

Regulatory approaches to professional standards and guidance

Background

The General Medical Council (GMC) set the standards for doctors by setting out the professional values, knowledge, skills and behaviours required of all doctors working in the UK. The standards are described in *Good Medical Practice*, which covers the fundamental aspects of a doctor's role.

The GMC will be carrying out a scheduled review of *Good Medical Practice* in 2021. As part of this review, the GMC wish to review the effectiveness of their model for developing, implementing and updating standards and guidance. While there are many strengths to the model – for example, it engages meaningfully with the inherent complexities, tensions and ambiguities in medical practice; contains sufficient flexibility to cater for individual circumstances and preserves the independence of clinical judgement – there are also significant challenges. In particular:

- it is resource intensive to develop and update, and the pace of demand for new guidance outstrips ability to respond
- there are conflicting criticisms and demands of the guidance – e.g. users want it to be both high level/short and specific/detailed
- the relationship between the guidance and fitness to practise is nuanced and can be unclear at times, creating anxiety for doctors, and confusion for others
- the guidance is written for doctors. It cannot necessarily be extended to other professional groups or easily adapted to other models of regulation if the GMC were considering fundamental reform

Reference is frequently made to other models as exemplifying what the GMC should do to improve their approach. However, such references are often vague and lack a detailed understanding of how the alternative model functions. This research aims to fill this gap by exploring what other models and approaches are being used by other regulators with similar roles to the GMC.

Purpose of the research

The aim of the research is to provide an evidence base to support the *Good Medical Practice* review in 2021 by looking at how other regulators in the UK and internationally approach standards, and the perceived strengths, challenges and impacts of their models.

The research will help the GMC Standards team in their approach to the *Good Medical Practice* review, and will help them to consider whether we should make any changes to our current model of standards and guidance.

Scope of the research

In collaboration with the GMC Standards team, ten regulators were identified to be included in the study. This selection process drew on internal expertise within the GMC to identify a mix of regulators who are similar to the GMC and a number of regulators whose approach differs from the GMC. This included a global mix of regulators however priority was given to English language speaking countries or countries where it was felt it would be easy to access standards documents in English. This included:



Methods

The research used a mixed method approach which included initial desk research, a qualitative survey to gather high level information from the ten regulators, followed by in-depth telephone interviews.

Desk research

Desk research was carried out for each of the ten regulators to identify their broad approach to standards and guidance as explained on their websites and on documents accessible from their websites. For consistency, this was done using a template based on the areas of interest identified in consultation.

Survey

A survey was sent to each of the ten regulators based on the template used in the desk research. The purpose of the survey was to gather more detailed information about the approaches and to identify potential contacts for interview. A copy of the survey is available in the appendix.

Telephone interviews

Telephone interviews were conducted with the ten regulators. The aim of the interview was to fill any gaps in the desk research and/or survey responses, and to explore certain issues in more detail. Each interview was tailored dependent on the response to the survey and the desk research.

Case studies

Following the interviews, a case study was written up for each regulator synthesising the evidence collected from the desk research, survey and the interview. The case studies were shared back with the regulators to allow them to check everything had been interpreted correctly and make any necessary changes.*

Structure of the report

The report first gives a high-level summary of each regulators approach to standards and then moves to look at some cross-cutting issues which were highlighted as being of interest for this study. This includes:

- How the regulators approach the development and review process of standards
- Approaches to standards
- The use of standards and guidance in education and training
- The use of standards in disciplinary proceedings

* Some of the regulators have yet to respond to our request to check and we have not pursued this at this time given the context of the pandemic

- Approaches to setting standards for multiple professions
- Engagement and dissemination of standards
- Usage and awareness of standards
- Perceived strengths and challenges

Overview of each regulators' standards and guidance model

Organisation	Who do they regulate?	Primary standards document(s)	Date of last update	Review timetable	Development process
General Dental Council	Dentists, dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians.	Standards for the dental team	30 th September 2013	Responsive	Consultation
Health and Care Professionals Council	Art therapists, biomedical scientists, chiropodists /podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, speech and language therapists	Standards of conduct, performance and ethics, Standards of proficiency	26 th January 2016	Scheduled	Consultation
Nursing and Midwifery Council	Nurses, midwives and nursing associates	The code and the Standards of proficiency	10 th October 2018	Responsive	Consultation
Solicitors Regulation Authority	Solicitors	The SRA Standards and Regulations	25 th November 2019	Scheduled	Consultation
Medical Council Ireland	Doctors	Guide to professional conduct and ethics for registered medical practitioners	May 2016	Scheduled	Consultation
French Medical Council	Doctors	Code of Medical Ethics	November 2013	Responsive	Consultation
Royal Dutch Medical Association	Doctors	Code of Conduct	28 th May 2013	Responsive	Consultation
German Medical Association	Doctors	Professional Code (Berufsordnung)	14 th December 2018	Scheduled	Consultation with the profession only
Australian Health Practitioner Regulation Agency	Doctors*	Good medical practice	17 th March 2014	Responsive	Consultation
Medical Council of New Zealand	Doctors	Good medical practice	1 st December 2016	Scheduled	Consultation

* The Australian Health Practitioner Regulation Agency (Ahpra) works with the 15 National Boards to help protect the public by regulating Australia's registered health practitioners. Each Board has a health profession agreement with Ahpra that sets out fees, budget and the services provided by Ahpra. For doctors, the National Board is the Medical Board of Australia.

Development and review of standards

Most of the regulators included in this study follow a similar engagement and consultation process for developing and revising their standards. Broadly the process involves:



There are two main exceptions to this approach taken by the French Medical Council and the German Medical Association.

- The French Medical Council's (FMC) standards document is a legal text and therefore the process for making changes uses a legal process. Only the FMC has the initiative to make formal proposals to review and/or update the standards. Its proposals are sent to the Ministry of Health for review and the final draft of the revision/update is adopted by the French Council of State through a decree.
- The German Medical Association (GMA) have a professional self-regulation model whereby the standards are set for doctors by doctors. Each year there is an annual meeting known as the German Medical Assembly, where state chamber delegates (who are all doctors) can suggest amendments or changes to the standards. The changes are discussed and are either approved or identified as needing further discussion or consideration.

There are perceived strengths and challenges to each of these approaches. A strength discussed by the regulators who take an engagement and consultation approach is that the involvement of a wide range of stakeholders and the public helps to ensure that the standards are evidence based and take into consideration a wide range of views and experiences. However, it also means that the process is resource intensive and not agile.

In comparison, a strength of the professional self-regulation approach taken by Germany is that this process creates a sense of ownership amongst the profession. It was felt that this led doctors to have greater trust and confidence in the standards as it was produced by those who understand the everyday working lives of the profession.

However, a challenge of the self-regulation model is that while doctors are experts in their own fields and in the day to day reality of medical practice, they are not necessarily experts in areas outside of medicine. For example, as technology becomes increasingly important in health care it is likely that many future amendments will have a technological element. It is unlikely that all the doctors involved in the process will be experts in the relevant field and may not be able to fully appreciate all the consequences of adopting a new form of technology.

Involvement of patients and the public

A key part of the consultation process is the involvement of patients and the public. The regulators mentioned a broad range of ways that they do this including: hosting meetings, conferences and webinars; conducting Delphi studies*, surveys and focus groups; engaging with patients at events; and consulting with patient advocate groups.

For the General Dental Council's (GDC's) standards review in 2020, they said they are keen to bring patients and the profession together face to face to discuss common expectations. It is hoped this will create a genuine feeling of co-production, where the profession feel they have ownership over their standards, but that it has been developed in consultation with their patients.

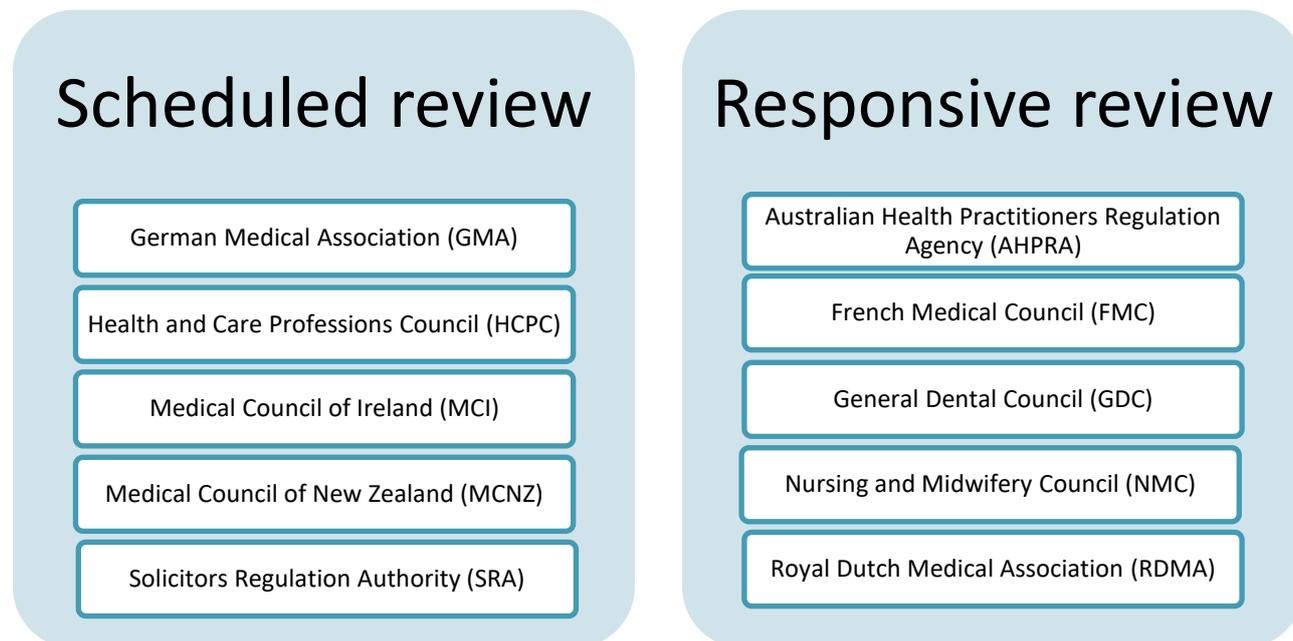
The Health and Care Professions Council (HCPC) noted that while they do hold engagement workshops across the UK, the attendees are predominately professional bodies and registrants. While patients and the public are invited it can be difficult to secure their attendance – this is something that HCPC hope to improve in future reviews of their standards.

The involvement of patient advocate groups was mentioned by multiple regulators as a way to hear the patient and public voice. For the Medical Council of New Zealand (MCNZ) this is especially important and allows them to hear from diverse populations across the country which would be difficult to do so without the advisory group e.g. patient groups who may struggle to respond to a public consultation.

* A Delphi study is a structured communication technique or method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts

Scheduled vs Responsive review

There are two main approaches to how often standards are developed - those that have a scheduled review process and others that update or review standards on a responsive basis.



HCPC and the Medical Council of Ireland (MCI) review their standards and/or guidance every five years. For both, changes outside of this cycle are rare and tend to only happen when there are legislative changes or if there is a very clear need for greater clarity. For HCPC, changes to guidance in-between the five-year cycle are more common than changes to standards. This is because their standards are at the minimum threshold level for safe and ethical practice, whereas the guidance specifies more directly the action a registrant should take in certain areas and therefore more regular updates may be necessary.

The MCNZ aim to review their standards every five years, however due to resource constraints this is not always possible and therefore they prioritise reviews where they are most needed.

The Solicitors Regulatory Authority (SRA) recently updated their standards in November 2019 and their aim is to review the standards at one year, three years and five years after their introduction.

As changes to the GMA's standards are raised at their annual meeting there is in theory an annual review cycle in place – however if no changes are suggested in the meeting the standards are not automatically reviewed.

The other regulators review their standards and guidance on a responsive basis, making sure it remains relevant and reacting to changes in healthcare and society as needed or updating where necessary. A perceived strength of the responsive review approach is that

it allows for these changes to happen at the right time. However, it can mean that there are long periods of time where no updates are made if a need has not been pro-actively identified.

For scheduled reviews, there is a confidence that the standards will be reviewed on a regular basis. However, changes to reflect developments in society and healthcare may be delayed until a formal review period. Moreover, legislative changes may necessitate the need for a change to be made in-between the scheduled review and then create more work if a full review is scheduled for not long after this.

Drivers of new or revised standards and guidance

In the interviews with the regulators there were a few key triggers which were discussed as drivers for changes to standards and guidance.

Changes in society and/or health care

For the regulators that review their standards on a responsive basis, a common driver is reacting to changes and developments in society or healthcare to make sure standards and guidance remain relevant e.g. changes in guidance around euthanasia.

Aligning with new organisational strategy or policy

Some of the regulators mentioned a change in organisational direction or policy which impacted their approach to standards. For example, in 2017 the GDC published a report called *Shifting the Balance* which described their move to a more 'upstream' model of regulation that meant emphasising public protection and refocusing the emphasis on fitness to practise. As a part of this the GDC wanted to encourage professionalism, and to help make dental professionals be more accountable and use their professional judgement to adhere to set rules.

Similarly, in 2015, the SRA published *Looking to the Future* which set out their vision for the future and the way they regulate. It outlined a proposal to make regulation targeted, proportionate and more fit for purpose as well as setting out their intention to redraft their standards. The aim of the new approach was to introduce simpler rules focused on high professional standards, increase focus on professional judgement and to be more flexible.

Like the SRA and GDC, the Nursing and Midwifery Council (NMC) also sought to reposition their standards model based on a new direction of travel. When they published the new version of *The Code* in 2015, they wanted to move away from the perception that the standards were a disciplinary tool to a model which encouraged professionalism and created a sense of pride amongst the professions they regulate.

Legislative change

Another trigger for change which was mentioned in the interviews is the need to respond to legislative change. Several of the UK based regulators referenced GDPR as an example where slight amendments were needed to their standards. Other recent examples included legal changes around abortion, euthanasia/assisted suicide and telemedicine.

Future proofing

The need to 'future proof' standards was highlighted as a challenge and a trigger for standard development in the future. For example, HCPC mentioned that the growth of advanced practice will have implications for the roles and responsibilities of multiple professions, and this will require changes to the standards to ensure they are at the right level. One option HCPC is looking at involves an 'information sharing' approach – where information can be shared more quickly in concise formats rather than as formal guidance which can be burdensome to produce. This will allow the regulator to be more flexible, agile, and responsive to reacting to areas where registrants would value greater support.

Resources required for development and review

Developing standards were seen by almost all as resource intensive – especially in relation to the consultation process. For example, the GDC acknowledged that to conduct a thorough consultation a significant amount of time and money is needed to plan and conduct the research activities. This wasn't the case for all regulators - The HCPC did not remark upon resource intensity as a challenge, but said that with 15 different professions, it can be difficult to understand the day-to-day experiences and specifics of all the roles. To overcome this the HCPC use professional liaison groups to stay on top of developments across their registered professions.

The fact that developing standards takes a long time also means that regulators are not able to be as responsive and agile as they would like. The GMA said that the significant time lag between a suggestion for a change to be made and the change being implemented makes it difficult to be reactive to rapid societal and technological changes.

Of the regulators that explicitly discussed the timeline of their development, it was clear that there is no set answer as the time it takes to develop varies based on the context and complexities. For example, the MCNZ said that on average reviewing their standards takes 12-18 months however their recent review of informed consent took eight months as the changes were relatively straight forward.

Approaches to standards

A common theme discussed in the interviews was the concept of moving away from a rules-based approach to a principles-based approach to standards. Rules-based approaches are described as being specific and precise prescriptions for behaviour and

having limited to no flexibility. Whereas principles-based approaches are described as being set at a higher level and more open and flexible with scope for interpretation.

There are strengths and challenges with both approaches, however a principles-based approach is often seen as allowing and promoting independent professional judgement which in turn encourages professionalism.

These concepts were mentioned to varying degrees by the regulators and it is difficult to explicitly categorise regulators as being one or the other as in reality there is often a more hybrid approach in place. For example, a principles-based approach may still be accompanied by guidelines which introduce more specific guidance and a rules-based approach can be subject to qualifications and exceptions. Examples of how these concepts were discussed by the regulators are detailed below.

Rules-based and principles-based approaches

The FMC takes a rules-based approach as their main standards publication is a legal document. The provisions of the standards were described as mandatory for all doctors on the medical register and deviations from the standards result in disciplinary action. However, the FMC also publish supplementary explanatory notes to clarify the Council's interpretation of the rules – and these are not legally binding.

The GMA and RDMA described their standards in terms as 'rules'. However, for both there is some flexibility. For the Netherlands, the rules are seen as general rules and doctors can apply their clinical judgement if they are able to justify their actions. In Germany, flexibility is permitted in areas of the standards which may not have kept pace with societal or technological change.

The GDC reflected that the language used in their standards is predominately prescriptive and can lead to dental professionals acting defensively to avoid breaking the rules (rather than focusing on what is in the best interest of their patient). The GDC are reviewing their standards in 2020 and a key component of their review a redevelopment of the standards in line with a regulatory approach angled towards prevention rather than supporting fitness to practice investigations. The GDC reflected that a challenge of moving away from a prescriptive set of standards is empowering registrants to have confidence in their professional decision making.

The SRA recently revised their approach and replaced their main standards document in November 2019 to focus it on the fundamental principles behind the rules to help encourage professional judgement and to move away from a document that was perceived as being a long list of complex rules. In making this change the SRA have also drastically reduced the amount of content in their standards document (from around 450 pages to 130) and simplified the language. They hope that by simplifying the language there will be less need for guidance and supporting materials.

While at the time of the interview it was too early for the SRA to comment on how the new standards have been received by the profession, it is envisioned that the change from a set of rules to a more goals-oriented approach will require a significant culture change.

The NMC re-developed their standards for behaviours and values in 2014 to encompass a principles-based approach by refocusing them around what being a good nurse or midwife means rather than a set of rules. The NMC reflected that their behavioural standards prior to 2014 were seen as a disciplinary tool whereas now their standards create a sense of pride of what being a good professional is. However, within this model the standards which set out the knowledge and skills needed by the professions are less flexible and set out what the professions must do.

APHRA have a dual approach with their registration standards being more rigid and their standards around conduct having some flexibility. The registration standards are required under national law and therefore mandatory. These standards relate to things like continual professional development requirements which must be met. However, even for these standards which are seen as legal rules there is still some flexibility in how APHRA check for compliance. Still, the standards which set out the expected behaviour of the profession are more aligned with a principle-based approach which states the application of the standards will vary according to individual circumstances, but the underlying principles should not be compromised. Standards around conduct such as technology based patient consultation guidelines are positioned as behaviours that registrants 'should' do and are therefore have more flexibility in their implementation.

Similarly, MCNZ has a hybrid approach where some standards are flexible and allow for individual circumstances and independent clinical judgement (such as practising in an area of resource limitation) while others (such as those around informed consent or prescribing) are more prescriptive. Generally, the statements concerning clinical competency are prescriptive and the statements around cultural competence of ethical conduct are more flexible.

In contrast to some of the other regulators, the MCI said they have always adopted a principle-based approach which focuses on flexible guidance. The standards were described as having a clear focus on professionalism, which encourages doctors to think about their broader professional behaviours, rather than following a set of rules.

Standards and guidance in education and training

Across the ten regulatory bodies that this research looks at, there are a variety of relationships between the standards and guidance and education and training.

Responsibility for setting and enforcing standards for medical education

The regulator

For some, the regulator's standards are embedded within education and training as the regulators has a remit which covers regulating initial education. The MCI work their professional standards into the set of quality assurance standards they issue for education and training. This is done to help ensure consistent messaging around expectations of professionalism.

Working with other bodies to regulate medical education

In New Zealand, the MCNZ identifies in their core standards text that for medical students, the standards identify the basic duties of a good doctor and should therefore serve as a source of education and reflection. The medical council also describe their role in making sure medical students and new doctors get the right training. Medical students are not regulated by the medical council, but the medical council does have a close relationship with the medical schools, and they are working together towards developing a common language around professionalism.

The relationship between the standards and education is not always so clear. In Australia, the standards outline expectations for the support of students in their learning and development, and what good medical practice look like in this area. However, the standards are not embedded into undergraduate education and training. The Australian Medical Council is the accreditation authority, and the functions undertaken under national law includes the development and review of accreditation standards and assessing programs of study and education providers against the standards, rather than doctors.

Occasionally there is variety across a country in how the standards for doctors are used in education and training, which is the case in the Netherlands. There are eight training institutions in the Netherlands, with usage ranging from a very literal interpretation, to a light use of some of the standards. Currently, the RDMA is working on an inventory, collecting information about how the standards are used in education and how it could be used in order to understand institutions further.

Regulating requirements for medical students and trainees

Both the GDC and NMC integrate their standards with educational and training programmes. The GDC have a set of 'learning outcomes' which detail the outcomes that an individual must be able to demonstrate by the end of their training. The outcomes derive from, and are consistent with, the GDC's *Standards for the Dental Team*. For the NMC educators are required to use the standards of proficiency to develop educational programmes that equip nurses, midwives and nursing associates with the right skills, knowledge and behaviours to meet the *Standards of proficiency* when they qualify.

For other regulators, the standards are integrated later in a registrant’s career – either once a registrant is fully registered or when they are undertaking their core training (but have finished their academic studies). For example, the FMC’s standards apply to medical residents (the equivalent of a doctor in training in the UK) even though they are not fully registered at this point in their career. This is because they are directly in contact with patients, and therefore have to abide by the same rules as qualified doctors.

The SRA state that the code applies to registered solicitors and not to students or trainees, but they have a statutory duty to make sure that those who are admitted as solicitors have the knowledge and skills necessary for practice. They do this by specifying the education and training that an individual must complete. There is a similar situation in Germany, whereby the Standards only apply once qualified, but there is some monitoring of the content of the training courses. School and undergraduate level education are organised by the state (this includes medical schools) in Germany. The competencies that medical students must reach at the end of medical school are set centrally, so whilst there may be variation in delivery across States or universities, all students will finish with the same minimum standard.

Standards and guidance in disciplinary proceedings

How registrants are held to account by the standards

Regulator	Use of standards in fitness to practise	Responsibility of enforcing disciplinary action
General Dental Council	Yes	GDC – Practice Committees
Health and Care Professionals Council	Yes, all standards are considered	HCPC – Investigating Committee Panel
Nursing and Midwifery Council	Yes, but only the Code is used, not the Standards of Proficiency	NMC
Solicitors Regulation Authority	Yes – the Principles and the Code of Conduct	SRA if the concern is about the solicitor being dishonest or behavioural concerns (breach of principles), the Legal Ombudsman if you are unhappy with the work or service provided
Medical Council Ireland	No, it can be referred to, but is not the main basis of decisions	MCI – Professional competence

French Medical Council	Yes, the French Code of Ethics, but not the explanatory notes	State Medical Chambers and in serious cases, the Professional Court
Royal Dutch Medical Association	Yes, the Code of Conduct, as well as additional guidelines	The Ministry of Health, Welfare and Sport
German Medical Association	Yes, the (model) professional code of conduct	The medical associations, and if necessary, the professional court
Australian Health Practitioner Regulation Agency	Yes, the Code of conduct primarily as opposed to the registration standards	APHRA, with the exception of NSW – this lies with the Office of the Health Ombudsman
Medical Council of New Zealand	Yes, the Good Medical Practice	Health and Disability Commissioner

For all but one of the regulators, standards are used within fitness to practice, but the degree to which they are used differs.

Using Standards in disciplinary proceedings

For the GDC, the HCPC, RDMA and SRA, the standards documents are used, but are not the key or only element considered in the fitness to practice process. And for all regulators, whether or not disciplinary action is taken would depend on the seriousness and gravity of the breach of the standard/guidance.

In the Netherlands, they use the *Code of Conduct* when testing doctors' actions against legal and disciplinary standards, such as for the interpretation of legal concepts such as 'responsible care' and 'care from a good care provider'.

HCPC, use both the *Standards of conduct, performance, and ethics* and the *Standards of proficiency* when considering the fitness to practise of registrants. They also use the guidance. The weight of the failure to meet guidance at the HCPC is less than the weight of the failure to meet standards. However, if a registrant wasn't following guidance this may call their fitness to practise into question. This is similar to France, where the principles enshrined in the articles of the *French Code of Ethics* have been supplemented by explanatory notes adopted by the FMC. The purpose of these notes is to clarify the Council's interpretation of each article. Although these notes can be considered as an integral part of the code, they are not legally binding rules.

The GMA, AHPRA, MCNZ and NMC are more stream-lined in their approach, as the standards are more often than not the key document used in their assessment of fitness to practise. For nurses and midwives, *The Code* provides the basis for how NMC assess

the fitness to practise of people who are referred to them. If nurses / midwives / nursing associates fail to comply with *The Code*, it may bring their ability to practise into question. Currently it is only *The Code* that is used for disciplinary purposes, however the NMC is considering how the standards of proficiency could be used.

In Germany, monitoring and addressing adherence/non-adherence to professional standards is the responsibility of the State Chambers. Their regional codes are used as the basis for proceedings in the Professional Courts. As *The model code* forms the basis for the regional codes, it is the code by which doctors' standards are assessed.

In Australia and New Zealand, complaints about a doctor's fitness to practice are called notifications, but work broadly in the same way as complaints. Notifications relate to whether the practitioner can continue to practice in an unrestricted way, or whether restrictions are placed on their capacity to practice. AHPRA would use the code of conduct, primarily, when they receive a notification about a practitioner, to understand if they had met the accepted standards of practice that are outlined in the *Code of Conduct*.

However, the standards and guidance are not always integral to fitness to practise proceedings. In Ireland, the *Guide to Professional Conduct and Ethics for Doctors* is referred to as part of fitness to practise proceedings but is not the main basis for decisions that are taken. The primary reference point regarding fitness to practise in Ireland is contained in Section 7 of the Medical Practitioners Act 2007.

Responsibility of enforcing disciplinary action

Enforcement of disciplinary action in the UK largely falls to the regulator themselves. For the NMC, GDC and HCPC, there is a form of independent panel of the regulator that is responsible for deciding the type of disciplinary action that should be taken, usually comprised of regulated professionals and lay members. The regulatory body would then enforce the decision. Ireland is also similar in its approach, where the regulatory responsibility lies with the MCI as opposed to an external body. The one exception to the rule is with the SRA, where if the concern is about the solicitor being dishonest or behavioural concerns (breach of principles) it goes to the SRA, but it goes to the Legal Ombudsman if you are unhappy with the work or service provided.

In the EEA and further afield, often the approach is more variable, and external organisations are used, especially if the standards are written into law. In Germany, the Professional Court is the highest legal institution for putting the professional code into practice. Only a Professional Court can remove a license from a doctor. The Professional Court is the final step in the disciplinary process and is only involved as the result of serious or repeated failure to meet the standards of *The model code*. State Chambers have the power to fine or suspend doctors in the first instance. In the Netherlands, the Ministry of Health, Welfare and Sport is responsible for disciplinary action, whereas in France the responsibility lies with the State Medical Chambers, and in serious cases, the Professional Court.

By law in New Zealand, notifications must be referred to the Health and Disability Commissioner (HDC). HDC deals with notifications about doctors not practicing to an acceptable standard. If the notification then raises concerns about the doctor's competence, then this could then be shared back to the MCNZ, who might decide to review the doctor's practice. One outcome of this might be that the doctor has to complete a 'competence programme' to show they have the right skills to practice in their chosen area. If the notification is about a doctor's behaviour, then this cannot be investigated by the MCNZ until the HDC has finished, but they are able to put restrictions on a doctor's practice while the investigation is going on in order to protect the public.

Challenges in using standard models for disciplinary proceedings

The GDC have encountered some challenges when using their current standards model in disciplinary proceedings, and are currently carrying out a piece of work to better understand how and when the Standards are used internally in their Fitness to Practice processes as part of their consideration of a move away from a rules focused approach.

The RDMA spoke about issues they experienced when thinking about changing *the Standards* and the impact that might have on how they are used in disciplining the profession. There are differing viewpoints from communications, legal and those in *the Standards* department within the RDMA as to who the target population of the code is, which means that its use within discipline could be affected as the style and direction of the document is altered.

Approaches to setting standards for multiple professions

Of the ten regulators included in this study, four regulate more than one profession: the HCPC, the GDC, the NMC and AHPRA.

Multiple vs single set of standards

Both the HCPC and the NMC have an overarching set of principles or code that focuses on values and behaviour which applies to all the professions they regulate and then a separate standard of proficiency for each profession, which focuses on knowledge, skills and specific competencies. The GDC model is slightly different in that it has one set of principles and standards that apply to **all** the professions they regulate. However, alongside this the GDC also publish a pared-back 'scope of practice' for each separate profession which lists the skills and abilities each registrant group should have and can exercise.

A challenge the GDC face in having one publication that applies to all professions is that the document is very long, as it needs to cover details of skill proficiency for a number of professions, and because it needs to set out rules as opposed to high level principles. As the standards need to apply to all the professional groups, the GDC has found that there needs to be a certain level of detail included to adequately cover all professions. Having a

detailed rules-based approach means that the focus from registrants can be on 'not breaking the rules' as opposed necessarily to acting in the patient's best interest, which can lead to defensive practice.

The HCPC is currently undertaking a review to achieve greater alignment in its standards of proficiencies for the 15 different professions they regulate. They are looking to align this so that the proficiencies can apply to all professions in a single publication or section and then for each profession to only have a very detailed set of profession-specific standards as an additional section/publication.

A common theme amongst these regulators is a belief in a need to have some form of separate publication or section of a publication for each profession (although the detail and context of the publication varies). In addition to this the inclusion of an overarching publication for all the regulated professions enables a framework where commonalities between professions and their conduct can be shared, particularly with respect to values and principles, and can outline a way in which these professions can work together.

Common expectations and standards across all healthcare professionals

There is an inter-regulator group mentioned by the GDC which is looking at the feasibility of establishing a common set of expectations and standards with respect to values and behaviours of all UK healthcare professionals.

The NMC have *the Code* which presents the professional standards of conduct and behaviours that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK. It recognises that nurses, midwives and nursing associates have different knowledge and skills and therefore they are expected to uphold *the Code* within the limits of their scope of practice, scope of knowledge and scope of competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the same standards. The professions the NMC regulate have different knowledge and skills, set out in three distinct standards of proficiency.

Engagement, dissemination and ongoing support of standards and guidance

All the ten regulators included in the sample publish their standards and/or guidance on their websites. Beyond this, there is a spectrum of further engagement and dissemination, with some regulators putting significant effort in to sharing the standards and guidance more widely and others taking a more minimal approach. Some of the approaches to engagement and dissemination are discussed below.

Newsletters & email

Newsletters and mailouts are one of the most common proactive approaches taken by regulators in sharing their standards more widely or more directly with their registrants. APHRA in Australia explained that they found newsletters a particularly effective dissemination tool as their evaluation shows that 50% of recipients open the email newsletter. Along with APHRA, other regulators also had good experiences of communicating standards through newsletters, as it is a line of direct communication to registrants. Several regulators described how they use newsletters to publish vignettes or real-life examples from practitioners which help to bring the standards and guidance to life.

Face-to-face engagement activities

Several regulators discussed the ways in which they actively go out and speak to their registrants (with physical presence) in order to share or expand on standards and guidance. Proactively seeking face-to-face engagement can help a regulator to show a 'human face' and address questions or concerns about standards and guidance.

The GDC discussed how a more proactive approach to disseminating their standards has been built into the current process of development. By considering how to share the standards through this type of face-to-face engagement from the outset, the new standards will be developed in such a way that enables this approach to dissemination.

Along with APHRA, the GDC discussed a preference for speaking at conferences as these tend to capture the profession but often also other stakeholders. A challenge of using conferences as a means for dissemination raised by APHRA is that, due to the size of Australia, it can be difficult to attend conferences with a good geographic spread.

Both the MCNZ and the GDC discussed a preference for an approach to dissemination and engagement which prioritises early interaction with students and those new to the profession. Both regulators regularly visit medical/dental schools and give talks about the standards, what they mean for students, and how they will apply to practice in the future. MCNZ are currently considering how they can replicate this early engagement for International Medical Graduates (IMGs) who join the register in New Zealand, as this key early interaction will have been missed.

Similarly, to APHRA, HCPC aim to have as much face-to-face engagement with their registrants as possible but the number of different professions, and the variety of environments in which they work, makes it very difficult for the regulator to achieve an even spread of visits across their professional groups. They encourage all those who attend talks or presentations to share what they've learned with colleagues to try and reach as many people as possible.

Most of the regulators in the UK cover registrants across England, Northern Ireland, Scotland, and Wales. Ensuring that engagement is appropriate for each can be a challenge as the healthcare context is different in each of the four countries. The NMC manage this

by running routine, tailored events in all four countries to ensure that engagement is as appropriate as possible.

This proactive engagement doesn't necessarily need to focus on the full content of standards and guidance. The MCI discussed how their president may pick up a specific element of an update or amendment to the guidance and use that as a theme for engagement when attending or speaking at various events. Whilst this doesn't cover the content of the guidance in full, it provides a gateway to discussion with focus on a key element.

Overall, across many regulators this proactive approach to face-to-face interaction with registrants is valued and felt to be effective in sharing the standards and guidance, but the cost and time implications of covering large geographic areas or numerous professional groups mean that it isn't always a viable way of sharing standards with a large number of registrants.

Case studies or other tools

It is common across the professional regulators to try and 'bring the standards and guidance to life'. Publishing case studies is a popular choice for giving examples of how standards and guidance can be applied in practice without the burden of needing to try and address every eventuality a registrant may encounter.

Most regulators have a largescale initial launch campaign when publishing new or updated standards, but publishing case studies or vignettes are seen as a way of continuing engagement with registrants beyond the initial launch. The GDC uses case studies such as the "*Student professionalism and fitness to practise - Standards for the Dental Team Case studies.*" These align with specific principles within the main standards document.

The SRA are unique in that they have developed a checklist for registrants to run through to understand how to address a situation in line with the standards and guidance. The checklist presents a series of questions a solicitor or firm should ask themselves when deciding how to deal with a particular kind of potential standards or ethical issue. This goes a step beyond a case study and tries to more directly aid registrants in applying the standards and guidance in practice in a principle-based way as to not affect professional judgement.

Social media

Social media is a popular choice for continued dissemination and engagement beyond the initial launch of new or updated standards and guidance. Social media offers a direct and dynamic line of communication with registrants, which can be adapted for specific purposes at different times.

Most regulators are already relatively heavily engaged with social media and the GDC are making it central to their new approach to dissemination and ongoing engagement with their standard and guidance.

The NMC gave an example of how they had used social media as part of their initial launch activity. Physical copies of the new standards were sent to all NMC registrants who were then asked to use Twitter to share where they were when they received them. The NMC felt that this complementary activity ensured that all registrants had full access to the standards via the hard copy, but the social media campaign helped to instil a sense of pride and ownership in the professional standards.

Enquiry services

Several of the regulators offered some form of enquiry service for registrants to make enquiries about ethics or query elements of the standards and guidance.

It was not always entirely clear in the interviews the level of detail that a regulator was able to give individual registrants on particularly situations, as responses would be given on a case by case basis. Broadly the enquiry services were there to direct registrants towards the most relevant area of the standards or guidance that would help them to make a decision, supporting autonomous professional decision making, as opposed to providing a definitive answer. In the case of the MCI the regulator might advise a registrant to contact their individual indemnifier who may be able to give them a more specific answer about how to approach a certain situation.

HCPC discussed how it is difficult to know whether the fact that they receive a substantial number of queries to their enquiry service means that their standards should be clearer in some areas, or whether it shows that registrants are well engaged with the standards and guidance.

HCPC and MCI both explained that they monitor the queries that come into their enquiry services and use this as part of their evidence base when deciding which, if any, areas of the standards and guidance may need updating or amending to give further information or clarity.

Sharing standards and guidance with the public

While most regulators made efforts to disseminate their standards more widely and engage with the profession, there was less uniformity in activity to engage with the public and patients/service users.

A key future focus for HCPC is developing engagement platforms to enable two-way flows of information between the regulator and service users. This is being developed following the success of their Employers Hub; an online space tailored for the needs of those who employ HCPC registrants. They plan to hold workshops in the coming year to understand the areas in which service users would get the most benefit from engagement.

The way that the standards and guidance are written also impact on how able the public are to engage with them. The GMA are very clear that their standards are a legal text and they feel this is the appropriate level for them to be pitched at. As part of the process for developing their guidance, the MCI work with an external organisation to ensure that they pitch the language in their guidance at such a level that it is meaningful to doctors as well as being accessible to the public. The NMC go a step further and specifically develop an easy read version of their standards which are accessible to people with learning difficulties.

Usage and awareness of standards and guidance

Use in day-to-day practice

Standards

Across regulators there was some uncertainty around to what extent registrants actively use the standards as part of their day-to-day practice. APHRA, MCI and MCNZ all discussed how their standards act as more of a reference document, rather than something to be read cover-to-cover or kept close at hand during practice. GMA were very explicit about the purpose of their standards; that they are a legal text and not intended as a day-to-day guide to medical practice.

The GDC carried out research in 2014 to try and understand the impact and use of their standards. They found that whilst there was general support by registrants for the concept of professional standards, many were less clear about the actual content or how it would apply in everyday practice.

Supporting information

There was a sense from several regulators that, where the standards act as a more high-level reference document, the supporting information is more actively used as part of practice.

The GMA see their supporting information as having a greater practical role in doctor's practice as the intention is to help professionals understand some more complex areas of the standards. An example would be that the guidance around remote treatment is designed to actively aid doctors in navigating legal grey areas which may be less obvious in the core standards.

Supporting a professional identity and behavioural norms

Though standards were felt to have a lesser direct impact on day-to-day practice, there was agreement across most regulators around the role of standards and guidance in promoting professional identity and behaviours.

Professional identity

For most regulators building a sense of professional identity and professionalism was a core aim of their regulatory approach. The MCI explained that this is why they opt for a principles-based, rather than rules-based, approach as they feel this better supports professional judgement, autonomy, and identity.

Research carried out by the GDC in 2014 found that 93% of registrants agreed that the standards “help me understand what is expected of me as a GDC registrant”.

HCPC discussed how their *Standards of proficiency* in particular were an important tool for shaping professional identity, as they help each professional group to understand their specific role in relation to the other registered groups. Complementing the generic standards with profession specific standards appears to be an important element of regulating multiple professional groups and ensuring that each can build and maintain an individual identity.

Behaviours and norms

A number of regulators explained how they felt their standards and guidance shaped the behaviours and norms of their registered professionals.

The MCI explained that their guidance is considered a helpful teaching tool, particularly during preclinical years as it offers insight into what clinical practice will be like and what the expectations on doctors are.

For those such as the GDC, HCPC, and NMC who regulate several professions, the profession-specific standards and guidance are especially important in this area as it's crucial to differentiate between the generic professionalism expected of all health care professionals, and the specific professional behaviours which must be exhibited by certain groups.

Positioning professional standards

A common thread through most of the regulators is the challenge of positioning the standards. RDMA discussed the necessary balance of enforcing professionalism as a professional regulator and respecting professional autonomy of registrants.

MCNZ discussed a similar theme, expressing the need to develop guidelines with a focus on enabling decision making, rather than as rules to be followed. MCNZ had some concerns that, whilst they intend their standards to be decision-making tools, that isn't how they are perceived by the profession who can view them as dictatorial. This concern was shared by several others. HCPC also discussed this challenge in relation to the difficulty of communicating the core purpose of standards and ensuring that stakeholders use them as they are intended. They raised the issue that some employers use the standards punitively, rather than as a tool for supporting professionals to deliver care safely and effectively.

HCPC also find that, as professional roles change, it can be difficult to know where to pitch the standards. HCPC has always delivered threshold standards – the minimum standards that professionals must meet to join and remain on the register, but with the assumption that professionals will come to act above that level. As advanced roles have developed within some of their registered groups, it is difficult to know if the threshold standards should be adapted to reflect the expected higher level of basic skill or responsibility for these more advanced roles.

Patient and public awareness

Like efforts to disseminate standards and engage with the public and patients, there are a range of feelings towards awareness and use of the standards by these groups.

For the GMA there is simply no need for the public to understand the details of the standards and guidance; they are legal tools for doctors, their regulators, and the legal profession.

Most other regulators felt that there was likely to be some benefit to awareness of the existence of the standards amongst the public, but there wasn't total unity in how much awareness was felt to be necessary.

Research carried out by GDC in 2015 found that 74% of patient were aware that the GDC have standards that dental professional must abide by, but further qualitative research found that there was little or no awareness of the specific content. HCPC suggested that most patients and service users are likely to have a broad expectation of their health or care professional, but that this is more likely to be based on commonly understood principles of professionalism (such as maintaining confidentiality, and giving respect) rather than an understanding of the content of specific standards and guidance. The GDC research also found that the details and content of the standards generally wasn't particularly important to members of the public; what mattered to them was knowing that the standards exist and that there is a regulator they can turn to if needed.

Review of overall approach to standards

The GDC, SRA, and NMC have all recently carried out, or are currently carrying out reviews of their standards or regulatory approach.

GDC and SRA have similar aims for their reviews; a relatively substantial overhaul of their regulatory approach. For both, the aim was to move away from a rules-based approach and develop a more upstream and flexible approach to regulation.

As a result of their review the SRA recently published a slimmed down version of their professional standards to replace the previously existing handbook. Similarly, a key outcome of the review currently being undertaken by the GDC is a redevelopment of the standards in line with a regulatory approach angled towards prevention rather than supporting fitness to practice investigations.

For the NMC, their review took a more practical look at the *Post-registration standards*, considering whether they're fit for purpose. The findings from this review are likely to feed into a larger-scale evaluation of standards planned for the coming year.

All three regulators have engaged in significant consultation with their registrants and stakeholders to ensure that any changes are developed via engagement with those they impact.

Perceived strengths of the approaches and models

All of the regulators identified elements of the approaches and models which worked well for them, especially in areas related to consultation and principled based approaches.

Engagement and consultation

The process of engaging and consulting with professions, the public and wider stakeholders was viewed as a strength by many of the regulators who did this e.g. GMA who only engage with the profession.

It was felt that this process helped to ensure that:

- the standards are evidence based
- took into consideration a wide range of views and experiences.

For example, the GDC said in their current review this year they anticipate that by speaking face to face with their registrants, patients and the public it will integrate their views and experiences more which should help to harness a feeling of ownership from the profession and the public. The GDC's aspiration for their current review is that they will get dental professions together with patients to discuss common expectations, to have a form of co-production for the standards. The aspiration being that this will result in something that is owned by the profession and developed in consultation with patients.

This sentiment was echoed by many of the other regulators, who spoke positively about their process of engaging with registrants. The RDMA said that through consultations with doctors they learnt more about how doctors want to use the standards, and this then changed the direction they were initially going down, thus making a more applicable document. AHPRA also mentioned the robustness of the consultation process as a strength of the model, ensuring that the document is future-proof and sufficiently detailed. The MCNZ consults widely when they develop their statements to make sure they incorporate a wide range of views and experiences. A key stakeholder in this process is the Consumer Advisory Group – the group includes members representing consumers from aged care, youth, disability, Māori, Pacific People, mental health, and health sectors. The Consumer Advisory Group has been instrumental in providing advice and feedback.

However, the involvement of the public and stakeholders within the development process was not always present. The GMA perceive that one of the strengths of their model is that it was created by doctors for doctors, with no public consultation, resulting in a robust document that enables self-regulation and creates a sense of ownership.

Principle based approaches

Although there were a few instances where a fully principle-based approach was implemented (the approach was more often a hybrid), it was often mentioned by regulators as a strength of the standards model that they used. It was felt that adopting a principles-based approach meant that there was more flexibility with scope for interpretation and promoting independent professional judgement, which in turn encourages professionalism.

MCI self-identified as a regulator that had always used a principle-based approach. Two key strengths of *The Guide* were identified:

- *The Guide* allows for a level of professional autonomy by facilitating decision making rather than aiming to give a specific answer. In this *the Guide* is felt to be supportive of the profession rather than dictatorial.
- *The Guide* has a clear focus on professionalism, which encourages doctors to think about their broader professional behaviours, rather than following a set of rules.

Perceived challenges of the approaches and models

There were a number of challenges that the regulators faced, depending on the specific development, enforcement and evaluative functions of their models.

Resource limitations

One of the more common challenges that the regulators spoke about was having enough resource to implement and support registrants sufficiently in meeting and raising awareness of standards. Sometimes this was hindered further by geographical constraints – the communication options to disseminate new standards in Australia can be more limited due to the size of the country. The MCNZ have received feedback from doctors who have said they are not aware of the content in the new statements and standards due to the limitations in disseminating information. To help counter this the MCNZ engages with the Medical Protection Society to try and help make doctors aware of the key statements

For other regulators, there were sometimes issues with human resource – the team responsible for developing, implementing and reviewing standards was often small, and therefore could only handle a certain amount of work at any one time.

There are certain timing issues with the development of the Standards, as often reviewing a standard or guideline can take a couple of years, which means that the regulator can't be as quick or responsive when things change. AHPRA, along with other regulators, mentioned the time and effort that the level of consultation incurs can be detrimental to the overall approach. It also requires for the language and communication of the guidance to be pitched appropriately and accurately (e.g. there might be differences in approach when talking to Torres Strait Islanders / Aboriginal populations), as you can risk comprehension errors with broad consultation which are potentially hard to repair.

Managing change

It can be particularly difficult for regulators to manage change when a fundamentally new approach to standards is introduced, or substantial changes are made. Among other challenges these changes often mean that colleagues in the regulator have to learn a new set of standards and how they apply to fitness to practice.

An example of this was provided by the SRA. The new approach to standards for the SRA signifies a change not just for the profession and legal firms but internally for staff as well. Internally for SRA staff there will be process changes around how they make decisions when they are considering whether a solicitor or law firm has breached the SRA requirements. For the profession, the new standards are more judgement based which means they will need to consider more fully why they are taking a particular course of action rather than just follow a rule. This is a culture change for the profession and may be challenging especially as much of their training is centred around rules.

New roles developing and advanced practice can make it difficult to set and change standards. The HCPC mentioned that there were a few areas, such as the standards for podiatric surgery or the standards of prescribing where they have stepped into more specific high-level standards. Advanced practice was felt to be a challenge as there are hundreds of advanced practice roles within each of the professions that the HCPC regulates, and understanding how they set the standards for that very high level, and potentially quite risky, area is difficult. In order to mitigate these difficulties, HCPC is engaging with lots of different stakeholders, but currently does not have a developed response to this challenge. Issues can also arise when there is a need to respond to rapid changes in healthcare/society e.g. telemedicine.

Getting the level of detail right

Another common challenge amongst regulators was the balance of finding the right amount of detail, but ensuring that the length of the standards and guidance does not become too long and unwieldy. The HCPC found it was difficult to find the balance in pleasing those who feel that guidance documents are overly dictatorial and restrictive, with those who want extensive guidance. The proposed solution is the move away from full guidance documents towards 'information sharing' in many areas, using clear concise formats.

Conclusion

In developing case studies of the 10 regulators via desk-based research, surveys and interviews, a number of similarities and differences have been identified. For example, the development process is largely similar, and in terms of overall 'philosophy' many appear to be moving towards a principle-based approach. Resource challenges were also mentioned by most of the regulators – so developing and setting standards is seen as challenging and resource intensive for everyone.

There were also many differences between the regulators, and this was often determined by the relationship between the regulatory body, the law and the profession that they covered. While many have a 'good medical practice' style set of standards, this was not always the case, and the weight of the guidance and standards often varied between regulators. Multiple different methods of dissemination were also used, often dependant on the country size, the number of registrants, and the style of the standards.

Appendix

Survey: regulatory approaches to professional standards and ethical guidance

Introduction

The General Medical Council (GMC) is carrying out research to understand how other regulators approach professional standards and ethical guidance. This questionnaire will gather information on your model of standards and ethical guidance, its perceived strengths, challenges and impact. The purpose of the research is to understand the models used by other regulators and whether there are lessons or potential improvements that the GMC can make to its own model in the future.

We plan to use the information provided in a report about approaches to standards and ethical guidance which we're intending to publish. We will share this report with you. If you'd prefer any of your responses to be kept confidential, please specify this in your answers.

We'd be grateful if you can complete the survey as fully as possible, involving colleagues where necessary.

Please return the survey to: karen.roberts@gmc-uk.org by the 19th August 2019.

Thank you.

About your organisation

1 Please provide the full name of your organisation.

2 Please provide your name, job title and contact information.

3 Please provide a brief overview of the organisation. E.g. type of organisation, professions regulated, objectives etc.

Your professional standards and ethical guidance

4 Do you have a set of requirements / standards / rules / guidance / Code of Practice that are set for professionals?

If so, please describe them here.

Please note we are interested here in professional standards and ethical guidance that support the development of a professional identity and professional behaviours / norms not those that are set for educational institutions.

5 What is their stated purpose and role?

6 What do they cover?

7 What do they describe? E.g. values, behaviour, skills, knowledge, normative standards, minimum standards, good practice.

8 Who do they apply to? E.g. at all stages of their career? Specific specialties? Multi-professional groups?

9 Is there one central set of standards or multiple ones? How do they relate to each other?

10 What is their legal status?

11 How are they connected to fitness to practice and disciplinary processes (if at all)?

12 How are they connected to education (if at all)?

13 How are they connected to other standards and guidance set by other bodies or organisations (if applicable)?

Development and implementation

14 How are they developed? Who with?

15 How are they reviewed or updated? E.g. how often, what process, who by?

16 What formats are they available in? E.g. online document, hard copy, video, app etc

17 How are they implemented or communicated? E.g. helpline, sessions at medical school, outreach sessions etc?

18 Do you respond to enquiries from registrants and others about the interpretation and application of your standards or guidance (for example by telephone, email or online)? If yes, how? If not, how/where do you direct such enquiries?

Impact

19 What do you think the strengths of your model are?

20 What do you think the challenges or weaknesses are?

21 What impact do you think your standards and guidance have? E.g. on keeping patients safe, on the profession etc

22 How well received are your standards and guidance by the profession(s) you regulate? E.g. do you know if they find them useful or do they find them as too long or burdensome?

23 What (if any) changes are you planning to make to your standards and guidance in the future?

Further information

24 If there are any other comments you would like to make about professional standards and ethical guidance please include them here.

25 Please list the titles of your standards and guidance and any other relevant documents here. We would be grateful if you can provide hyperlinks if they are available online or attach them when returning your survey.

26 We would very much like the opportunity to discuss the research and your answers in further detail in a telephone interview. Please include contact information here for any colleagues who are able to discuss your standards and guidance in further detail.

Thank you

Thank you for taking the time to complete this survey. Your assistance is very much appreciated.

Please return the survey along with any attached documents to:

karen.roberts@gmc-uk.org