Advice on student registration

Aim of this document

To provide the advice requested by the Secretary of State for Health on what the Council for Healthcare Regulatory Excellence, having consulted the regulatory bodies considers

- appropriate systems or processes to be put in place to assure the public that students are fit to practice during education and training as health professionals
- whether students and trainees should have relationships with their future regulators prior to qualification and what those relationships might mean
- how might this be achieved.

Summary

- *Professionalism and regulation should run as a developing strand of the curriculum throughout the course of study. Measures should be put in place between the Regulatory Body[1] and Higher Education Institution for the student to develop a thorough understanding of professionalism and the purpose of regulation, as indicated in the White Paper. Respondents agreed that this should begin at recruitment to the programme so that students enter programmes with the full knowledge of what will be expected of them beyond the straightforward academic achievement.*

- *Students should be made aware of the inherent risks in any learning situation and understand their responsibility in relation to the safety of the patient. The risk to patients from student practice varies from profession to profession and with the circumstances and style of their training. A single approach is therefore not desirable. The different professions expose students to patients to different extents and using different levels of supervision. There is strong support from regulators for professional behaviour being expected of students throughout their course whether working directly with patients or not.*

- *Higher Education Institutions should have formally agreed mechanisms for removing students from contact with patients if their fitness to practice is impaired. One approach would be for Higher Education Institutions to have Fitness to Practise committees that function in accordance with guidance from the relevant regulatory body and with the ability to remove a student from a course on the basis of a finding.*

[1] This refers to the nine healthcare regulatory bodies of the UK. GCC, GDC, GMC, GOC, GOsC HPC, NMC, PSNI, RPSGB.

- *Regulatory Bodies and Higher Education Institutions should agree to a Code of Conduct for students. The common values[2] agreed by the Regulatory Bodies should be used as the core principles for the document.*

- *There is insufficient evidence to suggest that registration of students is necessary to protect patients and the public.*

1. Background

In 2006 CHRE together with the Regulatory Bodies, Higher Education Institutions and other relevant stakeholders undertook a study into the behaviour of students of the healthcare professions. The main focus of the work was on sharing learning and approaches to promoting professional values in the educational setting. The nature of health and social care education and training sometimes puts students in situations where their behaviour could put patients at risk and this risk should be minimised.

The project concluded that ensuring student fitness to practise minimises the risk of future patient harm by identifying and managing concerns at an early stage and through instilling and developing professional values.

Several of the Regulatory Bodies have subsequently continued with their own work in this area. The GMC for example has conducted more research, held seminars and gathered information for various sources in order to understand the risks and consequences of medical students failing to learn and understand about professionalism during their course of study[3].

In considering the matter of student registration the Government White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*[4] in paragraphs 6.6 and 6.7 refers to student registration 'help[ing to] instil a clear sense of professional responsibilities at an early stage in practitioners' careers …'

In January 2008 CHRE was invited to consult with the Regulatory Bodies and other relevant stakeholders to develop a view of the practicality of registration and what could be achieved in relation to student behaviour on a proportionate risk based approach.

2. *Scope of the advice*

CHRE circulated a letter of consultation to interested parties at the Regulatory Bodies, the devolved administrations, Higher Education Institutions and some service representatives. Responses were received from all quarters together with some helpful additional comments.

2.1 Consultation issues

The statements below represent the proposals put to interested parties in the consultation letter. A compilation of the responses is given in italics after each statement.

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[2] See Annex 1 for the Common Values paper
[3] See Annex 3 for an extract from a paper by Papadakis M.A., et al on the Unprofessional Behaviour of Medical Students
[4] Published in February 2007

2.1.1 Throughout their training students should come to understand the requirements of professionalism and the standards that will be expected of them when they become registrants.

All respondents agreed to this concept. However, there was differing opinion as to whether this is currently being achieved successfully. Professional values must be key to successful education in a healthcare profession; indeed professionalism is itself a mode of regulatory control. One respondent reported that 'measures should be in place so that students leave pre-registration / undergraduate education with a thorough understanding of professionalism and the purpose of regulation'.

One session per semester is insufficient. Professionalism should be reflected in everything the student is engaged in and teachers on the programmes should be role models of such professionalism.

2.1.2 There is no evidence base to support an argument that achieving professional behaviour can be best achieved through registration of students with the relevant regulatory body. There are a range of different approaches currently being used by the regulatory bodies to establish a relationship and raise awareness of professional ethics, standards and behaviour.

All respondents agreed that a stronger relationship between students and their future regulatory body is a worthwhile aim. Views differed on how this could best be achieved. The different approaches currently used range from the General Optical Council (GOC) model of full student registration, to the General Chiropractic Council (GCC) model of a requirement of education institutions to have fitness to practise (FTP) committees with the power to remove a student from a course for purposes of public protection. A minority of regulatory bodies has a very minimal level of involvement with the student.

The GOC requires that anyone who is likely to undertake the fitting of contact lenses must be registered with the Council in order to undertake this procedure. There are two exceptions to this rule; doctors and medical students. Doctors are, of course, registered with the GMC. However, medical students are not registered with either the GMC as students or with the GOC for this particular purpose.

The GOC and Care Council of Wales register students pursuing their professions. Since starting registration GOC have processed xx students through their fitness to practice committees. Student opticians are required to work within The Code of Conduct for registrants. Failure to do so would bring them before Fitness to Practise Committee. This approach of applying the Code of Conduct is replicated in many of the regulatory bodies whether the student is registered or not. However, only the GOC use it for disciplinary cases.

Both the Care Council for Wales, and the General Social Care Council register students once they have been entered into a course of study with a recognised university. They adopt the same approach with students as they do with qualified social workers in terms of their regulation. Registration with the regulatory body is a condition of starting a social work course.

The service side respondents expressed concern about the mismatch for (in particular) nursing students between service requirements of fitness to practise and the Higher Education Institutions requirements of academic capability. A weakness that was identified was that universities may only be able to remove a student from a course via a university disciplinary process whatever the finding of a Fitness to Practise committee.

Some respondents raised the matter that some Higher Education Institutions are unable to remove a student from a course on a purely fitness to practise issue and that to do so would breach their contractual agreement with the student as in the above example. A way to address this is to ensure the Higher Education Institutions include in their disciplinary codes for healthcare students that they may be removed from a course of study either by academic failure or as a consequence of a Fitness to Practise decision.

2.1.3 Further work on enhancing the relationship between the student and their future RB should be based on the analysis of risk that the different student groups present to public safety.

Whilst there was consensus in favour of a risk based approach there was no suggestion that this should mean that some students should have little or no relationship with their Regulatory Body. Respondents felt that all students, at whatever stage of their course of study, should be familiar with the Code of Conduct for students, or similar, and have an understanding throughout the course of the importance of professionalism and its impact on patient care and their own professional standing.

2.1.4 The Codes of Conduct for students developed by Higher Education Institutions should be closely aligned with the standards, ethics and values required by the Regulatory Body

There was strong support for Codes of Conduct for students which could be used as 'a tool for aspiring professionals[5]*. There was a preference for these being prepared by Regulatory Bodies and espousing the common values agreed by the Regulatory Bodies. There was not support for these to be adaptations of Higher Education Institutions' Codes. Some respondents felt that this activity would achieve an enhanced engagement between the Regulatory Body and the student and lead to a 'safer student'.*

The GCC require their students to act / behave in accordance with the principles set out in the GCC Code of Practice which is predicated on the 'common values' agreed by all the Regulatory Bodies. This is brought to the attention of the student at commencement and continually reinforced.

2.1.5 Although CHRE recognises that disciplinary and fitness to practise issues are best dealt with through the Higher Education Institution in accordance with their own policies, CHRE proposes that there is a stronger relationship with the Regulatory Bodies based on analysis of risk. For example, Regulatory Bodies could produce guidelines that Higher Education Institutions would be required to follow with a proforma report submitted to the RB where action is taken.

This approach had a mixed response. In general the Regulatory Bodies were not averse to the proposal but the Higher Education Institutions felt that there would be potential for this to undermine local decision making and 'risks the Regulatory Body revisiting Fitness to Practise cases handled by universities'. A further proposal was that Regulatory Bodies and Higher Education Institutions should work together to develop stronger guidance about the processes around student fitness to practise cases and what level of information is shared.

[5] Comment from a devolved administration respondent

2.1.6 Student fitness to practise cases should be handled in line with the requirements of the Regulatory Body to ensure that the professional standards, ethics and values of that Regulatory Body are being upheld.

There was little disagreement with this expect for logistical challenge in changing the way Higher Education Institutions currently work. However, this may be overcome by agreeing an approach to fitness to practise as proposed in 2.1.5 above.

2.1.7 Mechanisms should be in place to ensure that students are kept aware of any issue of their behaviour or action that may prevent them from becoming registrants. Potential students should be made aware of registration stipulations of the Regulatory Bodies that may prevent them from becoming registrants before embarking on their course of study

There was full support for this and some Regulatory Bodies are already taking action.

2.1.8 CHRE proposes a joint sign-off by the student, the university and the clinical practice supervisor on completion of training on the professional suitability of the student to be entered onto the register.

Whilst this received, in general, strong support it was recognised that this should not be the first time that a student is faced with the possibility that they may not be fit to be registered. This 'sign-off' should be the culmination to the period of study and an agreement between all three parties of the individual's suitability to be registered.

If this proposal is accepted it could form part of CHRE's ongoing project on information sharing at the point of entry to the register.

Conclusion

Much of the evidence for the need for a closer relationship between the student and RB which has been presented to CHRE has been experiential and anecdotal. Although the anecdote provides a compelling sense that a closer relationship would lead to improved professionalism of the student to substantiate this with hard facts would require a full research study.

In conclusion, on the basis of the survey of opinion it is our view that registration of students for the purpose of developing a working knowledge of professional behaviour, ethics and values is not necessarily achieved through registration with a Regulatory Body. Anecdote refers to students who are removed from one course for a variety of reasons and sign on to another course elsewhere. However, without evidence it is difficult to understand the size of this potential problem. On a risk based approach it is unlikely that such behaviour would identify that registration is the only way forward. The experience of the GOC and the Care Council for Wales who both register their students is valuable. However, both these register relatively small numbers of students compared to, for example, those that would need to be registered with the NMC or GMC if this route was chosen.

On balance a stronger relationship between the HEI, RB and student through Codes of Conduct and guidelines for fitness to practise might be a more pragmatic way to proceed that would provide protection for the patient whilst the individual is a student plus better preparation for entry into professional practice on qualifying.

May 2008
Annex 1:

Common Values Statement by the Chief Executives Group of the Health Care Regulators on professional values

Values of Health Care Professionals

All health care professionals are personally accountable for their actions and must be able to explain and justify their decisions. Health care professionals work in may different types of practice. They all have a duty to protect and promote the needs of their patients and clients.

To do this they must:

1. Be open with patients and clients and show respect for their dignity, individuality and privacy:

· Listen to patients and clients;
· Keep information about patients and clients confidential;
· Make sure their beliefs and values do not prejudice their patients' or clients' care.

2. Respect patients' and clients' right to be involved in decisions about their treatment and health care:

· Provide information about patients' and clients' conditions and treatment options in a way they can understand;
· Obtain appropriate consent before investigating conditions and providing treatment;
· Ensure that patients have easy access to their health records.

3. Justify public trust and confidence by being honest and trustworthy:

· Act with integrity and never abuse their professional standing;
· Never ask for, nor accept any inducement, gift, hospitality or referral which may affect, or be seen to affect, their judgement;
· Recommend the use of particular products or services only on the basis of clinical judgement and not commercial gain;
· Declare any personal interests to those who may be affected.

4. Provide a good standard of practice and care:

· Recognise and work within the limits of their knowledge, skills and experience;
· Maintain and improve their professional knowledge, skills and performance;
· Make records promptly and include all relevant information in a clear and legible form.

5. Act quickly to protect patients, clients and colleagues from risk of harm:

· If either their own, or another health care worker's conduct, health or performance may place patients, clients or colleagues at risk;
· If there are risks of infection or other dangers in the environment.

6. Co-operate with colleagues from their own and other professions:

· Respect and encourage the skills and contributions which others bring to the care of patients and clients;
· Within their work environment, support professional colleagues in developing professional knowledge, skills and performance;
Not require colleagues to take on responsibilities that are beyond their level of knowledge, skills and experience.

ANNEX 2:

Extract of article by Papadakis; American expert in unprofessional medical behaviours

Virtual Mentor. April 2007, Volume 9, Number 4: 290-294.

Early Evidence of Unprofessional Behavior Found in Medical Student Records

A review of research that found that physicians disciplined by state medical boards were as much as three times more likely than controls to have had a record of unprofessional behavior in medical school.

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Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med.* 2005;353:2673-2682, e22.

As recently as a few decades ago, there was no mention of "professionalism" in most medical school curricula [1]. Since then, medical education has increasingly focused on professionalism and such related topics as ethics and humanism. Today, several governing bodies including the American Association of Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) endorse curricular attention to these matters, both in medical school and in subsequent residency training [2, 3]. It seems agreed upon that these topics are central to the development of good physicians. Unfortunately, little objective data exists to support this claim. For this reason, the study by Maxine Papadakis and her colleagues is significant.

The randomized controlled trial, or RCT, is the agreed-upon gold standard for evidence in modern medicine. For clinical topics like myocardial infarction literally thousands of RCTs are indexed electronically in the Medline database of the National Institutes of Health (NIH), accessible via PubMed.com. To the contrary, a PubMed search of RCTs containing the keyword "professionalism" yields only five results [4]. Even a search limited to non-randomized clinical trials yields just 22 results, and there is no MeSH (medical subject heading) search term for the topic of professionalism. In contrast, a search for *editorials* containing the keyword "professionalism" results in 164 hits.

One can reasonably conclude from this that current thinking on the subject remains mostly confined to expert opinion. Of course, as the history books demonstrate time and again, "experts" are often incorrect. It is often said that half of what is taught in medical school is wrong, we just don't know which half. For this reason, objective data is vital in helping to

direct medicine and medical education down the best possible path.

In this vein, Dr. Papadakis's article presents compelling evidence that professionalism matters, and that it matters *professionally*. In a pilot study published in 2004, Papadakis and colleagues found that disciplinary action against physicians by the Medical Board of California was associated with reported incidents of unprofessional behavior during medical school [5]. Building on the troubling results of this pilot study, the authors collaborated with two other medical schools, the University of Michigan and Jefferson Medical College in Philadelphia, to explore this link more fully. Complete school records were available dating back to 1970, and medical board actions were reviewed between 1990 and 2003. These are a matter of public record. To control for confounding variables, each disciplined physician was paired with two control physicians, whose specialty matched that of the disciplined physician. Research assistants gathered the data, and entries reflecting unprofessional conduct were scored by several investigators to confirm interobserver agreement and thus reduce bias and other sources of observer-based error.

Based on this case-controlled, retrospective study, Papadakis and colleagues found the following. First, physicians who were disciplined by a medical board were three times more likely to have a record of unprofessional behavior during medical school than were the controls. In particular, they were more likely to have demonstrated

irresponsibility, diminished capacity for self-improvement, poor initiative, impaired relationships with students, residents and faculty, impaired relationships with nurses, and unprofessional behavior associated with being anxious, insecure, or nervous [6].

"Severe irresponsibility" was most strongly correlated, occurring 1.8 to 40 times more often, followed by "diminished capacity for self-improvement," found 1.2 to 8.2 times as frequently. Interestingly, even MCAT scores appeared to be loosely linked with disciplinary behavior, with a trend towards lower test scores in physicians disciplined by the board. Furthermore, disciplined physicians were also twice as likely to have failed at least one course on their first attempt during medical school.

One must take care in interpreting these results, however. As a retrospective study, the most we can glean from the data is the knowledge that physicians disciplined by a medical board are significantly more likely to have documented evidence of unprofessional behavior in their medical school files. It is important to recognize that the stronger inverse inference *cannot* logically be made. In other words, one cannot assume that students who demonstrate unprofessional behavior during medical school are three times as likely to be disciplined by a medical board. To do so would amount to the commission of a logical fallacy known to philosophers as "converting a conditional," [7] saying, "if A then B, therefore if B then A." Of course, such an argument is fallacious.

Interestingly, the title of the original pilot study by Papadakis, "Unprofessional Behavior in Medical School is Associated with Subsequent Disciplinary Action by a State Medical Board," seems to suggest this illogical inference in its phrasing, purporting a causative link between medical student behavior and subsequent disciplinary action, rather than the converse association, which is what the data actually supports. At most, one can only presume a vague degree of statistical risk (1.15 to 4.02 times) of association between student behavior and subsequent discipline, based on the data. In fact, it may well be the case that a sizeable proportion of medical students exhibit unprofessional behavior at some point in their education, but do not go on to have professional difficulties and actions taken by their state medical board. Or, more likely, as I have found in my own

experience, a great deal of unprofessional behavior goes unchecked and unrecorded in medical school files. While there *is* likely to be a group for which the relationship is true, we simply have no way of knowing how often this is actually the case without further study.

This shortcoming lies in the fact that the study is retrospective and is not a randomized controlled trial. In the absence of RCT data one cannot know whether a particular medical school intervention would make a difference in the likelihood of subsequent medical board discipline. Neither can one know, without an RCT, or at least a prospective cohort design, exactly how strong the correlation may be. That said, one might argue that an RCT would not even be ethical, in that it would pose the risk of leaving recognized unprofessional behavior unchecked, which stands to threaten patients' well-being if it continues thereafter. It would also be rather difficult to design such a study, which is infinitely complicated by requiring a human intervention rather than just a pharmaceutical one.

Although there are surely some shortcomings to this study, including its retrospective design and consequent inability to demonstrate a causal link between unprofessional student behavior and subsequent professional difficulties, the same is true for most studies, no matter how meticulous the design. In the case at hand, one must not miss the forest for the trees. Papadakis's data are truly groundbreaking and cannot be ignored. Clearly, professionalism is an important theme in modern medicine—indeed, unprofessional behavior was the basis for at least 74 percent of the medical board violations noted in this study—but there also seems to be a sense in which professionalism just *feels* important to physicians and educators, as manifested in its prominence in most curricula today [1].

As a recent graduate of medical school, I can certainly recall witnessing several instances of unprofessional behavior, and it always felt profoundly and intuitively disturbing. I imagine this is true for many physicians. One must wonder how patients will feel about and react to it, and how it might shape others' perceptions of physicians and of the medical profession in general. There is much at stake in these situations, thus it is truly troubling that such behavior can continue over several decades, as this study clearly demonstrates.

The authors conclude that professionalism should play a central role in medical education and that admissions and graduation criteria should reflect an explicit assessment thereof. They also argue that their data "supports the importance of identifying students who display unprofessional behavior" [6]. I wholeheartedly agree, despite the fact that it remains to be shown just how often unprofessional student behavior subsequently results in professional difficulties. Regardless, professional behavior stands to have a significant impact on the patient-doctor relationship, and the persistence of unprofessional behavior over decades may be sufficient evidence to support such interventions. Countless interventions are currently under way at medical schools across the country. As Drs. Stern and Papadakis discuss in an article about the developing physician, professionalism is a topic that can clearly be taught and assessed within modern curricula and modeled by faculty [8]. Novel approaches continue to emerge, including an initiative to use the gross anatomy curriculum to teach and reinforce the tenets of professionalism [9]. Although untested objectively, such efforts are to be lauded as the best we have to date.

Professionalism is important to the future of medicine. It stands to define our interactions with patients, shape their perceptions of physicians and drive the overall success of

medicine in society. As professionals, we "profess" certain ideals, the antitheses of which are the irresponsibility, diminished capacity for self-improvement, and poor initiative found in many students in this study. I believe we owe it to our patients, and to our profession and its reputation, to continually strive to maintain medicine's historically noble professional ideology. Dr. Papadakis's study lends more credit to this noble goal.

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