Health Professions Council
Health Committee, 7th November 2006

Standards of conduct, performance and ethics: Reports from the discussion meetings and council away day

Executive Summary and Recommendations

Introduction

On 25th and 29th September 2006 meetings were held with representatives from patient groups and with professional bodies and unions to discuss the review and invite feedback on the standards. The standards were also discussed by the council at its away day on 4th October 2006.

The attached paper is a report of the discussion meetings and away day.

The paper also includes a summary of responses received from organisations as part of the 'Call for ideas' which were not included in the paper considered at the last round of committee meetings.

Decision

This paper is invited to discuss and consider the attached paper together with the paper 'Draft standards'.

Background information

None

Resource implications

None

Financial implications

None

Background papers

None

Appendices

None

Date of paper

12th October 2006

Standards of conduct, performance and ethics – discussion meeting, 25th September 2006

Attendees:

Patricia Wilkie – National Association of Patient Participation Groups (PW)
Monica Kreel – Disability Rights Commission (MK)
Keith Ross – Chair of Conduct and Competence Committee
Morag MacKellar – Chair of Investigating Committee
Jacki Pearce – Deputy Chair of Health Committee
Marc Seale – Chief Executive and Registrar
Victoria Nash – Communications Director
Michael Guthrie – Policy Officer

Main topics of discussion

Public Expectations

1.1 PW drew attention to the recent Picker Institute Study[1] which revealed that there was a divergence in perspective between what patients consider as important in the conduct and performance of their doctors and the perspectives and actions of the regulator.
1.2 The report revealed that patients expected their doctors to be competent and caring professionals and valued communication skills more highly than other attributes. The patients interviewed were less concerned with matters which arise outside of a doctor's professional practice (such as dishonesty or personal relationships).
1.3 PW felt that it was important to recognise that public expectations change rapidly and that regulators and other public bodies had historically been very slow to respond to these changes. Therefore the standards may well need regular up dating to ensure that they conform with public expectations.

Disability discrimination act

1.1 MK explained the project currently being undertaken by the Disability Rights Commission looking at barriers to access to regulated professions. The project is being undertaken with specific reference to teaching, social work and nursing. It is looking at the nature and extent of any barriers for disabled people seeking to enter regulated professions – including looking at regulatory standards and practice in education.
1.2 MK was keen to ensure that the standards didn't act as a barrier to disabled people becoming or practising as health professionals. In particular, she highlighted that disabled people were often worried about statements which encouraged disclosure

[1] Picker Institute Europe (Alison Chishol, Liz Cairncross and Janet Askham), Setting standards: The views of members of the public and doctors in the standards of care and practice they expect of doctors (commissioned by the GMC), March 2006, http://www.gmc-uk.org/guidance/good_medical_practice_review/setting_standards_final_march_06.pdf.

because of the possible repercussions. She suggested a more positive statement about disclosure and the support available for reasonable adjustments.

1.3 There was much discussion about whether this was possible, given the role of the regulator in protecting the public, which might include removing a registrant from practice.

1.4 There was general agreement that we might achieve something more positive by looking at changing the emphasis in standards 4 and 12. Disclosure might be more encouraged by explaining what we do with the information we receive and by moving the focus away from the potential of fitness to practise action by emphasising the positive duty of registrants to self-report to HPC and to make adjustments to their practise where necessary and appropriate.

Other points

1.1 There was some discussion about whether the use of "patients, clients and users" in the standard was appropriate and accessible for members of the public.

1.2 PW pointed out terminology can be important – someone visiting a pharmacist for prescribed medication would not normally consider themselves to be a patient of the pharmacist. However, PW concluded that generally 'patients' was a more accessible term.

1.3 The meeting discussed standard 16 which refers to a registrant not behaving in a way which might damage the reputation of their profession.

1.4 It was generally felt that in fitness to practise proceedings it was not necessarily the profession's reputation which was most important but the individual's reputation as a health professional.

1.5 It was suggested that we should consider adding a contents page and glossary to the standards.

Standards of conduct, performance and ethics – discussion meeting, 29th September 2006

Attendees:

Representatives attended from the following organisations:

British Association of Art Therapists
Institute of Biomedical Science
Alliance of Private Sector Chiropodists and Podiatrists
British Chiropody and Podiatry Association
Institute of Chiropodists and Podiatrists
Society of Chiropodists and Podiatrists
Association of Clinical Embryologists
Association of Clinical Scientists
College of Occupational Therapists
Association for Perioperative Practice
British and Irish Orthoptic Society
Chartered Society of Physiotherapists
British Association of Prosthetists and Orthotists
Society and College of Radiographers
Royal College of Speech and Language Therapists
British Psychological Society
Association of Professional Ambulance Personnel
Unison
Council for Healthcare Regulatory Excellence
Prince's Foundation for Integrated Health
Integrated Healthcare Advisory Services

Also in attendance:

Keith Ross – Council member
Morag MacKellar – Council member
Jack Pearce – Council member
Kelly Johnson – Director of Fitness to Practise (part)
Michael Guthrie – Policy Officer
Sam Mars – Policy Officer (part)

Main topics of discussion

Principles, structure, terminology

The standards should:

- focus where possible on providing guidance to registrants based around our expectations of their behaviour;
- be based on overarching principles which some further detail on key points (with more detailed guidance available elsewhere);
- be clearly applicable to all registrants including those engaged in research, clinical practice, education and roles in industry;
- be written in broad terms to accommodate changes in best practice, technology, legislation and in wider society; and that
- they should not seek to cover every situation which might arise in a registrant's professional life or in fitness to practise proceedings.

Questions:

- What are your expectations of the standards?
- In your experience, how do registrants view the standards?
- Are the principles appropriate?
- Are there any which are missing?
- Do the existing standards meet these principles?

1.1 There was broad acceptance of the principles used.
1.2 One group said that the standards should allow room for professional judgement.
1.3 There was agreement that the standards should be written in broad terms, with guidance available elsewhere (including professional body guidance).
1.4 There was unanimous agreement that it was important for there to be links to professional body guidance.
1.5 One group felt that it was difficult for the standards to be applicable to registrants in every area of practice – for example, those engaged in research.
1.6 One group felt that though the paragraphs were dense, they shouldn't be segmented any further
1.7 A number of groups thought that the division in the standards between conduct, performance and ethics was arbitrary and that ethics and ethical behaviour was an underpinning concept.
1.8 There was agreement that short standards were preferable to adding more detail.
1.9 One group commented that the terminology used tended towards the medical rather than the social model.
1.10 One group thought that clarification was needed as to which part of the paragraph was the standards. Was it the line in bold? Was the paragraph beneath guidance about meeting the line in bold? Was both the line in bold and the paragraph to be considered the standard?

Introduction

Questions:

- What do you think of the existing introduction?
- Should we remove information relating to fitness to practise proceedings?
- What additional information should it include?
- How might we make clearer the relevance of the standards to prospective registrants?

1.1 A number of suggestions were made regarding the introduction. In particular, echoing the comments made in relation to the principles, participants felt that we should refer to professional body publications and standards.

1.2 It was generally felt that although the information given about allegations was necessary, we should try to make the introduction more positive in focus.

1.3 The British Psychological Society reported that they had added a decision making section to their code in light of the queries they received. The section encouraged members to use the code as the basis on which they could make informed, reasonable decisions about their own practice.

1.4 A number of groups felt that it was important to make links to the standards of proficiency very clear in the document.

1.5 Two groups suggested that we might change the emphasis of the standards by moving the section on allegations to the back.

1.6 One group said that the introduction should consistently address registrants throughout.

1.7 It was suggested by a number of groups that the summary on page 2 might be moved and given more emphasis to aid understanding.

1.8 It was felt by some groups that the section printed on the inside cover of the standards was hard to read given the colour of the text and cover.

1.9 It was suggested that we might rephrase the following statement on page 1 of the introduction: "We might also take account of codes of ethics issued by professional bodies, if these are relevant". It was felt that it should say "we will take account… if these are relevant".

1.10 Two groups suggested that we might wish to address the audience of prospective registrants more explicitly.

1.11 One group felt that it was difficult to produce a document which was accessible by both the public and registrants and that we might consider providing separate information for each of these audiences.

Standards 1 to 4

Questions:

- Does paragraph 1 adequately cover the issues around gifts from patients, child protection and sexual relationships with patients? Do the standards need to be more explicit about these areas?
- Do you think standards 1 and 4 are clear enough about the positive duty of health professionals to report concerns which might affect patients, clients or users? Do you think there is any duplication?
- What are your views on the current requirement for registrants to tell us about significant changes to their health and any changes they have made to their practice?
- Is standard 3 clear enough in explaining that conduct outside of professional life is important and could affect registration?

Standard 1:

1.1 Several groups commented that gifts from patients were not adequately covered in the standards. One group said that we should include explicit information about this subject; another group said that registrants should abide by the policies of their employers regarding gifts of a nominal value.
1.2 Two groups felt that the standards needed to be stronger on personal relationships. Another group discussed the issues around personal relationships but felt that it would not be helpful to include further detail.
1.3 It was felt that child protection was not adequately covered in the standard.
1.4 One group felt that it was important to make reference to the duty of registrants to take action when systems or policies, as well as the conduct of others, might put patient safety at risk. In addition, it was felt that we should ensure that the standards were consistently positive in all the places where registrants were encouraged to report concerns.

Standard 3:

1.1 Two groups commented that it was important that this standard made it clear that it was not only supplying drugs which could lead to the denial of registration, or a striking-off order, but using drugs as well.
1.2 Another group commented whether it was appropriate to refer to drink driving offences where someone was hurt or killed – would it not be more appropriate to just refer to drink driving?
1.3 One group asked what we meant by high standards. They said that the information given under this paragraph implied that high standards were the absence of any convictions and cautions.

Standard 4:

1.1 Some participants drew attention to the bullet points on page 4 and asked what the threshold was for employer referrals to HPC.

1.2 It was felt that the top paragraph of page 5, regarding reporting significant changes to health, needed clarification about what types of information we would expect to receive – it would need to be relevant to scope of practice.
1.3 It was suggested that it should also be supplemented to include information about insight and understanding and should be written in a positive way.

Standards 5 to 8

Questions:

- In relation to standard 6, are there any issues about referring to unregulated professionals?
- Is the current standard on supervision appropriate? Should a health professional always remain responsible for the outcome of a task they have delegated? Are there any other issues about delegating to assistants or students?

Standard 5:

1.1 A number of participants felt that this standard should now refer explicitly to our standards for CPD.
1.2 One group felt that the standard was incorrect in that it required registrants who were not engaged in clinical fields to still maintain minimum standards of clinical practice, at variance with the standards of proficiency.
1.3 One group suggested that we include information for registrants about mechanisms for regaining their skills if they have been out of clinical practice in a certain area and wish to return.

Standard 6:

1.1 This standard was identified as a key area with professions constantly evolving and with the agenda of modernising workforces.
1.2 There was some discussion around the differences between referral, recommendation and delegation.
1.3 One group had a lot of discussion around referral to unregulated professionals. They felt that it was inappropriate to implement a "blanket ban". However, registered professionals had a duty of care to ensure that the referral was appropriate and that patients are clear on the basis upon which the referral is being made.

Standard 7:

1.1 There was some discussion about whether this standard should be supplemented to specify different ways of communicating including situations where patients do not speak English.
1.2 Another group commented that there was an overlap with this standard and standard 2 on confidentiality (i.e. confidentiality in communication with others) and that sometimes maintaining confidentiality and maintaining effective communications can be conflicting responsibilities.

Standard 8:

1.1 Supervision and delegation were seen to be difficult issues as it was sometimes unclear where the boundary between professional and non-professional lay.
1.2 There was a lot of discussion about whether it was appropriate to say that a professional was responsible for the outcome following delegation. It was suggested that with students, the professional should always stay responsible. There was also discussion about the nature of team working and supervision.

Standards 9 to 12

Questions:

- Should we say that registered health professionals should countersign the records of students? How about assistants?
- Should we add information about the importance of contemporaneous records?

Standard 9:

1.1 It was suggested that we might specify that consent should be verbal or written

Standard 10:

1.1 There were comments about the references in the standard to "writing and signing entries". It was felt that the advent of the electronic patient record may necessitate a change to this standard.

Standard 11:

1.1 It was felt that standard 11 might be too narrow in focus and should encompass negotiating health and safety risks and all other risks. It might be appropriate to rephrase this task as relating to "risk analysis".

Standard 13 to 16

Questions:

- What are the key principles in this area? Do you think that there is any overlap between the standards?
- Do health professionals have 'special responsibilities' which go beyond those expected of other people?
- With the focus now on protection of the public and maintaining public confidence, is it appropriate for us to refer to the "reputation of the profession"?

Standard 13:

1.1 It was felt that it was appropriate to refer to special responsibilities but that this doesn't mean "sweaky clean."
1.2 It was felt that this standard could be more concise – the part which refers to HPC's responsibilities rather than those of the registrant, should be removed.

Standard 15:

1.1 It was suggested that this standard might be broadened to refer more widely to issues around conflict of interest. However, there was no clear agreement amongst the wider group whether this would happen.
1.2 Another group commented that knowledge was not always scientific.
1.3 It was suggested that the standard might be reduced in length or removed with signposts for guidance available on the HPC website.

Standard 16:

1.1 There was discussion over whether the emphasis in this standard should be on the profession's reputation, or on confidence in and the reputation of individual professionals.
1.2 There were some suggestions for restructuring the standard.

Standards of conduct, performance and ethics – Council away day discussion, 4th October 2006

Attendees:

Registrant, alternate and lay council members and staff

Structure of discussion:

Small group discussion amongst five groups with facilitators

Main topics of discussion

Principles

1.1 It was felt that the principles were appropriate. The standards should be a line below which registrants should not fall.
1.2 It was felt that we might add examples to the standards, which could be positive ways of meeting the standards.

Introduction

1.1 It was felt that the introduction should have links to the SOPs.
1.2 One group questioned whether the summary standards on page 2 are necessary.
1.3 One group asked what the difference was between a duty and a responsibility. They also felt that the distinctions between conduct, performance and ethics made in the standards were to some extent arbitrary, but that the structure did not need amendment.
1.4 It was suggested that a glossary could be added.

Standards 1 to 4

Standard 1

1.1 One group agreed that more clarity, more explanation and more examples were needed in relation to gifts from patients.
1.2 It was also felt that it needed to be made very clear that it is not appropriate to enter into sexual relationships with a patient or member of a patient's family.

Standard 3

1.1 The group felt that this was controversial as one person's high standards were different to another person's.

Standard 4

1.1 One group questioned whether we would need to know information about health conditions if the change was temporary and asked what HPC would do with the

information when received. The group felt that guidance was needed on what should be reported. It was suggested that we could follow the practice of the DVLA and give examples.

Standards 5 to 8

Standard 5:

1.1 Should be expanded to encompass the standards for CPD and returners to practice requirements.

Standard 6:

1.1 It was suggested that more information in this standard about regulated and unregulated professionals and information about referring and accepting referrals would be helpful.

Standard 7:

1.1 The conflict between duties to refer and exchange information and obligations regarding confidentiality was discussed

Standard 8:

1.1 One group asked whether the reference to 'health professionals' was a reference to HPC registrants or others? What is a health professional?

Standards 9 to 12

Standard 9:

1.1 It was suggested that we might add information about capacity to give consent.

Standard 10:

1.1 One group discussed whether the notes of an assistant required a countersignature. They commented that some assistants may work without direct supervision and in some areas write up their own notes. They also discussed issues around timely/ contemporaneous records.

Standard 11:

1.1 It was suggested that this be expanded to include all risks, not just infection. Do we need to list sexually transmitted infections separately?

Standards 13 to 16

Standard 13:

1.1 ‘Is there a need to have a standard on ethics?’ asked one group
1.2 One group concluded that everyone has ‘special responsibilities’ in their job
1.3 It was suggested that we should remove ‘professional’ from the standard and focus on ethical behaviour. In particular, it was felt that the standards needed a good strong paragraph on ethical behaviour and then some key examples – this might also encompass standards 14 and 15.

Standard 16:

1.1 There was some discussion in one group about whether it was appropriate to refer to the reputation of the profession and some suggestions for change. However, there was general consensus that the standard should remain.

Addendum: Responses not included in the "Call for ideas"

College of Occupational Therapists (COT)

Do you think the introduction clearly explains the role and purpose of the standards?

The COT suggested that the introduction should emphasise the importance of members of the public being able to trust their health professionals and to explain that registrants and prospective registrants must maintain a good standard of practice and respect their patients and service users.

They also suggested that it would be helpful if the introduction acknowledged the code of ethics of individual professions. As the document is accessible by members of the public, it was also suggested that it may be helpful to list all the professions which HPC regulates and therefore all the professions to which the standards apply.

Do you think there are any standards which need more information or which might be usefully reworded?

The following were suggested:

- Standard 2 (confidentiality) might be clarified to detail when information can be released
- The standards relating to probity 'require further information and examples'. They said: 'There needs to be some guidance to distinguish between the expectation of behaviour in professional life and/or personal life'.
- There should be reference to each profession's code of ethics.

Do you think that there are any other standards which you think should be added?

The COT suggested that we should say that registrant's should take into account the service user's culture and beliefs and that there should be reference to / a standard relating to receipt of gifts such as money.

Institute of Biomedical Science (IBMS)

Do you think the introduction clearly explains the role and purpose of the standards?

The introduction was felt to be 'clear and concise'.

Do you think there are any standards which need more information or which might be usefully reworded?

The IBMS felt that terminology used might be biased toward direct patient contact and suggested the term 'clinical or scientific practice'.

They also suggested that we might improve standard 6 by adding information about evidencing competence.

Do you think that there are any other standards which you think should be added?

They suggested making 'practice in terms of health and safety legislation' more explicit.

British Dietetic Association (BDA)

General Comments

The BDA felt that the standards were published in clear language and that the format was accessible. However, they expressed concern that because they are broad and generic they 'can be perceived to be weak'.

They suggested that we might segment the standards further by numbering each separate point. They also suggested that we might provide more examples about behaviour but recognised that it is not possible to be explicit about behaviour which is always unacceptable.

They further suggested that specific reference to 'basic legislation' would strengthen the document.

The following suggestions were made with specific reference to particular standards:

Standard 1

- We should strengthen statements relating to anti-discriminatory practice
- We should add a new statement that person and religious beliefs should not influence treatment or advice
- A statement that bullying and harassment of clients and other staff is unacceptable should be added
- The concepts of advocacy and patient safety should be separated

Standard 4

- The issues of your own competence and health, and that of others, should be separated
- Clarification should be given on when to inform HPC of health conditions
- There is some duplication between this standard and standard 12

Standard 10

- In circumstances where there has been on direct supervision of a student or assistant, it may be difficult for a registrant to countersign another person's records as accurate.
- The statements about electronic records place too great an onus on an individual working in an organisation to ensure of records. In the employed sector, there is instead a requirement to follow local/ national policies and report concerns where necessary.

Standard 12

- This should be strengthened to include a requirement to seek medical advice and to inform your employer if you are employed.

Standard 14

- This standard needs further explanation and covers some of the same ground as standard 3.

Standard 16

- Further explanation is needed.

Mind

It was felt that the document, whilst clear and specific, might benefit from some change. In particular, it was felt that the use of 'musts' might be a 'bit alienating'. It was suggested that we might go straight for the main verb - e.g. 'Always act to protect the interests...' e.t.c.

It was suggested that there should be more information about treating people with respect and providing enough information to enable people to make informed choices.

It was suggested that health issues should be separated from disciplinary matters and that we should reinforce disabled peoples' rights under the Disability Discrimination Act. We also needed to explain more about what we meant by a significant change in health.

The term ‘service user’ was felt preferable to ‘patient ,client and user’.

Other comments

Other comments were made by a medical company specialising in rehabilitation services:

Conduct
It was suggested that standard 3 might be expanded to include more specific guidelines about steps practitioners could take to avoid allegations – e.g. chaperoning.

It was also suggested that we might add further detail about cooperation with other experts such as the need for practitioners to liaise with and voice concerns with other health professionals as their first port of call.

Performance
It was felt that standard 7 might be improved by adding ‘referrer’. They said: ‘Whilst most practitioners provide solid performance here, we have come across a number of practitioners who have failed to provide any communication following patient referral, even after we have phoned or written requesting updates’. They also suggested a standard about evidence based medicine.

Ethics
It was felt that we should include a statement on anti-discriminatory policy.

Conclusions

1.1 The discussion groups were a useful exercise, with many helpful suggestions, some of which are consistent with the information considered thus far as part of the review.
1.2 Overall, there was no desire for ‘far-reaching’ changes to the standards.
1.3 However, there were a number of areas of the standards where there was broad consensus amongst the different meetings:

1.3.1 We should give attention to revising use of the term ‘patient, clients and users’
1.3.2 The introduction should be positive with clear links to professional body guidance and standards
1.3.3 We should make clear links to the standards of proficiency
1.3.4 We might consider including information about child protection duties in standard 1
1.3.5 We should consider changing standard 2 to including using as well as supplying drugs
1.3.6 We might consider whether the structuring of the standards around conduct, performance and ethics is appropriate or helpful.