Education and Training Committee, 22 September 2009

# The CHRE's report of the regulator's health conditions and the impact on the HPC

## Executive summary and recommendations

**Introduction**
The Committee discussed the Disability Rights Commission (DRC) report on 2 December 2008.

The Committee discussed the role of the health reference as a requirement for entry to the Register on 11 June 2009. The Committee agreed to await the outcome of the Council for Healthcare Regulatory Excellence (CHRE) review and any recommendations it contained.

The CHRE recommended that the health regulators should look at their health requirements to make sure they do not go beyond determining whether someone is fit to practise, either at registration or during fitness to practise procedures.

This paper provides discussion and analysis of the health requirements the HPC makes for future and current registrants. The health requirements are discussed and analysed in relation to the CHRE report and recommendations.

**Decision**
The Committee is invited to:

- Discuss the attached paper and in particular the recommendation from the Executive to consult on removing the health reference and replacing it with a self-declaration.
- Agree to recommend a consultation on any changes that may be required in light of their discussion.

**Background information**

- DRC report: www.maintainingstandards.org
- Committee paper 2 December 2008: http://www.hpc-uk.org/aboutus/committees/educationandtraining_archive/index.asp?id=382 (enclosure 10)
- Committee paper 11 June 2009: http://www.hpc-uk.org/aboutus/committees/educationandtraining_archive/index.asp?id=388 (enclosure 15)

**Resource implications**
These depend on the outcome of the Committee's decisions.

- Writing and laying out a consultation document

**Financial implications**
These depend on the outcome of the Committee's decisions.

- Laying out and publication of the consultation document
- Mail out to the consultation list

**Appendices**

- 1: CHRE Health Conditions report
- 2: Workplan

**Date of paper**

10 September 2009

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|---|---|---|---|---|---|---|
| 2008-11-11 | a | POL | PPR | Report on the DRC report - coversheet | Final<br>DD: None | Public<br>RD: None |

# The CHRE's report of the regulator's health conditions and the impact on the HPC

## 1. Background to the review

The Disability Rights Commission (DRC) report 'Maintaining Standards: Promoting Equality'[1] published in 2007 concluded that health standards have a negative impact upon disabled people's access to regulated professions; lead to discrimination; and deter and exclude disabled people from entry to these professions. The DRC's main recommendation was that all health requirements should be revoked; they argued that there was no evidence that the health requirements provided protection for the public.

Following the DRC report, the Department of Health (DH) commissioned the Council for Healthcare Regulatory Excellence (CHRE) to provide advice on health regulators' requirements regarding registrants' health.

The DH sought to establish the purpose of the requirements made by the health regulators on registrants to be of 'good health' at initial registration, what information the health regulators looked for, and what rules and provisions required the health regulators to take account of health as part of their fitness to practise procedures.

The DH sought recommendations and advice from CHRE regarding whether it would be detrimental to individual registrants or the public if health requirements were removed. They also wanted to know whether the same requirements should apply to all health regulators or whether different approaches were required for different professions.

The Education and Training Committee discussed the DRC report on 2 December 2008[2] and received a paper to note on the role of the health reference as a requirement for entry to the Register 11 June 2009[3]. The Committee agreed that the Executive should keep them updated with any developments from the CHRE review.

The CHRE made five recommendations. This paper is primarily concerned with the recommendation that '…regulatory bodies consider the most proportionate means of ascertaining the information they need to determine whether those seeking entry to their registers are fit to practise'. This paper provides the

[1] DRC report: http://www.maintainingstandards.org/

[2] Enclosure 10: http://www.hpc-uk.org/aboutus/committees/educationandtraining_archive/index.asp?id=382

[3] Enclosure 15: http://www.hpc-uk.org/aboutus/committees/educationandtraining_archive/index.asp?id=388

background to our requirements and outlines potential changes that the Committee may want to consider in light of the CHRE recommendations.

## 2. Current requirements

Our health requirements are based on an individual's fitness to practise. We currently require health references for admission, readmission and renewal to the Register. For those joining the Register for the first time or readmitting the health reference must be completed by a registered medical practitioner. Those renewing their registration must self-declare that they do not have any health conditions which may affect their fitness to practise. Fitness to practise allegations of impairment on health grounds go to the Health Committee.

This section sets out the current requirements we make relating to the health of registrants and future registrants, and the legislation which informs the health requirements.

### 2.1 Registration

Our rules prescribe requirements for health references which applicants must provide when applying for admission and readmission to the Register.

Article 5(2)(b) of the Health Professions Order 2001[4] states: *'The Council shall from time to time prescribe the requirements to be met as to the **evidence of good health** and good character in order to satisfy the Education and Training Committee that an applicant is capable of safe and effective practice under that part of the register.'*

The Registration and Fees Rules stipulate how the reference should be provided and by who is able to complete the reference for those applying for admission.

Rule 4(2)(b) of the Registration and Fees Rules[5] requires *'…a reference as to the physical and mental health of the applicant given on the form provided by the Council containing the **declaration and information listed in Schedule 4 by the applicant's doctor** provided he:*

- *(i) is not a relative of the applicant, and*
- *(ii) has been the applicant's doctor (or in the case of a general practitioner is a partner in the practice of the doctor of whom the applicant has been a patient) for a period of at least three years ending on the date on which the reference is given;'*

At the point of admission and readmission an applicant must answer the following question: 'Do you have any condition that would affect your ability to

[4] Health Professions Order 2001: http://www.hpc-uk.org/publications/ruleslegislation/index.asp?id=199

[5] Registration and Fees Rules: http://www.hpc-uk.org/publications/ruleslegislation/index.asp?id=204

practise?' A heath reference must also be completed by a registered medical practitioner. They are asked to confirm one of the following three statements:

- 'I have been the applicant's registered medical practitioner for at least three years and based on my personal knowledge I am satisfied that the applicant's health does not affect their ability to practise the profession referred to above; or
- Having been given the applicant's medical records for the last three years, I have examined these records and based on my examination of these records I am satisfied that the applicant's health does not affect their ability to practise the profession referred to above; or
- I have examined the applicant and based on this examination I am satisfied that the applicant's health does not affect their ability to practise the profession referred to above'.

Individuals renewing their registration are required to self-declare the following: 'I confirm that there have been no changes to my health or relating to my good character which I have not advised HPC about and which would affect my safe and effective practice of my profession'.

### 2.2 Health and character process

A registered medical practitioner must sign the health reference to state whether in their professional opinion the applicant's health might affect their ability to practise safely and effectively in a way which poses no risk to patients, clients and users. An application with a health reference completed by a registered medical practitioner where no additional information has been included requires no further information.

In cases where the registered medical practitioner signs the reference but provides additional information, the application is passed on to a fitness to practise case team to review whether there is potential concern. In most cases there is no concern because the health condition is well managed. However, if the team decides that there is a health condition which may affect the applicant's ability to practise safely and effectively, for example, if the applicant had impairment through alcohol dependency with a risk of relapsing, the application would be referred to a registration panel.

The number of occasions where information included on a health reference form has raised potential concern is very small. To date, we have refused registration to two applicants where the health reference highlighted a poorly managed alcohol dependency problem. One applicant subsequently appealed, providing additional information, and a registration appeals panel decided to grant registration. The second applicant did not appeal.

Since May 2005:

- 47 applicants have declared a health problem.

- 20 of the applications raised concern and were sent to the registration panel.
- 2 applicants refused registration (both alcohol dependency).
- 1 applicant appealed and was successful.

Registrants must also manage their health. Standard 12 of the standards of conduct, performance and ethics (SCPE)[6] says: *'You must limit your work or stop practising if your performance or judgement is affected by your health.'*

When we receive a self-declaration it is unusual for the individual to be taken to a registration panel. By declaring, the registrant is demonstrating insight and understanding of their condition, managing their condition and therefore meeting SCPE 12.

### 2.3 Fitness to practise

The CHRE report stated that '…the concern of regulatory bodies should be whether a person is fit to practise, which is a question of whether they would meet the standards of competence and conduct. Issues around a person's health are of relevance only in relation to these standards, not in themselves.' (4.2, p.11).

The Health Professions Order 2001 provides for the health of a registrant to be taken into account as part of considering whether they are fit to practise.

Article 22(1)(a)(iv) states: *'This article applies where any allegation is made against a registrant to the effect that his fitness to practise is impaired by reason of his physical or mental health'.*

Fitness to practice allegations of impairment on the grounds of health goes to the Health Committee. The important aspect of these allegations is it is not the health itself that causes the issue, but the impairment (harm or risk of harm it has led to). The CHRE report stated that the regulator's ability to consider and deal with cases which are about impairment of fitness to practise due to ill health should remain. They say: 'Regulatory bodies need the power to consider the effects health may have on a professional's practice to carry out their role of protecting the public.' (3.5, p.9).

The CHRE report goes on to say: 'If a health condition is an underlying reason why a professional is departing from standards, regulatory bodies need to be able to establish this fact and consider whether the person's actions with respect to their health and practice represent a significant or persistent departure from their professional obligations, in order to make a determination on their fitness to practise.' (3.5, p.10).

[6] SCPE: http://www.hpc-uk.org/publications/standards/index.asp?id=38

The Health Committee looks at fitness to practise cases where health has been the primary issue. The decision about whether the allegation is primarily about health is made by the Investigating Committee. Hearings of the Health Committee normally take place in private.

In 2008–09 the Health Committee considered three substantive cases. In one case the registrant concerned was suspended, in another a conditions of practice order was imposed and the final case was not well founded.

### 2.4 Education

We set requirements around health for the education programmes we approve. The health requirements vary depending on the type of programme and the profession involved. For example, given the invasive procedures paramedics may undertake, vaccinations may be necessary. This may not be the case for other professions such as arts therapists.

SET 2.4 states: *'The admissions procedures must apply selection and entry criteria, including compliance with any health requirements.'* The guidance for this standard explains that it is the responsibility of the education and training providers to make sure they have taken all reasonable steps to keep to any health requirements, including making all reasonable adjustments in line with equality and diversity laws.

The feedback we have received about this SET (during the recent consultation) indicated that education providers found this to be a useful standard although it posed some difficulties about how the standard should be applied. One education provider told us that the standard was useful because it alerts them to ask the question of whether reasonable adjustments need to be made. They said the guidance was also helpful because it reminds them that each application must be treated on a case by case basis.

## 3. CHRE's recommendations

The DH sought advice and recommendations from CHRE about removing or amending health requirements. In their report, the CHRE concluded that '…regulatory bodies do not need health requirements that sit outside determining whether someone is fit to practise, either at registration or during fitness to practise procedures. Health issues may be material in determining whether a person meets the competence and conduct standards, but should not sit out with this as a separate requirement. However, health needs to be one of the grounds on which a regulatory body can find a person's fitness to practise to be impaired.' (7.2, p. 5-16).

CHRE made five recommendations to the DH and the regulatory bodies:

1. The language of good health should be overhauled and replaced with a single requirement of fitness to practise on initial entry to the register.

The CHRE report says the '…use of terms such as 'good health' does not add value to public protection and can obscure the issue regulatory bodies are seeking to address: will the person practise in accordance with the competence and conduct standards it sets for the profession's safe and effective practice.' (2.7, p.5).

To implement this recommendation the DH would need to amend the Health Professions Order 2001 and the legislation of the other regulators. The Executive agrees with this because we are addressing whether someone meets the conduct and competence standards. Any issues relating to health require the applicant to demonstrate that they are aware of a health condition and that it is managed effectively.

Guidance on registrants responsibility for managing their own fitness to practise derives from the wording in Article 5(2)(b) of the Health Professions Order 2001. Part of the Article refers to 'good health'. The term 'good health' has its own difficulties. We do not only register people who are 'healthy' or in what a lay person would call 'good health'. A registrant may well have a disability or long term health condition which would mean that they would not consider themselves to be in 'good health'. However, as long as the registrant or applicant has insight and understanding, and manages their condition or disability appropriately, this will not prevent them from registering.

A change to this wording would not affect our ability to change the requirements made of applicants at admission, readmission and renewal.

2. Consideration is given to changing the regulatory bodies' legislative frameworks so that they have a single fitness to practise committee.

We currently have two committees that hear cases, health and conduct and competence. We agree with the proposal to have a single fitness to practise committee that could consider health as well as conduct and competence. Many cases have some kind of health element to them and it is difficult for panels to determine whether health is an incidental, contributory or primary factor in a particular case. This also means that panels are also, to some extent, making judgements about what constitutes a health condition. For example, is a registrant who drinks alcohol whilst on duty impaired because of their health or is this misconduct?

There are instances where the committees cross refer cases between each other when health emerges as the primary issue at a hearing, or where a panel of the health committee concludes that health is not an issue and refers a case back to the conduct and competence committee to consider the case. This has the potential to delay the determination of the case which could cause stress for the person concerned.

With a single fitness to practise committee we would be able to clarify that fitness to practise looks at the consequences of actions whether or not health is an issue. We have discussed this with the Department of Health who have indicated their intention to change this in the future.

3. Regulatory bodies consider the most proportionate means of ascertaining the information they need to determine whether those seeking entry to their registers are fit to practise.

This recommendation should be considered and discussed by the Education and Training Committee. Further details on areas to discuss are outlined in section 4 of this paper.

4. Regulatory bodies consider how they can best explain to registrants and potential registrants that health is only considered in relation to their capability to practise safely and effectively, and will not be used to unfairly discriminate against them or place them at disadvantage.

The CHRE stated there is '…clear evidence that interpretations of regulatory bodies' requirements by other parties has led to disabled people being discriminated against.' (p.2).

We have produced guidance on the health reference, 'Information about the health reference'[7], and also guidance on becoming a health professional, 'A disabled persons' guide to becoming a health professional'[8]. Both pieces of guidance stress that health is only considered in relation to a registrant's capability to practise safely and effectively.

5. Regulatory bodies ensure appropriate guidance is given to those who look to and interpret the regulatory body requirements and standards for practice, particularly in education and training institutions.

The CHRE said guidance should '…make clear to institutions that students need to have certain competences as course outcomes, but that reasonable adjustments can be made in the methods by which these are reached.' (7.2(5), p.17).

As well as the guidance referred to above we have also provided guidance to accompany the standards of education and training. We are expecting to have 'Guidance on health and character' available which will be taken to the Council in October 2009.

[7] http://www.hpc-uk.org/publications/brochures/index.asp?id=109

[8] http://www.hpc-uk.org/publications/brochures/index.asp?id=111

## 4. Removing the health reference?

The Executive feels that the HPC meets, or is taking steps to meet, four of the five recommendations proposed by CHRE. The recommendation the Executive feels should be reviewed is the third recommendation: 'Regulatory bodies consider the most proportionate means of ascertaining the information they need to determine whether those seeking entry to their registers are fit to practise'.

This recommendation puts the onus on the regulators to consider what information they require to be sure that those seeking admission to a register are fit to practise. Although CHRE do not stress it explicitly in the recommendation, the report clearly states that CHRE sees the requirement for a health reference completed by a registered medical practitioner as unnecessary for public protection and sees it as providing a barrier to some applicants.

The CHRE report says: 'Regulatory bodies do not need access to unnecessary information or wrongful questioning of an applicant's fitness to practise from a medical practitioner making assumptions about how a profession is, and can be, practised. Although regulatory bodies would not take any action in relation to information unrelated to the safety and effectiveness of a person's practice, these unnecessary disclosures may serve to complicate the registration process and potentially cause confusion and distress to an applicant about their professional future.' (2.4, p.5).

They then go on to say that they '…have heard no convincing argument as to why practitioners might pose additional risks to public protection at initial registration justifying the requirement of a full reference, compared with accepting a self-declaration for renewing registration. There is no evidence that regulatory bodies with self-declarations have increased rates of fitness to practice cases within a couple of years of registration in which health is an underlying reason for a practitioner failing to meet their professional standards.' (2.6, p.5).

The Executive agrees that the requirement to have a health reference completed by a registered medical practitioner for those applying to join the Register, or those readmitting to the Register does not add to public protection. Our current requirements are set out in the Registration and Fees Rules. Health is rarely an issue at the point of initial registration when determining fitness to practise and is also seen as confusing and unnecessary by registered medical practitioners and applicants (see section 4.3).

A health reference provides some information which helps to determine fitness to practise, and the most appropriate time to collect this information is when someone is applying, readmitting or renewing. A self-declaration would require someone to advise us of any health condition which may affect their fitness to practise. A self-declaration demonstrates that an individual, autonomous professional, is demonstrating insight and understanding. The number of

applicants refused registration on the grounds of health suggests the public would not be at greater risk of harm if the health reference requirements were changed to a self-declaration.

### 4.1 The health reference and guidance

It is essential that any health reference we require should be fit for purpose. To identify whether this is the case there needs to be an evidence base to focus on those who may cause problems. However, there is little evidence available due to the small number of health issues that arise at the point of application or renewal.

There is a difference in the health requirements for those applying to join the Register and those renewing their registration. The current Rules require new applicants to provide a health reference from a registered medical practitioner. Those renewing registration are able to self-declare whether they remain in 'good health'. By self-declaring at the point of renewal, registrants are demonstrating that they are managing any condition and could be subject to fitness to practise proceedings if they make a false declaration.

We ask about any health conditions that may affect a person's fitness to practise, we do not require information about any health condition that is managed so that it does not affect someone's fitness to practise. We found there was confusion around what was required for the health reference. For this reason we produced a guidance document for applicants and registered medical practitioners called 'Information about the health reference'[9].

### 4.2 Health requirements of the other regulators

All of the other health regulators require a declaration on health at the point of application to their registers. The requirements vary between those who require a signed declaration from a registered medical practitioner and those who accept a self-declaration. The difference in approach between the regulators is due to the wording of the applicable legislation.

The General Medical Council (GMC) and the General Optical Council (GOC) require a signed declaration, and possibly a full statement, from the applicant about their physical and/or mental health that might raise a question their fitness to practise.

The Nursing and Midwifery Council (NMC) and the Royal Pharmaceutical Society of Great Britain (RPSGB) require a self-declaration to state they have good health sufficient to practise safely and effectively. For the NMC this must be supported by a declaration from a third party on first entry to the Register. The RPSGB require the declaration to be supported by a declaration from the supervisor in their pre-registration year in practice.

[9] http://www.hpc-uk.org/publications/index.asp?id=109

The General Dental Council (GDC) requires a medical practitioner to make an assessment of the applicant's fitness to practise and to provide a signed declaration. This requirement is for those applying to join the register and those renewing their registration.

The Pharmaceutical Society of Northern Ireland (PSNI), the General Osteopathic Council (GOsC) and the General Chiropractic Council (GCC) all require a health reference completed by a registered medical practitioner at the point of applying for registration. Those renewing their registration self-declare.

Outside of the health professions most other regulators also require some form of health reference. The Civil Aviation Authority (CVA) require those applying for a Private Pilot Licence to declare their medical fitness, the declaration must be endorsed by a registered medical practitioner with access to the applicants' medical records.

The Maritime and Coastguard Agency (MCA) requires those wanting to work on a UK registered ship to obtain a medical certificate from an MCA approved medical practitioner. The medical practitioner assesses the applicant against a list of identified conditions.

The approach of both the CVA and MCA is possible because of the fixed and controlled environments in which these professionals operate. These approaches are based on the fitness to carry out a particular role rather than the broader fitness to practise of those on our Register.

The Scottish Social Services Council (SSSC) regulates social services workers in Scotland. The SSSC has no formal requirements regarding health. SSSC applicants have their suitability to practise endorsed by their employer, this may include management of their health.

The SSSC still collect information on an applicant's health, however, this information is provided by the applicant's employers and only if the employer feels that the applicant's management of their health condition and their practice calls into question their ability to practise social work. The SSSC considers having these means available as being important in ensuring public protection.

The SSSC's access to references from employers contrasts with the access afforded to health regulators.

### 4.3 Issues raised by registered medical practitioners

We have been contacted by registered medical practitioners who are unwilling to sign the declaration because they have no history with the applicant, or where the applicant is not registered with a medical practitioner.

Although we have provided guidance on the health reference, some registered medical practitioners still refuse to sign the declaration because they feel they are being asked to confirm that the applicant is fit to practise all aspects of a profession. They express concern that they do not know all aspects of the professions and cannot therefore sign to say the applicant is fit to practise.

The health reference is often the subject of complaints from both applicants and registered medical practitioners. Applicants and registered medical practitioners don't understand why we require health references. Registered medical practitioners think they need to assess suitability and ability to be employed (occupational health checks) rather than 'fitness to practise' potentially meaning that decisions might be made on blanket judgements rather than looking at each individuals' situation.

We have also received anecdotal evidence that applicants have been charged for completing the reference. We have also been advised that some applicants lost the offer of positions because of the time it took to become registered as a result of the completed reference being delayed.

**5. Areas for further consideration**

Taking the HPC's experience and the CHRE report into account, the Education and Training Committee are asked to consider whether the requirement for a health reference completed by a registered medical practitioner is appropriate or proportionate to determine whether those seeking entry to the Register are fit to practise.

There seems to be three potential options:

1. To make no changes and keep the current health reference.

2. To replace the health reference with a self-declaration similar to the one currently completed by those renewing their registration.

3. To have no health reference or declaration relating to health.

If the Committee considers a change to the health reference is needed, this would be subject to public consultation. Any agreed changes would need to be made to the appropriate legislation or rules, subject to the outcome of the consultation.

**6. Proposal**

The Executive recommends consulting on removing the health reference and replacing it with a self-declaration.

The Executive suggests that on balance, a formal health requirement at the point of registration should be required and that all those applying to join the Register should be able to demonstrate insight and understanding of any condition they

may have. A self-declaration such as that completed by those renewing their registration is in keeping with the concept of an individual managing their own fitness to practise.

There is no evidence to suggest that there would be a greater risk to public safety if a self-declaration was made rather than a declaration by a registered medical practitioner. On the contrary, the number of self-declarations we currently receive shows that registrants are autonomous professionals who demonstrate insight and understanding of any condition they may have and how it may affect their fitness to practise.

All those on the Register are subject to the same standards and fitness to practise proceedings. Differentiating between those applying to join the Register and those renewing their registration provides an unnecessary barrier for autonomous professionals.

A self declaration would need to be included on the application form which would need to be completed. A declaration may be made in the following terms:

*'I confirm that I do not have a health condition which would affect my safe and effective practice of my profession'*.

However, this suggestion would need be considered alongside the proposed consultation document and would be subject to further discussion by the Education and Training Committee in November, and ratification by the Council in December..

Anyone who makes a false declaration on the application is subject to fitness to practice; this would also apply if the applicant made a false declaration relating to their health. Article 22(1)(b) of the Health Professions Order 2001 states: *'This article applies where any allegation is made against a registrant to the effect that an entry in the register relating to him has been fraudulently procured or incorrectly made'.*

council for healthcare regulatory excellence

# Health Conditions: Report to the four UK Health Departments
**Unique ID 11/2008**

**June 2009**

## Executive summary

All the health professional regulatory bodies have means to take an applicant's health into account when making a decision on whether to register them. For some regulatory bodies this is phrased in terms of the 'good health' of the applicant; others require that an applicant's fitness to practise is not impaired, although 'adverse physical or mental health' is one ground on which fitness to practise may be found impaired.

The regulatory bodies state that the only judgement they make about an applicant is whether the person would practise in accordance with the competence and conduct standards they set for the profession's safe and effective practice. The regulatory bodies do not set or apply standards for health that posit a general state of health required as a condition of registration; rather they consider a person's health only in relation to the effect it has on their practice, in order to determine whether their practice will meet the standards of competence and conduct. In making this assessment, they discuss with the individual their approach to their practice and seek evidence about their individual circumstances from suitably qualified professionals with expertise in the specific area. The purpose is to determine whether the person would practise with any necessary adjustments in ways that meet the required standards in one of the range of roles within the profession. We have seen no evidence that they do not follow this process.

Regulatory bodies have varying provisions for how they consider issues around a registrant's health in fitness to practise procedures. In considering whether a professional is fit to practise, the regulatory body is assessing whether their practice meets the necessary competence and conduct standards. Some regulatory bodies have separate committees for cases in which issues around a registrant's health are the underlying reason for their failure to practise in line with standards; others have a single committee for all types of case where a registrant's fitness to practise is in question.

We believe that there is an important distinction between formal health requirements and fitness to practise requirements. Regulatory bodies do not need health requirements that go beyond determining whether someone is fit to practise, either at registration or during fitness to practise procedures. Health issues may be material in determining whether a person meets the competence and conduct standards, but should not sit outwith this as a separate requirement. However, health needs to be one of the grounds on which a regulatory body can find a person's fitness to practise to be impaired. This is because if issues around the person's health are an underlying reason for their practice not meeting the competence and conduct standards, it is the health issues that are a ground for

establishing this and then finding fitness to practise to be impaired – failure to meet standards does not itself ground a finding.

We recommend that the language regarding the health of registrants is significantly modified. For both registration and fitness to practise procedures the concern of the regulatory body is whether the person is fit to practise – whether their practice meets the necessary competence and conduct standards. However, in some cases the particular circumstances of an individual's health and their approach to their practice may be of material relevance to the question of whether their practice meets these standards, and regulatory bodies need the ability to access and consider such information. We believe that there should be single requirement of fitness to practise for registration and that consideration be given to reordering regulatory bodies' fitness to practise procedures so that there is a single committee with responsibility for all fitness to practise hearings. The purpose of these changes would be to make clear that health is not considered in isolation, but only insofar as it relates whether a person's practice meets the necessary competence and conduct standards.

Engagement between regulatory bodies and registrants and prospective registrants is important to reassure them that disclosing information to regulatory bodies does not put their career at risk; rather their registration is only at risk if their practice is not in line with the profession's standards of competence and conduct. There is also clear evidence that interpretations of regulatory bodies' requirements by other parties has led to disabled people being discriminated against. There is a clear role for further guidance to these parties to help prevent this discrimination taking place and to ensure that disabled people are not impeded or discouraged from participation in the health professions.

## 1 Introduction

1.1 The core purpose of health professional regulatory bodies' registration requirements is to seek to assure the fitness to practise of those on the register and thereby entitled to practise as a member of the profession.[1] A person's fitness to practise as a member of a given profession is a question of whether they practise the profession safely and effectively – in line with the standards of competence and conduct set by the profession's regulatory body. The regulatory bodies all currently ask questions regarding an applicant's health on initial entry to the register. These vary in type across the regulatory bodies, from requiring full references from a medical practitioner to a self-declaration that nothing about the applicant's health calls into question their fitness to practise as a member of the profession. The regulatory bodies also have means by which they can consider the health of a registrant in their fitness to practise procedures, although the formal provisions for doing so vary.

1.2 In 2007 the Disability Rights Commission[2] published *Maintaining Standards: Promoting Equality*.[3] This report concluded that regulatory bodies having health requirements for those on, or seeking admittance to, their register leads to discrimination and has a negative effect on disabled people's access to the health professions.

1.3 The Department of Health commissioned the Council for Healthcare Regulatory Excellence to provide advice on the use and purpose of the health professional regulatory bodies' requirements regarding registrants' health. In particular, the Department sought to ascertain:

- Whether or not the registration procedures of any of the regulatory bodies includes a requirement on the registrant to be in good health at initial registration.

- Where regulatory bodies, as part of their registration process and/or revalidation process, ask questions about the health and/or disability of applicants or registrant, what the purpose is this serves.

- Whether there are any rules or other provisions that require the regulatory bodies to take account of health and/or disability as part of their fitness to practise procedures.

- The volumes of complaints regulatory bodies receive regarding discrimination against disabled people.

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[1] The nine health professional regulatory bodies are the General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI) and Royal Pharmaceutical Society of Great Britain (RPSGB).

[2] In October 2007, the Equality and Human Rights Commission took over the role and functions of the Disability Rights Commission along with those of the Commission for Racial Equality and the Equal Opportunities Commission.

[3] Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*. Available at: http://www.maintainingstandards.org (accessed 22 May 2009).

- Whether or not there would be any detriment to individual registrants or public protection if the health standards were to be removed from the legislative frameworks for the regulatory bodies.

- Whether the same requirements should apply to all regulatory bodies or whether it would be appropriate for different approaches to be taken for different professions.

1.4 The statutory main objective of CHRE when exercising our functions is to promote the health, safety and well-being of patients and other members of the public. The safety of patients and other members of the public is the underpinning principle throughout this report.

## 2 Registration

2.1 The core purpose of regulatory bodies' registration requirements is to seek to assure the fitness to practise of those on the register and thereby entitled to practise as a member of the profession. A person's fitness to practise as a member of a given profession is a question of whether they practise the profession safely and effectively, in line with the standards of competence and conduct set by the profession's regulatory body. It is important that these standards are expressed in terms of the competences necessary for practising as a member of the profession. Regulatory bodies' competence standards should not be expressed in terms that require the use of a particular method unless competence in that method is itself an essential part of a profession's safe and effective practice. The regulatory bodies have all stressed to us their commitment in seeking to ensure their standards are fair and are under an obligation to do so in order to meet their legal duties under the Disability Discrimination Act. Throughout this document when we talk about standards for competence and conduct, we are meaning legitimate competence standards in accordance with the DDA. By this we are not intending to pass judgement on the nature of regulatory bodies' existing standards with regard to the DDA; rather we are referring to the role competence and conduct standards have in the regulation of health professionals.

2.2 The regulation of professionals operates on a principle of taking action to protect the public before they are put at unwarranted risk of harm, not just reacting to adverse events. As a result, the regulatory bodies all require evidence about applicants for the purpose of ensuring there is no reason to believe the person will not practise in accordance with the expected standards should they be registered. To this end, they currently require evidence of applicants that: they have an appropriate professional qualification for entering the register which signals that they have the requisite professional knowledge and skills to practise in line with the profession's standards; their past actions do not give reason to believe they will behave in ways that are not in line the profession's standards; and factors to do with the personal circumstances of their health and management of their practice do not call into question their capability to practise in line with standards.

2.3 Across the regulatory bodies there are differences in the specific type of evidence required about an applicant's health. There are also differences in the legislative frameworks that underpin their registration requirements. These are summarised in an annex to this document.

2.4 The GCC, GDC, GOsC, HPC, and PSNI all require applicants to provide a formal health reference from a medical practitioner. Most of the regulatory bodies provide some guidance to the applicant and the medical practitioner on the purpose of the health reference and the sort of information they require. However, there is wide variation in the detail of the guidance. Robust guidance on the nature of a profession's practice and the necessary competencies is highly important because the purpose of requiring disclosure is to determine whether there may be any effects on the safety or effectiveness of their practice as a member of that profession, which require further consideration with the applicant. Regulatory bodies do not need access to unnecessary information or wrongful questioning of an applicant's fitness to practise from a medical practitioner making assumptions about how a profession is, and can be, practised. Although regulatory bodies would not take any action in relation to information unrelated to the safety and effectiveness of a person's practice, these unnecessary disclosures may serve to complicate the registration process and potentially cause confusion and distress to an applicant about their professional future.

2.5 The GMC, GOC, NMC and RPSGB require applicants to make a self-declaration on their registration forms to the effect that the applicant is not aware of anything about their physical and/or mental health that might raise a question about their fitness to practise as a member of the profession. The NMC and RPSGB also require that an application is signed off by either the applicant's education institution (NMC) or their supervisor in their pre-registration year in practice (RPSGB). The NMC and RPSGB both expect the person making this declaration to highlight any issues which might undermine the applicant's ability to practise in accordance with the necessary standards.

2.6 None of the regulatory bodies referred to in paragraph 2.4 above which require a full reference on initial registration have the same requirement for continuing registration. Most use a self-declaration on renewal of registration forms and place registrants under a general duty to inform their regulatory body if changes in their health affect their ability to practise in line with their regulatory body's standards. We have heard no convincing argument as to why practitioners might pose additional risks to public protection at initial registration justifying the requirement of a full reference, compared with accepting a self-declaration for renewing registration. There is no evidence that regulatory bodies with self-declarations have increased rates of fitness to practise cases within a couple of years of registration in which health is an underlying reason for a practitioner failing to meet their professional standards.

2.7 Most regulatory bodies have 'good health' as a formal requirement of registration, which emerges from its use in their respective legislative frameworks (see annex 1). The use of terms such as 'good health' does not add value to public protection and can obscure the issue regulatory bodies are seeking to address: will the person practise in accordance with the competence and conduct standards it sets for the profession's safe and effective practice. The phrase suggests there is some general state of health that is required for registration and implies there are standards set for health in and of itself, rather than health only being of relevance in relation to competence and conduct. The concern of regulatory bodies is not the state of a person's health in itself. The concern of regulatory bodies is whether a person is capable of practising in accordance with the standards of competence and conduct it sets for the profession. In itself, a health condition says nothing informative about this from which conclusions can be drawn to answer this question. The diagnosis of a

health condition does not provide reasons to conclude that in practice a person would pose a risk to the safety of patients or other members of the public. A risk would only arise if a person does not manage their practice to meet the necessary standards for safe and effective practice. In this sense, any person who does not practise in line with the necessary standards may be putting the safety of patients or colleagues at risk, regardless of whether their health is an underlying reason for this.

2.8 All the regulatory bodies are emphatic that they do not set specific standards for health on the basis of which diagnosis driven judgements are made; rather they judge each person's case on an individual basis. The regulatory bodies discuss with the individual their approach to their practice and seek evidence on their individual circumstances from suitably qualified professionals with expertise in the specific area. The purpose is to determine whether the person has the capability to practise with any necessary adjustments in ways that meet the required standards in one of the range of roles within the profession. The regulatory bodies see the function of their powers regarding health being to enable them to consider any impact of the wider issues around an applicant's health on their capability to practise safely and effectively in line with the standards of the profession. The function is not to set any additional standards outwith those set for professional competence and conduct, but to seek evidence there is no reason to believe an applicant would fail to comply with their obligations under these. All the regulatory bodies strongly believe that their processes are free from discrimination, involve no unjustified assumptions and are based solely on assessments of an individual case using detailed information from those with expertise on the risks involved. In no case would diagnosis itself be used as a predictor of professional performance such that the diagnosis alone is used as grounds for an absolute bar to registration. We have seen no evidence that leads us to doubt that the regulatory bodies apply their processes in this way.

2.9 Across the health professional regulatory bodies, there have been very few cases in recent years in which applicants have been refused registration on the basis of information regarding their health. We have learned of no cases in recent years in which health has been a sole basis for refusing registration, although we have been informed of a small number of cases in which information regarding an applicant's health has been considered material in the context of other issues raised with respect to their knowledge, skills and behaviours. There have also been a number of cases in which the registration process has taken longer for applicants with an impairment or health condition if a regulatory body has sought further information, such as expert opinions and discussions with the applicant about their strategies for managing their practice, before making a final decision to register them.

2.10 However, the semantics of 'good health' also raises problems beyond being an inaccurate descriptor for the regulatory bodies' purpose. Although many of the regulatory bodies provide advice to applicants, registrants and medical practitioners filling in health references about the requirement, with varying degrees of detail, the term can still create problems. Applicants, registrants and medical practitioners are formally being asked to attest to 'good health' and this has the potential to cause confusion to the parties involved when they may consider that their health is not 'good', but does not affect the safety or effectiveness of their practice. Similarly, a medical practitioner filling in a health reference might not fully understand the nature of a different profession's practice and how the expected standards can be met and so erroneously consider a person's health or impairment as an impediment to safe and effective practice.

2.11 We have seen evidence of instances in which having 'good health' as a formal requirement to be entitled to practise a profession creates the opportunity for bullying and discrimination of those with impairments or health conditions by other parties, even where regulatory bodies' own processes are applied so as to be free from discrimination. *Maintaining Standards* highlighted a number of cases in which employers had bullied employees on the basis that they are required to be of 'good health' to be registered and allowed to practise their profession.[4] It is unfortunate that regulatory bodies' requirements are misrepresented in this way. Wider issues around this and the role of guidance are discussed further in section six. The report also highlighted cases in which higher education institutions had sought to interpret regulatory bodies' requirements regarding whether a person would ultimately be registered and made unwarranted assumptions about disabled people leading to outcomes which discriminated against people who had a disability or health condition.[5]

2.12 The Scottish Social Services Council (SSSC), which regulates social workers and certain other social services workers, provides an instructive comparison to the health professional regulatory bodies because it does not have formal requirements regarding health. However, the SSSC has other means by which it receives and assesses information where an applicant for registration who has a health condition may not be meeting its standards due to not managing their practice appropriately. (It should be noted that the UK's professional regulatory bodies for social workers only enforce codes of practice regarding conduct but not competence in the same way the health professional regulatory bodies do, which limits the ways in which professionals might not practise in line with standards.)

2.13 The SSSC requires applicants to have their suitability to practise endorsed by their employer, in which the employer is required to raise any issues which might affect their suitability – including any issues about their management of their health/practice. There is a code of practice for employers which includes responsibilities on endorsing applications and is enforced by the systems regulatory body, the Scottish Commission for the Regulation of Care. If issues are raised in the endorsement the SSSC will discuss management strategies with the person to explain how they manage their condition and practice to be in line with the SSSC's standards. If the person fails to co-operate with the SSSC, it will deem them to be unsuitable and not register them. The SSSC may also ask for access to medical records and for the person to have a medical assessment, failure to co-operate will lead to the SSSC determine that the person is not suitable to be registered. Therefore, although the SSSC does not have any formal rules for considering an applicant's health at initial registration, it has other means to find out if an applicant's management of a health condition and their practice calls into question their ability to practise social work. The SSSC considers having available these means which allow it to consider implications in practice of a person's health where they emerge as being important in ensuring public protection. It is important that regulatory bodies have means to find out if there are issues surrounding a person's management of

[4] See Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*, p173-4.

[5] See Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*, p160-5.

their practice for which health is an underlying reason that mean they are unable to meet the necessary competence or conduct standards.

2.14 There are features of the employment arrangements that the SSSC regulates that sharply contrast with those of the health professional regulatory bodies. These mean that the health professional regulatory bodies would not have access to the information which the SSSC can get through references from employers. The SSSC has taken on the role of regulating an existing workforce of whom more than 99% are in established employment. The formal employment relationship provides a source of information from employers provided according to a code enforced by the systems regulatory body for which the health professional regulatory bodies have no equivalent. The SSSC also operates student registration meaning all students are registered and regulated against its code of practice for registrants before going into practice-based learning, providing another avenue for questions of suitability to be brought to its attention before a person is granted full registration.

2.15 We recommend that the language of 'good health' should be removed from the legislative frameworks governing the regulatory bodies' registration procedures. The only legitimate consideration for the regulatory body is whether a person is fit to practise. This is a question of whether the person will practise in accordance with the regulatory bodies' competence and conduct standards, although in some cases a person's health in relation to the way they practise may be relevant in making this determination. Regulatory bodies need access to this information and the ability to consider it where it is relevant to the question of whether a person will practise in accordance with competence and conduct standards.

## 3 Fitness to practise

3.1 The term 'fitness to practise' relates to whether someone meets the standards a regulatory body sets for competence or conduct; it is used as a term for a particular legal purpose. The use of the word 'fitness' is not intended to relate to any general state of health. In using the term it is not the purpose of the regulatory bodies to be making any abstract statements about an individual's fitness as regards their physical or mental health. Similarly, the use of the term 'impairment' when a person's fitness to practise is found to be impaired, is used in a legal sense and is not intended to relate to any disability, other physical impairment or health condition a person may have. If someone needs to limit their practice in certain ways for it to be safe and effective, and they do so, they are following their professional obligations – there is no sense in which as a result of this they are impaired in terms of fitness to practise.

3.2 Regulatory bodies' fitness to practise procedures should have the same focus as registration procedures: is the person's practice safe and effective and in accordance with the profession's standards for competence and conduct set by the regulatory body? This is the core of judging whether a person is fit to practise or whether their fitness to practise is impaired and action on their registration required. As with registration procedures, the regulatory bodies assure us that they do not set specific standards regarding registrants' health. The regulatory bodies use their powers regarding health to enable consideration of how the particular circumstances around a registrant's health do or do not affect their capability for safe and effective practice in line with the regulatory body's competence and conduct standards. Consideration of their particular circumstances will include factors such as management strategies and adjustments in their practice, information on their personal circumstances from

appropriately qualified practitioners and any wider evidence that may be relevant in their individual case.

3.3 Regulatory bodies have the role of setting standards for competence and conduct and need the ability to consider the health of applicants and registrants insofar as it is a factor relating to the person's capability of meeting these. This should not be framed in terms of standards or specific regulations regarding health. It should be framed in terms of fitness to practise, with health a factor that can be considered where it may affect the person's practice such that it calls into question whether they can practise in line with the regulatory bodies' standards. In a policy statement on the meaning of fitness to practise, the GMC illustrates how it considers health can be a factor in terms of fitness to practise:

> The GMC does not need to be involved merely because a doctor is unwell, even if the illness is serious. However, a doctor's fitness to practise is brought into question if it appears that the doctor has a serious medical condition (including an addiction to drugs or alcohol); AND the doctor does not appear to be following the appropriate medical advice about modifying his or her practice as necessary in order to minimise the risks to patients.[6]

3.4 This represents a situation in which the professional is failing to practise in accordance with the regulatory body's standards because their practice is putting patients at unwarranted risk of harm. We believe this is the appropriate way for regulatory bodies to consider the impact of a person's health on their fitness to practise. It demonstrates that it is not a health condition in itself that is the basis of the determination, but rather a professional's practice. The facts regarding a person's health and management of a condition may be relevant in determining whether and, if so, how they are able or unable to meet the regulatory body's standards. A diagnosis is no basis for concluding whether a person's fitness to practise is or is not impaired. As the DRC noted in *Maintaining Standards*:

> Health might be material to compliance with competence or conduct standards, or may not be, but diagnosis is irrelevant in determining competence or conduct.[7]

3.5 We agree with the DRC's statement. Regulatory bodies should not have any requirements for the state of a person's health as a condition of registration that go beyond the question of whether they can practise in line with the profession's competence and conduct standards. Regulatory bodies need the power to consider the effects health may have on a professional's practice to carry out their role of protecting the public. A diagnosis may mean a professional needs to modify the way they practise to ensure it is safe and effective, but the diagnosis itself does not mean the professional is not capable of practicing in line with their standards. It is only where the professional is unwilling to, has failed to, or for any reason cannot take appropriate steps to modify the way they practise in light of their health that their fitness to practise is in question. However, non-compliance with competence and

[6] General Medical Council (2007) *The Meaning of Fitness to Practise*. Available at: http://www.gmc-uk.org/concerns/the_investigation_process/the_meaning_of_fitness_to_practise.pdf (accessed 22 May 2009).
[7] Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*, p113.

conduct standards is not itself the legal grounds for finding a professional's fitness to practise to be impaired. A finding of impairment requires an incident or other fact regarding the professional to be found proved which is determined to represent a significant or persistent departure from the regulatory body's standards, as the grounds for finding the professional's fitness to practise to be impaired. If a health condition is an underlying reason why a professional is departing from standards, regulatory bodies need to be able to establish this fact and consider whether the person's actions with respect to their health and practice represent a significant or persistent departure from their professional obligations, in order to make a determination on their fitness to practise.

3.6 Regulatory bodies suggested to us that not to be able to fully consider health or deem it an underlying reason for fitness to practise being impaired would prevent a complete assessment being made on the specific risks involved in a given case. Testing a professional's competence only provides a snapshot at one moment in time and may not provide a full picture if a person has a fluctuating condition that they inadequately manage in relation to their practice. Such particularities need to be grounds a panel can consider if it is to make a comprehensive determination of the risks a person's practice poses to patients, the public or colleagues and then decide on any appropriate sanction.

3.7 In a similar vein, we were told that if health could not form grounds for panels in determining whether fitness to practise is impaired, at times this may impede the regulatory body's ability to build a comprehensive case. It may take the regulatory body more time to build a case in which appropriate action could be taken based solely on grounds of deficient professional performance or misconduct if wider information on their health and management of their practice could not be fully taken into account in the grounds for a decision. This would require more evidence of deficient professional performance or misconduct to ground a finding and may mean the regulatory body would be unable to take appropriate action until after more significant instances of deficient professional performance or misconduct had occurred. We were informed that the Council for the Professions Supplementary to Medicine had experienced problems in this specific regard prior to its supersession by the HPC with the power to consider health in its procedures. The GOC and RPSGB also noted that they had felt unable to take action when they believed a registrant's practice failed to meet standards prior to legislative changes that gave them the power to consider health as grounds in fitness to practise cases. However, like the other regulatory bodies, they only use health as grounds in determining whether a person's practice does not fall short of the

3.8 The largest number of fitness to practise cases in which health is an underlying reason for a person's failure to practise in line with their regulatory body's standards involve alcohol or drug dependency, which is not covered by the DDA. However, a significant proportion of cases involve a professional with a mental health condition that underlies effects in practice such that they are failing to practise in line with the regulatory body's standards. There are also a handful of cases involving other impairments or health conditions. Examples the regulatory bodies gave us of what these cases might involve include: epilepsy if the person is having regular and unpredictable episodes and practises in ways that may put patients at risk; early onset dementia if a professional is unable to recall relevant information in ways that may jeopardise the safety of those in their care; and some degenerative conditions if

a professional does not make needed adjustments in their practice to maintain its safety if the condition is having an effect on their physical capabilities.

3.9 We recommend that consideration is given to reordering regulatory bodies' fitness to practise procedures so that there is a single committee with responsibility for all fitness to practise hearings. This would help to make clear that the issue at hand in proceedings is a person's compliance with the regulatory bodies' competence and conduct standards in their professional practice, and that a person's health and surrounding issues are only considered where they are of material relevance to this. The GMC recently moved to having a single committee for fitness to practise hearings and believes that this far better facilitates consideration of different factors which may underlie a person's failure to practise in line with their standards. In such a system there can still be provisions to enable adjustments to be made for hearings to ensure the confidentiality of sensitive personal information or if other requirements are involved in a given case.

## 4 Public protection

4.1 We have sought to highlight how the regulatory bodies' procedures regarding professionals' health relates to public protection throughout this report. Similar principles apply regarding risks to the safety of colleagues if a professional is not practising in line with competence and conduct standards. Our core findings are presented in the paragraphs below.

4.2 The obscure language around 'good health' should be removed from the legislative frameworks of those regulatory bodies in which it is present. The concern of regulatory bodies should be whether a person is fit to practise, which is a question of whether they would meet the standards of competence and conduct. Issues around a person's health are of relevance only in relation to these standards, not in themselves. There need be no provisions for health to be assessed outwith its impact on the competence and conduct of the person and their capability for practising in line with these standards. A single requirement that a person's fitness to practise is not impaired to be eligible for registration is used by the GMC, GOC and RPSGB and has had no negative impact on public protection.

4.3 Regulatory bodies need to be able to find out if there is any reason a person's management of a health condition in relation to their practice might lead to them to be unable to practise in accordance with the regulatory bodies' standards of competence and conduct, and to prevent a person being registered if necessary. Although there are few cases in which a health professional regulatory body has turned applicants down on the grounds of health, we have heard of a number of cases in which a regulatory body has considered a person's management of their practice with regard to health to be material to their potential compliance with standards and the threat of not being registered has contributed to public protection. In such cases, people have taken further steps to ensure their practice meets the necessary standards, for example discussing with suitably qualified professionals or the regulatory body how best they can adapt their practice or making voluntary undertakings on this prior to registration. The SSSC, which lacks any formal legal powers regarding applicants' health, has established mechanisms to ascertain where health issues impact on a person's practice and may undermine their suitability. It considers these to be important to its role of protecting the public. All regulatory bodies are under a legal duty to ensure that their means for finding out this information are proportionate and

do not lead to any unjustified discrimination or disadvantage against disabled people, this is defined in the DDA. The regulatory bodies are also under a duty to make individualised assessments in relation to their competence and conduct standards, and taking into account the full circumstances of a person's particular case and considering evidence from those with appropriate expertise.

4.4 In fitness to practise procedures, like registration, the question is whether the person's practice is in line with the profession's competence and conduct standards. Health issues are relevant only in relation to making a determination on this. The GMC's view on the meaning of fitness to practise demonstrates how health issues should be considered by regulatory bodies in making decisions about a person's fitness to practise. We believe that it is important for public protection that regulatory bodies are able to consider issues around a professional's health in this way. The regulatory bodies assure us that they do not make decisions based on solely a diagnosis, which would be discriminatory to a professional and could not be justified on the basis of public protection. However, if issues around health are a major underlying reason why someone does not meet the standards of proficiency, they are grounds on which the person's fitness to practise is impaired. Consequently, we believe that there still needs to be appropriate provision in the regulatory bodies' legislative frameworks for them to be able to make this finding.

4.5 We believe that the same framework of assessing fitness to practise on registration and having single fitness to practise committees can apply equally across all the regulatory bodies. However, the way they operate within this must vary according to the context of different professions. There are different competence standards for different professions and so regulatory bodies' handling of issues regarding how an individual's circumstances might affect their ability to meet standards must be made according to their specific standards for the profession and context of its practice. In this respect, regulatory bodies' processes and requirements need to be specific to the profession. The nature of a profession's safe and effective practice is the grounds for regulatory bodies' competence and conduct standards, from which the type of evidence that is relevant on the question of whether someone meets these and is fit to practise can be determined. There is an onus on regulatory bodies to ensure all its standards are evidence-based and proportionate and to be transparent about how it processes operate and the ways it will consider people's information. Clarity in procedures could help reassure professionals that disclosing information to their regulatory body does not itself put their career at risk; rather their registration will only be at risk if their practice is not in line with the profession's standards of competence and conduct. [8]

4.6 We have also commissioned a piece of qualitative research into the opinions of patients, carers and other members of the public into how regulatory bodies should act with regard to the health of professionals. The conclusions were that the professional has the primary responsibility to recognise any impacts their health has on their practice and, along with an employer if relevant, manage their situation and make any necessary adjustments in order to meet the standards set out by their regulatory body. Regulatory bodies were expected to intervene when an issue was

[8] This fear was highlighted in Stanley N, Ridley J, Manthorpe J, Harris J and Hurst A (2007) *Disclosing Disability: Disabled students and practitioners in social work, teaching and nursing*. This was a research study to inform the DRC's investigation and is available at http://www.maintainingstandards.org (accessed 22 May).

not being satisfactorily managed, but did not need to be involved if a professional has a health issue which does not affect their practice.

## 5 Complaints to regulatory bodies about disability discrimination

5.1 Although in many cases the health professional regulatory bodies do not specifically code complaints regarding discrimination against those with disabilities, they have told us that to the best of their knowledge they receive few complaints in this regard. Some told us that they have never received any such complaint. They suggest that most of the complaints received are identify others as the discriminating party, particularly education and training institutions, rather than being directed against the regulatory body's own procedures or actions. We were told that complaints often regarded failures to make reasonable adjustments, particularly for examinations.

## 6 Guidance

6.1 There is wide variation in the level of guidance provided by regulatory bodies provide to potential applicants, registrants, education and training providers and others. We believe there are a number of reasons why it is important that high-quality guidance on health issues is provided to registrants, applicants and others who may be considering a particular health profession as a career. Guidance on how health issues are relevant in fitness to practise would promote transparency and help reassure people that no general assumptions will be made about them on the basis of any health condition they may have. It should stress that information with regard to health is assessed with regard to competence and conduct standards, and health in itself never forms the basis of decisions. The guidance should also made strong references to the rights that people have, particularly under the DDA, so that people do not feel as disempowered in the process and know that regulatory bodies are legally accountable for the information they request and the decisions they make.

6.2 Guidance to professionals would also be useful in empowering them where employers might use their health condition to bully them and threaten them with referral to their regulatory body, numerous cases of which were found by the DRC.[9] If professionals know that as long as they are practising safely and effectively in line with their regulatory body's standards of competence and conduct, their health provides no grounds on which action will be taken against them, this could help remove the fear which enables such bullying to take place. Professionals, and prospective professionals, should be made aware that a health condition or impairment limiting the extent of their practice has no direct bearing on their fitness to practise; rather of relevance is that the person acts appropriately in their individual circumstances by managing their practice to meet their professional obligations to practise safely. Fitness to practise is only in question if a professional fails to do this and places the safety of patients or colleagues at risk as a result. Last year concerns and misapprehensions regarding this difference emerged to GMC as a significant issue during its series of events for students on fitness to practise. Engagement with registrants and prospective registrants over this issue has potential to reassure people with impairments or health conditions that they are not at risk of losing their career if they are open about their condition and enhance their confidence in participating fully in public life.

[9] See Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*, p173-4.

6.3 Guidance to education and training institutions is important because they make decisions with regard to the relevant regulatory body's policies. As responsibility for interpreting regulatory bodies' policies rests solely with individual institutions they may apply different criteria in practice – the greater the range of interpretations open to institutions, the greater the likelihood of such differences occurring. Roberts et al (2005) found that in the medical profession the consequence of this was that 'students with the same disability may be admitted to one medical school whilst being denied entry to another'[10] (this study was before the GMC launched its range of guidance documents). Where institutions are making decisions on students' fitness to practise and making judgements using regulatory bodies' standards, formal structures in institutions and guidance from regulatory bodies would increase the transparency of decision-making and could help to ensure that students do not receive unfair discriminatory or differential treatment. The DRC noted in *Maintaining Standards* that:

> …in relation to nursing the DRC did not find, during its investigation, any evidence of complaints of disability discrimination against the NMC in the use of its powers to remove people from the register (or to refuse re-registration). However we came across cases and complaints where the "good health and good character" requirements were used as justification for discrimination against disabled people being refused entry onto higher education courses.[11]

6.4 Although a regulatory body might not itself be discriminating against disabled people, education and training institutions look to the regulatory bodies' policies in making their own assessments.[12] If other parties are using a regulatory body's policies as a basis for discriminatory decisions, it should seek to take action within their powers to prevent this by bringing maximum clarity to how their requirements should be interpreted. Institutions have their own legal obligations to make reasonable adjustments under the DDA and should have established procedures for so doing. However, as with admissions decisions there is significant potential for different institutions to make different decisions on whether making certain adjustments means the student may no longer be achieving a competence standard the regulatory body requires as an outcome of students. In both these cases, there is a role for regulatory bodies to work with institutions to ensure fair and consistent decisions are made and students not discriminated against or otherwise unjustly disadvantaged. This might help more people get on to and make it through courses and help promote the participation of disabled people in public life, which is something all public authorities must have due regard to under the DDA. There is also an onus on education and training institutions to provide effective counselling to disabled students about their future career options. We have heard of many cases in which institutions can make significant reasonable adjustments which enable students to pass through the course, but the students then face difficulties in finding employment where the types

[10] Roberts TE, Butler A and Boursicot KAM (2005) *Disabled students, disabled doctors – time for a change? A study of different societal views of disabled people's inclusion to the study and practice of medicine.* The Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine: Special Report 4.

[11] See Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*, p130.

[12] See Wray J, Gibson H and Aspland J (2007) *Research into decisions relating to 'fitness' in training, qualifying and working within Teaching, Nursing and Social Work*. This was research funded by the DRC as part of its investigation and is available at http://www.maintainingstandards.org (accessed 22 May).

of adjustments that were reasonable in the context of a university are reasonable in the context of smaller employers with fewer resources.

6.5 Some of the smaller regulatory bodies have told us the cost of producing guidance would be very high relative to the number of registrants or potential registrants with impairments or health conditions, but that they would welcome discussing any issues with registrants on an individual basis. However, there is a difficulty here in that if professionals are fearful that mentioning an impairment or health condition to their regulatory body may lead to action being taken against them, they may be unwilling to approach the regulatory body for advice in the first place.

6.6 This is an area in which collaboration involving a number of regulatory bodies may be useful to share good practice and lower each body's respective costs and facilitate greater involvement form groups with expertise who may otherwise struggle to engage with many different regulatory bodies due to lack of time or resources. There are many similar themes and standards across different professions which could facilitate joint working on guidance. Many individuals in education institutions and occupational health services will serve professionals from a number of different regulatory bodies meaning that shared guidance could ensure greater clarity and more consistent application in practice.

6.7 The NMC has recently conducted a major literature review to identify good practice in guidance around making reasonable adjustments in nursing and midwifery, which also explored adjustments in other health professions. It has disseminated the final document widely to interested parties. It provides a basis for regulatory bodies taking forward their own initiatives, as do documents already produced by some of the regulatory bodies[13]. The regulatory bodies have an established joint forum on equality and diversity that provides a vehicle for collaborating and taking forward work on good practice across a range of equality and diversity issues, of which the regulatory bodies have identified ensuring their processes are free from any from of discrimination against disabled people to be a key one.

## 7 Recommendations

7.1 There are a range of provisions in the regulatory bodies' respective legislative frameworks regarding the health of registrants with regard to initial registration and staying on the register. The regulatory bodies are clear that the only judgement they make about an applicant at registration or a registrant during fitness to practise procedures is whether the person would practise safely and effectively in accordance with the competence and conduct standards it sets for the profession. We have seen no evidence that leads us to doubt this.

7.2 There is a crucial distinction between formal health requirements and fitness to practise requirements. Regulatory bodies do not need health requirements that sit outside determining whether someone is fit to practise, either at registration or during fitness to practise procedures. Health issues may be material in determining whether a person meets the competence and conduct standards, but should not sit outwith

[13] See for example the GMC (2008) *Gateways to the Professions – Advising medical schools: encouraging disabled students*, available at http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/gateways_guidance/index.asp (accessed 22 May 2009) and HPC (2006) *A disabled person's guide to becoming a* health professional, available at http://www.hpc-uk.org/publications/brochures/ (accessed 22 May 2009)

this as a separate requirement. However, health needs to be one of the grounds on which a regulatory body can find a person's fitness to practise to be impaired. This is because if issues around the person's health are an underlying reason for their practice not being in line with the competence and conduct standards, the health issues are a ground for establishing this and then finding fitness to practise to be impaired – failure to meet standards does not itself ground a finding.

7.3 We have five core recommendations to the Department of Health and the regulatory bodies on the role of regulatory bodies in relation to the health of their registrants and prospective registrants:

(1) We recommend that the language of health should be overhauled. In the regulatory bodies' respective legislative frameworks, we recommend removing all references to 'good health' as a requirement for registration and that there be a single requirement that an applicant's fitness to practise is not impaired for them to be eligible for registration. The language of 'good health' is archaic and implies that there is some general state of health that is required for registration and implies there are standards for a state of health considered in abstraction; rather than health only being of relevance in relation to practising safely and effectively in line with competence and conduct standards.

(2) We recommend consideration is given to making changes to the regulatory bodies' respective legislative frameworks to move them to operating with a single fitness to practise committee. This would help to make clear that the issue at hand in proceedings is the safety and effectiveness person's practice and whether they can and do meet their professional obligations set out in their regulatory body's competence and conduct; health is only considered when it is relevant in this context and is not otherwise be grounds for finding impairment in fitness to practise proceedings. It may also be the case that moving to a single committee facilitates better consideration of the relation the different factors involved in a person's failure to meet standards in order to make a comprehensive assessment, as has been found by the GMC.

(3) We recommend that regulatory bodies examine how best they can ascertain the information they need to determine whether an applicant is capable of meeting their standards. We have heard no convincing argument as to why a full health reference from a medical practitioner is proportionate for initial registration, but a self-declaration proportionate for ongoing registration. There is no evidence that regulatory bodies with a self-declaration at initial entry have more fitness to practise cases which relate to a registrants health during the first couple of years of a professional's practice following registration. However, we have heard of a number of cases in which the information from self-declarations or health references has led regulatory bodies to discuss an applicant's particular circumstances with them, which in turn has led the applicant to seek further advice from suitably qualified professionals or undertake to manage their practice in particular ways so that it is in line with the regulatory body's competence and conduct standards. We believe that it is appropriate for regulatory bodies to seek particular kinds of information on applicants' health for use in assessing an applicant's fitness to

practise, but regulatory bodies should ensure their methods for so doing are proportionate to the information required. They should also ensure that they have clear guidance to those filling in any declaration about the kind of evidence they seek, why it is relevant to assessing an applicant's fitness to practise the profession, and that the assessment is only made in relation to an applicant's practice and is not in any way about their health in general.

(4) We recommend that regulatory bodies examine how they can best provide information to and engage with registrants, applicants, students and others considering a career in the profession over the role of health in regulatory processes. The aim is to assure people that the only concern of the regulatory body is the person's capability to practise in line with competence and conduct standards, not the state of their health or any impairment they might have, and explain that there are ways they can manage their practice to meet the regulatory body's standards. The purpose of this engagement is to promote the full participation of disabled people in the health professions by removing common fears about regulatory processes, helping them understand better how they can manage their practice to meet standards and seeking to undermine one of the grounds on which disabled professionals are victimised.

(5) We recommend that regulatory bodies issue further guidance to education and training institutions and occupational health services, which explains their requirements for fitness to practise for those on or entering the register. This is important to end the different interpretations of regulatory bodies' requirements, which has led to discrimination against disabled people and made the profession less accessible to them. It should cover how and why knowledge, skills and behaviours are required for a profession's safe and effective practice. Guidance should also make clear to institutions that students need to have certain competences as course outcomes, but that reasonable adjustments can be made in the methods by which these are reached. It may be worth the regulatory bodies consider the potential of collaboration to help ensure clarity and consistency for education institutions and occupational health services serving different health professions, to improve the cost-efficiency of comprehensive guidance, and to facilitate the greatest involvement from those external parties which have expertise in this area.

## Annex 1: Legislative requirements of regulatory bodies regarding applicants' health at initial registration

- The GCC, GDC, GOsC have the requirement a person 'satisfies' the Registrar 'that he is in good health, both physically and mentally' in order to be entitled to be registered. This is laid down in legislation in the Chiropractors Act 1994, the Dentists Act 1984 and the Osteopaths Act 1993 respectively.

- The GMC and RPSGB have the requirement, from the Medical Act 1983 and the Pharmacy and Pharmacy Technicians Order 2007 respectively, that a person's 'fitness to practise is not impaired' for them to be entitled to be registered. Both pieces of legislation specify that 'a person's fitness to practise shall be regarded as "impaired" for the purposes of this [Act/Order] by reason … of … adverse physical or mental health'.

- The GOC has the requirement from the Opticians Act 1989 that a person must be a 'fit person to practise as an optometrist or dispensing optician' in order to be entitled to be registered. The GOC defines a fit person as someone whose fitness to practise is not impaired under the terms of the Act, one ground on which this can be found is 'adverse physical or mental health'.

- The HPC and NMC, under the Health Professions Order 2001 and the Nursing and Midwifery Order 2001 respectively, have the power to 'prescribe the requirements to be met as to the evidence of good health … in order to satisfy the Education and Training Committee that an applicant is capable of safe and effective practice under that part of the register' (HPC) for them to be entitled to be registered. For the NMC the latter part of the extract reads '…in order to satisfy the Registrar that an applicant is capable of safe and effective practice as a nurse or midwife'.

- The PSNI, under the Pharmacy (Northern Ireland) Order 1976 may 'make regulations with respect to … the conditions as to character, physical and mental health and other matters to be satisfied by persons desirous of being registered as pharmaceutical chemists under this Order'.

## Annex 2: Disability Equality Impact Assessment

There is no evidence that the health professional regulatory bodies discriminate against disabled people in the application of their current registration or fitness to practise requirements. We have been informed by all nine regulatory bodies that they always judge a person's application for registration on its own merits without making any assumptions about a person's capability for practise on the basis of any impairment or health condition the person may have. This judgement is based on whether the person would practice in line with the regulatory body's competence and conduct standards, and will take the person's full individual circumstances into account and seeking expertise from suitably qualified professionals. We have seen no evidence that leads us to doubt this.

If regulatory bodies are making assessments in this way, unjustified discrimination against disabled people should not arise (providing the competence and conduct standards do not unnecessarily prescribe particular methods of a competence being achieved which disadvantage disabled people who could reach them in different ways). Therefore any changes to the legislation governing regulatory bodies' registration procedures is unlikely to have any direct impact on unjustified discrimination against disabled people when they are applying for registration.

It is important that these competence and conduct standards that professionals are judged against are expressed in terms of the competences necessary for practising as a member of the profession. Regulatory bodies' competence standards should not be expressed in terms that require the use of a particular method unless competence in that method is itself an essential part of a profession's safe and effective practice. The regulatory bodies have all stressed to us their commitment in seeking to ensure their standards are fair and are under an obligation to do so in order to meet their legal duties under the DDA. When reviewing standards ensuring they are expressed in terms of essential competencies, rather than any inessential methods, is necessary to prevent disabled people being judged against these standards suffering unjustified discrimination. Assessing whether a person is fit to practise, where the effect of their health may be an underlying reason for this being in question, is about whether their practice meets competence and conduct standards. Therefore it will only be free from discrimination if the content of these standards do not put disabled people at an unfair disadvantage in meeting them.

The regulatory bodies have told us that complete removal of powers with regard to health may hinder their ability to refuse registration to a person if health issues are an underlying reason why they believe the person may not be able to practise in line with their competence and conduct standards. Therefore there may be circumstances in which disabled people would be able to register if there were no powers available to regulatory bodies, but would be unable to if the regulatory body is allowed to consider health issues in relation to a person's practice as a reason they were not capable of practising safely and effectively. It is difficult to predict the size of any impact as there are so few cases where regulatory bodies have refused registration on these grounds from which to draw conclusions. If regulatory bodies are making assessments in the way they assure us they are – and we have seen no evidence that leads us to doubt this – there should not be any unjustified discrimination. The only cases that should be able to arise currently are where someone is turned down for registration because the effects of their health in relation to their practice prevent them from practising safely and effectively in line with the regulatory body's competence and conduct standards.

Complete removal of any powers for regulatory bodies to consider applicants' health as part of registration would prevent delays to disabled people being registered that currently occur if regulatory bodies decide they need further information before making a final decision. Whilst regulatory bodies will pay for the costs of assessments from suitably qualified practitioners, there is potential for a financial cost to the applicant if they are unable to start work in their profession because they are not yet on the register.

There is no evidence of different rates of participation in the social care professions by disabled people between Scotland and England, where the GSCC unlike its Scottish counterpart does assess health on application for registration. However, there could be other factors involved that have not been controlled for and make this an inadequate basis on which to draw conclusions about the effect of this assessment on disabled people's participation.

Changing the language around requirements to remove references to 'good health' and similar terms and replacing it with a single fitness to practise requirement may help limit the opportunities for disabled people to be victimised where threats to report their health to the regulatory body is the basis for the victimisation. Making it more clear that regulatory bodies will not take action on the basis of health alone, but only where a person is failing to practise in line with competence and conduct standards, may help limit the disempowerment disabled people feel vis-à-vis regulatory processes. Complete removal of health as a grounds on which fitness to practise can be found to be impaired might have an even greater reassuring impact, although for reasons outlined in the report we do not recommend this option.

Guidance and engagement with professionals to communicate this message and which highlights the rights disabled people have under the DDA and the ways regulatory bodies are legally accountable for their actions would be essential in efforts to empower disabled people in relation to victimisation and fear of negative impacts on them from regulatory processes.[14] This could help to limit one aspect of the workplace discrimination disabled people are exposed to encourage the fuller participation of disabled people in public life without fear of negative consequences.

Guidance to students, potential students and registrants on managing fitness to practise could have positive impacts for disabled people regarding suspicions of regulatory processes, and may help prevent adverse events by helping people feel more at ease about being open about seeking advice and making adjustments to their practice. For example, stressing a health condition or impairment limiting the extent of their practice has no direct relation to their fitness to practise; rather of relevance is that the person acts appropriately in their individual circumstances by taking any necessary advice and managing their practice to meet their professional obligations to practise safely.[15]

Guidance to education and training institutions on regulatory bodies' requirements could prevent the differential interpretation of these on the basis of which disabled people have received discriminatory treatment and been refused entry to some courses.[16] This

[14] Both these fears are highlighted in Disability Rights Commission (2007) *Maintaining Standards: Promoting Equality – Professional regulation within nursing teaching and social work and disabled people's access to these professions*

[15] Misapprehensions on the difference between these amongst students were highlighted by the GMC as a key issue emerging from its information sessions for students on fitness to practise.

[16] See Roberts TE, Butler A and Boursicot KAM (2005) *Disabled students, disabled doctors – time for a change? A study of different societal views of disabled people's inclusion to the study and practice of medicine.* The Higher Education Academy. Special Report 4. See also Wray J, Gibson H and Aspland J

discrimination based on wrong interpretations of regulatory bodies' requirements has prevented disabled people becoming health professionals and serves as a barrier to disabled people's participation in public life. Engagement between regulatory bodies and education and training institutions could help limit this discrimination and increase the accessibility of the professions to disabled people. Similarly, guidance on how reasonable adjustments can be made without this meaning a student is no longer reaching a defined necessary course outcome could help disabled students progress through courses and become health professionals.

(2007) *Research into decisions relating to 'fitness' in training, qualifying and working within Teaching, Nursing and Social Work*.

## Appendix 2

### Timescale

22 September 2009 - Discussion paper to ETC

If the ETC agrees to recommend a consultation on replacing or removing the health reference requirement, the next stages would apply:

25 November 2009 - Consultation paper to ETC
10 December 2009 - Council decision on consultation
4 January 2010-30 March 2010 - Consultation
8 June 2010 - Consultation response to ETC
7July 2010 - Consultation response to Council

If it was agreed to replace or remove the health reference requirement, the next stages would apply:

September 2010 - Council: Change to guidance notes (on health) subject to rules passing
October 2010 - Laying of rules (28 days)
January 2011- Remove health requirements
February 2011 - Implementation