REGULATION OF HERBAL MEDICINE AND ACUPUNCTURE
PROPOSALS FOR STATUTORY REGULATION
CRHP RESPONSE

Background to CRHP

CRHP was established in April 2003 by the National Health Service Reform and Health Care Professions Act 2002 (the Act) and has a statutory remit to:-

- Promote the interests of the public and patients in relation to regulation of the healthcare professions
- Promote best practice in the regulation of the healthcare professions
- Develop principles for good professionally-led regulation of healthcare professions
- Promote co-operation between regulatory bodies and other organisations

CRHP is grateful for the opportunity to respond to this consultation exercise. Because any new Council created as a result of this consultation process will automatically be eligible for inclusion on CRHP's Council (section 25 (3) (j)), CRHP needs to be satisfied that the proposals reflect the most up to date understanding of best practice in health care regulation. CRHP has a number of ongoing projects in this area and in 2003 commissioned a Scoping Study which maps the health care regulatory landscape (available on our website at www.crhp.org.uk). CRHP, as an organisation with unique oversight of all nine existing UK health care regulators, would expect to be used as a reference point and a resource in developing any new Council.

It is anticipated that a number of regulators represented on CRHP will make a separate response to this process. Accordingly, CRHP will limit its feedback to those areas of significance to the Council as a whole.

In general terms, CRHP thinks that regulation for acupuncturists and herbal medicine practitioners is timely and appropriate and supports the development of a shared Council. Detailed responses to questions are set out below.

Q1: CRHP agrees that statutory regulation should apply to herbal medicine and acupuncture practitioners in all four UK countries.

Q2: On balance, CRHP agrees that a shared CAM Council is the model which best needs the needs of patients, the public and practitioners. A shared Council is more likely to have the resources adequately to support the various functions of a fully modern regulatory body. These include:

- Registration
- Education
- Standard setting
- Fitness to Practise

In addition to the advantages in fulfilling statutory functions, economies of scale may also make a regulator more able to cope with emerging regulatory demands (including changes to health care regulation required as a result of the Shipman enquiry).

Q.3: CRHP supports a shared CAM Council.

Q.4: The name "CAM Council" is acceptable to CRHP. Recognising the disquiet surrounding the term "alternative", CRHP would also support the title 'Complementary Medicine/Health(care) Council' (or some similar variant).

Q.5: A shared Council provides an existing model to which further CAM therapies could be added if and when they were deemed ready for professionally-led statutory. Since a primary reason for pursuing statutory regulation is the protection of the public, a mechanism should be in place which facilitates the speedy addition of new therapies. A CAM Council could certainly be extended to other unregulated CAM professions where this is considered necessary in order to ensure patient and public protection. CRHP notes that public protection has been considered more of a priority in 'whole disciplines' than in other CAM professions. CRHP is mindful however that the House of Lords Select Committee did not consider statutory regulation necessary for the vast majority of CAM professions, for which voluntary forms of self-regulation were felt to provide a proportionate response and adequate protection for the public.

Q.6: CRHP supports the protection of the titles set out in paragraph 33. CRHP nonetheless advises that attention be paid to the range of titles which practitioners are currently using, so that practitioners cannot subvert the statutory scheme merely by using a title which falls outside the range of protected titles.

Q.7: CRHP thinks that this range of subsidiary titles may be more confusing to patients than it is helpful. The overarching title allows for different styles and guarantees that all registered practitioners have attained an appropriate level of training. Further subdivision may be unnecessary and indeed counter-productive.

Q8: CRHP is broadly supportive of the statutory functions set out in paragraph 35. The fundamental functions set out are consistent with those applicable to other regulatory bodies. However, the duty set out in paragraph 36 (i.e. to advise herbal medicine practitioners on the products they use as medicines in their professional practice) is not felt to be the appropriate role of a new CAM Council. Whilst recognising that the legal situation of herbal remedies is complex, it is inappropriate for this function to be assumed by the regulator, as opposed to a professional body. There may also be potential liability if a regulatory body gives advice on specific products which subsequently cause harm to an individual.

Q.9. CRHP is content with the suggestion of ten lay or other members on any new Council. CRHP fully supports the recommendation at paragraph 41 that any new Council should have a lay Chair. This is felt to be of particular importance should there be a shared Council as it would be essential to avoid the appearance of bias in favour of one or other profession.

Q.10. CRHP has no view on this matter, save that the views of all traditions should be capable of being heard.

Q.11. CRHP is broadly supportive of the proposed appointments mechanism, and is in favour of staggered appointments and terms of office. If the NHS Appointments Commission is to appoint the practitioner members of the first Council, there needs to be a transparent process if grass roots practitioners and other stakeholders are to have confidence in any new Council. Bearing in mind that most of these practitioners work outside of NHS practice, the use of the NHS Appointments Commission for this purpose may be thought by some to be slightly surprising.

Q.12. The Council has reservations about the workability and appropriateness of dual registration, whilst recognising that any practitioner who is regulated by another body could nonetheless make an individual decision to join any new register if he or she so wished. That said, it is important to consider how successful a collaborative approach would be in practice. The success of a collaborative approach, rather than dual registration, would depend on how far existing regulators would be willing to consult with and defer to the advice of any new CAM Council, particularly with regard to matters of education and training. If a collaborative approach is preferred, this needs to be kept under regular review to ensure that standards are sufficiently high to protect the public.

Q.13: CRHP recognises that there is considerable variation between regulators as to various committees and supports the principle that the CAM Council should be free to establish additional committees as it considers appropriate.

Q.14: The composition of the Education and Training Committee should be informed by further consultation. In terms of who should Chair, CRHP is generally in favour of the "best person" for the post, acknowledging that this will almost certainly be an educationalist. Given, however, the potential difficulties of a shared acupuncture and herbal medicine Council, a lay Chair may well be appropriate in the first instance to avoid bias or any perception of bias amongst Council members and registrants.

Q.15: CRHP would support any mechanism which protects the public and allows people to identify with ease any registrant whose fitness to practise is impaired in any way, or any practitioner who is subject to either conditions or undertakings in respect of their practice. Ordinarily these matters are dealt with by a separate Registration Committee.

Q.16: In principle, CRHP accepts that the holding of an accredited qualification should enable practitioners to apply for automatic registration with the CAM Council. In determining appropriate standards for registration, any statutory committee should give due weight to the successful work carried out by the British Acupuncture Accreditation Board and the proposals of the HMRWG. CRHP would emphasise the clear need for consensus to be achieved regarding Ayurveda training if Ayurveda is to be included in any statutory scheme.

Q.17: A parallel system could be in place to consider applications from practitioners who do not hold an accredited qualification. CRHP notes that such a system will be in place in any event in relation to overseas practitioners.

Q.18: CRHP is supportive of a core curriculum which could apply within and across CAM professions (and possibly even more broadly). CRHP does not have a view on whether this should be developed alongside or instead of National Occupational Standards.

Q.19: CRHP supports the recommendations for assessing overseas practitioners. In line with other regulators, any new Council should be empowered to check that applicants from outside the EEA have sufficient knowledge of English. CRHP notes that at least one health care regulator is interested in extending language testing to all new registrants.

Q.20: CRHP supports the notion of a grand-parenting scheme. There are some concerns, however, that the recommendations as they stand would permit a practitioner to join the register who has not been in practice for two years prior to applying. CRHP is reassured by the statement that any applicant may be required to take a test of competence. During a transitional period, as a matter of public protection practitioners who have been in practice for less than three years should be required to take a test of competence.

Q.21: A two-year transitional period is appropriate.

Q.22: Any pre-existing standards of proficiency should certainly inform the Education and Training Committee.

Q.23: Clearly the CAM Council will need to develop and publish codes of conduct. In doing so, any new Council should consider examples of best practice which already exist amongst the other regulators. Attention is drawn, in particular, to the model developed by HPC, combining common aspects to all therapies with profession-specific additions where necessary.

Q.24: It would be appropriate for the CAM council to be responsible for determining CPD standards.

Q.25: The GMC's new scheme is the preferred model and similar schemes are being considered by other regulators. Given the likely length of time before any CAM council comes into being, it is essential that fitness to practise mechanisms, and indeed other regulatory functions, represent the most up-to-date notions of best practice.

Q.26: Further thought would need to be given to the detailed composition of any Investigating Committee and adjudication panels. It would be premature to comment on this until the Shipman Inquiry has reported. In terms of adjudication, on balance, CRHP supports the idea that adjudication panels should be independent of Council members.

Q.27: As with fitness to practise generally, the range of sanctions available to the new Council should represent the current ideas of best practice. A number of regulators are awaiting s 60 Orders which will introduce a wider range of sanctions than currently pertain. CRHP recognises that there is an unacceptable level of variation in the sanctions that are available to different regulators and is hopes to work collaboratively with existing regulators in this area.

Q.28 The creation of an appeals tribunal is appropriate.

Q.29: CRHP agrees with the creation of a formal working group to help prepare for the establishment of the first CAM Council and would be happy to lend its support to such a group.