, between different departments within the same institution.

⁵⁰ For instance, General Medical Council Education Committee (2006) Strategic outcomes for undergraduate medical education General Medical Council, London. It is interesting that both the General Nursing Council and the UKCC used to admit students to a student index as a form of student registration, but that their successor, the NMC, does not.

⁵¹ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraphs 6.6 and 6.7.

Some educational institutions may be over zealous with regard to student fitness to practise issues and may even be inclined to use these to remove a student from a pre-registration programme where they are unable to do so through other academic routes. Other educational institutions may be more inclined to disregard fitness to practise issues in the more academically able students.

There is also the issue of continuity of provision regarding fitness to practise issues, as will be seen in Chapter 10. This element of the regulation of HCPs encompasses health issues as well as conduct issues and there is a need for health issues, which can exist over a long period of time, to be dealt with consistently throughout. When the student become registered with the relevant professional regulatory body, they would pass from the remit of the educational institution to that of the GMC or NMC with regard to their health issues, which again could lead to inconsistency.

By having a separate category of registration for students, the regulatory bodies would be able to apply the same sanctions to students as they can to those who have full registration, namely suspension or removal from the register, with a bar on further entry to the student register and hence no prospect of the individual attaining registration on the main part of the register. There would be consistency with regard to how all pre-registration students are treated with regard to fitness to practise issues, whether health or conduct related, and with regard to the sanctions, conditions or guidance that are issued.

Conclusion

This conclusion to Chapter 7 considers whether the education for initial registration element of the regulation of HCPs is fit for purpose; that is, does it contribute to an adequate level of public protection and public safety, whilst at the same time enable the HCP's clinical autonomy?

As discussed in Chapter 3, section 1, one of the features of a profession is that it controls the entry to the profession, usually through the setting of standards of initial education and training that lead to registration. The more exclusive the knowledge that is required of the professional, the higher the requirements to the profession may be said to be.

Chapter 1 determined that in order for regulation of HCPs to be fit for purpose it has to address the issue of entry to the profession and to the register. There are a number of issues involved in undertaking this: the screening process for entry to initial education; the length and level of education required for registration; the initial qualification that is required to enter the professional registration; and the competencies to be achieved for entry onto the register. In short, there needs to be clear criteria for determining who is able to achieve initial registration.

It was stated, in Chapter 6, that the professional regulatory bodies maintain the register of qualified HCPs for their own profession(s). To do this, they have to be able to control admission to the register as well as ensuring that the register is current and HCPs are removed from the register in line with proper procedures.

The current chapter has analysed how individuals are able to achieve initial registration to the professional registers maintained by the GMC and the NMC. The rationale behind having a pre-registration programme was stated as being the achievement by the newly registered HCP of a core knowledge base within their subject area, a set of skills and competencies within their area of professional practice and the acquisition of a professional attitude.

As analysed above, the professional regulatory bodies therefore set and regulate standards and guidelines for pre-registration education leading to admission to their respective registers, with defined competencies for prospective HCPs to achieve at end of their programmes. They also undertake, or require to be undertaken, audits and visits of educational

establishments to ensure that the standards are being used and that the preparation of future HCPs is performed according to the standards set out. The professional regulatory bodies are able to remove approval from those education institutions that do not follow its standards and guidelines on educational provision.

Therefore it would appear that with regard to his element of regulation of HCPs, the professional regulatory bodies undertake regulation that is fit for purpose in that it achieves its primary aim of public protection and patient safety through the mechanisms just discussed. However, achieving the primary aim of regulation is not, for this thesis, the sole factor in having regulation that is fit for purpose, there is also an aspect of ensuring that HCPs are able to exercise their clinical autonomy and are not restricted in this.

Having a set standard of education for pre-registration education that leads to registration with either the GMC or the NMC is not seen as being merely controlling, although undoubtedly it is controlling; there is also an enabling aspect to it to. If it were not for the standard set by the GMC and the NMC there would be no control on the educational requirement for entry to the register. It was noted in Chapter 6 that the requirement that HCPs are registered with one of the professional regulatory bodies has both a controlling and enabling aspect to it. It is not proposed to reiterate the arguments presented there, rather to acknowledge that both aspects are present.

The requirement that all potential registrants who have complete their pre-registration education programmes have to complete a declaration regarding their good health and good character and have the same confirmed by their educational institutions may at first glance be said to be controlling at the expense of being enabling. However, it is recognised within this thesis that in order to achieve the primary aim of regulation, public protection and patient safety, HCPs have to be fit to practise; that is they have to be able to undertake their professional practice competently.

If the potential registrant is not of good health or of good character, this may affect their competence to perform their professional practice; therefore this is seen as being an aspect of regulation that is necessarily controlling. Those potential HCPs who are not able confirm their good health or good character are not necessarily prevented from registering with the professional regulatory bodies, rather further checks are undertaken and it is only at the exhaustion of this process that the potential registrant is prevented from registering with the GMC or the NMC; that is, when the GMC or the NMC have supported concerns with regard to the potential registrant's ability to competently perform their professional practice. The potential registrant is given every assistance to undertake their registration with the professional regulatory bodies. Thus, although this is a controlling aspect of this element of regulation, it could be seen as enabling that the professional regulatory bodies provide assistance to those who may at first be deemed unsuitable for registration and allows them a further opportunity with regard to meeting the registration requirements. It is only when it is finally deemed that the HCP is not fit to practice that they are prevented from registering.

Although it was stated above, within this concluding section, that this element of regulation may be said to be fit for purpose, there have been a number of recommendations made within this chapter that would strengthen the regulatory aspect of this element with regard to providing public protection and patient safety.

These recommendations concern the professional regulatory bodies continuing to maintain the status quo regarding their involvement with setting the educational standard for initial entry to the register; that provisional registration is provided for all HCPs and not just those initially registered with the GMC; and that, despite the recent changes with regard to the removal of automatic registration of those who achieve the required qualification for initial registration,⁵² that there is a register maintained by the professional regulatory bodies of all students who are undertaking pre-

⁵² See section 4.4 above.

registration education programmes, so that those students who are deemed to be unsuitable for professional practice on one professional programme can be acknowledged as having been removed from a programme, if they chose to apply for another pre-registration programme.

This chapter has outlined a number of ways in which the education for initial registration is regulated. These include the professional regulatory bodies: setting the standards for pre-registration education, including requirements for entry onto educational programmes; determining the competencies required for initial admission to the professional registers; approving the educational institutions that provide the education programmes and approving the pre-registration programmes; and, undertaking quality assurance of both the educational institutions and pre-registration programmes, including auditing of both institutions and programmes at regular intervals to ensure that they continue to meet the set standards.

It is considered that this element of regulation of HCPs, that of education for initial registration is fit for purpose in that it achieves the primary aim of regulation, protection of the public and patient safety, through control of HCPs but without reducing their clinical autonomy.

Chapter 8

Clinical competence

Introduction to chapter 8

This chapter is concerned with clinical competence after initial registration, the competencies needed for initial registration having been analysed and discussed in Chapter 7.

Although competence has been discussed in Chapter 3, section 2.1, it was discussed from the perspective of the qualities needed to be a professional. Within the current chapter competence is analysed from the perspective of how a health care professional (HCP) is regulated to ensure that regulation is fit for purpose. As examined in Chapter 1, section 4.2, for the purposes of this thesis, clinical competence is one of the five elements that it is necessary to regulate, if the primary aim of regulation, that of public protection and patient safety, is to be achieved. Further, in Chapter 1, it was noted that for regulation to be fit for purpose, it not only had to regulate the five elements but also had to be enabling for the HCPs regulated in that their clinical autonomy had to be maintained and not constrained by the regulation in place.

Consequently, the purpose of this chapter is to determine whether this aspect of the regulation of HCPs, that of clinical competence, contributes to the regulation of HCPs being fit for purpose. Therefore the question that this chapter addresses is, does this element of regulation contribute to the protection of the public and patient safety without restricting the clinical autonomy of HCPs?

Following a discussion on the nature of competence from a regulatory viewpoint, this chapter is structured as follows: an examination of how HCPs can maintain their competence; an analysis of how HCPs can increase their competence in preparation for advanced roles; a discussion of the ways in which HCPs can prove their level of competence; a commentary on the three areas considered to reflect this element of regulation; and, finally, a conclusion that considers whether this element of regulation is fit for purpose.

1. Clinical competence

Competence refers to the HCP's ability to undertake particular tasks and roles to a set standard. From a regulatory perspective, clinical competence is in essence concerned with how a HCP maintains their knowledge and skills in relation to their clinical practice once they have achieved initial registration and also with how the HCP can increase their knowledge and skills in relation to new tasks they assume, and when working at specialist and advanced roles. It is also concerned with the standard that is set for HCPs competence and how the HCP is able to prove their current clinical competence against the standard that is set by the professional regulatory bodies.

As stated previously within this thesis, particularly in Chapter 6, the professional regulatory bodies maintain the register of qualified HCPs for their own profession(s). To do this effectively, they have to be able to control admission to the register, which includes setting the standard of competence required for initial registration, as well as ensuring that the register is current and that HCPs who no longer meet the agreed standard are removed from the register in line with proper procedures.

In order to ensure that the professional register is current, in terms of being an accurate up to date record of those HCPs who hold registration that allows them to perform professional practice, the professional regulatory bodies have to set the standard of competence that is required of each HCP on their respective registers, as well as setting and overseeing the requirements for any subsequent re-registration.

Whilst Chapter 6 outlined the professional registers maintained by the professional regulatory bodies and the various categories of registration possible, Chapter 7 analysed the educational requirements that the prospective HCP has to meet in order to prove their competence to achieve initial registration with one of the professional regulatory bodies.

However, being admitted to the professional register should not be the end-point of a HCP's commitment to professional education and development. Continued registration on the professional register should mean that there is a need for the HCP to maintain their clinical and professional competence throughout their professional careers.

For clinical competence to be an effective element of regulation it has to go further than initial registration and include a continuing education and updating aspect to HCPs maintaining their registration with the professional regulatory bodies. If it were possible to register with either the GMC or the NMC and then, subsequent to the current annual payment, to renew registration without any additional updating or participation in educational activities, it is difficult to see how the public would be protected from out-of-date HCPs or those HCPs whose skills were below the necessary standard.

Yet, this is precisely the situation that exists. In Chapter 6, it was noted that the registration arrangements of the GMC and the NMC do not currently require HCPs to demonstrate their competence on each annual registration. Therefore, at present it is theoretically possible for a HCP to obtain a pre-registration qualification, obtain initial registration and then not have to demonstrate their competence again but still remain fit to practise by the re-registration requirements of the GMC or the NMC.

For the public to be protected from the incompetent HCP or those whose performance is poor, or those who are not aware of the current practices within their area of clinical practice, there is a need for HCPs to undertake regular professional development. This is particularly so where the HCP, as discussed in Chapter 3,¹ advances their clinical practice into tasks and roles that was not a part of their traditional role and therefore not covered within the education they received for their initial registration. HCPs need to ensure that they are up-to-date with their sphere of practice in particular, and with health care in general. When they take on additional

¹ In particular see sections 5 and 6.

roles and responsibilities their area of expertise will change and the required competencies, to be able to undertake their roles and responsibilities effectively, will consequently change as well.

Grubb states that with regard to all forms of regulation in the health care arena, *'the aim of the regulation is said to be the protection of the public against incompetent or inadequate practitioners'*;² whilst Montgomery believes that *'the relationship between patients and health care professionals is based largely on trust that the latter are competent. Membership of the profession should indicate a level of training and expertise which enables the public to rely on the skill of the practitioner'*.³

The Kennedy Report is quite categorical on this point when it makes the statement that *'professionals should be able to do that which they profess they can do. From the patient's point of view, it is shocking to think that this might not be the case. Indeed, the need for healthcare professionals to acquire and maintain appropriate levels of competence is so obvious that it would seem unnecessary to refer to it'*.⁴ This point is an important one but it is equally important to note that there is a requirement for the regulatory bodies to ensure that they regulate the competence of the HCPs over which they have authority. Without guidance, statements and standards on the requirements for the maintenance and development of competence, HCPs would have to provide their own standards, and this could vary greatly from HCP to HCP, from the exceptional to the deficient.

As to how the regulatory bodies could ensure that all the HCPs they have authority over are competent to undertake their roles, there are a variety of ways of achieving this. They may issue guidance on the amount of continuing professional development (CPD)⁵ that a HCP has to undertake

² Grubb A (2004) Principles of Medical Law 2nd edition Oxford University Press, Oxford, at page 84 - 85.

³ Montgomery J (2003) Health Care Law 2nd edition Oxford University Press, Oxford, at page 133.

⁴ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 - 1995 CM 5207(1) Stationery Office, London, at page 323.

⁵ See the following section for information on CPD.

in a given period; or they could make it a requirement of re-registration that the HCP can demonstrate that they have undertaken CPD and are required to keep a portfolio, or similar, to provide evidence of this; or they could make it a requirement of membership and registration that the HCP adheres to periodic updates on clinical skills and knowledge, possibly assessed through the use of appraisal schemes; or they could undertake checks of clinical competence by the use of periodic assessments in those skills and knowledge.

The actual and proposed methods of the professional regulatory bodies in ensuring that their registrants are competent are explored below.

However, there is a difference between maintaining one's competence for that which one is currently registered, becoming competent for advanced and specialist practice, and being able to prove that one has the required level of competence; the next three sections of this chapter deal with these three issues.

2. Maintaining competence

This section examines how the professional regulatory bodies approach the issue of ensuring that those HCPs on their respective professional registers are competent to undertake their professional practice. Within this section, the maintenance of competence will be taken to encompass both educational and practice requirements.

Continuing professional development (CPD), which was introduced in Chapter 3 section 2.1, is known by a variety of terms within health care, some of which are profession specific. For instance, the medical profession has traditionally spoken of continuing medical education, whilst nursing has recently begun talking of lifelong learning. For the purposes of this thesis CPD is the continuing education that HCPs undertake, not to achieve initial registration, nor to achieve specialist

qualification, but to keep up to date and to meet the educational requirements necessary for re-registration and revalidation.⁶

As to the approach taken by the professional regulatory bodies to CPD, the following demonstrates their individual approaches as well as highlighting commonality between them.

*For the GMC, CPD ‘is a continuing learning process that complements formal undergraduate and postgraduate education and training. CPD requires doctors to maintain and improve their standards across all areas of their practice. ... (“practice” includes all the professional roles that doctors currently perform and those that they plan to perform.) CPD should also encourage and support specific changes in practice and career development. It has a role to play in helping doctors to keep up to date when they are not practising’.*⁷

*Whilst for the NMC, CPD, known as lifelong learning, is defined as ‘more than simply keeping up to date. It requires an enquiring approach to the practice of nursing and midwifery, as well as to issues which impact on that practice. Pre-registration education prepares ... [the registrant] for practice at the point of registration. Continuing professional development is linked to the registration renewal process though the Post-Registration Education and Practice (PREP) standards. These represent an important part of lifelong learning linked to professional practice and build upon the requirements for entry to the register. The concept of lifelong learning is one that the NMC supports across the two professions [nursing and midwifery]’.*⁸

It can be seen that CPD is related to the HCPs accountability, particularly with regard to the need for them to keep up to date in their practice. Both

⁶ Revalidation will be discussed below in section 4.3 of this chapter.

⁷ General Medical Council (2004) Continuing professional development General Medical Council, London, at page 2.

⁸ Nursing and Midwifery Council (2002b) Supporting nurses and midwives through lifelong learning Nursing and Midwifery Council, London, at pages 3 – 4.

the GMC and the NMC link CPD to the evolution of the HCP's role;⁹ they link the requirement for CPD to the concept of a lifelong, career development approach to education; there is an acknowledgment that CPD is related to standards of practice and the maintenance and development of these standards; and, finally, there is a recognition that CPD is additional to the education required for initial registration or for specialist practice. The relationship between CPD and re-registration/revalidation will be discussed below in section 4.

The GMC has no specific CPD requirement for its registrants; they are able to re-register each year, subject to fulfilling other registration requirements, without supplying details of any CPD they have undertaken in the previous year. In order to re-new their registration registrants with the GMC have to pay a renewal fee;¹⁰ there is no other requirement for renewing their registration.

For those HCP's registered with the NMC, there are a number of requirements that have to be met in order for them to renew their registration. These requirements are the payment of the annual renewal fee;¹¹ and every third year there must be self-recording of CPD activity in the preceding three years and completion of a notification of practice declaration.¹² The notification of practice declaration requires the HCP to declare that they have completed the CPD requirement and maintained a record of it, which is thirty-five hours over the last three years relevant to the area in which the HCP practices; that they have completed four hundred and fifty hours of registered practice in the preceding three years for each part of the register for which they are re-registering, that is to have worked in some capacity that requires them to be registered with the NMC; to inform the NMC of any police caution or conviction since 1st August 2004; and declare that their health and character allow them to practise safely and effectively.

⁹ Chapter 3, sections 5 & 6 provide discussion on the changing nature of HCPs roles.

¹⁰ See Chapter 6, section 2.4 for information on the fee payable.

¹¹ See Chapter 6, section 2.4 for information on the fee payable.

¹² A Notification of Practice form can be seen at: <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=2214>, accessed on 13th may 2008.

Whilst the GMC has no stated requirements, the NMC has combined the CPD requirement for renewal of registration with the practice requirement into what it terms the 'PREP standard' and issued guidance to their registrants on this.¹³ Indeed, the requirement for a HCP seeking renewal of registration with the NMC to meet the twin aspects of the PREP standard is contained within the legislation governing the NMC.¹⁴

The NMC has no specific method for HCPs to achieve the CPD requirement, and provides the following information to its registrants: *'You can meet the PREP (CPD) standard in many different ways. The important things to remember are that: it doesn't have to cost you any money; there is no such thing as approved PREP (CPD) learning activity; you don't need to collect points or certificates of attendance; there is no approved format for the personal professional profile; it must be relevant to the work you are doing and/or plan to do in the near future; [and] it must help you to provide the highest possible standards of care for your patients and clients'*.¹⁵

Although it has been stated that the GMC has no specific requirement for the maintenance of competence with regard to renewal of registration, there is a provision within the code of practice that all registrants with the GMC update their knowledge and skills throughout their professional practice and engage in CPD activities.¹⁶ Likewise, the NMC code of conduct¹⁷ has a similar provision. Both of these provisions will be discussed in Chapter 9 where the standards of professional practice required by the GMC and the NMC are examined.

¹³ Nursing and Midwifery Council (2006a) The PREP handbook Nursing and Midwifery Council, London.

¹⁴ The Nursing and Midwifery Order 2001 (SI 2002/253) at article 10. Although this does not set out the actual terms of the requirement, it requires the HCP to meet those requirements for CPD and practice that the NMC has set.

¹⁵ Nursing and Midwifery Council (2006a) The PREP handbook Nursing and Midwifery Council, London at page 9.

¹⁶ General Medical Council (2006) Good medical practice General Medical Council, London at page 12.

¹⁷ Nursing and Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives Nursing and Midwifery Council, London, see page 7.

3. Competence for advanced practice

Advanced practice is utilised as shorthand here for practice that is undertaken at a level beyond that achieved at initial registration. It encompasses the various titles that nurses have been employing in recent years when they take on additional tasks and roles and extend their practice past that traditionally seen as that of a nurse,¹⁸ as well as those on the specialist and General Practitioner (GP) registers maintained by the GMC.

It was noted in Chapter 6 that the NMC only has one register with three parts, unlike the GMC which has the specialist register and the GP register, the NMC register does not differentiate between levels of practice other than between first and second level nurses, that is what used to be termed registered and enrolled nurses.

Therefore unlike the GMC the NMC currently has no specific criteria for those who undertake tasks and roles beyond that expected at initial registration, apart from the recordable qualifications which it holds, those of teaching and prescribing.¹⁹ The fact that only the GMC has a register which differentiates those working at an advanced level was seen as a weakness in the overall regulation of HCPs in Chapter 6.²⁰ Although it is noted that the NMC has recognised this and agreed that there should be a register for those HCPs working at an advanced level and is waiting for Privy Council approval to set up such a register.²¹

The difference between the two professional regulatory bodies with regard to the registers they hold may be linked to the way in which each regulates post-registration education.

¹⁸ See Chapter 3, section 6 and Chapter 6, section 3.1 for discussion on these titles and nurses extending their roles past the traditional role of the nurse.

¹⁹ See Chapter 6, sections 2.1 and 2.2 for more information on the GMC and NMC registers, and Chapter 3, sections 5 and 6 for information on extended tasks and roles.

²⁰ In particular see section 3.5 re this point.

²¹ See NMC 'Advanced nursing practice – update 4 May 2006' webpage at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2038> accessed on 13th June 2006.

3.1 Education and training for advanced practice

This thesis is putting forward the suggestion that there are three distinct phases to HCP education and training. These are:

- pre-registration - initial education and training allowing the student HCP to become registered on the professional register of the relevant professional regulatory body, as examined in Chapter 7;
- CPD – these are the educational requirements that are necessary to remain on the professional register, discussed above; and,
- post-registration - further education and training that allows HCPs to move through the career structure and allows them to work at an advanced level, also for doctors it allows them to achieve specialist registration. For nurses and midwives, at present, there is a limited area of practice that allows them to be registered with the NMC as specialist practitioners, that is specialist community public health nursing.²²

For completeness, and to aid later analysis, the following examination of the education and training of HCPs will include discussion of the pre-registration phase as well as that of the post-registration.

Education and training for HCPs used to be a relatively simple process. For doctors the process was: medical school; qualify as a medical student and apply for provisional registration with the GMC; undertake a one-year pre-registration house officer year; then follow a chosen route for the specialist registrar or general practice registrar, usually involving membership of appropriate Royal Colleges and the obtaining of additional qualifications. For nurses the process was: nursing school with provisional registration; qualify as a nurse with full registration with the regulatory

²² This is seen as advanced practice as the HCP who is registered as such has to also be registered as a nurse or midwife and cannot train just for this role or be solely registered on this part of the register. See chapter 6, section 2.1 for further information on this part of the register.

body (GNC,²³ UKCC²⁴ or NMC); further career progression was based upon application for jobs.

Following proposals in The NHS Plan,²⁵ in 2002, the Chief Medical Officer Sir Liam Donaldson issued a consultation paper that proposed reform of the senior house officer year,²⁶ which was the first year of full registration. The response from the four UK Health Ministers to the consultation²⁷ accepted most of the proposals and this has led to the overhaul and modernisation of the career structure of doctors. This has led to changes in the way that trainees are assessed, such as the use of competencies.

Ultimately, the changes have encompassed the full period of training. The development route for doctors is now: an undergraduate course leading to graduation and provisional registration; a two year foundation programme, with year one leading to full registration; a two or three year basic specialist training programme, originally proposed to have eight pathways for the various medical specialities, (which would be the entry point for overseas doctors), this would be the exit point for those with the General Practice Certificate; then higher specialist training programme of two to six years, initially suggested as fifty programmes, leading to the certificate of completion of specialist training, allowing the individual to apply for consultant positions.²⁸

Other changes have meant that training will be a managed process, linked to specific programmes, and not the previous model whereby doctors would apply for jobs of their choosing in order to advance their careers in

²³ GNC was the General Nursing Council and the predecessor of the UKCC.

²⁴ UKCC was the United Kingdom Central Council for Nursing, Midwifery and Health Visiting; it was the immediate predecessor of the current regulatory body for nurse and midwives, the NMC.

²⁵ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London, in particular see chapters 8 & 9.

²⁶ Chief Medical Officer (2002a) Unfinished Business: proposals for reform of the Senior House Officer grade Department of Health, London.

²⁷ Department of Health (2003a) Modernising Medical Careers: the response of the four UK Health Ministers to the consultation on Unfinished Business: proposals for the reform of the Senior House Officer grade Department of Health, London.

²⁸ For information on medical training see the Modernising Medical Careers website, available at: <http://www.mmc.nhs.uk> accessed 18th May 2008.

their chosen specialities. Each element of training will be time limited resulting in a reduction in the overall time taken to reach consultant grade.²⁹

The reform of medical education and training should not be dismissed lightly; it represents a major change in how doctors proceed throughout their careers and as can be imagined, such a change has not always been readily accepted, especially as some see it as being imposed upon the profession.

For instance, Poole³⁰ sees the changes as being necessary to meet government commitments to increasing the number of consultants, the new career structure reducing the amount of time it takes to reach consultant grade and hence allowing more consultants to be appointed in a shorter period. Others see the shortened training period as leading to ill-equipped doctors, thereby endangering patients, and the effective introduction of a sub-consultant grade.³¹

In addition, with regard to postgraduate education and training, for medicine this is regulated by the Postgraduate Medical Education and Training Board (PMETB),³² which went 'live' in Sept 2005. The principal functions of PMETB are to:

'(a) to establish standards of, and requirements relating to, postgraduate medical education and training;

²⁹ Part of the reason for the reduction in training time has been the effect of the Working Time Directive (Council Directive 93/104/EC), for more on this topic see Chapter 3, section 5.2.

³⁰ Poole A (2003) 'The implications of Modernising Medical Careers for specialist registrars' *British Medical Journal Careers Focus* 7 June 2003 p. 194.

³¹ For instance see Foster M (2004) 'Johnson dubs MMC shake-up "greatest threat" to patients' *BMA News* 24 April 2004 p. 1, in which the Chairman of the BMA describes the reforms as '*half-baked*' and '*the greatest current threat to patient care*'; and Wafer A (2004) 'Training shake-up: real career threat' *BMA News* 3 July 2004 p. 1.

³² The Postgraduate Medical Education and Training Board was created by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (SI 2003/1250); the enabling power arises out of Health Act 1999 particularly sections 60 and 62. It is a revision of the 'Medical education standards board' originally envisaged and discussed in the NHS Plan (Secretary of State for Health (2000) *The NHS Plan: a plan for investment, a plan for reform* Cm 4818-I The Stationery Office, London), see paragraph 8.28.

(b) to secure the maintenance of the standards and requirements established under sub-paragraph (a); and
(c) to develop and promote postgraduate medical education and training in the United Kingdom'.³³

A doctor has to satisfy PMETB that they have met certain requirements before they are awarded the necessary certificate of completion of training. However, there is still no national curriculum for postgraduate education and training. So long as the standards and competencies are met, educational providers are able to design their own curricula and place their own emphasis upon the standards and competencies,³⁴ as with pre-registration education discussed in Chapter 7. PMETB can appoint visiting panels to inspect education providers and their curricula.

It should be noted, that as a result of the government response³⁵ to a recent Inquiry into 'Modernising Medical Careers',³⁶ PMETB will merge with the GMC by 2010, so that the whole of medical education will be under the remit of one statutory body; until that time there will be a transitional arrangement where the two bodies work together with increasing reasonability being assumed by the GMC.³⁷

With regard to nursing, pre-registration programmes are provided at both diploma and degree level.³⁸ It was only in the last fifteen years or so that

³³ General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003, Statutory Instrument 2003/1250 at article 3(2).

³⁴ Wooding K, Maxted M & Owen H (2004) Baseline analysis and scoping study on postgraduate medical education and training curricula in the UK The Postgraduate Medical Education and Training Board, London. This report was designed to establish how far the current curricula met the PMETB's standards. Its findings suggest that there is a long way to go with standards being met on average by only half the curricula.

³⁵ Department of Health (2008) Secretary of State's for Health's response to aspiring for excellence: final report of the independent inquiry into Modernising Medical Careers Department of Health, London.

³⁶ Modernising Medical Careers is a framework for post-registration medical education and for recruitment to Foundation and Speciality training. For further information see its website, available at: <http://www.mmc.nhs.uk/> accessed 13th May 2008.

³⁷ The Inquiry is Tooke J (Chair) (2008) Aspiring to excellence: final report of the independent inquiry into Modernising Medical Careers Modernising Medical Careers Inquiry, London.

³⁸ See Chapter 3, section 3 for further information on this.

nursing training has moved into the higher education sector.³⁹ There have been several reforms of pre-registration nurse education over the years, with the last major reform⁴⁰ following the publication in 1999 of a report examining whether nurse education prepared nurses who were fit to practise.⁴¹ This reform resulted in a system of nurse education that was competency based at the point of registration. That is, in order to achieve registration, prospective registrants had to prove that they were competent in a given number of areas. Like medicine, there is no national curriculum for pre-registration nurse education. Unlike medicine, nurses do not have provisional registration for a period after qualification; rather they are able to achieve full registration at the point of qualification.

With regard to education that is undertaken after initial registration, unlike medicine, there is currently no central co-ordination of this. Unless the education leads to a specialist practitioner qualification that can be recorded on the NMC professional register, for example non-medical prescribing or specialist practitioner - adult nursing, the NMC does not approve or undertake separate quality assurance of these programmes. The fact that the NMC has a register of one group of specialist practitioners, that of the specialist community public health nursing, and merely records other specialist practitioner qualifications,⁴² would appear to suggest that the NMC does not hold these in as high regard or see the need for these to be protected in the same way.

Therefore, health education institutions are free to provide whatever programmes of study they believe will meet the requirements of their prospective students. Additionally, there is no structured career

³⁹ For instance see, Levine E, Leatt P & Poulton K (1993) Nursing practice in the UK and North America Chapman & Hall, London. The authors discuss the '*small numbers of nurses [who] obtain registerable professional qualifications in conjunction with a university degree*', at page 61.

⁴⁰ Although, as Chapter 7, section 4.2 noted, the NMC has recently undertaken a consultation entitled 'The review of pre-registration nursing education' which is available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2641> accessed on 10th May 2008. The outcome of the consultation is still awaited.

⁴¹ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) Fitness for practice (The Peach Report) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

⁴² See Chapter 6 for an examination of the NMC register.

progression for nurses, no pre-ordained route from initial registration to higher registration or advanced practice. Likewise, there is no specified pathway into specialisms such as coronary care nursing or infection control nursing. Nurses are therefore free to undertake the post-registration education that they wish to undertake or feel will best enhance their professional careers.

Notably, once nurses have registered with the NMC, they may extend their roles into areas not covered by the education that prepared them for initial registration, provided that there is not a requirement for them to hold a specialist qualification, for instance in teaching or prescribing.⁴³

A 2004 Department of Health document examining nursing for the future stated that: *'the idea of a nurse as a uniform product is not true now and will in future be less so. The registration qualification requires definitive standards, but recognises that after that stage it is an agreed framework of principles that is crucial, not detailed rules. This is recognised by current regulatory arrangements. Whilst definitive standards are required for registration, principles and standards frameworks are key thereafter'*.⁴⁴ This vision has not yet materialised as there is no framework for nurses with regard to their post-registration education or for their career progression.

To summarise, the GMC has parts of the register reserved for those undertaking advanced level practice and a framework of education for those wishing to enter specialist and GP practice. The NMC does have a separate part of the register for specialist community public health nurses but this accounts for only 0.5 % of the total number of registrants.⁴⁵ Apart from recording qualifications in prescribing and teaching and some specialist practice qualifications, the NMC does not have a separate register for those who work at an advanced level, nor is there an

⁴³ See Chapter 3, sections 5 & 6 for more information on professional boundaries and extended roles.

⁴⁴ Department of Health (2004j) The challenges for nursing and midwifery in the 21st century Department of Health, London at paragraph 99.

⁴⁵ See Chapter 2, section 2.2 for further details.

overarching framework of education for those who wish to practice at an advanced level.

4. Proving competence

This section is concerned with more than HCPs simply maintaining their competence or improving it for advanced practice. It is concerned with how HCPs can prove their competence to practise at whatever level they undertake that practice.

Having proven their competence through their initial registration and any further specialist registration, anecdotal evidence suggests that many HCPs are of the opinion that they do not need to further demonstrate their competence. They believe that once they have proved their competence, it has been proven for the duration of their professional careers unless they decide to practice in a different speciality.

Indeed, it used to be that once a HCP had achieved registration with their professional regulatory body they remained on the register unless they did something that warranted their being removed, subject to paying the annual fee.

However, proving competence should not be a single event. If regulation is concerned with public protection and patient safety, there should be no such thing as a licence to practise for life. As Evans et al recognise '*it is no longer enough to do a job to the best of one's ability. Other people have to be assured that professionals can be trusted*'.⁴⁶ Being assessed for competence once only does not mean that the HCP will be competent throughout their professional life. As discussed in Part 2, health care moves forward apace and there are new roles and responsibilities for HCPs that emerge to meet the changes in health care; HCPs need to move with it and be seen to be doing so.

⁴⁶ Evans R, Elwyn G & Edwards A (2004) 'Review of instruments for peer assessment of physicians' *British Medical Journal* vol. 328 p. 1240 – 1243, at page 1240.

The problem with regard to regulation of HCPs relates to the method of assessing competence and the system to be utilised to assure others that the HCP is competent.

4.1 Appraisal

The notion of a formal annual appraisal system for all HCPs can be traced to the development of clinical governance in the NHS.⁴⁷ This resulted in a consultation document from the Chief Medical Officer,⁴⁸ which developed the earlier proposals and strengthened the call for appraisal to be linked to personal development plans. This all occurred against the background of the Bristol Royal Infirmary Inquiry,⁴⁹ which was set up in 1998, and the 1999 Inquiry into the practice of Rodney Ledward, which questioned why his performance had not been picked up and acted upon by his employers at an earlier stage.⁵⁰

The NHS Plan indicated that mandatory annual appraisals were being introduced for consultant grade doctors. The aim is to '*enable the professional and clinical needs of consultants to be identified and support clinical governance and revalidation*'.⁵¹ They were introduced for consultants in April 2001⁵² and, in April 2002, for GPs⁵³ as a contractual requirement. However, appraisals are not a new phenomenon for HCPs; it is argued that it is the context in which they occur, and the way they are utilised, that has changed in recent years.

⁴⁷ Department of Health (1998) A first class service: quality in the new NHS Department of health, London, particularly chapter 3.

⁴⁸ Chief Medical Officer (1999) Supporting doctors, protecting patients Department of Health, London.

⁴⁹ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

⁵⁰ Department of Health (2000a) Report of the inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward (Chair Jean Ritchie – the Ritchie Report) Department of Health, London, in particular see the terms of the inquiry at page 5 – 6.

⁵¹ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London, at paragraph 8.21.

⁵² Department of Health (2001b) Advance letter (MD) 5/01 'Consultants' contract: annual appraisal for consultants' Department of Health, London.

⁵³ Chief Medical Officer (2002) Letter to all NHS General Practitioners 'Annual appraisal of General Practitioners in the NHS' PL/CMO/2002/3 Department of Health, London.

Regarding the nature of appraisal, Conlon sees it as being a '*structured process of facilitated self reflection*'.⁵⁴ For Gatrell & White,⁵⁵ there are three purposes of appraisal: as a developmental tool in the training process, this includes all aspects of the training process including that of specialist education; as an annual assessment of all doctors to meet revalidation requirements; and as a management tool which measures performance against job description and organisational objectives. Although they write specifically about appraisal for doctors, the principles may be applied to all HCPs. For instance, as part of the Agenda for Change framework⁵⁶, all HCPs, other than those covered by the doctors and dentists pay review body and senior managers, have to undergo an annual appraisal or personal development review, as it is known, to assess their performance within the knowledge and skills framework and hence their pay and promotion prospects.

Appraisal allows HCPs to review their performance over a given period, to identify their strengths and areas for improvement, and thereby formulate a personal development plan that will allow them to concentrate upon the areas that need developing and hence improve their clinical performance and the care that their patients receive as well as other areas of practice such as their management and communication skills.

The appraisal is undertaken according to set procedures and using specific documentation, although these may be different for the various groups of HCPs, for example that of hospital consultants is different of that of GPs. The appraiser is usually another member of the HCP's own professional group who has undergone specific training. Therefore the person who is assessing the competence of the HCP is another HCP. There have been calls for a strengthening of the appraisal performance including a more

⁵⁴ Conlon M (2003) 'Appraisal: the catalyst of personal development' British Medical Journal vol. 327 p. 389 – 391 at page 389.

⁵⁵ Gatrell J & White T (2001) Medical appraisal, selection and revalidation – a professional's guide to good practice The Royal Society of Medicine Press, London.

⁵⁶ See Chapter 3, section 5.2 for a discussion of Agenda for Change.

objective assessment of performance that includes past performance as well as examining current competence to practise.⁵⁷

4.2 Clinical supervision

Clinical supervision has been described as one method through which HCPs can prove their competence to practise; it is seen as '*an exchange between practising professionals to enable the development of professional skills*'.⁵⁸ It is a process that has been traditionally associated with the psychotherapy and counselling professions,⁵⁹ and the psychiatric speciality within medicine.

Although it is not undertaken by all HCPs, for midwives, clinical supervision has long been a mandatory hallmark of their professional status. Although, interestingly, their professional regulatory body, the Nursing and Midwifery Council (NMC), does not extend the mandate to nursing, the other professional group it regulates; it merely recommends that it is available to all nurses.⁶⁰

For midwives, it is a statutory requirement that originates from the Midwives Act 1902.⁶¹ Within the midwifery system, a supervisor is an experienced midwife who undergoes training for the role and is appointed by a Local Supervising Authority (LSA); supervisors can also be deselected by the LSA. Supervisors are responsible for a group of midwives; they must meet each midwife at least annually. Midwives are able to request the assistance of a supervisor at any time; this may be for advice and guidance or to actually attend with the midwife. Supervisors have two roles, one for the pregnant woman, the other for the midwife. They can

⁵⁷ Secretary of State for the Home Department and the Secretary of State for Health (2004) Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future (Chair Dame Janet Smith DBE) Cm 6394 The Stationery Office, London, in particular see paragraphs 27.110 – 27.116.

⁵⁸ Butterworth T, Faugier J & Burnard P (1998) Clinical supervision and mentorship in nursing 2nd edition Stanley Thornes, Cheltenham, at page 12.

⁵⁹ Faugier J & Butterworth T (1993) Clinical supervision: a position paper University of Manchester, Manchester.

⁶⁰ Nursing and Midwifery Council (2006b) A - Z Advice sheet: Clinical supervision Nursing and Midwifery Council, London.

⁶¹ Although originating from the Midwives Act 1902, the current authority arises under Nursing and Midwifery Order 2001 (SI 2002/253), particularly articles 41 – 43.

monitor the midwives practice, investigate any allegations at a local level and they may, via the LSA, suspend a midwife from practice where there is cause for concern.⁶²

Clinical supervision may be said to be a formal arrangement whereby HCPs meet with other HCPs to discuss aspects of their professional practice with a view to improving their practice and/or developing their skills and competencies. The supervisor is an experienced HCP who assists, coaches, mentors or counsels the supervisee with regard to their clinical practice. As Butterworth & Faugier note, it is not line management and that it '*should not be confused with simple managerial oversight. Its purpose is to facilitate reflective practice and push toward a patient-centred focus*'.⁶³

There are various models of clinical supervision but all share certain characteristics. These characteristics being that there are regular meetings or communication via e-mail, telephone etc; the supervision is from supervisors who have undertaken training for the role; the supervision is undertaken in the workplace; and the supervision reflects upon issues affecting the supervisee professionally, whether this be formative - to gain/develop knowledge and skills, restorative - where the supervisor supports the supervisee in terms of their personal well-being and reduction of stress, or normative - the maintenance of standards, or a combination of the three.

The models for clinical supervision include both individual and group supervision, ranging from the one to one individual sessions with a supervisor from the supervisee's own discipline or speciality; to one to one expert supervision, where the supervisor is the more experienced; to one to one session with supervisor is from another profession; to pair

⁶² See Nursing and Midwifery Council (2004d) Midwives rules and standards Nursing and Midwifery Council, London, in particular rule 12 which details the information above and also rule 3 which requires midwives to inform their LSA of their intention to practise every 12 months.

⁶³ Butterworth C & Faugier J (1994) Clinical supervision in Nursing, Midwifery and Health Visiting: A briefing paper University of Manchester, Manchester, at page 1.

supervision, where two HCPs of similar experience are supervised together; to group supervision such as peer group supervision involving a group of HCPs from similar or same discipline; to network supervision, where there will be no direct meetings, contact may be from a distance, and the network will be of a group who do not normally work together. The supervisor in one setting becomes the supervisee in another so that all receive supervision.

Clinical supervision was highlighted in 1993 as being a formal process by which HCPs, specifically nurses, could develop their knowledge and competence and so further the protection of patients in the clinical environment.⁶⁴ It was felt that *'the exploration of the concept of clinical supervision of practitioners other than midwives, should be further developed so that it is integral throughout the line of practice, thus enabling practitioners to accept personal responsibility for and keep that care under constant review'*.⁶⁵ Following this, a Chief Nursing Officer letter was distributed which stated that clinical supervision was *'fundamental to safeguarding standards, the development of professional expertise and the delivery of quality care'*.⁶⁶ This was followed by a position paper by the UKCC which promoted clinical supervision to the professions and made the statement that *'clinical supervision is necessary in clinical practice to enable practitioners to establish, maintain and promote standards and innovation in practice in the interest of patients and clients'*.⁶⁷

More recently, clinical supervision has been linked to the clinical governance agenda as a way of ensuring that HCPs met their CPD requirements; it ensures that practice is continually improving through the

⁶⁴ Department of Health (1993b) A vision for the future: The nursing, midwifery and health visiting contribution to health and health care HMSO, London.

⁶⁵ Ibid, at target 10.

⁶⁶ Chief Nursing Officer (1995) CNO Professional letter 94/5 'Clinical supervision: for nursing and health visiting' Department of Health, London, at page 1.

⁶⁷ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1995) Position statement on clinical supervision for nursing and health visiting United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London, at page 3.

establishment of an environment where poor performance can be examined and excellence encouraged.⁶⁸

4.3 Revalidation

Revalidation is a new approach to the checking of a HCP's competence. Within the Government's White Paper on the future regulation of health care professionals, revalidation is defined as '*a mechanism that allows health professionals to demonstrate that they remain up-to-date and fit to practise*'.⁶⁹

The current position, with regard to both the GMC and the NMC, is that there is no system in place whereby their respective registrants have to prove their competence to practise. This will change with the current proposals to introduce revalidation for all HCPs in the near future,⁷⁰ so that both the GMC and NMC will require HCPs who wish to renew their registration with them to undergo a system whereby they periodically prove that they are fit for practise.

It would appear that revalidation is unpopular with HCPs themselves; searches of any of the professional journals can result in articles that are dismissive of the benefits of revalidation or are concerned about the burden that will be placed upon HCPs in meeting revalidation requirements.⁷¹

However, as to the effect upon HCPs, the White Paper states that '*for the large majority revalidation will provide reassurance and reinforcement of their performance, and encourage continued improvement. For a very*

⁶⁸ For instance see Department of Health (1998) A first class service: quality in the new NHS Department of Health, London, and Department of Health (2002g) Public health and clinical quality: clinical governance Department of Health, London.

⁶⁹ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraph 2.2.

⁷⁰ Ibid, see Chapter 2.

⁷¹ For instance see van Zwanenberg T (2004) 'Revalidation: the purpose needs to be clear' British Medical Journal vol. 328 p. 684 – 686.

small minority, the scheme will provide a way of identifying problems and an opportunity to put things right'.⁷²

5. Commentary on clinical competence

The following provides a commentary on whether clinical competence provides an adequate level of public protection and patient safety, thereby contributing to regulation of HCPs that is fit for purpose. Where there is an issue affecting this element's fitness for purpose, in providing public protection and patient safety, recommendations will be put forward.

5.1 Maintaining competence

The essence of the HCP maintaining their competence is that health care changes, and therefore the HCP cannot remain stagnant in their practice and merely remain on the relevant professional register; they have to update their knowledge, skills and ultimately their practice in order to be credible in the contemporary health care environment.

CPD is seen, by this thesis, as a way of ensuring that the HCP has kept their competencies, skills and knowledge up to date and remains safe to practise in their profession. The current formal requirements for CPD differ between the professional regulatory bodies.

Since April 1995, nurses and midwives have been required to maintain a personal professional profile outlining details of their professional development and to have undertaken a minimum of thirty five hours of study, over a three year period, of relevance to their practice in order to re-register.⁷³

However, for doctors, at present there is no requirement that they specifically undertake CPD. This will be linked to revalidation

⁷² Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraph 2.2.

⁷³ Nursing and Midwifery Council (2006a) The PREP Handbook Nursing and Midwifery Council, London.

requirements but these are not currently in force.⁷⁴ There is a requirement that doctors keep themselves up to date but this does not require any specific CPD activities.⁷⁵ However it has been a requirement of some of the Royal Medical Colleges that, in order to maintain specialist practitioner status, doctors must achieve a certain number of continuing medical education credits; credits being linked to the number of hours of education undertaken.⁷⁶

It is acknowledged that it is not always an easy process for a HCP to gain access to relevant CPD activities. There have been numerous reports and articles within both the medical and nursing professional press over the past eighteen months or so with regard to the lack of employer support, in terms of both funding and time, for HCPs wishing to undertake CPD. This is attributed to the funding that is available being diverted to other areas of the health care budget.⁷⁷ There is also the possibility that employers do not place as much emphasis or value on CPD as do the HCPs themselves.

Being required to undertake specific learning activities, and to keep a record of these and link them to the HCP's own learning needs, may be seen as a form of regulation. This is controlling as failure to do so may mean that the HCP is unable to maintain their professional registration.

However, CPD is seen by this thesis as also being a positive aspect of regulation. It allows a distinction to be drawn between competence at initial registration and current competence; that is, it allows the HCP to maintain and develop the competences they had at initial registration. Therefore in promoting achievement of the primary aim of regulation, public protection and patient safety, it can also be said to enable those

⁷⁴ Revalidation is analysed in section 4.3 above and commented on in section 5.3 below.

⁷⁵ General Medical Council (2006) Good medical practice General Medical Council, London at page 12.

⁷⁶ For instance see Federation of Royal Colleges of Physicians of the UK (2002) CPD for UK Physicians Federation of Royal Colleges of Physicians of the UK, London, which at page 10 states '*participation in a CPD Scheme will be considered mandatory for Fellows and members normally practicing in the UK to remain 'in good standing' with their College*'.

⁷⁷ As an example of this see Taylor J (2008) 'The great training robbery' Nursing Times vol. 104 no. 14 p. 20 -21 who describes a campaign to support HCPs in undertaking CPD.

HCPs whose clinical practice is current and enables them to provide safe effective care for their patients.

It is enabling because it allows the HCP to practice with confidence knowing that they are up-to-date in their professional field, that they have a strategy in place for continued updating and that their registration is not at risk.

The NMC informs their registrants that *'the best thing about PREP is that it is entirely up to you to decide how to meet the standards. The NMC believes that you are the best person to decide what learning activity you need to undertake. You should choose whether it is free or if you wish to pay for it. You are the best person to decide the extent to which you are practising as a registered nurse, midwife or specialist community public health nurse'*.⁷⁸ This means that there is no accreditation of what counts as CPD and as long as the HCP reflects upon the CPD,⁷⁹ anything can count as a CPD activity. The NMC lets the HCP decide upon their CPD activities and then to self-declare that they have met the CPD requirement.

However, to be an effective aspect of regulation, that is fit for purpose, CPD needs to be more than a self-selecting, self-reporting activity; there needs to be a system of auditing in place to ensure that CPD is being undertaken, and undertaken in an appropriate manner.

Scott reports that, whilst the NMC has a statement regarding their registrants being audited on PREP requirements,⁸⁰ the NMC has recently dropped its auditing of PREP (that is CPD); also that, although there are

⁷⁸ Nursing and Midwifery Council (2006a) The PREP Handbook Nursing and Midwifery Council, London, at page 3.

⁷⁹ In declaring their CPD registrants with the NMC are required to maintain a portfolio of CPD activity that requires them to reflect upon the activity they have undertaken and how it contributed to their practice. See Nursing and Midwifery Council (2006a) The PREP Handbook Nursing and Midwifery Council, London, at pages 10 -11.

⁸⁰ Nursing and Midwifery Council (2006a) The PREP Handbook Nursing and Midwifery Council, London; the auditing statement is on page 26.

over 660,000 registrants on the NMC register,⁸¹ between July 2001 and March 2002 only 10 audits on registrants' CPD were undertaken.⁸²

If the NMC is committed to the principle of CPD then failing to undertake audits of self-declared CPD activity is an ineffective method of informing the profession it regulates regarding its stance on CPD. Rather the reverse is true, by dropping auditing of CPD, which was widely reported within the professional publications, the NMC is sending a message to all its registrants that there is no need to undertake CPD as no-one will ever know if the individual HCP has ever undertaken it or not.

Recommendation

That CPD is linked to registration across all professional regulatory bodies.

For CPD to fulfil its regulatory role, it needs to be structured, directed and have set parameters, that have demonstrable outcomes on patient care. Linking CPD to registration will provide the framework in which this can occur. Merely having a set number of hours that the HCP has to fulfil is not enough. Whilst HCPs need to know how much CPD they are expected to achieve in a given period as a minimum, with such a system, HCPs may undertake any activity that provides them with sufficient hours with the least disruption to them, rather than the activities with the most benefit.

The current NMC requirement of thirty five hours of CPD in the previous three years is not an effective method of ensuring that HCPs are safe, competent, up-to-date practitioners. It would be possible for the HCP to have undertaken a five day course thirty five months ago and then have undertaken no further CPD since that time. The requirement for CPD should be on a year by year basis with the actual requirement set by the professional regulatory bodies, but consistently across all health care professions.

⁸¹ See Chapter 6, section 2.2 for information on the NMC register.

⁸² Scott G (2006) 'Regulatory body drops PREP audit numbers from its website' *Nursing Standard* vol. 20 no. 33 p. 12.

It would appear as if a system of appraisal and CPD linked to registration requirements would achieve the regulatory aim of ensuring that HCPs maintain their competence and have current clinical credibility. Linking CPD to a HCP's appraisal would allow the identification of areas of deficit in a HCP's practice and then allow for a training plan/needs assessment to be drawn up between the appraiser and HCP to address these areas, so working toward meeting the competencies required for practice. This would result in CPD activities that are credible and relevant for the individual HCP.

In addition, having a defined link between CPD requirements and the HCP's appraisal would mean that employers were able to undertake checks on an individual HCP's CPD and ensure that the activities undertaken were relevant to identified learning needs, and not irrelevant to their practice. This would also go some way to addressing the situation where a need is identified by the HCP but there is no support in terms of finance or time from the HCP's employer for them to undertake the identified CPD activity. Having the CPD recognised within the HCP's appraisal will involve the employer in the identification of the CPD activity that is needed and linking this to registration should mean that the employer supports the HCP in their achievement of this CPD, in order that the employee is able to fulfil the full range of duties required by the employer.

Having a formal link between CPD and registration would also ensure that those HCPs who do not undertake CPD can have their registration suspended by the professional regulatory body, until they can prove they have undertaken the necessary requirements and that their competence is up-to-date. In order for this aspect to be achieved the professional regulatory bodies would need to instigate an efficient audit mechanism for the checking of an individual HCP's CPD, with a clearly defined standard of how many checks were to be made in a given period; although, for compliance, this may need to be on a random basis so that HCPs were not aware of when they were to be audited. An alternative method of auditing would be for the employer to verify that CPD has been undertaken through

the appraisal system. This would leave only those without an employer and a smaller random sample to be audited by the professional regulatory bodies.

Recommendation

There is also a need for the practice requirement that HCPs need to undertake in order to achieve renewal of their registration to be consistent across the health care professions. Therefore it is recommended that all professional regulatory bodies make it a requirement of renewal of registration that HCPs have undertaken a set number of hours in a relevant practice environment for the part of the register which they are seeking to renew their registration.

This recommendation is related to that in Chapter 6, section 3.6, where it was recommended that all HCPs are required to inform the professional regulatory body of their intent to practice in a given period. Allied with this is the non-practising part of the register suggestion, that where a HCP is not engaging in active practice they are moved to an non-practising part of the register for a given period and may return to the practising part of the register within a set time period or, if outside of that time period, by the completion of a return to practice course that would perform the function of CPD and achievement of the relevant practice hours requirement. Therefore if a HCP was not able to demonstrate achievement of the practice requirement when seeking renewal of their registration they would be moved to the non-practising part of the register until they had either achieved the practice requirement or completed a return to practice course.

5.2 Competence for advanced practice

There is not a consistent approach among the professional regulatory bodies with regard to competence for advanced practice. Although, as examined in Chapter 7, both the GMC and the NMC have frameworks in place for education leading to initial registration, with regard to providing

a regulatory framework for those who wish to advance their practice, only the GMC has a sufficiently robust framework in place.

The NMC is decidedly lacking in this aspect of regulation. Not only does the NMC not have a register of those who are able to undertake clinical practice at an advanced level, titles of advanced practitioners are not regulated. The NMC does not even specify what qualifications, criteria or competencies are needed to be able to practice at an advanced level. Therefore, there is no coherent way of assessing competence of a so-called advanced practitioner and the public or patient has no way of determining whether the nurse or midwife who claims to be an advanced practitioner actually is, or what they are able to undertake that a non-advanced practitioner cannot.

With nurses and midwives being able to take on new tasks and roles that take them beyond the traditional roles they have previously undertaken, as discussed in Chapter 3,⁸³ this would appear to be a severe deficiency on the part of the NMC.

Recommendation

That, in order to allow for further expansion of roles and the development of new roles for HCPs, there is a clear definition of all HCPs that details what they can and cannot do, that is it states any roles or areas of care or treatment that must be confined to a specific HCP group. The present arrangement where roles are largely undefined does not allow for a coherent strategy with regard to role development, which happens piecemeal at present.⁸⁴

5.2.1 Education and training for advanced practice

Although the implementation of a systematic approach to medical education⁸⁵ is to be welcomed and seen as a key feature of the regulatory framework within this element, it is interesting that this does not apply to

⁸³ In particular see section 5 and 6.

⁸⁴ See Chapter 3 for a discussion on the expansion of roles.

⁸⁵ See Chapter 8, section 6.

the nursing and midwifery professions. The new foundation programme exposes doctors to a variety of different clinical specialities with progression being based upon the attainment of defined competencies and the doctor's abilities at the end of each stage of training, ultimately linked to registration as a specialist.

As discussed, the NMC has acknowledged that it needs to regulate titles such as advanced practitioner and that failure to do so has led to confusion regarding their use. There have also been several consultations on the need for a framework for post-registration education and the requirements for advanced practice. For instance, in 1990, the UKCC undertook a consultation concluding, with regard to advanced practice, that '*formal requirements are needed to set, maintain and improve standards so that the needs of patients and clients are safeguarded*'.⁸⁶ The NMC has been considering a consultation on the issue of a post-registration nursing framework and advanced practice since 2005. Although the NMC states that progress is being made to date, no outcome has been forthcoming on either a coherent framework for post-registration education or on the standard for advanced practice.⁸⁷

It is interesting that the NMC has had both pre- and post-registration education under its remit but failed to create a coherent framework, whilst the GMC, which has not, has created a coherent framework for education of the medical profession.

Recommendation

That all HCP groups have a clear, robust, formalised framework for post-registration education that provides the basis for progression to more advanced and specialist areas of practice, linked to additional registration.

⁸⁶ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1990) The report of the post-registration education and practice project United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London, at paragraph 7.4.

⁸⁷ The update on the 2005 consultation can be seen at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2038> accessed on 13th June 2008.

As discussed above, at present, there is no common agreement or formal requirement regarding roles, job descriptions, competencies, education levels or qualifications for many of the new nursing roles discussed in Chapter 3.⁸⁸ By having a formal route through career progression that is based upon defined competencies, the disparity that can exist between different HCPs undertaking the same role or using the same title can be reduced, thereby increasing public protection. There is a need to know that a HCP using a specific title, such as specialist practitioner or advanced practitioner, has the competencies to fulfil the role. It is the level of practice rather than the specialism that needs to be regulated through registration and having the title protected by law, as currently happens for the registered nurse and the registered medical practitioner, as well as setting competencies that are required for HCPs to be able to achieve advanced registration. This will lead to a more effective system of regulation of HCPs for public protection and patient safety.

At present there is no objective measure of assessing whether a nurse or midwife is capable of promotion to the next grade, for example sister or charge nurse, unlike in medicine where promotion is based upon the attainment of qualifications and membership of certain specialist bodies.⁸⁹

The combined approach of setting competencies coupled with the registration of those HCPs who have met these competencies will ensure that there is a national standard for advanced practice and that the public will know what it is that advanced level practitioners do, as well as which HCPs can undertake these roles and have demonstrated their ability to do so by achieving registration at the higher level.

In addition to the above, in Chapter 7 it was noted that pre-registration education was seen as being fit for purpose with regard to its regulatory aim. The creation of a robust post-registration framework under the control of the professional regulatory bodies would mean that there was an

⁸⁸ See sections 5 and 6 in particular.

⁸⁹ For more on this aspect of the selection and promotion of HCPs see Cornock M (1995) 'Earn your stripes' *Nursing Standard* vol. 9 no. 50 p. 36.

education framework from student thorough to consultant grade that was fit for purpose.

5.3 Proving competence

The primary comment with regard to HCPs proving their competence is that HCPs cannot continue to remain on the register throughout their professional careers without having their competence assessed. Regardless of the method of assessment adopted, there has to be assessment of HCPs' fitness to practise if the primary aim of regulation is to be achieved.

5.3.1 *Appraisal*

With regard to the use of appraisals to assess a HCP's competence, whilst appraisal can be linked to the assessment of competence, this is usually in relation to the developmental needs of the HCP being appraised, and identifying any educational requirements that the employing organisation can provide.⁹⁰ Appraisal assesses competence by establishing whether the HCP or their appraiser believes that the HCP needs further education and support to undertake their current role. An appraisal is a snapshot of where the HCP is at present and where the HCP wants to go and the means by which they can get there, whilst also undertaking the employing organisation's objectives.

Many appraisals of HCPs do contain a set of criteria against which the HCP is judged and assist in determining fitness to practise. However, appraisals are not in themselves a means of determining competence as they do not involve any specific assessment of the HCP's practice.

The appraisal does not contain an objective assessment of the HCP. It is a two way process whereby the appraiser is there to assist the appraisee in meeting the objectives, a formative process and not a summative one which would have a pass/fail element to it, it is not possible to 'fail' an

⁹⁰ For those HCPs not in employment, for instance GPs and independent midwives, the onus on identifying educational requirements reverts back to them.

appraisal. Therefore another system of assessment is needed in addition to appraisal to assess a HCP's competence.

5.3.2 Clinical Supervision

For midwives, the model of clinical supervision would appear to be an effective method of providing the support of experienced HCPs for both clinical and professional issues. However, it is notable that no other health care profession has a statutory requirement for clinical supervision. Given the discussion on extended roles in Chapter 3, it is perhaps a model that could usefully be expanded to other HCPs who are taking on new roles and tasks and may benefit from the additional support the model provides. Although it is not compulsory, it is recommended for all nurses by the NMC.⁹¹

Where it is fully integrated in the working practices of HCPs, as with midwives, clinical supervision appears to be a model that has benefits for the HCP and the wider service. However, it is not seen as a management tool or a means of performing checks upon HCPs. It can have a regulatory effect because some forms of clinical supervision involve the supervisor actually working alongside the supervisee to assess their practice directly. This can identify both good and poor areas in the HCP's practice and also 'encourage' them to adopt the standards of practice, professional skills and attributes that are established by the supervisor. Where poor practice is identified, this can be acted upon and, if necessary, reported to the relevant authorities. However this method of clinical supervision is not the norm and, for a HCP's competence to be assessed, another method needs to be employed.

Recommendation

It was recommended above, and in Chapter 6, section 3.6, that all HCPs notify their professional regulatory body of their intention to practise by virtue of their registration each year. Linked to this, for midwives, is the

⁹¹ For instance see Nursing and Midwifery Council (2002b) Supporting nurses and midwives through lifelong learning Nursing and Midwifery Council, London.

fact that in doing so they are allocated to a specific supervisor of midwives who is responsible for providing support to the HCP at a local level, whether they are practicing in the NHS or in private health care or independently.⁹² The supervisor of midwives may be seen as an additional safeguard with regard to clinical competence of HCPs as it allows for practice to be monitored and for allegations against an individual midwife to be monitored, but it also allows the HCP to request assistance, guidance or advice from a more senior and/or experienced colleague.

It is recommended that the statutory supervision of midwives is extended to other HCP groups, and that the supervisor be involved in the appraisal of the HCP and the assessment of their clinical competence.

5.3.3 *Revalidation*

In recent years, revalidation has been suggested to fulfil the need for assessment of clinical competence. It should be noted that the GMC was already considering revalidation as far back as 1998,⁹³ prior to any attempt to impose it upon them by an external organisation, and prior to the scandals which led to public inquiries and subsequent calls for reform such as Shipman,⁹⁴ Ledward⁹⁵ and children's heart surgery at the Bristol Royal Infirmary.⁹⁶ However, although initially set to commence in 2005, development and introduction of revalidation by the GMC was delayed following comments and issues raised by Dame Janet Smith in the Shipman Inquiry fifth report.⁹⁷

⁹² See Chapter 6, section 3 for a discussion on the supervisor of midwives.

⁹³ See the GMC website on licensing and revalidation, available at: <http://www.gmc-uk.org/register/licensing/index.asp> accessed on 14th June 2008.

⁹⁴ Secretary of State for the Home Department and the Secretary of State for Health (2004) Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future (Chair Dame Janet Smith DBE) Cm 6394 The Stationery Office, London.

⁹⁵ Department of Health (2000a) Report of the inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward (Chair Jean Ritchie – the Ritchie Report) Department of Health, London.

⁹⁶ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

⁹⁷ As outlined in a written statement by the then Secretary of State Health Dr John Reid on 27th January 2005. Hansard House of Commons vol. 455 column 26WS (written Ministerial Statements 27 January 2005 The Secretary of State for Health).

As previously discussed, in Chapter 5, there have been far reaching consultations and reports on the future regulation of all HCPs. In 2006, there was consultation on the future regulation of medical HCPs⁹⁸ and another consultation on the future regulation of non-medical HCPs;⁹⁹ these ultimately led to the publication of a White Paper by the Government in 2007 that set out its proposals for the reform of HCP regulation.¹⁰⁰

The culmination of all these consultations and proposals is that revalidation is going to be a reality for HCPs. The introduction of revalidation will require legislative provision as this is not provided for in the current legislation governing the activities of the GMC and the NMC. It is most likely that the legislative changes will be in the form of 'section 60 orders'.¹⁰¹

Whereas appraisal is concerned with providing feedback on a HCP's performance and outlining their developmental needs and those of the organisation, revalidation is more than this. It is a system whereby HCPs regularly demonstrate that their skills and competences are current and that they are fit to practise.

There are two main issues with regard to assessing competence: what is the HCP assessed against, i.e. what is the competence standard, and what method of assessment is to be used to assess the HCP against this standard?

As to the competence standard, it needs to be something that measures the HCP's ability to perform the role they currently have, that they are indeed fit to practise. However, the details of the competence standard is largely

⁹⁸ Department of Health (2006b) Good doctors, safer patients: a report by the Chief Medical Officer Department of Health, London.

⁹⁹ Department of Health (2006a) The regulation of the non-medical healthcare professions Department of Health, London.

¹⁰⁰ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London.

¹⁰¹ See Chapter 5, section 4.1 for a discussion of 'section 60 orders'.

irrelevant, in terms of regulation, provided it can be agreed upon by the interested parties, which should include HCP representation, possibly through their professional support bodies,¹⁰² representation of patient and lay organisations, the professional regulatory bodies, employers, the Chief Health Officers, and both the Healthcare Commission and National Patient Safety Agency (NPSA).¹⁰³ The standard may be based upon the HCP's professional code, and may demonstrate how the HCP meets the various parts of their code.

As to the actual method of competence assessment, this could occur in a variety of ways: written examinations, objective tests and other tests of knowledge; clinical supervision; patient surveys; practical assessments; direct observation of clinical practice; peer reviews; portfolios relating to specific criteria set around the competence standard; or, a combination of these methods.

Again, the method of assessment of the HCP's competence can be left to the interested parties who set the standard. What is important is that revalidation needs to be sufficiently robust, with regard to competence and performance standards, that it can distinguish between those who should, and those who should not, be allowed to practise.

The current proposals for the revalidation of HCPs within the medical profession are the subject of a consultation which closed on the 5th June 2008.¹⁰⁴ The outcome of the consultation is presently awaited. However, there is also a working group entitled '*The Medical Revalidation Working Group*' chaired by the Chief Medical Officer, Sir Liam Donaldson, which is in place, in part, to support the introduction of revalidation within the medical profession.¹⁰⁵

¹⁰² For instance the British Medical Association for doctors and the Royal College of Nursing for nurses.

¹⁰³ Further information on the NPSA is available at their website, <http://www.npsa.nhs.uk/> accessed on 14th June 2008.

¹⁰⁴ See Department of Health (2008a) *The medical profession (miscellaneous amendments) Order 2008: consultation paper* Department of Health, London.

¹⁰⁵ For further information see the working group's website at: <http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Mo>

It would appear as if the revalidation process for HCPs within the medical profession will consist of yearly appraisals and a five yearly relicensing process.¹⁰⁶

With regard to the revalidation of HCPs who are registered with the NMC, no details of the actual process have been forthcoming; the NMC website states that it is '*considering the way forward for a proportionate and risk based approach to revalidation*'.¹⁰⁷

One of the interesting aspects of the introduction of revalidation for HCPs is that the White Paper introduced by the Government in 2007 states that while '*revalidation is necessary for all health professionals ... its intensity and frequency needs to be proportionate to the risk inherent in the work in which each practitioner is involved*'.¹⁰⁸ Thereby suggesting that not all HCPs will be subject to the same revalidation requirements.

If revalidation is considered a necessary aspect of the regulation of HCPs, in particular for HCPs to prove their competence, then it should be the same for all HCPs. It would be an inefficient form of regulation that allowed a patient to be treated by a HCP who had not undergone the same revalidation as another HCP simply because they held different roles. Whilst it is perfectly permissible to have a different standard against which different groups of HCPs are assessed with regard to their competence, given that different groups of HCPs will have different roles to each other and therefore different sets of competencies and skills, what cannot be different is the period of revalidation to which different HCPs group are subject.

[dernisingprofessionalregulation/ProfessionalRegulationandPatientSafetyProgramme/MedicalEducationRevalidation/index.htm](http://www.nmc-uk.org/aArticle.aspx?ArticleID=3196) accessed on 14th June 2008.

¹⁰⁶ See General Medical Council (2008) *GMCToday* March/April 2008 General Medical Council, London at pages 8 – 9.

¹⁰⁷ NMC 'Projects on the go' webpage available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3196> accessed on 14th June 2008.

¹⁰⁸ Secretary of State for Health (2007) *Trust, assurance and safety – the regulation of health professionals in the 21st century* Cm 7013 Department of Health, London, at paragraph 2.29.

Revalidation of HCPs is likely to have a significant cost implication; if HCPs have to be actually assessed for competence, someone has to pay for that assessment and for the training of the individuals who make the assessments. As to who will bear this cost, it is highly likely that this will be the HCPs themselves, though no costings have so far been released that show the impact upon individual HCPs.

Recommendation

That every HCP undergoes periodic revalidation to confirm that they are currently competent and thereby fit to practise. That the period of revalidation is the same for all HCPs and that this revalidation is assessed against a competence standard that is set and agreed by a body set up to specifically undertake this task and is representative of all the interested parties, but that the actual assessment of competence within the revalidation is made by those who can actually undertake the role being assessed, and thereby are able to determine whether the practice of the HCP being assessed is a variation of the norm or is at variance with it.

As the then Secretary of State for Health, Alan Milburn, stated in an interview in July 2002, *'I can't ... decide who is a good heart surgeon and who isn't. The only people who are equipped to do that in the end are heart surgeons ... but what we do have to have in place is a better and more modern system of accountability. ... I can't make decisions about what's right clinically – that's a decision for the doctor'*.¹⁰⁹

As discussed previously, see section 5.1 above, there is a role for employers in ensuring that a HCP is competent to undertake their professional practice. This would be through a co-ordination of revalidation through the appraisal system, CPD, clinical supervision and with the involvement of relevant other regulatory bodies, such as the Royal Colleges and professional support bodies, and, where a HCP may be deemed to be

¹⁰⁹ Majekodunmi O (2002) 'Hellooooo! Most things are my fault' Hospital Doctor 4 July 2002 p. 18 – 19 at page 19.

failing to meet their competencies, the involvement of National Clinical Assessment Service (NCAS).¹¹⁰

Although unpopular with some HCPs,¹¹¹ revalidation would achieve the regulatory effect of assessing clinical competence on a regular basis, with the aim of detecting those who are underperforming prior to them putting a patient at risk of harm, something that is lacking at present.

Those who do not wish to comply with revalidation should have their wishes respected subject to the proviso that they are automatically removed from the professional register.

5.4 Underperforming HCPs

It is likely that a system of revalidation as recommended above will highlight HCPs who are not meeting the competence standard. They may be said to be underperforming clinically. Systems should be put in place to ensure that these HCPs have the necessary support and guidance to reach the competence standard. This may include educational needs, a period of clinical supervision and/or the use of a mentoring scheme to help the HCP regain their competence.

At present, the NCAS provides a similar service only for doctors and dentists.¹¹² There is no similar organisation for other HCP groups. A further issue with the current NCAS system is that, whilst it can make recommendations, it has no statutory power to enforce them.

Recommendation

That there are two classifications to those HCPs who are deemed not to meet the competence standard; those who are said to be underperforming, but whose performance is not seen as being harmful to patients or the

¹¹⁰ Further information on the NCAS is available at their website, <http://www.ncas.npsa.nhs.uk/> accessed on 14th June 2008.

¹¹¹ See section 4.3.

¹¹² See Chapter 8, section 15.1 for a discussion on the National Clinical Assessment Service.

public, and those whose performance is such that it raises concerns about whether they should be in contact with patients.

With regard to the first group of underperforming HCPs, when revalidation raises a concern, this should be resolved through local procedures where possible, that is by the employer's own processes. Where this is not possible, or does not resolve the issue, the NCAS should be involved. However, this should be for all HCPs and not just doctors and dentists. In addition, any recommendation by the NCAS should have statutory authority to ensure that they are binding upon both the HCP and their employer and so complied with. Failure to comply with the recommendation by the HCP should result in a referral to the professional regulatory body and a failure to comply by the employer should be referred to the Healthcare Commission.

This would ensure that there is a system put in place for supporting all those HCPs who do not meet the competence standard, but whose practice is not harmful to patients.

Where the concern is of the second type of underperforming or incompetent HCPs described above, this should result in the HCP being suspended from clinical practice and an immediate referral to the professional regulatory body who should implement the appropriate fitness to practise procedures.

Conclusion

With regard to regulation, there are two aspects to clinical competence. The first is in ensuring that HCPs are clinically competent to undertake their professional practice; that is, having the necessary, qualifications, skills and experience, whether for the role the HCP is currently undertaking or in achieving competence for a future role. The second is in ensuring that those HCPs who are incompetent, are identified and prevented from undertaking their professional practice until they are deemed to be clinically competent once more.

The three aspects of clinical competence presented above, maintaining competence, competence for advanced practice and proving competence cannot be said, at present, to represent an element of regulation that is fit for purpose. It is not the case that one of the professional regulatory bodies provides an effective form of regulation within this element of regulation and the other does not; rather both are seen to be lacking in this element of regulation.

To be fit for purpose, this element of regulation has to ensure that HCPs are able to maintain their competence by having the opportunity to undertake CPD, thus ensuring that they have the right knowledge and skills to undertake their current role; that they are able to achieve competence in advanced roles before they undertake them autonomously; and, that they are able to demonstrate their competence.

Yet at present both the GMC and the NMC allow HCPs to renew their registration without any demonstration of the HCP's clinical competence. Whilst the NMC does require their registrants to self-declare that they have met certain CPD requirements, this in itself does not require any assessment of competence and the GMC does not even require a self-declaration of CPD undertaken.

For this element of regulation to be fit for purpose, each HCP should have a framework within which the competencies that they require to safely and effectively undertake their role are mapped. This would include the skills they require as well as the knowledge that is essential for them in their role. At regular intervals, the HCP's actual performance would need to be assessed against this framework. Until this is happening, this element of regulation will not be fit for purpose.

There will not be efficient and effective public protection and patient safety upheld if HCPs are allowed to practise without the need for them to update their competencies and prove that this has occurred.

It is important to note that most HCPs undertake their professional practice competently and do not bring themselves or their profession into disrepute by virtue of their clinical work. This fact was recognised, with regard to doctors, in 'Supporting doctors, protecting patients',¹¹³ which also acknowledged that organisational factors can play their part in so-called clinical incompetence of individuals.¹¹⁴ Therefore any system of determining clinical competence has to be robust enough to detect those who are incompetent, whilst at the same time not being too onerous on those who are performing competently.

Recommendations have been made, above, that CPD is linked to the registration of the HCP and that, without achieving CPD requirements, the HCP would not be able to renew their registration. In addition, it was recommended that HCPs also meet a practice requirement in order to be able to renew their registration.

With regard to advanced practice, it was recommended that there is a post-registration framework in place for both professional regulatory bodies that provides for the development of a HCP's advanced practice according to the achievement of set competencies and that the fact that these have been achieved is registered with the relevant professional regulatory body.

Further recommendations were made with regard to the revalidation of HCPs, that is, how HCPs can prove that they have the required competencies to safely undertake their clinical practise.

It is impossible at this point to state with any authority how the proposed revalidation systems will affect the clinical competence of HCPs, but it is important that the system is introduced and then evaluated in terms of its effectiveness and any necessary amendments introduced. The earlier that

¹¹³ Chief Medical Officer (1999) Supporting doctors, protecting patients Department of Health, London, in particular see section 1.

¹¹⁴ *Ibid*, see section 2.

revalidation is introduced, the earlier that this element of regulation will move toward being fit for purpose.

The key aspects of this regulatory element of clinical competence is about ensuring that HCPs maintain their competencies to be able to safely undertake their role and also about their ability to prove that they are fit to practise. This may be seen to be controlling in the element of regulation requires the HCP to do something and their failure to do so will mean that they are unable to renew their registration, and hence not be able to undertake clinical practice.

With regard to the enabling aspect of clinical competence, there are no provisions within this element of regulation that prevent the competent HCP from having autonomy over their clinical practice. Rather, if this element of regulation is to be an effective form of regulation, if the recommendations above are adopted, the competent HCP will be enabled in that: their practice will be current; they will be able to maintain their currency through undertaking CPD with regard to both education and practice requirements; they will be able to advance their practice, should they wish to do so, by following a coherent framework; and they will be able to demonstrate their competency.

For the HCP who is not competent, this element will be controlling in that it will prevent them from undertaking clinical practice. However, that is the point of this element of regulation, the removal of those HCPs who are incompetent from clinical practice. In doing this it would be achieving its regulatory aim of public protection and patient safety. This is not be seen by this thesis to interfere with the right of the HCP to undertake clinical practice autonomously, for the incompetent should not be undertaking autonomous clinical practice but seeking assistance to regain their competence.

Chapter 9

Standards for performance

Introduction to chapter 9

This chapter is concerned with the performance standard that is set for health care professionals (HCPs) to undertake their professional practice. So far within this thesis various standards have been introduced. For instance, Chapter 6 has introduced standards for registration and Chapter 7 standards for pre-registration education. Other forms of standard include clinical standards, those which provide the detail of how to undertake procedures or manage aspects of care, and include aspects of clinical knowledge and skill.¹ However, these forms of standard are not the subject matter of this chapter. Chapter 10 will analyse fitness to practise; how the professional regulatory bodies deal with a HCP whose performance is said to be below the acceptable standard. If a HCP is to be judged against a standard they need to be aware of this standard. This is the standard that is the subject matter of this chapter.

Therefore, this chapter is concerned with those standards that inform a HCP how they should behave, how they should undertake their professional practice, those standards by which they will be judged; in essence the over-arching standard that defines their professional practice, what may be termed codes of conduct. The term 'code of conduct' will be used throughout this chapter as shorthand for those standards which indicate to a HCP how they should behave and undertake their professional practice.

The chapter is arranged as follows: an examination of the role of standards for performance; an analysis of how the professional regulatory bodies set, and inform their registrants of, standards for performance; a commentary and recommendations; and finally a conclusion that considers whether this element of regulation is fit for purpose.

¹ An example of clinical standards are those published by the National Institute for Health and Clinical Excellence, whose clinical standards and guidance are available at: <http://www.nice.org.uk/guidance/index.jsp> accessed on 15th June 2008.

1. The role of standards for performance

Chapter 3 noted that one of the hallmarks of being a professional is the adoption of a code of conduct. Indeed the setting of standards for professional behaviour and practice is part of the trade-off between the profession and society. In return for the granting of professional status by society, with the associated status and power and the right to undertake practice autonomously, the profession agrees to undertake the practice to a high standard and to enforce that standard against members of the profession who are seen as failing the agreed standard.² In this sense, the setting of standards for performance can be seen an enabling feature of the regulation of HCPs. For Green, a code of ethics is designed to prohibit HCPs from putting their interests ahead of their patients.³

The purpose of a code of conduct, as stated above, is to inform the HCP of the standard required of them in undertaking their professional practice. Allied to this is the fact that the code provides the professional regulatory body with the standard for assessing a HCP's fitness to practise. A third purpose of the code is that it provides those external to the profession, for example members of the public, with information on the standard that they can expect from an HCP. The setting and publication of codes of conduct by the professional regulatory bodies is therefore an important aspect of the regulation of HCPs.

However, some authors feel that codes of conduct are ineffective as the statements they contain are too general, or that they represent an idealised view of how HCPs should behave and are unworkable.⁴

Codes of conduct evolve over time and represent the views and interests of the profession and society at the particular point that they are produced.

² See Chapter 3 in particular section 3.

³ Green D (2000) foreword to Gladstone D, Johnson J, Pickering W, Slater b & Stacey M (2000) Regulating doctors Institute for the Study of Civil Society, London, see particularly pages viii – x.

⁴ See Stone J (2002) 'Evaluating the ethical and legal content of professional codes of ethics' Chapter 4 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London.

Thus codes from fifty or so years ago would be very different in content to the codes that are in existence today.

Given that codes of conduct do represent the society in which they are produced the codes that are in current use are based upon ethical and legal principles that are an *'attempt to synthesize agreed ethical standards and minimum legal requirements for the ease of their membership'*.⁵

The following section examines codes produced by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

2. The professional regulatory bodies and codes of conduct

Chapter 3, section 2.3, raised the use of swearing of oaths and declarations by HCPs to indicate the values and commitments of the health professions. It may be thought that these should protect the public from poor practice and misconduct in the HCP. However, these oaths and declarations have 'no teeth' and not all HCPs swear them.

Each professional regulatory body has its own standards and documentation for its registrants. These are provided to HCPs by their professional regulatory body as a code of conduct.

The GMC and the NMC both produce codes of conduct for their registrants. As may be imagined the codes have changed over the years, both in terms of the philosophy behind them and in their content. The change in philosophy can be witnessed, in the case of the GMC, by the change in the title of the code of conduct from that of forty years ago to the present title.

⁵ Stone J (2002) 'Evaluating the ethical and legal content of professional codes of ethics' Chapter 4 in Allsop J & Saks M (eds) (2002) Regulating the health professions Sage, London, at page 72.

In 1963 the GMC code of conduct was entitled 'General Medical Council. Functions, procedures and disciplinary jurisdiction',⁶ although it was known colloquially as 'The blue book'. The current GMC code is entitled 'Good Medical Practice'⁷ and was published in 2006.

The first code of conduct for nurses and midwives by a professional regulatory body was published in 1983 and entitled 'code of professional conduct for nurses, midwives and health visitors based on ethical concepts'.⁸ The latest code was published in 2008; it is entitled 'The Code Standards of conduct, performance and ethics for nurses and midwives'.⁹

Although they have different titles, both codes of conduct cover essentially the same aspects of professional practice expected from the HCP. These aspects including: upholding the values of the profession; keeping up to date; relationships with patients; working with colleagues and team work; obtaining consent; confidentiality issues; delegating effectively; ensuring practice is evidence based; acting with integrity; and dealing with problems. Both codes of conduct contain a statement that informs the HCP that failure to comply with the code will bring their fitness to practise into question and put their registration at risk.

However, the codes of conduct published by the GMC and the NMC are not rule books that have to be followed to the letter, nor are they intended to provide the answer to each and every problem or dilemma that the HCP may face. Rather they are intended to be frameworks within which HCPs can develop their practice competently and safely to ensure that the needs of their patients are met professionally.

⁶ General Medical Council (1963) General Medical Council. Functions, procedures and disciplinary jurisdiction General Medical Council, London. Details and copies of the 'Blue book' from 1963 to 1993 are available on the GMC website at: <http://www.gmc-uk.org/guidance/archive/index.asp> accessed on 15th May 2008.

⁷ General Medical Council (2006) Good medical practice General Medical Council, London.

⁸ United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1983) Code of professional conduct for nurses, midwives and health visitors based on ethical concepts United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

⁹ Nursing and Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives Nursing and Midwifery Council, London.

The standards are not legally binding in the sense that failure to follow them will result in HCPs finding themselves in a criminal or civil court. However they are binding with regard to their registration and failure to adhere to them may result in the HCP being brought before a disciplinary committee being accused of professional misconduct and, if found guilty, may ultimately be removed from the register.

Given that the codes of conduct are a set of shared values to which the HCP subscribes through their registration with their respective professional regulatory body, it is appropriate that both the GMC and the NMC undertake consultations on changes to the codes.¹⁰

The power to publish codes of conduct for their respective registrants is based in the legislation that governs the constitution and functions of the professional regulatory bodies. With regard to the GMC, section 35 of the Medical Act 1983 states: *'the powers of the General Council shall include the power to provide, in such manner as the Council think fit, advice for members of the medical profession on—(a) standards of professional conduct; (b) standards of professional performance; or (c) medical ethics'*.¹¹ For the NMC, the Nursing and Midwifery Order 2001 states that *'the principal functions of the Council shall be to establish from time to time standards ... conduct and performance for nurses and midwives'*.¹² However, neither piece of legislation details the provisions which are contained within the respective codes.

The emphasis that the GMC and NMC use within their respective codes of conduct is an interesting note of difference between them. The NMC commences each clause or statement within its code with the words *'you*

¹⁰ For information on consultations regarding their respective codes of conduct see the websites of the GMC and the NMC.

¹¹ The Medical Act (1983) (consolidated version with amendments).

¹² The Nursing and Midwifery Order 2001 (SI 2002/253), at article 3(2).

must'.¹³ Whilst the GMC has an explanatory note at the beginning of its code which states, 'in *Good Medical Practice* the terms 'you must' and 'you should' are used in the following ways: 'You must' is used for an overriding duty or principle; 'You should' is used when we are providing an explanation of how you will meet the overriding duty; 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the guidance'.¹⁴

The difference between the two codes in their wording of clauses, statements and paragraphs is part of the difference in the philosophy between the two codes. The NMC code appears on reading to be a list of statements with which the HCP must comply in order to meet the standard of performance expected of them. There is no overall introduction to the code, nor is there a guide to it, however in comparison to the GMC code it is extremely small, both in physical size and in terms of the number of words. The GMC code on the other hand appears on reading to be more of a more comprehensive guide on how to meet the standard of performance expected of a HCP.

There also appears to be difference in the approaches to setting codes of conduct between the two professional regulatory bodies. The GMC appears to have taken an all encompassing approach in that it covers many more areas than the NMC code but also makes reference to other guidance issued by the GMC that expands upon the points made in the code of conduct; whilst, as just stated, the NMC code appears to be a list of statements for compliance by the HCP. For instance the GMC code includes reference to teaching whilst the NMC code does not; also the GMC code when discussing consent makes reference to GMC guidance on consent that is published separately.

¹³ Nursing and Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives Nursing and Midwifery Council, London.

¹⁴ General Medical Council (2006) Good medical practice General Medical Council, London, at page 5.

The separately published guidance from the GMC can be said to take the basic points made in the code of conduct and expand upon them, providing further explanation as well as applying rationale to their inclusion in the code, so that their registrants can understand how the principles in the code of conduct should be applied in practice. The printed NMC code does not make reference to any other document in relation to individual clauses or statements but has a paragraph at the beginning which states that the code should be considered with other NMC guidance and advice. However, the web-based version of the code contains links to further information in relation to some of the clauses.¹⁵ The code together with the extra advice on the website is a major step forward for the NMC and makes the code much easier to understand. However, as the code is sent in printed form to every registrant, it appears illogical to only have the additional information available in the web-based version, as most registrants would be unlikely to actively search the NMC website for the code and therefore would not access this additional information.

An example of the additional guidance that the GMC issues to supplement that within their code of conduct is the guidance issued with regard to children and young people. Within the GMC code of conduct there are five specific points made regarding how HCPs should interact with and protect the interest of those under eighteen.¹⁶ However, in October 2007, further guidance came into force, which consists of over forty pages. As stated in the introduction to the new guidance '*our booklet Good Medical Practice describes what is expected of all doctors registered with the GMC. The guidance which follows, which is for all doctors, develops the duties and principles set out in Good Medical Practice*'.¹⁷ The new guidance then provides details on various aspects of dealing with those under eighteen as well as providing sources of information and guidance from other bodies and statutory and case law relating to the information contained within the

¹⁵ See NMC webpage 'The Code in full' available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3056> accessed on 15th May 2008.

¹⁶ General Medical Council (2006) *Good medical practice* General Medical Council, London, paragraphs 24 to 28.

¹⁷ General Medical Council (2007a) *0 – 18 years: guidance for all doctors* General Medical Council, London, at page 1.

guidance and finally a series of useful resources. In short, the additional guidance may be seen as a handbook for providing a professional standard of health care to those under eighteen.

However, not all additional guidance may be as straightforward and uncontroversial. Patients and the public are also able to challenge guidance from the professional regulatory bodies and professional bodies to their respective HCPs. For instance, in the case of Burke v General Medical Council,¹⁸ Mr Burke challenged, via judicial review, the legality of guidance from the GMC on the withdrawal of artificial nutrition and hydration.¹⁹ At first instance, Munby J agreed that the guidance from the GMC gave insufficient weight to the rights of the patient to request this form of treatment and that the guidance, as it stood, would breach his rights under the Human Rights Act 1998, particularly articles 3 and 8.

On appeal by the GMC,²⁰ the judgment was reversed on the grounds that the common law provided adequate protection for those in Mr Burke's circumstances and that there was nothing in the GMC guidance that departed from this.

Codes of conduct are issued to all those who are registered with the professional regulatory bodies, for instance they issue the current version of their code on initial registration and then issue new codes when published to all those on the register. Both the GMC and the NMC also have versions of the current code on their websites. The NMC also issues a credit card sized document to all its registrants which contains the overriding principles, or key values, upon which their code of conduct is based.

Additionally, both the professional regulatory bodies offer advice to their registrants on issues where there may be conflict or concern as to the

¹⁸ R (on the application of Burke) v General Medical Council [2004] EWHC 1879 (Admin).

¹⁹ General Medical Council (2002) Withholding and withdrawing life-prolonging treatments: good practice in decision-making General Medical Council, London.

²⁰ R (on the application of Burke) v General Medical Council [2005] EWCA 1003.

appropriate way to act. Currently both offer a telephone advice line that is available during office hours. Thus a HCP who is unsure about a possible course of action may contact their professional regulatory body to discuss the various options that may be available to them before committing themselves to one particular outcome that is both clinically appropriate and professionally acceptable.

3. Commentary on standards for performance

Both HCPs and the public are entitled to know that standards are available to ensure the quality of the health care and that these standards are designed to promote and ensure that best practice is achieved. This is achieved through the publication of the codes of conduct that are issued to HCPs and through the codes being available on the professional regulatory bodies' respective websites. In addition, the codes are available free of charge to those who request them.²¹

It was noted above that the professional regulatory bodies each provide guidance to their registrants on the standard for professional performance, through the use of codes of conduct.

Given the comments made in previous chapters²² regarding the blurring of boundaries between HCPs, it is noticeable that there are still separate and distinct codes of conduct for the different HCP groups. The HCP has to comply with the requirements of their own professional regulatory body's code. However, it is recognised that the professional regulatory bodies have jointly published a '*statement of common principles for health care professionals*',²³ which detail the shared values and ethical standards upon which professional health care practice is based.

As there are more commonalities between the various professional codes than differences and inconsistencies, and the fact that all the codes are

²¹ Including members of the public.

²² In particular see Chapter 3, section 5 and 6.

²³ General Medical Council (2001) Council Paper 8a July 2001 – UK Health Regulators' Statement of Common Principles for Health Care Professionals General Medical Council, London.

designed to guide the HCP with regard to professional standards and so aid public protection, a common professional code for all HCPs might be appropriate.

Recommendation

That given the overlap in roles and the commonality between the codes, as discussed above, there is a single universal code of conduct, applicable across all the health care professions, for all HCPs to follow.

Recommendation

Given the differences in the philosophy behind each of the two codes of conduct analysed above, it is recommended that the GMC code is taken as the example of good practice and that this is the philosophy and template used for the single code recommended above. The GMC example of having a code that provides the standard required for performance, along with guidance on why the standard exists and guidance on how to achieve the standard, is seen as providing the most efficient form of regulation for both HCP and for achieving the regulatory aim of public protection and patient safety.

Conclusion

The aim of this element of regulation is to set the standard for performance that HCPs adhere to when undertaking their professional practice. By having a standard for performance, this allows those HCPs who do not meet the standard to have sanctions applied against them. This then ensures that the health care that a patient receives is provided professionally, as unprofessional HCPs have their practice controlled until they reach the required standard for performance.

The professional regulatory bodies achieve this standard setting through the publishing and issuing of codes of conduct to their respective registrants. The codes of conduct provide the over-arching standard that defines professional practice to the HCPs, and indicate how they should behave and undertake their professional practice. The codes themselves

are contemporary documents and reflect the views of both society and the profession itself. When they no longer met their aim they are withdrawn and new codes of conduct issued in their place, thus ensuring that the standard for performance is always contemporary in their outlook.

The fact that only two recommendations are made with regard to this element of regulation would suggest that this element of regulation is achieving its regulatory aim. With regard to being fit for purpose, the standard for performance that is set by the professional regulatory body provides the HCP with a boundary, within that boundary the HCP is aware that their practice is within the desired standard, outside of the boundary and the reverse is true. Thus, this element of regulation is seen as being enabling for the HCP as it provides them with a framework within which they can work autonomously.

As noted above, it is the setting of standards for performance that is part of the bargain that the HCP makes with society in return for the power and status of being able to perform their practise autonomously.

The GMC and the NMC now perform the role of setting the standard for performance; however, this does not remove the HCP's autonomy provided that they act within the agreed standard.

The ultimate effectiveness of the codes of conduct published by the professional regulatory bodies is only evident when the GMC and NMC disciplinary committees utilise the codes within fitness to practise hearings and take sanctions against those HCPs who do not follow the principles within the codes. This is the subject of the next chapter.

Chapter 10

Fitness to practise

Introduction to chapter 10

This chapter presents the last of the five elements of regulation, that of fitness to practise, and seeks to determine whether as an element it is fit for purpose with regard to its regulatory aim of public protection and patient safety. The question that this chapter addresses is, does this element of regulation contribute to the protection of the public and patient safety without restricting the clinical autonomy of Health Care Professionals (HCPs)?

In addressing this question, the chapter is structured as follows: an analysis of how fitness to practise can provide public protection and patient safety; the legislative basis for the professional regulatory bodies to undertake fitness to practise procedures; an examination of the fitness to practise procedures of the professional regulatory bodies; a commentary on the issues raised; and a conclusion on whether this element of the regulation of HCPs is deemed to be fit for purpose, or not.

1. Fitness to practise as an element of regulation

Fitness to practise is not defined within the legislation that governs the professional regulatory bodies regarding this element of regulation.¹ Rather procedures and processes are established that guide the professional regulatory bodies in undertaking this aspect of their regulatory role.

For the purpose of this chapter, fitness to practise may be said to be the final stage in the regulation of HCPs. This element achieves the primary aim of regulation, public protection and patient safety, through the 'disciplining' of those HCPs who are unfit to practise. As the Nursing and Midwifery Council (NMC) state '*fitness to practise is a nurse or midwife's suitability to be on the Register without restriction*'.² Thus this chapter analyses the procedures utilised by the professional regulatory bodies to

¹ See the next section for detail of the legislation that governs the professional regulatory bodies re this element of regulation.

² NMC 'What is fitness to practise?' webpage, available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3021> accessed on 21st June 2008.

determine if a HCP is fit for practise, and the options available to them if the HCP is found not to be fit for practise.

Being unfit to practise may involve the health of the HCP, or that the HCP has failed to meet the required standard of performance set by the professional regulatory bodies, or it may mean that the HCP is clinically incompetent.

There should be two aspects to the role of the professional regulatory bodies with regard to fitness to practise. These are to restrict from patient contact those HCPs who are unfit to practise; and to remove from the professional register those HCPs for whom it is deemed rehabilitation is not possible.

As will be seen below, the ultimate sanction that the professional regulatory bodies can apply to a HCP is to remove them from the professional register. As noted in Chapter 6, section 1, anyone not registered with the General Medical Council (GMC) or the NMC is unable to obtain employment that requires the HCP to be a registered medical practitioner, midwife or nurse.

This provides protection for the public and patients, by ensuring that those who are deemed to be unfit to practise are removed from the relevant professional register and thus are unable to practise as a HCP. This is noted with regard to the roles given to the professional regulatory bodies, for example the primary aim of the NMC, in this element of regulation, is to *'establish and keep under review effective arrangements to protect the public from persons whose fitness to practise is impaired'*.³

In order to be able to restrict a HCP's professional practice or to remove them from the register under fitness to practise processes, the regulatory body needs the authority to do so. Therefore regulatory bodies need to ensure that there is authority within their 'constitution' for them to

³ The Nursing and Midwifery Order 2001 (SI 2002/253) at article 21(1)(b).

challenge a HCP on fitness to practise grounds and for there to be appropriate sanctions that they can apply.

The next section of this chapter therefore examines the authority of the GMC and the NMC with regard to fitness to practise processes.

2. Legislative basis of fitness to practise

This thesis has previously identified the calls for reform to the regulation of HCPs that have occurred within recent years as a result of various Inquiries and resulting public concern regarding HCP regulation. With regard to fitness to practise procedures, a number of Inquiries, for instance Shipman,⁴ Ledward⁵ and the Bristol Royal Infirmary,⁶ have made specific comments that the then current procedures were not capable of meeting the primary aim of regulation, that of public protection and patient safety, and that in order to meet the primary aim there was a need for change within fitness to practise procedures. No comment will be made regarding historical procedures except where they illustrate a current point.

As a result of the comments and recommendations from the Inquiries and also from the implementation of the Human Rights Act⁷ in October 2000, there have been changes in the fitness to practise procedures of both the GMC and the NMC with resultant legislative amendments. Many of these amendments have been made using the 'section 60' orders described in Chapter 5.⁸

⁴ Secretary of State for the Home Department and the Secretary of State for Health (2004) Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future (Chair Dame Janet Smith DBE) Cm 6394 The Stationery Office, London.

⁵ Department of Health (2000a) Report of the inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward (Chair Jean Ritchie – the Ritchie Report) Department of Health, London.

⁶ Kennedy I (Chair) (2001) Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM 5207(1) Stationery Office, London.

⁷ Human Rights Act 1998.

⁸ In particular see Chapter 5, section 4.1.

It was 2004 that saw the introduction of new legislation governing fitness to practise procedures for both of the professional regulatory bodies.⁹ It is noted that those cases which were already being investigated prior to the introduction of the 2004 procedures will continue under the pre-existing procedures. However as the 2004 procedures will be used on all new cases, it is these procedures that will form the focus of the analysis of fitness to practise within this chapter.

The primary legislative authority for the GMC with regard to fitness to practise processes lies within the Medical Act 1983,¹⁰ whilst for the NMC it lies within the Nursing and Midwifery Order 2001.¹¹ There is also specific legislation that governs certain aspects of the fitness to practise procedures for each of the two professional regulatory bodies; for example, with regard to the role of legal assessors¹² and the constitution of fitness to practise committees.¹³

The result of the legislation within this area for the regulation of HCPs is that both the GMC and the NMC have statutory authority to receive complaints and allegations against their respective HCPs, to investigate these and to conduct fitness to practise hearings to determine if a HCP is fit to practise and, where it is deemed that the HCP is not fit to practise, to apply sanctions to the HCP.

⁹ The new fitness to practise procedures were introduced by The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608) which came into force on the 1st November 2004 and by The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761) which came into force on the 1st August 2004.

¹⁰ The Medical Act (1983) (consolidated version with amendments), it is Part V and Schedule 4 that primarily outline the GMC's powers with regard fitness to practise.

¹¹ The Nursing and Midwifery Order 2001 (SI 2002/253), the fitness to practise procedures are contained within Part V.

¹² For the GMC this is governed by The General Medical Council (Legal Assessors) Rules 2004 (SI 2004/2625) and for the NMC by the Nursing and Midwifery Order 2001 (Legal Assessors) Order of Council 2004 (SI 2004/1763).

¹³ For the GMC this is governed by The General Medical Council (Constitution of Panels and Investigation Committee) Rules Order of Council 2004 (SI 2004/2611) as amended by The General Medical Council (Constitution of Panels and Investigation Committee) (Amendment) Rules Order of Council 2005 (SI 2005/402), and for the NMC by The Nursing and Midwifery Council (Practice Committees) (Interim Constitution) Rules Order of Council 2003 (SI 2003/1738).

There are on-going reforms of the regulation that HCPs are subject to that include further reform to fitness to practise procedures, some of which have recently been introduced, for instance in the burden of proof used within GMC fitness to practise hearings, and others that are yet to be introduced, such as an independent adjudicator.¹⁴ These will be analysed as appropriate within the relevant sections of this chapter.

3. Fitness to practise procedures

It is not proposed to provide a detailed analysis of every aspect of fitness to practise procedures within this section. Rather the aim of this section is to provide an overview of the main aspects of fitness to practise procedures undertaken by the GMC and the NMC, in order to provide a basis for the commentary on fitness to practise that follows.

3.1 Allegations regarding a HCP's fitness to practise

In order for the professional regulatory bodies to be able to investigate an individual HCP's fitness to practise they have to be aware that there is a possible problem with regard to that HCP's fitness to practise. Therefore there has to be a mechanism whereby possible problems, with regard to fitness to practise, can be brought to the professional regulatory body's attention. In addition, the professional regulatory body has to have the necessary jurisdiction over the allegation in order to instigate an investigation of fitness to practise.

The remit of both professional regulatory bodies, with regard to fitness to practise of an individual HCP, is concerned with allegations of impaired fitness to practise.¹⁵ Prior to the introduction of the revised fitness to practise procedures in 2004,¹⁶ the GMC and the NMC were not able to consider matters relating to a HCP's competence or fitness to practise that, unless it related to an allegation of misconduct, was not considered to be 'serious'. Therefore there was the possibility that fitness to practise that

¹⁴ These are discussed further in section 4.3.5 below.

¹⁵ For the GMC this is provided by the Medical Act (1983) (consolidated version with amendments), section 35C(1); whilst for the NMC it is provided by The Nursing and Midwifery Order 2001 (SI 2002/253), at article 22(1)(a).

¹⁶ See section 2 above.

was only just below the threshold standard for performance would not be classed as being a serious breach and would not result in the HCP receiving a sanction.

The introduction of the 2004 fitness to practise procedures amended this, so that the professional regulatory bodies are able to consider all instances where a HCPs' competence or performance does not meet the required standard for performance. For the GMC, an impairment of fitness to practise includes:

- '(a) misconduct;*
- (b) deficient professional performance;*
- (c) a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;*
- (d) adverse physical or mental health; or*
- (e) a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect'.¹⁷*

The NMC has a very similar definition of impairment of fitness to practise, however it refers to point b as '*lack of competence*' and in point e refers to a '*determination by a licensing body*' rather than to a regulatory body.¹⁸ However there is no practical difference in the range of factors that can be construed as being an impaired fitness to practise.

The GMC is able to investigate allegations against HCPs on its register that are either fully or provisionally registered.¹⁹ Additionally both professional regulatory bodies are able to instigate an investigation even if the matter

¹⁷ The Medical Act (1983) (consolidated version with amendments), section 35C(2).

¹⁸ The Nursing and Midwifery Order 2001 (SI 2002/253), at article 22(1)(a).

¹⁹ The Medical Act (1983) (consolidated version with amendments), section 35C(1)(a) and (b).

occurred outside of the United Kingdom,²⁰ meaning that decisions of overseas professional regulatory bodies can be investigated; and also where the HCP was not registered with the GMC or NMC at the time of the incident resulting in the allegation.²¹ This last point can be related to the comments in Chapter 7, section 4.4, regarding the registration of students. Although the GMC & NMC can take sanction against those who were not registered with them at the time of the incident, they can only do so once the HCP applies to register with them.

3.1.1 *Raising an allegation*

Anyone can raise an allegation about a HCP to the respective professional regulatory body. This can include members of the public; employers; the police, who have a duty to inform the professional regulatory body of any caution given or a criminal conviction through the court service;²² other HCPs; and other regulatory bodies such as the Healthcare Commission.

Although both the GMC and the NMC have proformas that can be used for reporting a HCP to them, and both professional regulatory bodies state that the preferred method of receiving a complaint is via completion of these forms, there is no set method for making a complaint. Completion of the forms is preferred as they provide the GMC or the NMC with the relevant information to begin an investigation into the individual HCP. However, the forms, or any other method of making complaint such as a letter, may be mailed, faxed or e-mailed to the relevant professional regulatory body. Both the GMC and the NMC have a telephone advice line through which prospective complainants can seek advice on the making of their complaint.

²⁰ For the GMC this is provided by the Medical Act (1983) (consolidated version with amendments), section 35C(3)(a); whilst for the NMC it is provided by The Nursing and Midwifery Order 2001 (SI 2002/253), article 22(3).

²¹ For the GMC this is provided by the Medical Act (1983) (consolidated version with amendments), section 35C(3)(b); whilst for the NMC it is provided by The Nursing and Midwifery Order 2001 (SI 2002/253), article 22(3).

²² There are also 'memoranda of understanding' between the police and professional regulatory bodies, whereby each informs the other of any investigation into potential criminal activity.

The websites of the professional regulatory bodies have clearly marked sections which detail the procedures for making a complaint and downloadable copies of their respective complaint proformas.²³ The complaints sections are easy to use and contain a wealth of information not only on how to make a complaint and the process that occurs following the complaint, but also on the types of complaint that they can investigate and the possible outcomes. For instance, the GMC complaints section of its website states that it can '*issue a warning*' to the HCP but it cannot '*make a doctor apologise to you*'.²⁴

A criticism could be made of the previous fitness to practise procedures with regard to the making of an allegation in that the professional regulatory bodies were unable to investigate matters that they were aware of that could lead to an investigation if they had been not received an allegation about the matter. Now, both the GMC and the NMC have the authority to investigate matters without the need for an allegation to be made to them.²⁵

With regard to the number of allegations that arise in a given period, the NMC provides detailed information on this through its 'Fitness to Practise Annual Report', which is available on its website.²⁶ However, the GMC does not appear to produce the same detailed information.

For the 1 April 2006 to 31 March 2007 year, the NMC reports that there were 1,624 allegations received concerning nurses and midwives and that

²³ The GMC's web pages are in a section entitled 'Complaints and the role of the GMC' available at

http://www.gmc-uk.org/concerns/complaints_and_role_of_the_gmc/index.asp accessed on 21st June 2008. The NMC web pages are in a section entitled 'Referring a nurse or midwife to the NMC' available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=2667> accessed on 21st June 2008.

²⁴ GMC webpage 'Complaints and the role of the GMC' available at http://www.gmc-uk.org/concerns/complaints_and_role_of_the_gmc/index.asp accessed on 21st June 2008.

²⁵ For the GMC this was effected through The Medical Act 1983 (Amendment) Order 2002 (SI 2002/3135), article 13 which substituted Part V the Medical Act (1983) and inserted section 35CC which allowed this to occur; whilst for the NMC this is a provision within The Nursing and Midwifery Order 2001 (SI 2002/253), at article 22(6).

²⁶ See <http://www.nmc-uk.org/aArticle.aspx?ArticleID=1674> for reports going back to 2000, accessed on 21st June 2008.

this was an increase of 17.8% on the previous year. With regard to the source of the allegation this is reported as 50.25% from employers, 22.91% from the police, 15.02 from the public and 5.42 from other HCPs. In the same period 834 cases were either closed or decided as 'no case to answer', 142 HCPs were removed from the NMC register, 40 HCPs received a caution, 7 HCPs had conditions placed upon their registration and 4 HCPs were suspended.²⁷

With regard to the GMC, it is reported that they receive approximately 5,000 complaints each year and that of this number between 1,300 and 1,800 proceed to be investigated and this leads to around 300 being considered by a fitness to practise panel.²⁸

3.2 Fitness to practise process

Both the professional regulatory bodies have set defined processes for the handling of an allegation against a HCP. This section provides a general outline of the procedures utilised by the GMC and the NMC with regard to fitness to practise.

3.2.1 *Committees and panels*

The professional regulatory bodies have various committees that are statutory in origin that are used to investigate and make decisions regarding fitness to practice allegations.

The three committees of the GMC are the:

- Investigation Committee;
- one or more Interim Orders Panels;
- one or more Fitness to Practise Panels.²⁹

²⁷ Nursing and Midwifery Council (2007b) NMC Fitness to practise annual report 1 April 2006 to 31 March 2007 available at <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3695> accessed 21st June 2008.

²⁸ General Medical Council (2008a) GMCToday January/February 2008 General Medical Council, London, at page 5

²⁹ The Medical Act (1983) (consolidated version with amendments), section 1(3).

The NMC's committees are:

- the Investigating Committee;
- the Conduct and Competence Committee;
- the Health Committee.³⁰

Both the GMC and the NMC have rules and regulations with regard to the composition³¹ and functioning of their respective committees.³² Both professional regulation bodies allow for the inclusion of lay members and registrants on their committees. One interesting difference between the GMC and the NMC with regard to the composition of their committees is that with the GMC no member of Council may sit on either of its two Panels but may sit on the Investigation Committee,³³ however, with regard to the NMC it is a requirement of the governing legislation that both the chairman and deputy chairman of all its committees are members of Council.³⁴

3.2.2 *Investigation stage*

The GMC and the NMC have similar procedures with regard to their management of fitness to practise procedures but vary in processes. There are detailed rules and regulations concerning the handling of allegations under fitness to practise procedures.³⁵ It is not proposed to provide a detailed analysis of these rules and regulations here but to present an overview for later examination. The procedures outlined below are general

³⁰ The Nursing and Midwifery Order 2001 (SI 2002/253), established under article 3(9) with their functions described in articles 26 to 28 respectively.

³¹ For the GMC, this is governed by The General Medical Council (Constitution of Panels and Investigation Committee) Rules Order of Council 2004 (SI 2004/2611) as amended by The General Medical Council (Constitution of Panels and Investigation Committee) (Amendment) Rules Order of Council 2005 (SI 2005/402), and for the NMC by The Nursing and Midwifery Council (Practice Committees) (Interim Constitution) Rules Order of Council 2003 (SI 2003/1738).

³² For the GMC, this is governed by The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608), and for the NMC by The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761).

³³ The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608), at rule 3(3).

³⁴ The Nursing and Midwifery Council (Practice Committees) (Interim Constitution) Rules Order of Council 2003 (SI 2003/1738), at rule 3(a).

³⁵ For the GMC, this is governed by The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608), and for the NMC by The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761).

principles; however, where one of the two professional regulatory bodies makes a significant departure, this is noted.

Both the GMC and the NMC separate their fitness to practise procedures into two distinct stages, the investigation stage and the adjudication stage. The adjudication stage is examined in section 3.2.3 below. The investigation stage is examined here.

The first aspect of the investigation stage is to assess the validity of the allegation against the HCP, for example if the allegation is made to the GMC but concerns a nurse then the GMC will be unable to investigate the allegation and it would fail at the investigation stage; although the GMC would pass the allegation to the NMC who would initiate their investigation stage. Other reasons for allegations not proceeding to be investigated would be if it falls outside of the definition of impairment of fitness to practise, as defined in section 3.1 above.

However, for the GMC, where the allegation is considered not to warrant investigation by them, they are able to refer the allegation to another process, for instance NHS complaints procedures. The GMC requests that they are updated with regard to the process of the matter and any outcome reached. It is open for the matter to be referred back to the GMC at a later stage.³⁶

Where the allegation concerns a registrant of the professional regulatory body and is covered by the definition of impairment of fitness to practise being utilised, the investigation stage commences.

The GMC makes use of 'case examiners' in the screening of allegations. A case examiner is defined as *'a medical or lay officer of the General Council appointed by the Registrar for the purposes of exercising the functions of*

³⁶ See General Medical Council webpage 'Referral to local procedures' available at http://www.gmc-uk.org/concerns/making_a_complaint/local_procedures.asp accessed 19th June 2008.

the [Investigation] Committee.³⁷ There are always two case examiners, one lay person and one medically qualified, working on a case. The NMC does not use screeners in its investigation stage rather the Investigation Committee considers all allegations.

At the investigation stage the allegation is made available to the HCP and their employer, if appropriate, and the complainant is notified that an investigation is being undertaken. Further information may be requested and an assessment may be made of the HCPs performance. Where the allegation concerns the HCP's health, an assessment of their health may be undertaken.

For the NMC, the outcome of the investigation stage may be that the case is closed and no further action is taken, or that the allegation is referred to the adjudication stage.³⁸ The GMC has a different outcome process which is related to the fact that they use case examiners.

The possible outcomes for the GMC at the end of the investigation stage³⁹ are that the case is closed and no further action is taken; that the case examiners can offer a warning to the HCP; that the case is referred to the adjudication stage; or the case examiners may agree undertakings with the HCP.⁴⁰ The decision of the two case examiners must be unanimous with regard to the outcome. Where they are unable to agree the case is referred to the GMC Investigation Committee. The allegation can also proceed to the Investigation Committee where the case examiners have decided to offer a warning but the HCP has disputed the facts, or where the HCP themselves request that it proceeds to an oral hearing of the Investigation Committee.

³⁷ The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608) at rule 2.

³⁸ The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761), at Part 2.

³⁹ The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608) at rule 8.

⁴⁰ Sanctions such as a warning and undertakings are examined below in section 3.2.4.

Both the proceedings of the NMC Investigation Committee and the GMC case examiners are held in private. Where a case is referred to the GMC Investigation Committee, the committee may hear the case in private unless it is an oral hearing when it will be held publicly, unless the matter concerns the health of the HCP.

The HCP is entitled to be present at the GMC Investigation Committee oral hearing and to be represented, although the Investigation Committee can proceed in the HCP's absence provided that there has been proper notification of the hearing.⁴¹

The Investigation Committee has three possible outcomes that it can consider when the HCP has refused to accept a warning from the case examiners or requested an oral hearing:⁴² to close the case without taking any further action; to issue a warning; or to refer the case to the adjudication stage. Where a case is being considered because the case examiners have failed to agree on the outcome of the allegation, the Investigation Committee may also determine that an oral hearing should be held or that undertakings be allied to the HCP's registration.⁴³

3.2.3 *Adjudication stage*

The adjudication stage for the GMC is referral of the allegation to a Fitness to Practise Panel which considers all matters concerning a HCP's impaired fitness to practise. For the NMC the adjudication stage is divided between the Conduct and Competence Committee and the Health Committee depending upon the nature of the HCP's alleged impairment of fitness to practise;⁴⁴ whereas the GMC has moved toward a combined fitness to practise process which investigates poor performance, health and conduct

⁴¹ The particulars which have to be notified to the HCP are contained within The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608) at rule 11(5).

⁴² Ibid, at rule 11(6).

⁴³ Ibid, at rule 9.

⁴⁴ See NMC webpage 'FtP Panels' available at

<http://www.nmc-uk.org/aArticle.aspx?ArticleID=2228> accessed on 19th June 2008.

cases within the Fitness to Practise Panel.⁴⁵ Where the allegation involves the HCP's health, an appropriately qualified registered medical practitioner will be present to advise the Panel for both the GMC and the NMC.⁴⁶

In considering bringing an allegation before an adjudication panel, the professional regulatory body will have considered the likelihood of being able to prove a case before the Panel and the seriousness of the allegation.

Adjudication panels are the final stage of the professional regulatory bodies' fitness to practise procedures; although there is a mechanism for appeal.⁴⁷

The GMC has a three stage process with regard to Fitness to Practise Panels and their findings. After hearing evidence from both sides, the Panel announces its finding of fact; it then it announces its finding on whether the HCP's fitness to practise is impaired after hearing evidence and any submission from the HCP, giving reasons for its finding; following this where the HCP's fitness to practise is found to be impaired it will hear submissions and evidence with regard to the appropriate sanction to apply before announcing its sanction and again giving reasons. The adjudication panels have the option of finding that the allegation against the HCP has not been proved and that their fitness to practise is not impaired. With regard to the GMC, where the Panel has found that there is no evidence of impairment, it may still give a warning to the HCP after hearing evidence and submissions on doing so.⁴⁸

⁴⁵ General Medical Council (2008b) Managing fitness to practise panel hearings – guidance for panel chairmen General Medical Council, London.

⁴⁶ The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608) at rule 3(2); NMC webpage 'The Health Committee Panels' available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3034> accessed 19th June 2008.

⁴⁷ See section 3.2.5 below for details of appeals.

⁴⁸ Fitness to Practise Panel procedures are contained within The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608) at rule 17; and within The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761), at Part 5.

It is also available to the adjudication panels, of both the GMC and the NMC, to determine that the allegation has not been proved and that the HCP has no further case to answer, or that even where the allegation has been proved, that it is not appropriate to take any further action against the HCP.

In determining whether a HCP's fitness to practise is impaired the adjudication panels will look to the standard of the average HCP and not to the highest possible standard. Breaching the code of conduct does not automatically mean that the HCP's fitness to practise is impaired if there are mitigating circumstances.

There are a range of sanctions available to adjudicating panels,⁴⁹ although it is not possible to remove a HCP from the professional register where their fitness to practise is impaired by virtue of their health.⁵⁰

3.2.4 Interim Orders

Both professional regulatory bodies have an additional level to their fitness to practise procedures; this is the Interim Orders Panel or hearing. Where there is a risk to the protection of the public or patient safety, from the continued professional practise of the HCP who is facing the allegation, or for the protection of the HCP themselves, the GMC may refer the HCP to the Interim Orders Panel, whilst the NMC may refer cases to an Interim Orders hearing.

The outcome of an Interim Orders Panel or hearing may be an order that HCP's registration be suspended, or conditions imposed upon their

⁴⁹ Sanctions are examined below in section 3.2.4.

⁵⁰ The NMC is able to remove a HCP from the professional register by virtue of impaired fitness to practise due to health reasons where the HCP has been either continuously suspended or subject to conditions upon their registration for at least two years preceding the current decision. Section 35D(2)(a) of the Medical Act (1983) (consolidated version with amendments) prohibits erasure from the professional register on account of impaired by virtue of the HCP's health.

registration, for a period of up to eighteen months.⁵¹ Interim orders have to be reviewed for the GMC initially within six months and then at intervals of not longer than six months, and for the NMC initially after six months and then after each three months. Further extensions are possible on application to the High Court.

The Interim Orders aspect of fitness to practise procedures may be instigated at either the investigation or adjudication stage. Therefore before the final outcome of the fitness to practise procedure is decided a temporary measure may be made to provide immediate public protection.

3.2.5 *Sanctions*

Even where a HCP's practice has been found to be impaired, it is open to the professional regulatory bodies to take no action further and place no restrictions on the HCPs registration regarding their practice. However, where it has been found that the HCP's fitness to practise is impaired and that a sanction is appropriate, there are a variety of measures that the professional regulatory bodies can impose upon a HCP.

In order of severity the sanctions that are available to the professional regulatory bodies are:⁵²

- Warning (GMC) or Caution (NMC) – this is essentially seen as guidance from the professional regulatory body to the HCP that, although no further action is being taken at this time, the sort of behaviour that they had been undertaking is something of which the professional regulatory body is critical and if the HCP were to continue with their behaviour, and come before the professional regulatory body again, the outcome may be very different. A warning or caution may be issued where the behaviour justifies a higher sanction but the evidence is lacking and may last for a period

⁵¹ Interim orders are governed by section 41A of the Medical Act (1983) (consolidated version with amendments) for the GMC and article 31 of the Nursing and Midwifery Order 2001 (SI 2002/253) for the NMC.

⁵² For medicine this is governed by the Medical Act (1983) (consolidated version with amendments), sections 35C and 35D, whilst for nursing this is governed by the Nursing and Midwifery Order 2001 (SI 2002/253) article 29.

between one and five years for nurses and midwives⁵³ and five years for doctors;⁵⁴

- Reprimand – this is a ‘telling off’ from the professional regulatory body with no further sanction;
- Conditions on practice – this may arise as a result of poor practice due to the conduct of the HCP or because of a health problem that is affecting their practice. There are various forms that the conditions could take generally include administrative conditions where the HCP has to inform the professional regulatory body when they apply for positions or move abroad to practice, and having to inform their employer that they have had conditions placed upon their registration. Administrative conditions allow the professional regulatory body to be kept informed of the HCPs activities. The conditions themselves can include almost anything, for example a condition that the HCP not work with children or vulnerable adults, that they undertake a communication course to improve their dialogue with colleagues or patients, that they undertake management training to address their managerial deficiencies, or that they work under supervision for a prescribed period. Conditions upon registration may be enforced for up to three years;
- Suspension from the register – for a period of up to twelve months;
- Erasure from the register – this is the ultimate sanction that the professional regulatory bodies have at their disposal. If the HCP is removed from the professional register, they are unable to work in that field unless, or until, they have their name restored to the register.

There is one further sanction that is available to the GMC, an agreement of undertakings. This is only available during the investigation stage and where the case examiners both agree that the undertakings are a sufficient method of providing public protection and that there are no additional

⁵³ Nursing and Midwifery Council (2008a) Indicative sanctions guidance for panels of the Conduct & Competence and Health Committees Nursing and Midwifery Council, London.

⁵⁴ General Medical Council (2008c) Guidance on warnings General Medical Council, London.

concerns regarding the HCP's fitness to practise. The HCP has to agree to the undertakings and they may not be offered if there is a realistic prospect that if the case were presented to a Fitness to Practise Panel it would result in the erasure of the HCP from the professional register.⁵⁵

Prior to The General Medical Council (Fitness to Practise)(Amendments in Relation to Undertakings) Rules Order of Council 2007⁵⁶ coming into force in December 2007, undertakings were only available in impaired fitness to practise involving ill health or deficient performance. Since the introduction of this provision they are available for all instances of impaired fitness to practise. They are often referred to 'consensual disposal' as both the GMC and the HCP have to consent to the application of the undertaking.

Neither the GMC nor the NMC are able to impose a financial penalty or fine upon the HCP.

The aim and justification behind the application of a sanction to a HCP is to remedy the impairment of the HCP's fitness to practise and thereby provide public protection. Sanctions must therefore be proportionate to achieve this aim of public protection.

3.2.6 Appeals

For the majority of disciplinary decisions, there is a statutory right of appeal for the HCP against a harsh finding or sanction.⁵⁷ Appeals are generally to the Administrative Court of the High Court, Queen's Bench Division; it provides judicial review of the professional regulatory bodies' decisions on appeal from HCPs. The Privy Council used to exercise this function for doctors. Concerns regarding lenient decisions or sanctions of

⁵⁵ Undertakings are governed by rule 10 the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608).

⁵⁶ The General Medical Council (Fitness to Practise)(Amendments in Relation to Undertakings) Rules Order of Council 2007 (SI 2007/3168).

⁵⁷ The doctors right of appeal is governed by Medical Act (1983) (consolidated version with amendments), at section 40; whilst for nurses and midwives it is governed by the Nursing and Midwifery Order 2001 (SI 2002/253) article 38.

the professional regulatory bodies are identified by the Council for Healthcare Regulatory Excellence (CHRE) and are heard by the same court.⁵⁸

The court hearing the appeal may dismiss it; quash the original decision of the professional regulatory body; substitute its own judgment for that of the professional regulatory body; or refer the case back to the professional regulatory body with directions as to its handling. In addition, the court may make an order regarding costs.

3.2.7 Restoration to the register

Where a HCP has had their registration erased, they may apply after a period of five years for their name to be restored to the register. Applications are made to the Fitness to Practise Panel for the GMC and to the relevant Committee for the NMC. If their application is unsuccessful, the HCP must wait a further twelve months before they can make another application for restoration. If this second application for restoration is unsuccessful, the professional regulatory body may suspend the HCP's right to make further applications for restoration, although this should be reviewed three yearly.⁵⁹

4. Commentary on fitness to practise

This section of Chapter 10 is a commentary on whether fitness to practise achieves the primary purpose of regulation, that of public protection and patient safety, and thereby leads to the element being judged as fit for purpose.

It is not proposed to consider all the previous comments that have been made in the past, for instance from Inquiries or consultations, regarding

⁵⁸ For the role of the Council for Healthcare Regulatory Excellence see Chapter 5, section 5.

⁵⁹ For medicine this is governed by the Medical Act (1983) (consolidated version with amendments), at section 41, and The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608), part 6; whilst for nursing and midwifery this is governed by the Nursing and Midwifery Order 2001 (SI 2002/253) at article 33, and The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761) at rule 25.

the fitness to practise procedures and failings of the GMC and the NMC, rather this section is concerned with the current fitness to practise procedures and whether they are fit for purpose.

4.1 Fitness to practise

With regard to fitness to practise the major issue is whether the regulatory aim, of public protection and patient safety, can be managed and enforced effectively.

It is important to know how infractions of the regulatory body's rules and regulations can be raised. Is it possible, for instance, for the patient or members of the public to raise complaints with the regulatory body? It is equally important to know how far the particular regulatory body can assist in protecting the public and patients from rogue HCPs.

Each infraction or complaint about a HCP needs to be dealt with consistently, according to agreed and accessible procedures. The rules and procedures need to be clearly available, so that they can be understood not only by the HCP against whom they are being used but also by the regulatory body officials who are applying them. As the Better Regulation Task Force states, *'there should be no uncertainty regarding enforcement of rules and regulations. Those being regulated must be made aware of their obligations and be helped to comply by enforcing authorities'*.⁶⁰ It should be common knowledge how the regulatory body will deal with a HCP who is not demonstrating the required level of competence or who is performing below par.

Those who are looking to the regulatory body for protection need to feel that enforcement of rules and regulations is more than a gesture, that the regulatory body is taking this aspect of its role seriously and is implementing it effectively. If there is no enforcement of the regulatory body's rules and regulations, the HCPs who are subject to its jurisdiction

⁶⁰ Better Regulation Task Force (2000) Alternatives to state regulation Cabinet Office, London, at page 29.

may take the view that they are free to ignore them without fear of sanction, leading to a lack of public confidence in the professional regulatory body itself, and possibly the profession they regulate.

Equally those who are subject to the regulatory control need to be confident that procedures will be applied consistently and fairly, and that, whilst those who breach the standard and conduct expected or perform their practise incompetently will face appropriate sanctions, those of them who are adopting the standards of the professional regulatory body will not face disciplinary action.

4.2 Legislative basis of fitness to practise

It was noted above that the legislative basis for the professional regulatory bodies' fitness to practise procedures was capable of amendment by section 60 orders.⁶¹ This is a method of amending legislation without the need of undergoing the full legislative process of an Act of Parliament.

There are two aspects to this, the first is that it allows for change to be made to the fitness to practise procedures of the professional regulatory bodies to be made quickly where there is a perceived deficiency with the procedures or where the current procedures may result in an injustice to HCP or even to a complainant.

However, the second aspect is that it allows for legislative change to occur without being subject to full consultation or to the rigour of Parliamentary debate. This could lead to changes been implemented to the fitness to practise procedures of professional regulatory bodies which in themselves may lead to an injustice; although, once identified, the section 60 order process would allow for it to be amended promptly.

4.3. Fitness to practise procedures

This section of the commentary analyses the fitness to practise procedures of the GMC and the NMC.

⁶¹ See section 2 above.

4.3.1 Allegations regarding a HCP's fitness to practise

In order to provide public protection and patient safety, fitness to practise procedures need to be able to deal with any and all instances where a HCP's fitness to practise is impaired. As noted in section 3.1 above the introduction of new procedures in 2004 allowed both the GMC and the NMC to extend their remit to include areas of impaired fitness to practise that they were not previously able to investigate or adjudicate upon.

The current definition of impaired fitness to practise, that both professional regulatory bodies use to judge the standard of the HCP who is alleged to be failing the standard, is wide in its coverage. It includes impaired fitness to practise by reason of health, competence and misconduct, and does not confine itself to issues which are deemed to be serious in nature but is inclusive of all instances where practise is impaired. Both the GMC and the NMC are allowed to consider incidents that have occurred overseas or when the HCP was not a registrant with them, and to instigate their own investigations.

The one flaw that this thesis considers is present is that it does not allow for the fitness to practise of students to be investigated or adjudicated upon. A recommendation has been made on this issue in Chapter 7, section 4.4.

With regard to raising an allegation against a HCP, both the GMC and the NMC provide extensive guidance and support to those wishing to raise an allegation concerning a HCP's fitness to practise. However, it appears that it is only the GMC who are able to refer an allegation, that does not warrant investigation by them, for local investigation and management.⁶²

Recommendation

That all professional regulatory bodies take the opportunity to refer appropriate allegations for local investigation and management.

⁶² See section 3.2.2 above.

That not all allegations have to be investigated by the full procedures of the professional regulatory bodies is seen in a positive regard by this thesis. Where the allegation may be effectively dealt with 'locally', this means that the HCP will have not to endure the full 'might' of the fitness to practise procedures of their professional regulatory body. However, in terms of public protection and patient safety, as the professional regulatory body would have a continued oversight of the allegation, this is still ensured.

This use of local procedures was highlighted in the Government White Paper where it was stated that local procedures need to be strengthened with regard to their use and the introduction of GMC 'affiliates' was advocated to support the local procedures currently in place.⁶³ The GMC is piloting the use of 'affiliates' in the latter half of 2008.⁶⁴ This thesis is of the opinion, as recommended above, that local procedures, and hence affiliates if they are implemented following the results of the pilot scheme, are utilised by all the professional regulatory bodies.

4.3.2 Fitness to practise process

As examined in section 3.2 above, both the GMC and the NMC have defined processes governed by legislation for their fitness to practise procedures.

Both the GMC and the NMC provide information on their websites in relation to their role in the fitness to practise of a HCP, the issues that they can address, the process and procedures they undertake as well as the possible sanctions available to them. The information is sufficient that it should make the procedure accessible, both in terms of availability and being understandable, to the public and employers, and other interested parties.

⁶³ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraph 3.18.

⁶⁴ General Medical Council (2008d) GMC affiliates Council Paper 4D for Council Meeting 22 May 2008, General Medical Council, London.

With regard to the HCP who is subject to a fitness to practise allegation, both of the professional regulatory bodies provide information and guidance on the process itself, the criteria that will be used to judge the standard of the HCP's fitness to practise and the range of possible sanctions. The GMC may be said to be more advanced in this regard in that it produces a booklet for its registrants,⁶⁵ therefore all the relevant information is in one place. However the information from the NMC is available from its website, even if it is contained within separate webpages.

Recommendation

That the NMC follow the example of the GMC and publish a self-contained booklet regarding its fitness to practise procedures for those registrants that are alleged to have impaired practise. Although it is expected that HCPs who are informed that they have an allegation made about their practise will seek advice and assistance from their professional support bodies, it is seen as good practice for the professional regulatory body to issue a guidance booklet with the letter informing the HCP of the allegation.

4.3.3 Transparency of proceedings

In order for there to be both public faith and HCP confidence in the fitness to practise procedures of the professional regulatory bodies, a degree of transparency regarding their procedures is necessary. As discussed above both the GMC and NMC publish information on their fitness to practise procedures. The NMC also produces an annual report on fitness to practise which provides anonymised statistical information such as the number of allegations made, the reasons for the allegation and the outcome of cases heard.

Both the GMC and the NMC publish the decisions of fitness to practise hearings, including interim order decisions, on their websites, which detail the name of the HCP, their registration number with the professional

⁶⁵ General Medical Council (2007b) [A guide for doctors reported to the GMC](#) General Medical Council, London.

regulatory body, and the details of the allegation, the decision of the Committee hearing the allegation and the outcome of the hearing, including the sanction imposed and the length of the sanction. The GMC also publishes the HCP's field of expertise and place of practice,⁶⁶ while the NMC publishes the part of the register the HCP is registered on and their country of registration.⁶⁷

As noted in Chapter 6, section 2.3, it is possible to search the professional registers for an individual HCP's details, and part of the information provided is any fitness to practise outcomes recorded against the HCP.

With regard to the fitness to practise hearings themselves, those involving allegations of health are held in private as are those in the investigation stage, whilst those in the adjudication stage are generally public hearings.

It is thought by this thesis that the above suggests there is appropriate transparency within the fitness to practise procedures for the public to have trust and confidence in them. The HCPs' right to confidentiality regarding their health status outweighs the need for a public hearing. This would appear to be the case as the Human Rights Act states that '*the protection of private life*'⁶⁸ constitutes a circumstance where the press and public may be excluded from proceedings.

Where a fitness to practise hearing has imposed a sanction against a HCP for a reason related to their health, although the information is released as above, a private set of notes are kept by the professional regulatory body which detail the health issues that related to the impaired fitness to practise and the awarding of the sanction, the information released

⁶⁶ The GMC's fitness to practise decisions are available its 'Search Fitness to Practise and IOP decisions' webpage at http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_decisions.asp accessed 20th June 2008.

⁶⁷ The NMC's fitness to practise decisions are available at its 'FtP hearings and decisions' webpage at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=1954> accessed 20th June 2008.

⁶⁸ Human Rights Act 1998, Article 8(1).

publicly would be a more generalised account and not have this specific information. This is considered by this thesis to be in keeping with the right of every individual to have their medical information kept confidential whilst allowing the professional regulatory body to undertake their fitness to practise procedures accordingly. This should not be seen as demeaning the transparency of the procedures as the information that is released provides enough detail for the public to judge whether the HCP has been dealt with sufficiently.

However for the HCP who has an allegation made against them, the question is whether the transparency of the fitness to practise procedures is an abuse of their right to privacy.⁶⁹

The NMC state that with regard the investigation stage *'proceedings are held in private. It would not be fair to registrants who had unjustly been reported to the NMC if their names were publicised at this stage'*.⁷⁰ However, this would seem to imply that if a decision is made to progress an allegation to the adjudication stage that the HCP is already judged to have impaired fitness to practise. However, this is not necessarily the case as the adjudication Committees may find that the HCP's practise is not impaired. Therefore the NMC's position appears illogical. However, the provisions of Article 8 of the Human Rights Act 1998 are subject to meeting public safety issues. Therefore although illogical at first glance, the stated position of the NMC, and the position of the GMC in practice, may be said to provide the HCP with the protection that they would expect under the statutory provisions of the Human Rights Act 1998, as it only publishes details of allegation to the wider public where there is a reasonable prospect that a finding of impaired fitness to practise will be reached. Thus, the current position provides for the right to privacy of the HCP through the private nature of the investigation stage of the fitness to practise procedures but also provides for public protection, and public confidence in the fitness to practise role of the professional regulatory

⁶⁹ As defined within Article 8 of the Human Rights Act 1998.

⁷⁰ NMC webpage entitled 'Investigating Committee Panels' available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3031> accessed on 23rd June 2008.

bodies, through the transparency of the procedures at the adjudication stage.

With regard to the publication of the fitness to practise hearing and any sanction applied against the HCP, Whitefield v GMC⁷¹ provides that if the finding of judgment and sanction were reasonable and not oppressive that this is not a breach of Article 8 of the Human Rights Act 1998.

4.3.4 *Committees and panels*

The various panels and committees that undertake fitness to practise procedures for the professional regulatory bodies include lay members and HCPs. This provides a balance between two aspects of fitness to practise, that of providing public protection whilst at the same time protecting HCPs from spurious or inappropriate allegations.

It is an oddity of the rules and regulations governing the composition of the various committees and panels that the NMC require a Council member to be present on every committee, indeed they have to act as either chairman or deputy chairman, whilst the GMC specifically exclude Council members from its panels and they may only sit on the Investigation Committee.⁷²

Having Council members sitting on the fitness to practise panels and committees raises questions about the HCP's right to a fair trial and the independence and impartiality of the panels and committees.

It may be argued that Council members have a conflict of interest if they served on fitness to practise committees and panels as they are the governing body of the professional regulatory body. Thus, they may have a vested interest in the findings that are made with regard to certain allegations and the sanctions imposed upon HCPs.

⁷¹ Whitefield v GMC (2003) HRLR 243.

⁷² See section 3.2.1 above.

This would appear to be recognised by the GMC who do not have them sitting on panels in the adjudication phase. However, whilst this is commendable, it does not go far enough to avoid any possible allegation of impropriety. Justice does not just have to be done but be seen to be done, if there is a chance of lack of independence this is enough to raise questions about the fairness of a HCP's trial and this should be avoided. Fitness to practise committees and panels have to be seen to be independent and impartial.

Recommendation

That Council members of either professional regulatory body are specifically excluded from sitting on any of their respective fitness to practise committees or panels.

Section 4.3.5 below provides discussion of the proposals re The Office of the Health Professions Adjudicator. The present proposals would leave the GMC with Council members on its Investigation Committee; however this thesis considers that Council members should be excluded from sitting on this committee as well.

Another issue with regard to the composition of committees and panels is that of consistency, in terms of both process and outcome. Both the professional regulatory bodies have a large pool of individuals who may sit on their respective committees and panels.⁷³

This has many benefits in terms of independence and impartiality but could raise issues with regard to consistency across the many committee and panels that sit for the professional regulatory bodies, and may have different members at different times.

⁷³ For instance the GMC states that its '*pool of panellists is large (almost 300)*'. Information available at GMC 'Fitness to Practise Panel' webpage at http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_panels.asp accessed on 23rd June 2008.

The GMC have a considerable amount of guidance that they publish with regard to the whole of fitness to practise procedures specifically for their 'decision makers'.⁷⁴ An examination of the guidance reveals that it has significant detailed information on how fitness to practise is to be assessed, the management of allegations at the various stages, along with guidance on appropriate sanctions. The amount of guidance available would appear to address the issue of consistency across committees and panels as it provides the basis for decisions to be reached.

Recommendation

Although it is recognised that members of fitness to practise committees and panels have training, it is recommended that the NMC produce guidance similar in nature and scope to that of the GMC for its committee members, and that if this information is already produced but not made public it is further recommended that the guidance is made public.

This thesis considers that in order to have consistency across fitness to practise committees and panels guidance of the sort produced by the GMC is essential. Further, that in order for the public to have confidence in the system and for the process to be fair for the HCP who is facing it, they and their advisors and legal representatives need to have access to it.

A final point with regard to the composition of committees and panels, is that of the expertise of the HCP member. For instance Professor Southall, who was erased from the GMC professional register for serious misconduct,⁷⁵ claimed that the members of his fitness to practise panel were lacking in the appropriate qualifications to judge his practise and

⁷⁴ This information is available on their GMC website. The main link into this guidance is through the 'Sanctions guidance (information for lawyers and others)' webpage which has links to the guidance itself. Available at [http://www.gmc-uk.org/concerns/hearings and decisions/sanctions referrals guidance.asp](http://www.gmc-uk.org/concerns/hearings_and_decisions/sanctions_referrals_guidance.asp) accessed 23rd June 2008.

⁷⁵ See Dyer O (2008) 'GMC strikes Southall off register for serious misconduct' *British Medical Journal* vol. 335 p. 1174.

that, in particular, the HCP member was an orthopaedic surgeon whilst he was a consultant paediatrician.⁷⁶

However, both professional regulatory bodies bring in specialist advisors and therefore do not perceive a need for a specialist to sit on each committee or panel. Additionally, the NMC ensures that the HCP members on its committees are on the same part of the register as the HCP who is facing the allegation.

In R (Application of Biswas) v GMC⁷⁷ it was held that the question of the expertise and qualification of the panel members was not a sufficient ground to challenge a decision of a fitness to practise panel where the panel was procedurally sound.

4.3.5 Investigation and adjudication stages

The investigation and adjudication stages of the fitness to practise procedures have been combined within this commentary as they raise similar issues.

The main issue is whether the fitness to practise procedure of the professional regulatory bodies allows the HCP who is brought before them to receive a fair trial. There are two aspects to this, the first concerns the actual procedures at fitness to practise hearings, the second relates to the underlying philosophy to fitness to practise by the professional regulatory bodies.

For fitness to practise procedures to be fair and effective they must comply with any statutory provisions concerning that regulation. One statutory provision that can be readily identified is that of the Human Rights Act 1998.

⁷⁶ See Tibbetts G (2007) 'Southall attacks 'flaws' in GMC panel' The Daily Telegraph 7 December 2007 p. 17.

⁷⁷ R (Application of Biswas) v GMC [2007] EWHC 1644.

The Human Rights Act 1998 applies to public authorities. Although the professional regulatory bodies are established by legislation, it needs to be determined whether they are public authorities for the purposes of the Human Rights Act 1998.

Section 6(1) of the Human Rights Act 1998 states that '*it is unlawful for a public authority to act in a way which is incompatible with a convention right*'. However, there is no specific definition of a public authority within the Human Rights Act 1998 and it is open to question whether a specific regulatory body is a public authority. With regard to the professional regulatory bodies, a key judgment was given by Lord MacKay in Tehrani v United Kingdom Central Council for Nursing, Midwifery and Health Visiting⁷⁸.

In this case, Lord MacKay stated that where the professional regulatory bodies '*are exercising their disciplinary function, they clearly fall within the definition of public authority, to be found in s 6(3)(b) of the 1998 Act*'.⁷⁹ A view which was confirmed by the Privy Council in Haikel v General Medical Council,⁸⁰ where Sir Otton stated that '*their Lordships recognize that the PCC [a previous adjudication committee of the GMC] is a public authority for the purposes of the Human Rights Act and as such must act in a way which is not incompatible with a convention right*'.⁸¹

It would appear therefore that the professional regulatory bodies are public authorities for the purposes of the Human Rights Act 1998 and so it must be assumed so too is CHRE as one of its functions is to appeal the decisions of the professional regulatory bodies to the High Court.

As such, it remains to determine whether any articles of the HRA are applicable with regard to the regulation of HCPs.

⁷⁸ Tehrani v United Kingdom Central Council for Nursing, Midwifery and Health Visiting [2001] IRLR 208, accessed via LexisNexis on 28th August 2006.

⁷⁹ Ibid at paragraph 31.

⁸⁰ Haikel v General Medical Council [2002] Lloyd's Rep Med 415.

⁸¹ Ibid, at paragraph 13.

Examination of the Human Rights Act 1998 reveals that the main provision most likely to be raised in relation to the regulation of HCPs is that of Article 6.

Article 6 of the Human Rights Act 1998 states that '*in the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing, within a reasonable time by an independent and impartial tribunal established by law*'.

It could be argued that the right to undertake professional health care practice is a civil right and therefore one that might be protected by the Human Rights Act 1998. However in Chaudhury v The General Medical Council,⁸² Lord Hutton stated that '*although the right to practise medicine is a civil right, it is not one of the rights guaranteed by the Convention*'.⁸³ Therefore, specific employment as a doctor or a nurse is not a right protected by the Human Rights Act 1998.

However, this still leaves the right to a fair trial. Analysing the right to a fair trial within Article 6, it can be seen that there are four separate aspects to the right. These being that the trial must be public, within a reasonable time, impartial and independent, and established by law.

Taking this last aspect first, it was acknowledged in section 4.2 above that the fitness to practise committees and panels of the professional regulatory bodies have legal authority.

The right to a public hearing was discussed in section 4.3.3 above. Here it is further noted, that whilst there is a right to a public trial, this must be a right that the defendant can refuse, if all parties agree.

With regard to the right to have a trial within a reasonable time, the rules governing fitness to practise proceedings may be said to be ambiguous

⁸² Chaudhury v The General Medical Council [2002] UKPC 41.

⁸³ *Ibid*, at paragraph 20.

with regard to the timeframe of the various elements of the proceedings, the GMC's referring as they do to '*as soon as is reasonably practicable*', whilst the NMC's only refers to time periods in relation to notifying a registrant at various points in the procedure.⁸⁴ Therefore, it may be that the HCP could challenge the length of time before their case comes before a fitness to practise hearing and they receive the outcome of that hearing.

Indeed in the case of Giele v General Medical Council⁸⁵ the court was critical of the GMC's delay in concluding a hearing. Collins J stating that: '*it lasted no less than 29 days, spread over 15 months between December 2003 and March 2005. Hearings of these lengths which have to be conducted with substantial gaps due largely to the difficulties in bringing Panel members together are clearly undesirable. I am bound to say that to take 29 days for a case of this nature seemed to me to be prima facie unacceptable. One of the problems appears to be the lack of any means whereby the defence case can be properly identified in advance. It is apparent that the GMC should seriously consider amendments to its rules to ensure that there is power, which should be exercised robustly but fairly to avoid unnecessary delays and length of hearings*'.⁸⁶

Delay in hearing fitness to practise allegations does not just affect HCPs. There is also an affect on public protection as the delay prevents the HCP from having the appropriate sanction applied to them and hence the public are not receiving the full protection that they should. For instance, Revill reports, that in June 2006, 175 nurses were awaiting their hearing because of a backlog of cases at the NMC;⁸⁷ whilst, by November 2006, the BBC reported that the number of nurses awaiting a hearing was 345.⁸⁸

⁸⁴ For the GMC, see The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608), in particular rules 7(1), 8(4) and 15(1); for the NMC see The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/1761), in particular rules 3(2), 5(5), 8 and 11(2)(b).

⁸⁵ Giele v General Medical Council [2005] EWHC 2143 (Admin).

⁸⁶ *Ibid*, at paragraph 2.

⁸⁷ Revill J (2006) 'Patients' lives being left at mercy of abusive nurses: 175 carers are allowed to stay on the wards despite accusations of serious misconduct' The Observer 25th June 2006 p. 13.

⁸⁸ BBC News (2006) Delay in nurse misconduct cases 28th November 2006 available at <http://news.bbc.co.uk/1/hi/health/6144848.stm> accessed 24th June 2008.

However, there is a further aspect to the timing of a hearing. That is when the HCP is unable to attend, for instance through ill health. In Brabazon-Drenning it was decided that it is a breach of both natural justice and Article 6(1) of the Human Rights Act 1998 when an adjudication committee fails to postpone a hearing where it is impossible for the HCP to attend.⁸⁹

The Human Rights Act 1998 does not proscribe an appropriate standard of proof for hearings but rather requires procedural fairness.

Traditionally, given the severity of sanctions available to them, the professional regulatory bodies have used the same standard of proof in deciding fitness to practice cases as the criminal courts, that of beyond reasonable doubt.

However, recently there have been moves to reduce the standard to that used in the civil courts, that is, the balance of probabilities. In 2000, the NHS Plan stated that '*the GMC should also explore introducing a civil burden of proof.*'⁹⁰ Also in 2000, the Report of the Ledward Inquiry recommended that the GMC should consider hearings based upon the civil standard of proof;⁹¹ whilst Dame Janet Smith stated that '*the GMC should reopen its debate about the standard of proof to be applied by FTP [fitness to practise] panels. The civil standard of proof is appropriate in a protective jurisdiction. It is arguable that the criminal standard of proof is appropriate in a case where the allegations of misconduct amount to a serious criminal offence.*'⁹²

⁸⁹ Brabazon-Drenning v The United Kingdom Central Council for Nursing, Midwifery and Health Visiting [2001] HRLR 6.

⁹⁰ Secretary of State for Health (2000) The NHS Plan: a plan for investment, a plan for reform Cm 4818-I The Stationery Office, London, at paragraph 10.14.

⁹¹ Department of Health (2000a) Report of the inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward (Chair Jean Ritchie – the Ritchie Report) Department of Health, London, recommendations at page 323.

⁹² Secretary of State for the Home Department and the Secretary of State for Health (2004) Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past -

Some of the arguments in favour of moving to the civil standard are that it will allow more evidence to be presented to hearing, such as hearsay evidence which would not be allowed under the criminal standard; that the criminal standard results in the hearing being more adversarial; that not all outcomes result in erasure from the register; and that the criminal standard does not protect the public as cases are closed because evidence cannot be admitted.

As may be imagined, the question of changing from the criminal to the civil standard of proof has been controversial within the health care professions.⁹³ Indeed, such has been the controversy that the NMC has reversed its proposal to move from the criminal to civil standard.⁹⁴

However, despite the controversy, the GMC moved to the civil standard of proof for all cases heard since the 31st May 2008. At present, the NMC is using the criminal standard of proof. However following a proposal in a Government White Paper,⁹⁵ the NMC is again reversing its position and moving to the civil standard. It is expected that this will occur in October 2008.⁹⁶

As to the appropriateness of using the civil standard of proof, the GMC states that *'the application of the civil standard of proof more accurately reflects the true function of a GMC Fitness to Practise panel. The panel is*

Proposals for the Future (Chair Dame Janet Smith DBE) Cm 6394 The Stationery Office, London, at page 61.

⁹³ As witnessed by a search of any of the professional health journals. For instance, Smith N (2000) 'GPs could be struck off with weaker evidence' GP 1 September 2000, p. 4; Editorial (2003b) 'NMC must retain safeguards for nurses' Nursing Times vol. 99 no. 3 p. 13; Doherty L (2006) 'Lesser standards of proof may condemn more nurses' Nursing Times vol. 102 no. 44 p. 9; and Pritchard L (2007) 'Standard-of-proof change not justified, insists BMA' BMA News 24 November 2007 p. 4.

⁹⁴ Nursing and Midwifery Council (2003a) NMC News December 2003 Nursing and Midwifery Council, London.

⁹⁵ Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraph 4.18.

⁹⁶ With regard to the implementation date see NMC webpage 'Using the civil standard of proof' available at <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3141> accessed on 24th June 2008.

not a criminal court and it is not applying the criminal law'.⁹⁷ This is supported by the judgment in Wickramsinghe v United Kingdom,⁹⁸ where it was held that proceedings before the GMC were a civil rather than a criminal matter.

Additionally, Richards LJ provides the following: *'although there is a single civil standard of proof on the balance of probabilities, it is flexible in its application. In particular, the more serious the allegation or the more serious the consequences if the allegation is proved, the stronger must be the evidence before a court will find the allegation proved on the balance of probabilities. Thus the flexibility of the standard lies not in any adjustment to the degree of probability required for an allegation to be proved (such that a more serious allegation has to be proved to a higher degree of probability), but in the strength or quality of the evidence that will in practice be required for an allegation to be proved on the balance of probabilities'*.⁹⁹

This means that the fitness to practise panel have to consider the possible sanctions that may be awarded, if a finding of impaired fitness to practise were found in the case before them. This is seen by some as raising the possibility of the process be undermined by those adjudicating the allegation having their minds concentrated on a possible sanction.¹⁰⁰

However, it appears that public protection would be increased, as it is easier to make a finding of impaired fitness to practise whereas under the criminal standard it was not always possible to prove an allegation beyond reasonable doubt. It would appear appropriate that the civil standard is used in fitness to practise hearings with a sliding scale of quality of

⁹⁷ General Medical Council (2007c) Civil standard of proof frequently asked questions General Medical Council, London, at page 1.

⁹⁸ Wickramsinghe v United Kingdom (1998) 3 EHRLR 338.

⁹⁹ Regina (N) v Mental Health Review Tribunal (Northern Region) and others [2005] EWCA Civ 1605 at paragraph 62.

¹⁰⁰ For instance see Editorial (2007) 'Public interest not served by GMC's decision to introduce a lower standard of proof' Medical News Today 28th August 2007, available at <http://www.medicalnewstoday.com/articles/80694.php> accessed 24th June 2008.

evidence necessary to reach a finding of impaired fitness to practise dependent upon the appropriate sanction to be applied.

A further aspect with regard to a fair trial is that of the reasoning behind the fitness to practise committee or panel's deliberations regarding the finding of impairment or the sanction imposed. Thus, although the HCP will receive notification of the outcome, they may not receive the reasoning behind their judgment or the sanction.

This has been raised recently in Threlfall v General Optical Council,¹⁰¹ where it was acknowledged that although there was '*no express statutory obligation on a Disciplinary Committee to give reasons for its decisions*'¹⁰², Burnton J was of the opinion that in order for the defendant to have an effective right of appeal '*Article 6 does require adequate reasons to be given by it [the adjudication committee] in good time for the right of appeal to be exercised*'.¹⁰³

More recently, the principle of giving reasons to the defendant for the sanction applied against them has been confirmed by the Court of Appeal where Wall LJ stated that '*very grave outcomes are at stake. Respondents to proceedings before the PCC [a previous adjudication committee of the GMC] of the GMC are liable to be found guilty of serious professional misconduct and struck off the Register. They are entitled to know in clear terms why such findings have been made*'.¹⁰⁴

Instances of the professional regulatory bodies exerting too harsh a sanction upon one of its registrants are not uncommon. A few cases will serve to illustrate this. For instance, in the Misra case,¹⁰⁵ the Privy Council held that the GMC had been excessive and disproportionate in erasing the HCP from the professional register and that a sanction of admonishment

¹⁰¹ Threlfall v General Optical Council [2005] Lloyd's Rep Med 250.

¹⁰² *Ibid*, at paragraph 29.

¹⁰³ *Ibid*, at paragraph 36.

¹⁰⁴ Phipps v General Medical Council [2006] Lloyd's Rep Med 345, at paragraph 86.

¹⁰⁵ Misra v General Medical Council (2003) 72 BMLR 108.

was more appropriate. Whilst in the case of Rao,¹⁰⁶ not only did the Privy Council consider the sanction too harsh, they also considered that incorrect advice had been given to the professional conduct committee as to what constitutes serious professional misconduct and thus the finding of the professional conduct committee was disputed. Furthermore the Administrative Court of the Queen's Bench Division found in Cream that not only had the professional conduct committee reached a wrong conclusion but that its conclusion was both irrational and perverse.¹⁰⁷

It is not just the HCPs clinical practice that will result in them coming before their professional regulatory body's professional conduct committee for, as noted in the Roylance case,¹⁰⁸ it is anything that has a sufficiently close link to their profession that may be considered by the professional regulatory body. In this case, Roylance was acting as a hospital Chief Executive Officer, a management position, and not undertaking any clinical activity.

As regards to the underlying philosophy to fitness to practise by the professional regulatory bodies, this aspect can be argued to cause the greatest concerns with regard to a fair trial that is impartial and independent. With respect to fitness to practise, the professional regulatory bodies undertake any investigation regarding allegations of impaired fitness to practise, determining which allegations are unfounded and which need to proceed to an adjudication hearing, following which they determine innocence or guilt and then set the sanction that is to be applied.

Following the principle in Gautirn and others v France concerning impartiality of a tribunal, it is not necessary to prove that there was an actual lack of impartiality but that the '*applicants fear* [of a lack of

¹⁰⁶ Rao v General Medical Council [2002] UKPC 6.

¹⁰⁷ R v General Medical Council, ex parte Cream [2002] Lloyd's Rep Med 292, see in particular paragraph 34.

¹⁰⁸ Roylance v General Medical Council (1999) 47 BMLR 63.

impartiality] *could be objectively justified*'.¹⁰⁹ That is, a tribunal, as well as being impartial, should be seen to be impartial.

With regard to the current fitness to practise procedures of the GMC and the NMC, an argument can be made that they lack the appearance of impartiality. Indeed it is questionable whether having one body undertake all these roles provides adequate protection for the rights of the HCPs concerned, and for the protection of the public, or whether it would be more effective to have separate bodies for the separate roles, a form of separation of powers.

It is noted that a legal assessor sits with adjudication panels to advise them of their legal powers and on matters of law. Additionally, the separation of fitness to practise procedures into investigation and adjudication stages is seen by this thesis as a move in the right direction in separating some of these functions.

However, the introduction of an independent adjudicator, the Office of the Health Professions Adjudicator (OHPA),¹¹⁰ is seen as being the crucial to fitness to practise hearings being impartial and independent. It will result in the GMC having a similar role to that which the Crown Prosecution Service has in criminal trials, with the OHPA acting as the judge and jury.

At present the OHPA is contained within the Health and Social Care Bill¹¹¹ before Parliament. It is not yet a feature of the legislative provision governing fitness to practise but it is identified by this thesis as a means of introducing impartiality and independence into fitness to practise procedures as they currently stand.

¹⁰⁹ Gautirn and others v France (App. Nos. 21257/93, 21260/93) [1998] ECHR 21257/93 at paragraph 55.

¹¹⁰ The Office of the Health Professions Adjudicator was a proposal in Secretary of State for Health (2007) Trust, assurance and safety – the regulation of health professionals in the 21st century Cm 7013 Department of Health, London, at paragraph 4.36, as a response to criticism of the role of the professional regulatory bodies in protecting the public from HCPs with impaired fitness to practise.

¹¹¹ Health and Social Care Bill 2007 – 08, available at <http://services.parliament.uk/bills/2007-08/healthandsocialcare.html> accessed 24th June 2008.

One issue with the current suggested provision with regard to the OHPA that is being proposed, it is only going to have an adjudication role for the GMC and the General Optical Council.¹¹²

Recommendation

Given the blurring of boundaries between the health care professions as examined in Chapter 3,¹¹³ and the fact that the professional regulatory bodies undertake the same functions as each other albeit with their own registrants, it is recommended that, when introduced, The Office of the Health Professions Adjudicator has their remit extended to cover all the health care professional regulatory bodies. Interestingly, in their report on the NMC published in 11 June 2008, CHRE supports this recommendation.¹¹⁴

A further advantage of the OHPA is that as an independent adjudicator it will remove some of the public vilification of the professional regulatory bodies that can occur regarding sanctions that are perceived as being too harsh or too lenient.

4.3.6 Interim Orders

Interim orders, examined in section 3.2.4 above, are an effective measure of providing immediate public protection from a HCP whose professional practise may be impaired. They may also be seen as being condemning upon the HCP who is subject to them, as Forbes J stated '*the protection of the public is vitally important, equally one to balance against that the needs of the doctor and the recognition that his livelihood together with the final stages of his medical career are at stake*'.¹¹⁵

¹¹² See sections 93 – 105 of the Health and Social Care Bill 2007-08.

¹¹³ In particular see sections 5 and 6.

¹¹⁴ See Council for Healthcare Regulatory Excellence (2008) Special report to the Minister of State for Health Services on the Nursing and Midwifery Council Council for Healthcare Regulatory Excellence, London, in particular page 17.

¹¹⁵ General Medical Council v Sathanathan [2008] EWHC 872 (Admin) at paragraph 37.

However, there have been instances where they have been used inappropriately as noted in General Medical Council v Uruakpa, where Collins J expressed concerns about the duration of time that the GMC had sought to impose an interim order stating '*interim orders mean what they say, they are interim and must be approached on that basis*'.¹¹⁶

Their use is governed within the fitness to practise legislation and they are only to be used when there is an immediate danger to either the public or the HCP concerned. In Madan v General Medical Council it was stated that there is a requirement that appropriate reasons are given as to the need for the interim order as well as disclosing how the interim order is proportionate to achieving public protection.¹¹⁷ They therefore fulfil the aim of public protection when used appropriately.

4.3.7 Sanctions

Once the decision of an HCP's impaired fitness to practise is made by a fitness to practise committee or panel, the question of sanctions is raised.

Any application of sanction has to be undertaken according to the professional regulatory body's established procedures. Both the GMC and the NMC, as established above in section 3.2.5, are governed by legislative provision with regard to the sanctions they can apply to a HCP.

With regard to the use of sanctions, Lord Scott of Foscote is of the opinion that '*their purpose is threefold, namely, the protection of the public, the maintenance of public confidence in the medical profession and the maintenance of proper standards of behaviour by medical practitioners*'.¹¹⁸ Although referring specifically to the GMC and the medical profession, Lord Scott of Foscote's comments may be equally applied to the NMC and the midwifery and nursing professions.

¹¹⁶ General Medical Council v Uruakpa [2007] EWHC 1454 (Admin) at paragraph 41.

¹¹⁷ Madan v General Medical Council [2001] EWHC 577 (Admin).

¹¹⁸ Crabbie v General Medical Council [2002] UKPC 45 at paragraph 24.

There should be justice apparent in the application of sanctions, and in the procedures that cover the application of sanctions. This should also address the provision of an appeal process for the HCP who has had a sanction applied against them.¹¹⁹ Any sanction applied needs to be demonstrable as being proportional to the breach committed by the HCP and the resultant need for public protection.

In order for the sanctions to be effective, they need to be enforceable. Whilst it is not disputed that both the GMC and the NMC have the legal authority to enforce sanctions applied by their fitness to practise committees and panels, these sanctions are not able to be applied immediately to the HCP, for instance they are not immediately erased from the professional register. Rather, as they have a right of appeal, twenty eight days have to lapse before the sanction becomes effective. If an appeal has been made, the sanction generally does not take effect until the outcome of the appeal.

With regard to proportionality, the aim is to balance the effect of the sanction upon the HCP with the need to achieve public protection. This is the responsibility of the fitness to practise committee or panel who, according to the judgment in Madan v General Medical Council, have to assure themselves '*that the consequences of the remedy on the applicant were not disproportionate to the risk from which it was seeking to protect the public*'.¹²⁰

As to the balance between the two this is not necessarily weighted equally. As stated in Singh v General Medical Council '*the [adjudication] Committee was entitled to take the view that the policy of preserving public trust in the profession prevailed over the strong personal mitigation which Dr Singh was able to put forward*'.¹²¹ Equally in Marinovich v General Medical Council it was held that '*the [adjudication]*

¹¹⁹ Appeals are examined in section 4.3.8 below.

¹²⁰ Madan v General Medical Council [2001] EWHC 577 (Admin) at paragraph 50.

¹²¹ Singh v General Medical Council Privy Council 13 May 1998 reported at LTL 12/6/98, at paragraph 7.

Committee was entitled to give greater weight to the public interest and to the need to maintain public confidence in the profession than to the consequences to the Appellant of the imposition of the penalty’.¹²²

Whether the public confidence would be harmed by the actions of the HCP, and the nature of the sanction to be applied, was considered in Giele v General Medical Council where Collins J was of the opinion that it is the ‘*views of an informed and reasonable member of the public*’ that should be considered.¹²³ Whilst in Meadow v General Medical Council, the test to be used is that of ‘*conduct which would be regarded as deplorable by fellow practitioners or properly informed members of the public*’.¹²⁴

As to what may be considered the public interest, it is not just public protection that is an issue. Lord Goff of Chieveley noted that ‘*it is however recognised that, from time to time, it is nevertheless necessary to impose such penalties, in the public interest, for the purpose of registering disapproval of unprofessional conduct and for maintaining high standards of conduct in the medical profession*’.¹²⁵

The range of sanctions available to the fitness to practice committees and panels¹²⁶ also provides the opportunity for proportionality to be addressed in the determination of the appropriate sanction to be applied in a particular case. The fact that the GMC is able to issue a warning to a HCP at the investigation stage means that they are able to address ‘minor’ concerns with a HCP’s fitness to practise in a manner that is both faster and less cumbersome than proceeding to the full adjudication stage.

The GMC case examiners are also able to agree undertakings with the HCP where aspects of their practice may be limited, the HCP may agree to work under supervision for a given period, or undertake education and training

¹²² Marinovich v General Medical Council [2002] UKPC 36, at paragraph 29.

¹²³ Giele v General Medical Council [2005] EWHC 2143 (Admin) at paragraph 33.

¹²⁴ Meadow v General Medical Council [2006] EWHC 146 (Admin) at paragraph 30.

¹²⁵ McMillan v General Medical Council (1993) Privy Council Appeal No 52 of 1992 Privy Official Transcripts at paragraph 11.

¹²⁶ See section 3.2.5 above.

on a particular issue. This is particularly appropriate when the issue behind the HCP's impaired fitness to practise is health related, as this may allow the HCP to receive the appropriate help to remedy their health problem as well as remedying their impaired practise.

All HCPs should be subject to similar regulation and sanctions for the same breaches of rules and regulations. Thus the fact that both the GMC and NMC have commonality in the sanctions available to them is a positive factor. However, there are differences in the application of sanctions, such as, the GMC are prohibited by statute from erasing a HCP from the professional register where their fitness to practise is impaired by their health, whereas the NMC are able to this in certain circumstances.¹²⁷

Recommendation

That the professional regulatory bodies adopt a more uniformed approach to the application of sanctions.

Although when making this recommendation, it is recognised that CHRE has recently undertaken a consultation of the harmonising of sanctions across all the HCP professional regulatory bodies which ended in February 2008. The outcome of the report has been presented to the CHRE Council but no strategy has yet been identified that would harmonise sanctions across the professional regulatory bodies.¹²⁸

4.3.7a Guidance regarding sanctions

Both professional regulatory bodies have produced excellent guidance for their fitness to practise panels on sanctions, which includes information on the purposes of sanctions, proportionality and the use of sanctions.¹²⁹

¹²⁷ See section 3.2.3 above.

¹²⁸ Council for Healthcare Regulatory Excellence (2008a) Harmonising fitness to practise sanctions across regulators Council for Healthcare Regulatory Excellence, London. Paper 3 presented to CHRE Council on 11th June 2008.

¹²⁹ The GMC guidance is General Medical Council (2005) Indicative sanctions guidance for fitness to practise panels General Medical Council, London; the NMC guidance is Nursing and Midwifery Council (2008a) Indicative sanctions guidance for panels of the Conduct & Competence and Health Committees Nursing and Midwifery Council, London.

4.3.8 Appeals

The HCP has a right of appeal under the legislative provisions governing fitness to practise procedures.¹³⁰ An appeal is to the High Court and there are set timeframes and processes for making the appeal.¹³¹ For instance, HCPs are not allowed to appeal regarding certain conditions that have been placed on their registration. In Meagher v General Medical Council it was held that the correct course of action would be to seek a variation of the disputed condition through the GMC's fitness to practise processes.¹³²

As to whether the courts are entitled to consider the decisions of the fitness to practise committees and panels of the professional regulatory bodies, the case of Ghosh v General Medical Council, provides relevant guidance. Here the Privy Council held that whilst they '*would accord an appropriate measure of respect to the judgment of the [adjudication] Committee ... it would not defer to it more than warranted*'.¹³³ The implications of this case and its judgment are that the courts are able to substitute their own judgment for the one of the professional regulatory body and can effectively hear any appeal as a rehearing of the original professional regulatory body case.

With regard to decisions that are considered to be unduly lenient, in order to provide public protection, CHRE has the power to refer the decision of fitness to practise panels to the High Court.¹³⁴ CHRE is able to review the decisions of both the GMC and the NMC fitness to practise committees and panels, where they have not erased a HCP from their respective professional registers.

¹³⁰ For the GMC this is contained within section 40 of the Medical Act (1983) (consolidated version with amendments), whilst for nursing and midwifery this is within the Nursing and Midwifery Order 2001 (SI 2002/253) at article 38.

¹³¹ Generally the HCP has twenty eight days in which to make their appeal.

¹³² Meagher v General Medical Council [2006] EWHC 2303, the correct process would be through section 35D(12) of the Medical Act (1983) (consolidated version with amendments)

¹³³ Ghosh v General Medical Council [2001] Lloyd's Rep Med 433, at page 433.

¹³⁴ National Health Service Reform and Health Professions Act 2002, section 29.

This function of CHRE, to challenge decisions of the professional regulatory bodies, was unsuccessfully challenged in the case of Ruscillo,¹³⁵ where Dr Ruscillo had been acquitted of serious professional misconduct by the GMC but CHRE had sought to refer the case to the High Court. Dr Ruscillo argued that CHRE had no authority to refer his case as he had been acquitted by the GMC and that CHRE only had the power to refer cases where the sanction applied was too lenient and not to refer a not guilty finding. However, it was decided in this case that CHRE has the right to refer cases both where the sanction applied was considered lenient and when a HCP is acquitted by the professional regulatory body.

There has also been the ludicrous situation where the GMC had to request CHRE to consider a judgement it had made as the GMC itself had concerns it was too lenient!¹³⁶ This situation occurred because the GMC currently acts as prosecutor, jury and judge, and is therefore unable to appeal itself as this would mean that it was appealing its own procedures and decisions. This situation would be removed following the establishment of the OHPA because, as discussed in section 4.3.5 above, it would remove the jury and judge role, the adjudicator role, from the GMC.

The right of appeal is a final protection mechanism for the HCP, and for public protection through CHRE, until such time as the OHPA is established and this right becomes a function the GMC.¹³⁷

4.3.9 Restoration to the register

Having a process whereby a HCP who has been erased from the professional register may apply to have their name restored to the register is right and proper if fitness to practise procedures are to achieve an aim of protecting the public and promoting patient safety without being

¹³⁵ Council for the Regulation of Health Care Professionals v General Medical Council and Dr Giuseppe Antonio Ruscillo [2004] EWHC 527 (Admin).

¹³⁶ General Medical Council (2004a) Press release 'GMC statement concerning Dr Bee' 4 October 2004, General Medical Council, London.

¹³⁷ If the recommendation at section 4.3.5 above is adopted, then the right of appeal will also apply to the NMC.

draconian or unfair to the HCP. Section 3.2.7 above provides details of the processes involved in restoration to the professional registers.

It is an important principle of restoration hearings that they should not be designed to rehear the original allegation or to reapply sanctions to the HCP; rather they should be intended to determine if the public needs further protection from the individual HCP or if the HCP's fitness to practise is such that they can be restored to the professional register.

With regard to the fact that both the GMC and the NMC may suspend a HCP's right to seek restoration to the register, it was found in Gosai v General Medical Council that a '*suspension direction was not inappropriate or excessive*'¹³⁸ and that the public interest consideration was paramount.

Conclusion

This chapter has analysed how the fitness to practise element of regulation contributes to the overall regulatory aim of public protection and patient safety. This conclusion considers whether it is fit for purpose, that is, that it provides for public safety whilst at the same time enabling the HCP's clinical autonomy.

There are many ways in which a HCP's fitness to practise can be impaired. The GMC's document 'the meaning of fitness to practise' provides the following:

- *'a doctor's performance has harmed patients or put patients at risk of harm; ...*
- *a doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients; ...*
- *a doctor's health is compromising patient safety; ...*
- *a doctor has abused a patient's trust or violated a patient's autonomy or other fundamental rights; ... [or]*

¹³⁸ Gosai v General Medical Council (2004) 75 BMLR 52, at paragraph 24.

- *a doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others*.¹³⁹

This range of impaired practise may equally be applied to nurses and midwives.

As is demonstrated by the above list, there is a considerable range of issues that can lead to a finding of impaired fitness to practise. The respective fitness to practise procedures of the GMC and the NMC must be able to address each issue identified.

It is important to note that both the GMC and the NMC have to consider their primary aim of public protection and patient safety in their fitness to practise procedures. These procedures are solely used to achieve this aim. The public, and patients, should be able to trust the HCPs who treat them, and have confidence that they will be treated according to the agreed standard. Any sanctions that are ultimately applied through their fitness to practise procedures must be used for this reason alone.

As to whether this element of regulation is capable of achieving its primary aim, the analysis above has explored and demonstrated how this element of regulation contributes to public protection and patient safety. By assessing a HCP's fitness for practise through fitness to practise committees and panels and being able to take sanctions against those HCP's whose practice falls below the required standard, this element of regulation is able to remove those HCP's whose practice is considered to pose a danger to patients and the public.

However there should be two aspects to the role of the professional regulatory bodies with regard to fitness to practise. These are the removal from patient contact of those HCPs who are unfit to practise; and also the assistance that is offered to those who are declared to be unfit to practise, so that they may be able to undertake practice again in the future, if this is

¹³⁹ General Medical Council (2001a) The meaning of fitness to practise General Medical Council, London, at pages 2 and 3.

achievable, particularly where the HCP is deemed unfit to practise for a health reason, for example, imposing a requirement that a HCP receives counselling for an addiction problem.

It is this latter aspect that is seen as part of the enabling side to this element of regulation. Through the use of cautions, warning, undertakings, conditions on practise and suspension, and consideration of the HCP's health within fitness to practise proceedings, the HCP whose practice is impaired is given the opportunity to achieve the required standard in their practice, to return to the professional register. The use of local procedures to investigate and manage appropriate allegations, and the use of earlier stage sanctions, might mean that the HCP would not need to be removed from the professional register to achieve public protection.

The public, as evidenced above in this chapter, can have confidence that the professional regulatory bodies are effective in providing public protection through their fitness to practise procedures. There is a legislative basis which gives them the necessary authority to both act upon allegations and to impose sanctions. The range of sanctions available to the professional regulatory bodies, including the use of interim orders, is seen as being key in providing adequate public protection. There is a transparency in the fitness to practise procedures that each professional regulatory body utilises, although it has been recommended that the NMC follow the example set by the GMC in providing access to documentation on its procedures and advice to its committee and panels.

The introduction of the civil standard of proof has been identified as a positive step for the GMC with regard to increasing public protection through being able to decide an allegation on the lesser standard of proof than was previously used by the GMC. It was noted that the NMC has yet to implement the civil standard of proof, and as such is not as effective as the GMC in this regard.

With regard to the undertaking of fitness to practise hearings themselves consideration was given to the need for a fair hearing for the HCP themselves. Principles of a fair hearing were discussed and it was noted that these have been judged upon in cases before the courts with the result that the HCP is better protected with regard to having a hearing that is timely, in public where appropriate, and to receive reasons both for the outcome reached and for any sanction to be applied.

With regard to the independence and impartiality of fitness to practise proceedings as a whole, the separation of the investigation and adjudication stages goes some way to achieving this. However, it was postulated that the introduction of a separate adjudicator, independent of the professional regulatory bodies, will be needed for this to be seen to be free from any perceived bias or partiality. Therefore the proposed introduction of The Office of the Health Professions Adjudicator is welcomed by this thesis. Although, the fact that this will only apply to the GMC, and, not to the NMC, is seen as a missed opportunity and recommendation was made that its remit be extended to cover all professional regulatory bodies.

This element of regulation, fitness to practise, is seen as being generally fit for purpose; it will be fully so when the independent adjudicator has assumed their proposed role. The element provides public protection and patient safety through the fitness to practise procedures of the professional regulatory bodies and the use of sanctions against those HCPs whose practise is deemed to be impaired. It is enabling in that it provides opportunity for HCPs to improve their practice to the accepted standard and, where necessary, to be restored to the professional register. It is also enabling in that HCPs are provided with the opportunity for a fair hearing on any allegation made against them. Having a fitness to practise procedure does not remove the HCP's autonomy in undertaking their practice, where they do so according to the agreed standard.

Those HCPs who undertake their professional practice according to the agreed standards will not face the sanctions that the professional regulatory bodies can impose on their registrants. The reason for fitness to practise procedures is to ensure that those whose practice is not in accordance with the agreed standards can be managed and not allowed to continue to undertake their impaired practice.

It could be argued that where the professional regulatory bodies have to issue sanctions against their respective registrants this reflects upon their ability to provide effective regulation, as it implies that there are poorly performing HCPs in practice. However, this is not the view taken by this thesis as this is seen as the professional regulatory bodies undertaking their role effectively to achieve their primary aim, public protection and patient safety. By imposing sanctions against HCP's whose practice is not to the required standard, the professional regulatory bodies are acting upon instances of poor practice and performance and thereby reducing their occurrence.

Thus, where there is a need to impose a sanction this is not an issue with the validity of the regulation, but rather of the HCP. As Sir Thomas Bingham MR stated in Bolton v Law Society '*the reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but ... [the imposition of a sanction when appropriate] is a part of the price*'.¹⁴⁰

¹⁴⁰ Bolton v Law Society [1994] 2 All ER 486 at page 494.

Part 5

Conclusion and summary of recommendations

Introduction to Part 5

The part of the thesis draws together the preceding parts in a summary and presents a list of the recommendations made earlier. It then discusses some of the recommendations before drawing a conclusion as to whether the current regulation of HCPs is fit for purpose.

1. Thesis summary

This thesis has examined the regulation of health care professionals (HCPs) within England. The aim of the thesis is to determine whether or not the current form of regulation of HCPs is fit for purpose.

The hypothesis proposed is that the regulation that HCPs are currently subjected to is not an effective and efficient means of regulation, that the regulation of HCPs is not fit for purpose and that there need to be changes within the regulation of HCPs for it to become fit for purpose.

Part 1 introduced the thesis by examining the nature and purpose of regulation in Chapter 1. This included the examination of the nature and purpose of regulation in the health care context. It undertook this through consideration of: what is regulation; the forms of regulation that exist; the reasons for regulation of HCPs; what is being regulated; and regulation as enabling for the HCP. It was suggested that whilst self-regulation had been the dominant form of HCP regulation in the past, this was not the case at present and that there had been a move toward state-sanctioned regulation. One of the main aspects of Chapter 1 was to provide the definition of regulation that was used throughout the thesis. Two definitions of regulation were advanced and the 'narrow' definition was considered as providing the framework for analysis in Part 4. It identified five key elements that would need to be regulated in order for regulation of HCPs to achieve its purpose of public protection and patient safety.

Following the examination of the nature and purpose of regulation, Part 2 of this thesis set the scene and context of the area of inquiry with which the thesis was concerned. It undertook this in two ways. Chapter 2 addressed the context of health care in which HCPs work. It was observed that the majority of HCPs work within the National Health Service (NHS). The NHS itself was examined and its structure discussed from inception to current form. It was noted that elements of the structure of the NHS have had an impact upon the nature of HCP regulation, for instance, the power base that the medical profession established for itself.

Chapter 3 developed the theme of this thesis by examining the nature of being a professional, addressing what is meant by the term HCP, and identifying who is being regulated. A major feature of this chapter was the examination of the roles and responsibilities of HCPs, and the changes that have occurred in recent years in the roles of HCPs. It was proposed that there is a blurring of boundaries between the various HCP groups.

This chapter also raised the fact that there are other groups involved in delivering health care to patients within England and that these are not classified as HCPs but rather as health care workers, because they do not meet the criteria of professional presented earlier in the chapter. It was noted that these health care workers are not currently subject to any form of regulation outside their employment.

Part 3 of the thesis provided a contextual basis to the types of regulation to which HCPs are currently subject, by applying the 'wide' definition of regulation identified in Chapter 1 to a framework, based upon the work of Bosk, that considered regulation to fall within the classifications of internal – external and informal – formal. This resulted in examination of regulation that HCPs are subject to that fall outside of the 'narrow' definition but which may influence the regulation within the 'narrow' definition utilised by this thesis.

Part 4 of this thesis analysed the 'narrow' definition for regulation, that of the professional regulatory bodies, to determine if the regulation of HCPs is fit for purpose. Chapter 5 presented an overview of the professional regulatory bodies, the General Medical Council and the Nursing and Midwifery Council, and examined recent changes to their composition and functions. Chapters 6 to 10 each examined one of the five elements of regulation considered to be necessary for regulation to achieve its primary aim and analysed its contribution to the overall process of regulation and whether as an element it was fit for regulatory purpose. Each of Chapters 6 to 10 also provided a commentary on their respective element of regulation and put forward recommendations that were considered to be necessary for regulation to be fit for purpose.

2. Recommendations

This section presents a summary of the recommendations from Chapters 6 to 10.

Protection of titles and registration

- That new titles be protected
- That all HCPs undergo provisional registration for one year
- That registration fees are based upon a percentage of HCP income
- That health care workers are 'registered' with a regulatory body
- That there is a single register of HCPs
- That all HCPs notify the professional regulatory body of their intent to practise each year

Education for initial registration

- That the professional regulatory body continues to maintain the professional register

- That a register is maintained of students on pre-registration courses that lead to provisional registration

Clinical competence

- That continuing professional development (CPD) is linked to registration for all HCPs
- That the CPD requirement is consistent across the professional regulatory bodies
- That there are clear definitions of new roles
- That there is a clear, robust, formalised framework for post-registration education
- That statutory supervision is extended to all HCPs
- That every HCP undergoes periodic revalidation
- That there is a support mechanism for under performing HCPs whose practice is not seen as harmful to patients

Standards for performance

- That there is a single code of conduct for all HCP groups

Fitness to practise

- That all professional regulatory bodies take the opportunity to refer appropriate allegations for local investigation and management
- That all professional regulatory bodies publish a self-contained booklet regarding their fitness to practise procedures
- That Council members of the professional regulatory bodies are excluded from sitting on any fitness to practise committee or panel
- That all professional regulatory bodies publicly publish guidance for their Committee members
- That, when introduced, The Office of the Health Professions Adjudicator has their remit extended to cover all the health care professional regulatory bodies

- That the professional regulatory bodies adopt a more uniformed approach to the application of sanctions

3. Discussion of recommendations

The primary aim of regulation is protection of the public and patient safety. This includes having trust that the HCP has achieved the necessary standard to attain registration with the professional regulatory body.

In order to be an effective method of regulation, the regulatory framework needs to have the confidence of the public and those being regulated. There should be a statutory framework within which the regulatory regime works, providing the necessary authority, and an element of statutory control.

The regulatory body should have an element of lay-membership, as well as membership drawn from the relevant profession, to ensure that, whilst professional expertise is acknowledged, there is not professional dominance of the regulatory processes.

Although students are regulated by educational institutions, it is thought that public protection would be more effective if the professional regulatory bodies undertook the regulation of HCPs 'from cradle to grave'.

There should be identified standards against which those regulated will be judged; these should be incorporated into codes of conduct issued to those who are being regulated. In order to be effective, the rules and regulations have to be known by those who are being regulated and by those who enforce the regulation, their purpose must be understood and they have to be applicable to the practice they are regulating.

Any breach of the recognised codes of practice or conduct should be dealt with by a clear procedure designed for the purpose; sanctions should be publicised

and fair. There should be a procedure by which individuals can complain about HCPs, which should be transparent, accessible and well-publicised.

The regulatory bodies need to ensure that their processes and procedures comply with the provision of the Human Rights Act 1998, most notably Article 6.

A number of recommendations suggest that there must be consistency across the professional regulatory bodies and taken together these may be addressed by the creation of a single regulatory body for HCPs. This also relates to the recommendation to have a single adjudicator, as this thesis considers that it is not the purpose of the professional regulatory bodies to act as judge in fitness to practice hearings. Rather, their role is to set the standard, identify those HCPs alleged to be breaching the standard and bring them forward for judgment.

Conclusion

The hypothesis of this thesis is that the regulation of HCPs is not fit for purpose and that changes need to be made in order for that regulation to become fit for purpose. It is this hypothesis that this conclusion addresses.

Taken individually, none of the five elements of regulation - protection of titles and registration, education for initial registration, clinical competence, standards for performance, and fitness to practise - provide regulation that is fit for purpose.

However, when taken altogether it may be said that a coherent regulatory framework exists for the regulation of HCPs. As has been demonstrated within this thesis, the professional regulatory bodies undertake all five elements of regulation. They protect the titles of HCPs through the maintenance of the professional register; they set the standard required for pre-registration education and the competencies necessary to achieve initial

registration; they determine the competence required for continued registration and for advanced practice; and they set the standards of performance expected of every HCP. Where necessary, they enforce the first four elements through their fitness to practise procedures; the ultimate sanction being that a HCP who is not fit to practise is unable to do so.

For regulation to be fit for purpose all five elements need to be co-ordinated effectively.

With regard to the current regulatory framework, this thesis has concluded that three of the five elements are individually fit for purpose, another achieves its primary aim but could be more effective, whilst one is not fit for purpose.

Protection of titles and registration, education for initial registration, and standards for performance all achieve the primary aim of regulation, that of public protection and patient safety. As they enable the HCP, as well as controlling them, they can be said to be fit for purpose as analysed in their respective chapters above. Fitness to practise may be said to achieve its regulatory aim but as the commentary within its chapter suggests, there is scope for improvement and increased effectiveness. It is the element of clinical competence that fails in the primary aim of regulation. At present neither of the two professional regulatory bodies examined within this thesis has a coherent mechanism or framework for ensuring that its registrants are competent at the point of each renewal of registration. Until this is in place, public protection will not fully exist as failing HCPs will be allowed to continue their practice until they are identified by some other mechanism and undergo the professional regulatory body's fitness to practise procedures. At that point the public receives the protection it deserves. However, it should not be for an agency external to the professional regulatory body to undertake this role and identify possible failing HCPs.

The changes that have occurred to the constitution and roles of the professional regulatory bodies, over the past few years, have increased public protection and have also increased the enabling mechanism inherent within the regulatory framework. That this is so is a revelation for this thesis as, at the outset of the process of research for this thesis, it was thought that the regulation of HCPs was a controlling mechanism and that it was too controlling at the expense of being enabling. However, as has been demonstrated in the chapters above, the various elements of regulation are enabling for individuals HCPs as they allow HCPs to undertake their clinical practice through the setting of boundaries for that practice and that, where the HCP remains within that boundary, they are unfettered to so so, provided they adhere to specific requirements for renewal of registration.

It may be stating the obvious to say that regulation of HCPs is controlling in that it puts rules and procedures in the way of the HCP and prevents them from doing anything that they wish by putting boundaries around their practice. However, when the question of why this occurs is explored, it is identified that this is in order to achieve the primary aim of public protection and patient safety. The next question that needs to be addressed is, is this justifiable, is it a reasonable restriction on the HCP or does it remove too much of their autonomy and hence all its enabling quality? The answer to this, as demonstrated in the chapters above, is that the regulatory framework of the professional regulatory bodies only controls those areas where it is necessary for it to do so, to prevent abuse of the primary aim. The professional regulatory bodies are not an all controlling mechanism. They provide opportunity for HCPs to undertake their professional practice and even to advance their practice should the HCP so wish.

Each of the five elements of regulation, as discussed within their respective chapters above, is enabling for the HCP. Overall they present a framework, that represents the agreement between society and the profession. HCPs are allowed to exercise their autonomy, but within set parameters; parameters

that have been judged to represent patient safety and public protection. The professional regulatory bodies undertake to regulate those parameters on behalf of society and do not interfere with lawful exercise of that autonomy.

The fact that some HCPs are prevented from undertaking their professional practice, whether either temporarily or permanently, is a consequence of the agreement between society and the profession. Without that mechanism in place, the public would not have the protection they require, or deserve. It is a consequence of having autonomy in their professional practice that those found to abuse the autonomy given to them will be sanctioned when found to be doing so.

In order to be enabling as well as controlling, the regulation in place has to ensure that the controlling aspect does not disproportionately affect those who are safe and competent in their practice. This is not thought to be the case with the current regulatory framework of the professional regulatory bodies.

This thesis considers that the proposals for changing the current regulatory framework that are yet to be implemented will only further increase the regulatory effectiveness of the professional regulatory bodies in achieving their primary aim.

As to whether the hypothesis has been proved, the current regulatory framework of the professional regulatory bodies does not provide an effective form of regulation to achieve the primary aim of regulation in all five elements, therefore the hypothesis has been proved. The public are not fully protected and patient safety not guaranteed by a regulatory system that requires failing HCPs to be identified by means other than the regulation exercised by professional regulatory bodies. Until the regulation of HCPs is such that it undertakes monitoring of HCPs performance and is thereby able to identify failing HCPs, whether this be through their conduct or their competence, regulation will not be fit for purpose.

There is not a need for more regulation but for more effective regulation, effective in being able to provide full public protection and patient safety. This thesis considers that the recommendations it has put forward will achieve that effectiveness.

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