

Education and Training Committee, 13 September 2012

Student fitness to practise

Executive summary and recommendations

Introduction

This paper discusses the area of student fitness to practise in light of the HPC consultation on this topic in late 2011 to early 2012 and the outcomes of a commissioned literature review. Suggestions are made for potential future changes to the standards of education and training to be considered during their next review.

Decision

The Committee is invited to discuss the attached paper and appended literature review. No specific decision is required.

Background information

As outlined in paper.

Resource implications

None as a direct result of this paper. The resource implications of the future periodic review of the SETs will be accounted for departmental planning in future years.

Financial implications

None as a direct result of this paper. The financial implications of the future periodic review of the SETs will be accounted for departmental budgeting in future years.

Appendices

Prime Research and Development (2012). Student fitness to practise and registration – a literature review.

Date of paper

3 September 2012

Student fitness to practise

1. Introduction

- 1.1 We consulted between November 2011 and March 2012 on a number of different options for assuring the fitness to practise of students, including the specific issue of registration of social work students in England.¹
- 1.2 'Student fitness to practise' was used in the consultation as a shorthand term to refer to students having the necessary health and character so that they will be able to practise safely and effectively once they become registered. It is also about students' ability to act appropriately with those whom they come into contact with when they are training, including service users.
- 1.3 Alongside the public consultation, we commissioned Prime Research and Development Ltd to undertake a review of the literature in this area. The research looked at the field of student fitness to practise more generally rather than focusing solely on the role of regulators and student registration. The research is appended to this paper.
- 1.4 The Council has agreed that it is not necessary to register social work students in England or students in any of the other HCPC registered professions. The Council has also agreed to put in place a 'social work student suitability scheme' to manage the transition between registration of social work students and the approval of social work programmes against the HCPC's standards of education and training.²
- 1.5 The consultation and the literature review looked at the issue of student fitness to practise 'in the round'; they were not limited solely to questions about student registration. This paper aims primarily to draw together the broader outcomes of the consultation and the literature review to invite the Education and Training Committee to discuss whether there are any developments to the HCPC's policy and practice in this area (e.g. possible changes to the standards of education and training) that might be considered in the future.
- 1.6 This paper is divided into five sections.
 - Section one introduces the document.
 - Section two provides background information.

¹ Consultation on student fitness to practise and registration and summary of responses to the consultation

<http://www.hcpc-uk.org/aboutus/consultations/closed/index.asp?id=131>

² Council, 19 June 2012. 'Social work student (England) suitability scheme.'

<http://www.hcpc-uk.org/aboutus/committees/archive/index.asp?id=618> (click on enclosure 02)

- Section three provides a summary of the findings of the literature review.
- Section four provides a summary of the findings of the public consultation.
- Section five discusses whether any changes to the HCPC's policy and practice might be indicated.

2. Background

2.1 This section outlines some background relevant to the broader discussion in this paper including information about the social work student suitability scheme.

Social work student suitability scheme

2.2 At its meeting in May 2012, the Council agreed that the most effective and proportionate means of assuring the fitness to practise of social work students in England is through the standards of education and training and the approval of education and training programmes.³ This decision has meant that social work students in England are no longer required to register with the regulator.

2.3 In recognition that the social work community, including education providers and employers, may face additional changes during the transition to the HCPC's quality assurance arrangements, the Council agreed to establish a transitional social work student suitability scheme.⁴

2.4 This transitional scheme will be in place whilst we assess social work programmes in England against the SETs. The scheme will provide a mechanism for dealing with concerns about students where this is deemed necessary.

2.5 Specifically, it will enable us to:

- provide an opinion, in exceptional circumstances, to a social work education provider on whether an applicant is of suitable character to be admitted to a programme;
- investigate where we consider that the education provider has failed to deal with a credible complaint about a student appropriately;

³ HPC statement on the Council's decision on the interim arrangements for assuring social work students' fitness to practise

<http://www.hcpc-uk.org/mediaandevents/statements/socialworkerstudentsuitabilityscheme/>

⁴ For more information please see: Social work suitability scheme in England

<http://www.hcpc-uk.org/education/studentsuitability/>

- consider the outcomes of an education provider's fitness to practise procedures to determine whether a student should be prohibited from a programme;
- maintain a record of students who are not permitted to participate in a social work programme in England; and
- manage open cases (at the time of transfer) concerning individuals applying to be on the student register maintained by the GSCC and those individuals who are on the GSCC student register.

HCPC standards

- 2.6 The standards of education and training include a number of standards relevant to student fitness to practise. They are reproduced overleaf.
- 2.7 Please note: the standards given here are those most relevant to the definition given in paragraph 1.2. Student fitness to practise is sometimes used in a wider sense to include activities such as monitoring practice placements (see findings from the consultation and literature review later in this paper).

Table 1

	SET	Key points from guidance
2.3	The admissions procedures must apply selection and entry criteria, including criminal convictions checks.	<ul style="list-style-type: none"> - Enhanced disclosure or equivalent required. - Arrangements for making decisions about students with criminal convictions including willingness of practice placement providers to accept students.
2.4	The admissions procedures must apply selection and entry criteria, including compliance with any health requirements.	<ul style="list-style-type: none"> - Health requirements (e.g. vaccinations) if appropriate. - May vary between different professions.
3.16	There must be a process in place throughout the programme for dealing with concerns about students' profession-related conduct.	<ul style="list-style-type: none"> - Focus on identifying and addressing concerns. - Range of outcomes including an award which does not lead to registration. - Process should be fair. - Communication with practice placement educators.
5.10	There must be regular and effective collaboration between the education provider and the practice placement provider.	<ul style="list-style-type: none"> - Joint working and communication between the education provider and practice placement provider (for example, to ensure that poor conduct is reported).
5.11	Students, practice placement providers and practice placement educators must be fully prepared for placement which will include information about an understanding of...expectations of professional conduct.	<ul style="list-style-type: none"> - Students and practice placement educators should be well informed about what is expected of them and their responsibilities during a placement.
5.12	Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.	<ul style="list-style-type: none"> - Information required about how students learn about the behaviour expected of them on placement.
6.3	Professional aspects of practice must be integral to the assessment procedures in both the education setting and practice placement setting.	<ul style="list-style-type: none"> - Includes values and ethics and responsibilities of regulation.

- 2.8 The standards of conduct, performance and ethics (SCPE) are referenced in SET 4.5 and apply to both registrants and 'prospective registrants'. In addition, the HCPC also publishes guidance on conduct and ethics for students which elaborates upon the SCPE to explain more about the expectations of students; and guidance on health and character (recently revised and republished) which provides guidance to applicants, registrants and education providers on matters related to the disclosure of criminal convictions/cautions and health issues.
- 2.9 The HCPC reviews its standards periodically approximately every five years. The next review of the SCPE will commence in 2012/2013. The SETs were last re-published in 2009 and are due to be reviewed from 2013/2014 (subject to other organisational priorities).

Council for Healthcare Regulatory Excellence (CHRE)⁵

- 2.10 The CHRE has previously explored the role the regulators should play in student fitness to practise, particularly whether the regulators should routinely require education providers to disclose the outcomes of student fitness to practise committees or their equivalent.⁶ The CHRE has made a number of recommendations, discussed at a previous meeting of the Committee.⁷
- 2.11 The following outlines the two chief recommendations made by the CHRE in the report and a summary of the HCPC's response.
- 2.12 Recommendation: The applicant and the education provider should declare information about student fitness to practice sanctions to the regulator.
- The HCPC does not routinely require applicants for registration or education providers to declare information about student fitness to practise sanctions, but education providers are asked to inform us if they have removed someone from a programme owing to serious concerns about their conduct.
 - The standards of education and training ensure that only someone who passes an approved programme, having met both the 'practical' or 'technical' competence elements and the required conduct elements, will gain eligibility to apply for registration.

⁵ The CHRE will become the Professional Standards Authority for Health and Social Care during 2012

⁶ CHRE (2010). Should the regulators receive the outcomes of student fitness to practise committees?

<http://www.chre.org.uk/satellite/166/>

⁷ Education and Training Committee, 16 September 2010. 'Student fitness to practise – should we receive every outcome?'

<http://www.hcpc-uk.org/aboutus/committees/archive/index.asp?id=541> (click on enclosure 14)

- If an education provider has taken action short of removing a student from a programme and that student has subsequently successfully completed the programme, and therefore met all of the standards of proficiency, they will be eligible for registration. The decision to refuse registration is as serious as a striking-off order and it is unlikely that the HCPC would refuse registration solely on the basis of misconduct which had already been identified and remedied whilst a student on an approved programme. There would be the potential to receive routinely information upon which it is unlikely any action would be taken.
- It is important to support the creation of a learning environment where students are able to learn from their mistakes during their education and training. This might not be the case if actions short of dismissal from a programme could lead to refusal of registration.

2.13 Recommendation: Regulators should collect aggregated data about student fitness to practise in their role in quality assuring the provision of pre-registration education and training.

- This is suggested as way of collecting information which might improve the regulators' standards of education and training and improve guidance for students about their professional conduct and competence. The GMC collects this information from medical schools through their Enhanced Annual Return (EAR).⁸
- Aggregated data may potentially be useful – for example, in suggesting changes to the standards of education and training or areas of the guidance of conduct and ethics for students which might be enhanced.
- The Committee has previously agreed that it might be helpful for the Executive to explore this suggestion further, but that this was not identified as a high priority at that time. The suggestion that this might be explored further was superseded by the transfer of the regulation of social workers in England and the issues around student fitness to practise and registration this raised.

⁸ General Medical Council - Student fitness to practise information from the 2010 enhanced annual report (EAR) from Medical Schools Council (2011), Student Fitness to Practise Summary Report
www.medschools.ac.uk/Pages/default.aspx

Professionalism in healthcare professionals

2.14 This study by Durham University (commissioned as part of the work looking at revalidation) sought to explore what is perceived as professionalism by both students and educators and why and how professionalism and lack of professionalism may be identified.⁹ A number of the findings are relevant to the material drawn upon in the student fitness to practise and registration literature review.

- Professionalism was conceived as both a holistic concept ('doing the job well') and as a multi-dimensional, multi-faceted concept covering aspects such as professional identity, attitudes and behaviours.
- Regulation was seen as providing basic guidance, providing a baseline for behaviour rather than a specification for action.
- Professionalism had a basis in individual characteristics and values, but was defined by context including factors such as the following.
 - Organisational support.
 - The workplace.
 - Expectations of others (including role modelling).
- Rather than a set of discrete skills, professionalism is instead a 'meta skill', knowing about what is most appropriate in a specific situation, drawing on appropriate technical and practical skills.
- The research suggests that one approach to the lack of a clear definition of professionalism may be to recode professionalism simply as using 'appropriate behaviour' in relevant communication and technical skills. It is suggested that educators might focus on professionalism by seeking to raise awareness of and increase students' capacity for making professional judgements.

⁹ Health Professions Council (2011). Professionalism in healthcare professionals. <http://www.hcpc-uk.org/publications/research/index.asp?id=511>

3. Key findings from the literature review

3.1 The following provides a summary of the findings of the literature review (appended) which are relevant to the broader issues of student fitness to practise.

- There is a relative lack of substantive literature about student fitness to practise in the professions regulated by the HPC and in social work.
- There is lack of information in the research literature about the risks posed by students, beyond descriptions of unprofessional behaviour during training and some research literature about the relationship between conduct during training and subsequent fitness to practise action once qualified.
- Student fitness to practise is not a well-defined term and is used interchangeably with terms such as professionalism, professional suitability and good character. Student fitness to practise is less about academic suitability or ability and more about conduct, values and attitudes; it is often defined by 'bad' behaviours to be avoided rather than good. Student fitness to practise concerns the propensity of individuals to make professional judgments in given situations.
- Education providers have roles to play in developing fitness to practise; assessing fitness to practise; and dealing with instances of poor conduct. Three key areas are identified/

Development of fitness to practise

- Setting clear expectations about what is and is not professional behaviour.
- Co-ordinating throughout the whole curriculum teaching and learning about professionalism.
- Role modelling alongside student reflection on their progress.
- Holding students accountable to a code of conduct.

Assessment of fitness to practise

- Assessment on selection - but acknowledgement that we are only really able to exclude the obviously 'unsuitable'.
- Formative and summative assessment of 'non-academic performance'.
- Identifying 'unfitness' relies on the professional judgement of experienced and qualified tutors and supervisors.

'Unfitness to practise'

- There is a lack of data about the incidence of concerns about the conduct of students and some evidence of under-reporting.
 - There is general agreement about the need for specific policies related to students studying on programmes leading to professional registration, in addition to general academic misconduct policies.
 - There is variation in the policies used by universities.
 - There is general agreement that procedures should be timely, robust and documented and that there should be a range of different outcomes.
- Regulators should describe what is meant by fitness to practise and ensure that a range of proactive measures (e.g. curricula; high quality placements) and reactive measures (e.g. addressing poor behaviour when it occurs) are in place. They have a role in ensuring consistency and in conveying values about public protection in their practices.
 - Some regulators have produced more specific guidance on how education providers should handle fitness to practise concerns about students. A number of areas are noted where the HCPC's guidance does not go into the same depth, including the following.
 - Threshold for decisions.
 - Confidentiality and disclosure.
 - Pastoral care and student support.
 - Composition and training of panels (including separation of investigation and adjudication).
 - Hearings, outcomes and appeals.

4. Key findings from the public consultation

- 4.1 The following summarises the findings from the public consultation on student fitness to practise and registration which are relevant to the broader issues discussed in this paper.
- The potential risks of students to service users could be managed effectively in a number of ways including through the following.
 - Selection.
 - Supervision.
 - Risk assessment of placements.
 - Exception reporting by supervisors.
 - Student fitness to practise arrangements.

- The following arrangements are helpful in ensuring a safe learning environment and effective supervision of students.
 - Good communication – between students and supervisors; supervisor, student and course tutor; and education providers and practice placement providers.
 - Preparation of supervisors to perform their role.
 - Preparation of students for placements so that they are aware of their limitations (as far as possible).
 - Arrangements for assessment on placements, as well as for feedback, evaluation and reflection on placement experience.

- Expectations of professional conduct should be embedded throughout a programme and linked to assessment. This could be supported through a mandatory code of conduct and/or guidance from the regulator.

- There was no evidence of systematic inconsistency in student fitness to practise decisions by education providers but this was a potential risk.

- There was no clear agreement on whether additional guidance or advice on this topic, over and above the HCPC's existing arrangements, would be helpful.

5. Discussion

5.1 The literature review concludes with a series of recommendations for the HCPC and for regulators generally. Each of those recommendations is listed below, with a commentary about the HCPC's current approach.

Table 2

Recommendation	Commentary
The literature indicates that it would be good practice for regulators to:	
Describe behaviours that indicate fitness to practise in students and those that do not, including in those descriptions examples of academic behaviours which relate to ethical professional practice.	<p>The SCPE includes examples of behaviours which would lead to removal from the register. These are referenced in the guidance for education providers included in the guidance on health and character.</p> <p>The guidance on conduct and ethics for students elaborates upon the SCPE for students, including examples which are related to academic as well as professional behaviours.</p>
Recognise in any guidance produced the complexity of making judgements about behaviour and that such judgements should take into account the context in which they were set and also the stage of the student's development.	<p>The guidance on health and character outlines the kinds of factors that education providers might take into account in deciding whether to offer a student with criminal convictions / cautions or a health condition a place on a programme.</p> <p>The SETs guidance (to SET 3.16) refers to the education provider making 'every effort' to address concerns about students.</p>
Require educational institutions to have specific and separate professional student fitness to practise policies and procedures, which have the capacity to remove students from courses if required.	<p>The SETs guidance (to SET 3.16) refers to education providers having a process in place which is focused on fitness to practise and which has an appropriate range of outcomes. It does not specify that this needs to be separate from other academic suitability procedures.</p>

Recommendation	Commentary
The literature indicates that it would be good practice for regulators to:	
Require educational institutions to make their student fitness to practise policies and procedures timely, robust, fair, documented clearly, contain reliable systems for documenting concerns and identifying and managing students whose behaviour is problematic, using a system of graduated interventions and to implement the policies and procedures consistently.	Many of these points are included within the SETs guidance and referenced above. The existing guidance (to SET 3.16) does not refer to the process being 'timely', 'consistent' and 'robust', however this is perhaps implicit in the guidance that the process must be 'thorough, fair and open', and that education providers must be able to justify their choice of process and their decisions about students.
Evaluate the consistency with which student fitness to practise policies and procedures are applied and improve their regulatory approaches as a result.	SET 3.16 (about the need for a process to deal with student conduct) was only effective from 2009/2010 for new programmes and has been implemented via annual monitoring during 2010/2011 and 2011/2012. We do not collect data and have not undertaken specific research to look at consistency. The current wording of the SET does not explicitly require consistency.
Ensure that its approved educational programmes contain a range of proactive measures for developing and assessing student fitness to practise, including the assurance of high quality practice placements.	SET 5 addresses a number of issues about the quality of practice placements. SET 4.6 is relevant here as it relates to development of autonomous thinking including knowing the limits of safe practise and personal responsibility. Please also see Table 1.
Seek evidence from approved educational programmes as to how they ensure consistent application of student fitness to practise policies and procedures.	The SETs do not specifically address the consistency of procedures. Please see above.
Evaluate all of its own approaches, practices and performance over time for the messages that these send to the public educators and students.	This paper is intended to stimulate discussion on this.

- 5.2 The research suggests that we might further consider:
- ways in which we can improve our standards for, and guidance to, education providers in relation to developing and managing student fitness to practise; and
 - how we can best enhance students' understanding of fitness to practise, and the relationship of fitness to practise to public protection.
- 5.3 Overall, it appears that many of the findings and recommendations of the literature review, and the findings of the consultation, are well reflected in the existing standards of education and training and in guidance. However, there may be some scope for review and improvement.
- 5.4 The Council has recently agreed to commence a review of the SCPE with research in 2012/2013; a PLG from 2013/2014; consultation from 2014/2015; and re-publication of the standards in 2015. The Executive intends to begin work to update and seek views on the existing guidance on conduct and ethics for students during 2014/2015, with a view to consult on any changes once the revised SCPE has been agreed in 2015. This review will be informed by the literature review.
- 5.5 The following discusses some areas identified by the Executive as potentially meriting further consideration, particularly during the next planned review of the SETs. The Executive considers that the nature of the potential changes are developmental rather than radical and that no early review of the SETs is necessary.

Guidance on student fitness to practise

- 5.6 The literature review particularly references guidance produced by the General Medical Council (GMC) and the Medical Schools Council (MSC), primarily on the process that should be followed by education providers in handling student fitness to practise.¹⁰ The definition of student fitness to practise outlined in this document and its underpinning principles for dealing with poor student conduct are consistent with the SETs guidance and other documents such as the guidance on health and character.
- 5.7 However, this guidance does go into much more depth on this area. For example, guidance is provided on the role of the investigator; the composition of panels; the circumstances in which certain outcomes should be considered (analogous to the HCPC's indicative sanctions policy for fitness to practice panels); and the standard of proof which should be used at hearings.

¹⁰ Medical values: Professional values and fitness to practise
http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp

- 5.8 The consultation responses indicated that generally whilst inconsistency in student fitness to practise outcomes between education providers was a potential risk, there was little evidence to support incidence. Further, whilst there is literature noting variations in procedures and policies between universities, there is little evidence of this leading to inconsistency in outcomes. In the consultation, there was a lack of agreement about whether additional ('stand alone') guidance from the HCPC would be helpful.
- 5.9 SET 3.16 (requiring a process for dealing with concerns about the conduct of students), was first introduced in 2009. The Executive suggests that this is a standard that will particularly need reviewing in the next SETs review. The Executive has made the following observations.
- The commentary in response to the recommendations outlined in table 2 mainly describes discretionary 'should' requirements in the guidance rather than 'must' requirements in the standard itself. The next SETs review will be an opportunity to review the balance between the SET and guidance.
 - The existing standard is about both picking-up conduct problems and managing them informally, as well as the specifics of a formal process which could lead to removing a student from the programme. However, the guidance focuses mainly on a formal process. The next SETs review will be an opportunity to review this, perhaps by separating the two areas into separate standards or sub-clauses.
 - Unlike other standards, the wording of this standard does not use phrases such as 'effective' or 'appropriate' which would allow more qualitative judgements to be made. The standard simply expects a formal process to be in place, with some expectations set out in the guidance. This was reasonable when the requirement was first made, but the next SETs review will be an opportunity to consider amending the standard so that visitors are able to assess the effectiveness of the processes that are in place.
 - The next SETs review could provide an opportunity to use terminology now used commonly in this area such as 'student fitness to practise'.
 - More specific requirements in the standard or guidance could be considered including expectations of a formal process (e.g. separation of investigation and adjudication) and the composition of panels.

Declaring the outcomes of student fitness to practise proceedings

- 5.10 Paragraph 2.11 sets out the HCPC's approach and the Executive considers that this remains a sound approach. Requiring every outcome to be disclosed by the education provider or by applicants for registration when they have completed successfully an approved programme would be disproportionate in the Executive's view.
- 5.11 The guidance on health and character says the following: 'If you remove a student from your programme because of misconduct, you should tell us. If we believe the misconduct is serious enough, we can keep the information and look at it if the person ever applied to us for registration in the future.' The HCPC operates a 'watch list' which allows it to retain relevant information (e.g. notifications of criminal convictions) related to individuals who may apply for registration in the future, so that this information, if relevant, can be considered at the point of application.
- 5.12 The Education Department and Fitness to Practise Department plan to review the HCPC's approach to maintaining and communicating the watch list in the future (exact timing dependent on other organisational and departmental priorities).

Professionalism and the curriculum

- 5.13 The literature review, consultation responses and the professionalism research all indicate the importance of 'professionalism' (e.g. expectations of professional behaviour; the ability to make professional judgements about appropriate behaviour in given situations) being embedded throughout the curriculum.
- 5.14 SET 4.5 requires education providers to ensure that students understand the implications of the HPC's SCPE. The guidance says that they must be taught and met throughout a programme and could be covered as part of a module on ethics or could be built into the curriculum as a whole. SET 6.3 requires that this is followed through in the assessment: 'Professional aspects of practice must be integral to the assessment procedures in both the education setting and practice placement setting.'
- 5.15 The next SETs review may provide an opportunity to make this area more explicit in the curriculum and assessment standards and/or guidance. For example, through using language such as 'professionalism' and 'student fitness to practise' rather than the terms used currently which, arguably, may be less familiar to stakeholders

Collection of aggregated data

- 5.16 The CHRE has previously suggested that the regulators should collect aggregated data about student fitness to practise outcomes from education providers and that this might be used to improve standards of education and training and to improve guidance for students. The literature review has suggested that evidence should be sought from education providers about how they ensure consistency in the way they apply their student fitness to practise procedures.
- 5.17 Collecting aggregated data could arguably be useful in helping to achieve both of these aims. It might be that such data would be helpful in indicating the areas of conduct dealt with by education providers, the outcomes and potentially the incidence of concerns. However, given the case-by-case nature of cases, it might be more difficult to draw conclusions about consistency.
- 5.18 The Executive proposes to collect a sample of aggregated student fitness to practise data in the 2013/2014 academic year to feed into the next review of the standards of education and training. This is proposed as a one-off pilot exercise (pending consideration of the value of the data).

Prime Research & Development Ltd

Student Fitness to Practise and Student Registration A literature review

A project for the Health Professions Council

George Boak, Lindsay Mitchell and David Moore

February 2012

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Chapter 1: Introduction

1.1 Nature and scope of the review

This report describes an independent review of the literature about student fitness to practise. The research was commissioned by the Health Professions Council (HPC) as part of its policy work on student registration.

The purpose of the research was to assist in building an increased understanding of the potential nature, scale and importance of the policy problem under consideration and the effectiveness of different approaches to managing student fitness to practise. The HPC had undertaken a preliminary search of the topic and found limited published evidence about the issue under review.

The aims of the research were to:

1. identify and appraise the available research literature and evidence about student fitness to practise, including student registration
2. assist in building a clearer picture of the risks associated with students in the professions regulated by the HPC and in social work, and the effectiveness of different approaches to managing those risks
3. contribute towards future decisions about the most effective and appropriate means of assuring the fitness to practise of students, including whether the existing register of social work students in England should continue to be maintained.

This literature review formed one strand of a development programme being undertaken by the HPC in the light of the Government's decision to abolish the General Social Care Council (GSCC) and transfer its responsibility for regulating social workers in England to the HPC (subject to the parliamentary approval of the Health and Social Care Bill 2011).

1.2 The HPC's programme of work on student fitness to practise and registration

The HPC is taking forward a number of pieces of development work in order to assume responsibility for the regulation of social workers. A key piece of work relates to student fitness to practise because the GSCC and HPC have different approaches.¹ The GSCC currently registers social work students but the HPC does not register students of any the 15 professions it currently regulates (ie arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, and speech and language therapists). It does publish standards and guidance for education providers about approaches to student fitness to practise. The Health and Social Care Bill 2011 has provisions to enable the HPC to establish voluntary registers of students studying on programmes leading to HPC registration, should the Council determine it is appropriate to do so.

¹ Further information on the current processes of the HPC and the GSCC in relation to Student Fitness to Practise is considered in section 4 of this review.

In order to fully explore the issues relating to student registration in the context of student fitness to practise, the HPC has established a programme of work to gather evidence and to seek views to inform its policy development. The programme consists of three strands:

1. undertaking a first stage impact assessment focusing on the development of the policy problem and the options available to address it
2. consulting with stakeholders on the most effective way of assuring the fitness to practise of students
3. commissioning a literature review to gain more evidence about student fitness to practise processes, the risks posed by students, and the effectiveness of different approaches to manage those risks – the subject of this report.

The HPC's definition of student fitness to practise

In its consultation document on the subject, the HPC defines student fitness to practise as relating to:

'students have(ing) the necessary health and character so that they will be able to practise safely and effectively once they have become registered. It is also about students' ability to act appropriately with those they come into contact with when they are training, including service users.' (HPC, 2011a)

This definition recognises that until students have completed their pre-registration programmes, they are still in the process of developing their knowledge and skills to practise safely and effectively. This is in contrast to the fitness to practise of registrants which is defined as having 'the skills, knowledge, health and character in order to practise their profession safely and effectively' (HPC, 2011a).

The HPC's definition of student fitness to practise is consistent with the approaches adopted by other regulators (see chapter 4) and has been used as the basis for this review of the literature.

The impact assessment

The first stage impact assessment on student fitness to practise was published on the HPC website at the same time as the consultation (ie 1 November 2011). The summary of the impact assessment notes that:

'The HPC Council has determined that student registration should be considered across the existing HPC regulated professions. The issue under consideration is therefore to consider the most effective and appropriate means of assuring the fitness to practise of students, including whether the existing register of social work students in England should be maintained.' (HPC, 2011b)

This decision by the HPC is set in the context of it being a multi-professional regulator that works within a single piece of legislation with many common standards and processes.

The impact assessment sets out the policy objectives of developing student fitness to practise regulatory processes and the effects they are intended to achieve. The objectives apply both to the consultation and to this literature review and are reproduced below:

- *'To ensure that the public are adequately protected from the potential risk of harm posed by students.'*

- *To ensure that concerns about students are adequately dealt with so that only someone who is fit to practise completes a programme with an award that leads to eligibility for registration.*
- *To ensure that students are aware of the duties, responsibilities and standards expected of them as future registrants.*
- *To ensure consistency and equity of regulatory approach across the HPC register, wherever possible and appropriate.*
- *To ensure that any voluntary register of students is feasible on a self-financing basis, avoiding cross-subsidisation from the HPC's statutory functions.'* (HPC, 2011b)

The impact assessment also notes that 'further evidence and data (if available) needs to be gathered about the relative effectiveness of the different options' (page 15), setting the context for this literature review.

The consultation questions and possible outcomes

The consultation document did not make specific proposals about how student fitness to practise should be taken forward but sought stakeholders' views on aspects including: the objectives to be achieved in student fitness to practise approaches; the risks posed by students and the supervision arrangements to address those risks; student engagement with professional regulatory standards; consistency of fitness to practise processes across education institutions; the costs, benefits and equality and diversity implications of the different approaches.

In the consultation document the HPC clarified that the responses would inform its decisions about student fitness to practise and registration, including whether:

- the HPC's current approach to student fitness to practise should be maintained across the Register; or
- the HPC should maintain a voluntary register of social work students in England; and/or
- the HPC should establish any voluntary registers of students for some or all of the existing HPC regulated professions.

These matters remain open at the time of reporting this literature review which predates closure of the consultation in March 2012.

1.3 Conclusion

This chapter has outlined the purpose and aims of the literature review in the context of the work on student fitness to practise currently being undertaken by the HPC. The next chapter outlines the methodology adopted to identify and review the literature. Chapter 3 reports the findings from an evaluation of available literature about student fitness to practise. Chapter 4 extends the findings by reporting on the policies adopted by other health and social care regulators in the UK and by way of comparison, also in a selection of other countries. Conclusions and recommendations are set out in Chapter 5.

Chapter 2: Methodology

2.1 Search strategy

The aim of the project was to review literature and evidence about the nature of mechanisms to monitor and assure student fitness to practise, including registration. The identification and appraisal of information was informed by reference to areas of particular interest to the HPC:

- the nature, incidence and impact of risk to patients, clients, users and the public posed by students
- the impact of supervision on student risk
- the incidence of 'programme hopping'
- student engagement with regulatory standards
- the consistency of approach among education providers to students declaring convictions or other information potentially of relevance to an evaluation of professional conduct
- the relative costs and benefits of approaches to managing student fitness to practise, including registration.

Prior to the commissioned research the HPC had undertaken a preliminary search and found limited published evidence about these issues. Initial searching confirmed the absence of a well-populated or narrowly circumscribed body of literature that would lend itself to systematic review. As a consequence we have undertaken an integrative review (Whittemore and Knafl, 2005), a method which includes a synthesis of diverse sources and types of information (ie both primary and secondary, both empirical and theoretical, and both catalogued and grey literature) to provide a fuller understanding of the issue. The method involves problem identification (described above in the opening paragraph), literature searching, data evaluation and data analysis (described below), and presentation of findings (the substantive part of this report).

The nature and scope of the problem justified a search of multiple databases. Ten electronic databases were searched during October, November and early December 2011 (table 1). Searching was limited to English language journals and to articles from 1990 onwards (although not all electronic databases span this period in its entirety). In some cases searching highlighted works of potential interest published prior to 1990, some of which were selected for review. However the bulk of literature identified as sufficiently relevant to warrant analysis is drawn largely from the last fifteen years. The majority of literature selected for review was accessed electronically, but some was available only as print holdings, which were photocopied.

To limit the scope of the project, searching was largely confined to occurrences of key terms in titles and abstracts only. The search strategy commenced with a number of key terms used in various combinations (including 'student', 'registration', 'regulation', 'education', 'conduct', 'misconduct', 'fitness', 'practise') but evolved iteratively with the addition of other terms (such as 'malpractice', 'struggling students', 'professional competence', 'professional standards', 'suitability', 'risk', 'accreditation', 'termination' 'interruption')

'discipline') that were suggested from a cursory review of initial results, or were identified to better exploit the thesauri of particular databases.

Table 1: Electronic databases searched

Allied and Complementary Medicine Database (AMED)
Applied Social Science Index and Abstracts (ASSIA)
British Education Index (BEI)
British Nursing Index (BNI)
Cumulative Index of Nursing and Allied Health (CINAHL)
Education Resources Information Centre (ERIC)
Medline/PubMed
PsycINFO
Social Care Online
Social Service Abstracts

2.2 Search results

The search strategy inevitably generated records running into the thousands, most of which concerned registered (rather than student) practitioners or aspects of pre- and post-registration education and training of no direct relevance to this review; but we were unable to find a means of consistently and satisfactorily limiting initial searches without also missing potentially relevant material. 'Advanced searches' were successful in reducing the number of records generated but, when evaluated against 'simple searches', appeared to omit records we had judged potentially relevant – a conclusion also reached by others (Flemming and Briggs, 2006). A substantial part of the project has therefore involved sifting the initial search results record by record, by title or by title and abstract, to identify potentially relevant literature for evaluation. Sifting was conducted with reference to the issues identified in the opening paragraph to this section. Additional literature was also identified from references in the works reviewed. A record was built-up of all the items selected for full evaluation.

From initial returns running into the thousands, focused searching and a process of rigorous sifting resulted in the selection of around 400 articles published in learned and professional journals, the vast majority of which have been fully evaluated for this review. Each item was read and reviewed and a short summary prepared for use within the team. Some items were reviewed blind by all three members of the team to check for analytical parity. Having discarded literature judged irrelevant, the literature remaining was further examined and is cited in support of the analysis that forms the substantive part of this report.

Government, regulatory and professional bodies were the main focus of web-searching for grey literature. Over 100 reports, policy statements and guidance documents were reviewed. Many have been used to inform an analysis of the position adopted by other UK

health professions regulators, and also to provide an account of some international comparators.

In identifying relevant literature we did not discriminate between categories on the basis of a ‘hierarchy of evidence’, for example as might occur in a systematic review by specifying strict inclusion and exclusion criteria, not least because this would have compromised the integrative approach adopted. However we did undertake a post-hoc categorisation of sources to provide an overview of the relative proportions of empirical and non-empirical literature cited in this report (table 2).

The categorisation is relatively crude and is intended to give no more than a general sense of the types of study, commentary and opinion uncovered. For the purposes of this review papers reporting empirical studies have been differentiated by the principal (which is not necessarily the only) research method. Inevitably this conceals other distinctions but further differentiation was considered unnecessary for the purpose here. The survey category has been interpreted liberally to include all studies that collect (quantifiable) data by questionnaire or another research instrument from (usually sampled) populations of participants.

For empirical studies the country in which the research was conducted has been identified. This reveals a broadly similar number of studies from the two largest contributors to this category, the US and the UK. The largest category – of what are, broadly speaking, non-empirical pieces – includes literature reviews and descriptive, discursive, analytical and propositional papers. Much of this literature would fall outside the parameters of a systematic review yet provides illuminating commentary on a number of the issues under consideration. Nevertheless, it is notable that there is a dearth of information about some of the specific issues of interest to the HPC identified in the opening paragraph.

Table 2: Literature by type

<i>Case control studies</i>	Papdakis et al, 2005 (US); Teherani et al 2005 (US); Yates and James, 2010 (UK).
<i>Cohort studies</i>	Goldie et al, 2002, (UK); Humphrey et al 2011 (UK); Papdakis et al, 2008 (US); Steggers-Jager et al 2011 (Netherlands); Stern et al, 2005 (US).
<i>Focus (and other) group methods</i>	Baingana et al, 2010 (Uganda); Banks, 2005 (UK); Cleland et al, 2005 (UK); Cleland et al, 2008 (UK); Furness and Gilligan, 2004 (UK); Lafrance et al, 2004 (Can); Morrow et al, 2011 (UK); Rees and Shepherd, 2005a (UK); Rees and Shepherd, 2005b (UK).
<i>Interview based studies</i>	Basnett and Sheffield, 2010 (UK); Fontana, 2009 (US); Stanley et al, 2011 (UK).
<i>Observational studies</i>	Burack et al, 1999 (US); Hodges et al, 2001 (US); Weissmann et al, 2006 (US).
<i>Survey based studies</i>	Al-Dwairi and Al-Waheidi, 2004 (Jordan); Andreson and Obenshain, 1994 (US); Bailey, 2001 (US); Baldwin et al, 1998 (US); Barlow and Coleman, 2003 (Can); Brockbank et al, 2011 (UK); Brown et al, 2011 (US); Daniel et al, 1994 (US); Dillon, 2007 (UK); Dyrbye et al 2010 (US); Elzubier and Rizk, 2003 (UAE); Geddes et al, 2004 (Can); Hilbert, 1985 (US); Hilbert, 1987

	(US); Jette and Portney, 2003 (US); Korszun, 2005 (UK); Kovach et al, 2009 (US); Lown et al, 2009 (UK); Manthorpe et al, 2010 (UK); McGrugen et al 2010 (Aus); Rennie and Crosby, 2002 (UK); Rennie and Rudland, 2003 (UK); Rizk and Elzubier, 2004 (UAE); Roff et al, 2011 (UK); Self and Baldwin, 1998 (US); Stockhausen, 2005 (Aus); Stone et al, 2009 (US); Tam and Coleman, 2009 (Can); Unsworth, 2011 (UK).
<i>Literature reviews and works of a descriptive, discursive, analytical or propositional nature</i>	Aldridge et al, 2009 (UK); Arnold, 2002; Banks 2010; Boon and Tuner, 2004; Bradshaw and Lowenstein, 1990; Brainard and Brislen, 2007; Butters and Strope, 1996; Carr et al, 2010; Chaffer. 1998; Clark, 2006; Cleary and Horsfall, 2010; Cruess and Cruess, 2006; Cruess et al 2010; Curren and Atherton 2008; Curren, 2009; David and Ellison, 2010; Dean 2011; Duffy and Hardicre, 2007a; Duffy and Hardicre, 2007b; Elliott et al, 2009; Fiesta, 1998; Fowler, 2008; Fox et al, 1995; Gaberson 1997; Ginsburg 2000; Goldie, 2008; Hall, 2004; Hickson et al, 2007; Hilton and Slotnick, 2005; Holmstrom and Taylor, 2008; Howe 2002; Howe et al, 2010; Hughes et al, 2009; Jha et al, 2007; Karnieli-Miller et al, 2010; Kasar and Muscari, 2000; Kenny, 2007; Kolanko et al, 2005; Lucey and Souba, 2010; Lynch et al, 2004; Martimianakis et al 2009; McGregor and Brown, 1998; McLaughlin, 2010; Papadakis et al, 1999; Parker et al, 2008; Postle 2009; Price, 2006; Reid, 2010; Sin and Fong, 2008; Sin and Fong, 2009; Sellman, 2007; Semple et al, 2004; Smith et al, 2007; Snelling and Lipscombe 2004; Tee and Jowett, 2009; van Mook et al, 2009a; van Mook et al 2009b; van Mook et al, 2009c; van Mook 2009d; Watkinson and Chalmers, 2008; Wagner, 1993; Wear and Castellani, 2000; Whiting, 2007; Wilkinson et al, 2009.

In conclusion, analysing the literature involved identifying and examining sources of information relevant to the issues set out in the opening paragraph of this chapter. In evaluating the literature we searched for patterns across multiple sources – comparing, contrasting and clustering the opinions, assertions, findings and conclusions reported – in an effort to encapsulate contemporary thinking on these matters.

Chapter 3: Findings from the published literature

Introduction

A principal aim of the research was to identify and appraise the available research literature and evidence about student fitness to practise, including student registration.

Broad key themes emerging from the literature concerned:

1. perceptions of student fitness to practise, and related terms such as professionalism, suitability and good character
2. factors believed to affect student fitness to practise
3. approaches by educational institutions to managing student fitness to practise
4. approaches by regulators to managing student fitness to practise.

3.1 Perceptions of student fitness to practise and related themes

Overview

The development and assessment of a student's fitness to practise in health and social care is achieved through a mixture of academic and practical activities. There is a large literature on the development and assessment of knowledge and skills, but the research literature we have reviewed for this report, concerning fitness to practise, is much less concerned with issues of assessment of academic ability – the understanding of relevant facts and theory – than with other abilities that contribute to fitness to practise. Publications identified by searches for articles containing the expression 'fitness to practise' generally addressed issues of behaviours of qualified practitioners alleged to have been in breach of professional standards, or procedures for handling student misconduct. In the context of student learning and assessment, fitness to practise is closely related in the literature to three other high level themes:

- professionalism, particularly in relation to medical training
- professional suitability, or suitability to practise, used in the context of students training for social work
- good character, in relation to training for nursing.

Each of these themes, in their own professional areas, are presented in the publications we reviewed as being central to an individual's ability to practise the profession to a suitable standard. In the sections that follow, therefore, we will focus on these elements, as central components of fitness to practise.

In each of these three areas, writers reflect that there is difficulty in defining and assessing the theme. This is sometimes contrasted with the relative ease of defining and assessing the academic standards that students are expected to meet.

We found little published work on fitness to practise in relation to HPC-registered professionals, and hence the discussion on the following pages largely addresses these themes as they are presented in the context of other professions.

The effect of health impairment and disability, and the danger of unfair discrimination are also potentially relevant in relation to fitness to practise. These are discussed separately below.

Professionalism

Professionalism is the term most frequently used in relation to aspects of the behaviour of medical students, in the UK and the USA, that relate to fitness to practise.

In the UK, the General Medical Council's and the Medical Schools Council' (2009) definition of professionalism includes providing good clinical care, maintaining good medical practice, good behaviours towards patients and colleagues, maintaining professional skills, and also 'being honest and trustworthy, and acting with integrity'. Defined in this way, professionalism is clearly essential for good clinical practice.

A number of articles in the UK and North America put forward alternative understandings of professionalism to that of the GMC. Literature reviews by Arnold (2002), Lynch et al (2004), and Jha et al (2007) show a range of different approaches and definitions have been taken towards medical professionalism.

In 2002 the physician charter, developed in collaboration with the American College of Physicians (ACP) Foundation and the European Federation of Internal Medicine (Smith et al, 2007) was published simultaneously in the Annals of Internal Medicine and the Lancet (ABIM, 2002; Lancet, 2002). It described three guiding principles of professionalism:

- patient welfare
- autonomy, and
- social justice

which were to be exhibited in commitments to competence, honesty, confidentiality, propriety, quality, access, justice, knowledge, trust, and self-regulation.

An alternative perspective, put forward by Hilton and Slotnick (2005) in a review of medical professionalism in the UK and the USA, suggested that professionalism will be exhibited in six domains:

- ethical practice
- reflection /self-awareness
- responsibility for actions
- respect for patients
- teamwork
- social responsibility.

The six domains have been found useful in more recent publications (eg Royal College of Physicians, 2005; Goldie, 2008; Morrow, 2011). According to Hilton and Slotnick, a defining characteristic of professionalism is 'practical wisdom' – which is acquired only after a prolonged period of experience and learning.

Professionalism, however defined, is seen as of central importance to good medical practice (Hilton and Slotnick, 2005; Cruess et al, 2006). A failure of professionalism is related to poor practice: it is said that more medical fitness to practise and disciplinary cases and complaints relate to issues of professionalism than any other reason (eg Papadakis et al, 1999; Ginsburg et al, 2000).

Whilst the majority of publications on professionalism in the health and social care professions are set in the field of medicine, Jette and Portney (2003) report a US study resulting in the development of a model of professional behaviour with physical therapy students. The authors tested a model that had been developed on a consensus basis by May et al (1995). Surveying physical therapy students, Jette and Portney refined May's model into seven factors, each indicated by a number of constituent behaviours:

- professionalism
- critical thinking
- professional development
- communication management
- personal balance
- interpersonal skills
- working relationships.

The factor of professionalism comprised over 30 behaviours, but is defined by Jette and Portney (p439) as:

- a) a commitment to service
- b) adherence to ethical standards
- c) a demonstration of humanistic values such as integrity, honesty, respect for others, compassion and altruism
- d) responsibility and accountability
- e) commitment to professional advancement.

In an article on professionalism for occupational therapists, US clinicians Kasar and Muscari (2000) argue that professionalism requires specific knowledge, attitudes, and values – all indicated by professional behaviours that include: dependability, professional presentation, initiative, empathy, cooperation, organisation, clinical reasoning, supervisory process, verbal communication and written communication.

These examples show a number of approaches to defining professionalism, including listing individual traits and characteristics, and defining roles, domains and activities (see Martimiakis et al, 2009 for an analysis of different perspectives that have been taken).

Individual characteristics suggested in different studies, sometimes in conjunction with roles and activities, include: self-motivation, independent learning, interpersonal relationships, dependability, and integrity (Kovach et al, 2009); compassion; empathy; positive outlook; interest in people; honesty and trustworthiness (Lown et al, 2009); being honest, acting with integrity (Dyrbye et al, 2010); reliability (Wilkinson et al, 2009); honesty/integrity, responsibility/reliability, compassion (Parker et al, 2008).

A survey of medical schools in USA and Canada revealed that 54.5% (of the 88 respondents) had defined, written standards covering issues other than academic performance (Boon and Turner, 2004). The most frequently cited were honesty; professional behaviour; dedication to learning; professional appearance; respect for law and for others; issues of confidentiality; and avoidance of substance abuse.

Taking an alternative approach, a US study by Teherani et al (2005) found three domains of unprofessional behaviour, that were associated with subsequent disciplinary action: poor reliability and responsibility; lack of self-improvement and adaptability; and poor initiative and motivation. Papadakis et al (1999) provide examples of unprofessional behaviour used in one medical school to signal the need for remedial development, which are unmet professional responsibilities; lack of effort towards self improvement and adaptability; diminished relationships with patients and families; and diminished relationships with the healthcare team. In a study by Burack et al (1999), supervising medics categorised problem behaviours by students as showing disrespect for patients, cutting corners, and outright hostility or rudeness.

Lucey and Souba (2010) argue for a more sophisticated view of professionalism as a complex adaptive challenge, which may be posed on a regular basis to students and practitioners. Morrow et al (2011), in a study of the understanding of professionalism by allied health profession groups, argue that professionalism can best be seen in the actions of individuals in specific situations.

The risks posed by a failure of professionalism include poor practice by medical students resulting in harm to patients – a risk potentially mitigated by clinical supervision (Butters and Strope, 1996), and also the risks of poor practice after graduation. Studies by Papadakis et al (2005 & 2008) found that disciplinary action by a medical board was strongly associated with prior unprofessional behaviour in medical school. The strongest association was with those students who had been described as irresponsible, or as having a diminished ability to learn to improve their behaviour.

Most of the literature in this area accepts that the capability to behave professionally develops over the course of a student's education (eg Kasar and Muscari, 2000; Wear and Castellani, 2000). Hilton and Slotnick (2005) argue that the practical wisdom at the core of professionalism is only acquired over time, with experience and learning, alongside a developing knowledge base. The state prior to professionalism they define as 'proto-professionalism'.

In summary, professionalism has been defined, and understood, in different ways. Although a core of behaviours may be seen in the examples cited (such as behaving with honesty and integrity, working for the benefit of the patient, self improvement and learning) some definitions appear wider than others.

Professional suitability

In social work the equivalent concept is most often referred to as professional suitability, or suitability to practise. The General Social Care Council (GSCC) requirements include:

'To award the [social work] degree, universities should be satisfied that students have ... shown they are suitable to practise as a social worker.' (GSCC, 2002a: 13)

Currer and Atherton (2008: 281) note that this requirement is stated separately from the other GSCC requirements, which include the requirement that students have been assessed against the approved curriculum, have met the relevant National Occupational Standards, followed the Code of Practice, and have satisfied checks on criminal records. 'The issue of suitability is important enough to be mentioned in its own right.' (p281)

Yet according to Currer and Atherton, the concept of suitability is 'used in different ways in the documentation, and also differently interpreted by individuals in practice' (p282). Elsewhere, Currer argues that 'the concept of 'professional suitability' is undefined and—some would argue—indefinable, at least in the abstract' (Currer, 2009: 1495). Noting that there is uncertainty, even in the GSCC's guidance, about whether unsuitability refers to a characteristic of certain individuals or to behaviours that are or are not acceptable, Currer (2009: 1482) argues that 'unsuitability' is best understood as a judgement to be made 'in relation to particular cases and circumstances.'

Tam and Coleman (2009) report on a Canadian study that developed a scale to evaluate professional suitability for social work practice. The scale comprised five dimensions: overall suitability; analytical suitability; practice suitability; personal suitability; and ethical suitability. The model was validated with 188 practising supervisors. The 33 elements of the dimensions covered a range of abilities and attitudes, for example:

- able to transfer learning from one context to another
- has good interpersonal skills
- demonstrates integrity
- is able to critically examine political issues
- is committed to changing social inequality
- maintains stable emotions
- demonstrates effective writing skills.

In a small study using focus groups and interviews with field instructors, Lafrance and Gray (2004) found the constituents of professional suitability to be: personal and emotional maturity; honesty and integrity as the foundation for ethical practice; and comfort with one's own emotions and the emotions of others. In addition, abilities and attitudes seen as important were: the capacity for self awareness; the capacity to establish relations with others in the social work context; and congruence of individual values with the values of the social work system.

In a study that includes a survey of 20 undergraduate programmes in social work across Canada, Barlow and Coleman (2003) gave examples of professionally suitable behaviours including:

- a belief in the values and goals of the profession
- demonstration of caring and sensitivity in all professional relationships
- the ability to respond in authentic ways with attitudes, beliefs, and behaviours that accord the client dignity and worth
- competence in oral and written communication
- an ability to work independently as well as part of a team

- a capacity for personal change and an openness to learning
- an acceptance that one's professional abilities, personal integrity, and attitudes is a measure of professional conduct.

Banks (2010) argues that professional integrity, in the sense of adhering to the code of conduct for social work, is often construed as equating to professionalism, but argues that two other interpretations of professional integrity are also, in practice, extremely relevant: professional integrity as a commitment to a set of deeply held values, and professional integrity as a capacity for reflexive sense-making that enables moral competence in solving ethical dilemmas. Banks argues that each of these three understandings of professional integrity is insufficient in itself, that they overlap, and that all of them should be taken into account in developing professionalism in practitioners.

As with professionalism, some approaches have been to define behaviours that indicate 'unsuitability'. In one study, Koerin & Miller (1995) considered the behaviours and situations addressed by termination policies in relation to 'non-academic reasons' for termination, and five categories emerged:

1. violations of the Code of Ethics
2. concerns about mental health or substance abuse
3. poor performance in the field
4. 'illegal activities' - which included matters of deception
5. inappropriate classroom behaviours.

Furness and Gilligan (2004), drawing on conversations with over 70 social work practice teachers and tutors compiled a list of unprofessional practices that included: damage to service users; crossing professional boundaries; disrespect to service users; colluding with service users; not challenging bad practice; taking a judgemental approach; carrying serious issues; and 'not using supervision'. Barlow and Coleman (2003) also give examples of unprofessional behaviours identified in their study.

Recent publications in the social work field address the issue of professional suitability in the context of the registration of social work students at the beginning of their studies, a situation that does not apply in the health professions, where students apply for membership of the profession on successful completion of their courses (Manthorpe et al, 2010). Academic staff who make decisions about admitting applicants to courses are thus acting as 'gate-keepers to the profession' (eg Barlow and Coleman, 2003). A number of papers question the extent to which judgements about suitability can be made at this stage (eg Holmström and Taylor, 2008; McLaughlin, 2010). Assessment of suitability at the point of recruitment to a course of training will be discussed in more detail below.

As with professionalism in a medical context, the risks of professional unsuitability include poor practice by students under supervision, and also the risks of poor practice after graduation. As Barlow and Coleman note (2003: 152), 'social workers serve vulnerable populations who have the right to receive competent and ethical practice' therefore it is important to ensure their professional suitability, in order to maintain public trust, and to protect clients from unethical or incompetent service.

In summary, the issue of professional suitability in social work is perceived in similar ways to that of professionalism in medical training, in that it is agreed to be an important component of ensuring fitness to practise, but that it is not easy to define or to assess. Attempts to define it bring together descriptions of behaviours, beliefs, values and other underlying characteristics.

Good character

In the UK, the Nursing and Midwifery Council requires 'good character' as a condition of entry to the UK register of nurses, and also for entry to and continuation on pre-registration nursing programmes in the UK (Sellman, 2007). Chaffer (1998) says that 'good character' is broad and difficult to interpret, as do McGregor and Brown (1998).

In the previous sections, examples of different perceptions of professionalism and of professional suitability have shown that it is common to include some underlying characteristics in the definition. In a social work context, Clark (2006: 88) states that good professional practice is influenced by 'the moral character of the practitioner'.

Good character in nursing is linked to the Code of Professional Conduct: Sellman (2007) discusses the difficulties for nurse educators in attesting that students really have 'good character' ie that they really engage with and accept the tenets of the Code, rather than simply ensuring they do not transgress it in their behaviour (a difference also discussed in the context of social work by Banks, 2010). Snelling and Lipscombe (2004) give examples of a range of breaches of the Code of Professional Conduct, arguing plausibly that these examples are not all equally morally reprehensible.

In an exploration of the meaning of 'good character' CHRE (2008) suggested that the term 'is potentially problematic because it is not widely used outside English-speaking countries and has no equivalent in Europe', and as a result, the term may not be easily understood by applicants, referees and regulators from other countries. The CHRE identified four core indicators that might call into question an individual's 'good character': where the individual has acted, or there is reason to believe they are liable in future to act:

(i) in such a way that puts at risk the health, safety or wellbeing of a patient or other member of the public

(ii) in such a way that his/her registration would undermine public confidence in the profession

(iii) in such a way that indicates an unwillingness to act in accordance with the standards of the profession

(iv) in a dishonest manner

(CHRE, 2008; 2-3)

The report argues that these are the key factors pertaining to 'good character' that are relevant to fitness to practise issues.

Misconduct

Professionalism, professional suitability and good character are terms that have different interpretations, and therefore may be difficult to operationalise. In the context of judgements about student fitness to practise, one concern is to identify signs of the absence of these positive attributes. Various types of clinical or academic misconduct, or failure to meet certain standards, may, in themselves, be in breach of codes of conduct and indicate a lack of professionalism, suitability, or good character. Examples of this approach have been noted above (Papadakis et al, 1999; Teherani et al, 2005; CHRE, 2008).

A number of papers report on the use of surveys seeking ratings of, or comments on, behaviour that may be construed as misconduct (eg Rizk and Elzubier, 2004; Al-Dwairi et al, 2004; Brockbank et al 2011) or unethical (eg Hilbert, 1985; Rennie and Crosby, 2002; Rennie and Rudland, 2003; Roff et al, 2011). These studies often reveal a range of judgements on the degree to which a behaviour indicates lack of fitness to practise. There are issues to take into account concerning the nature of the misconduct (eg Hickson et al, 2007; Wagner, 1993), and the stage of the individual's education (eg Arnold et al, 2002). Certain behaviours may be considered unacceptable from the first day of study, whereas some situations may pose very difficult ethical dilemmas, challenging even to experienced practitioners (Lucey and Souba, 2009). This issue will be discussed further below, in the sections on how student fitness to practice may be developed and assessed.

Academic misconduct is discussed in a number of articles in relation to fitness to practice. Behaving with a lack of integrity and honesty in academic matters (such as by plagiarising others) may be considered a breach of a code of professional ethics in itself, as well as potentially an indicator of a propensity to behave unethically in other contexts (Bradshaw and Lowenstein, 1990; Gaberson, 1997).

Kenny (2007) argues that a nurse who plagiarises work may be in breach of the professional code, as they don't have the necessary underpinning knowledge to do (part of) their job, and taking a similar view in relation to education for dentistry, Hughes et al (2009) argue that plagiarism will reduce students' learning. Stone et al (2009) cite a small number of papers linking academic misconduct with cheating at work and engaging in counter-productive work behaviours. A small study reported by Yates and James (2010) suggests that early academic difficulties at medical school (which other studies have shown to be a driver of academic misconduct) could be a risk factor for subsequent professional misconduct (although Yates and James note the findings are preliminary and should be interpreted with caution). Postle (2009) argues that plagiarism can indicate unsuitability for social work practice.

Health impairment and disability

Impaired health may prove a barrier to individuals being able to successfully complete their professional education, or subsequently to be able to practise at the required standard. This factor is different from the dimensions of professionalism, professional suitability, or of good character, discussed in the previous sections.

A paper reporting the findings of a General Formal Investigation launched by the Disability Rights Commission (Sin and Fong, 2008) into the application of the nursing regulator's requirements, found that key national stakeholder organisations, higher education

institutions (HEIs) and employers experienced difficulty in interpreting the 'good health' requirements consistently. The paper reports that methods of implementation varied between organisations, and that this variability can lead to discrimination against disabled people.

The social work regulatory framework requires individuals to demonstrate mental and physical fitness in England and Wales (although not in Scotland). In an inquiry into fitness requirements for social work education, Sin and Fong (2009) found that the terminology around fitness, and the assessment of fitness, in this professional area was perceived by HEIs to be unclear. This, together with a lack of guidance on the procedures to be used to assess fitness, had resulted in a wide variety of approaches within different HEIs.

Furthermore, students with disabilities may be unfairly discriminated against as HEIs consider issues of mental and physical fitness (Sin and Fong, 2009). In a related piece of research, Stanley et al (2011) found that disabled students, or applicants to courses of study, may be reluctant to declare their disability, or may do so only with trepidation.

This is a difficult area, with HEIs required to balance the rights of students with health difficulties or disabilities with the rights of the public, service users and patients (Watkinson and Chalmers, 2008). A number of the healthcare profession regulators, including the HPC, have produced guidance in this area (HPC, 2006).

Summary

Fitness to practise is made up of knowledge and skills that are relevant to the professional discipline, plus another component, variously defined as professionalism, suitability, good character. This additional component is complex, difficult to define with exactitude, and has been described in terms of attributes, values, roles and activities. One approach that has been taken is to define behaviours that constitute misconduct, and indicate a deficiency in professionalism, suitability and good character. These issues of definition and recognition of this component of fitness to practise are relevant to questions of how it can be assessed and developed, and the actions that HEIs, regulators and other bodies can take in relation to this matter, discussed below.

This section has also considered another aspect of fitness to practise, that of health impairment and disability, and the potential raised in the literature, for variable practice by institutions in assessing these factors, and the potential for unfair discrimination against disabled people on these grounds.

3.2 Factors affecting student fitness to practise

Students develop the abilities required for fitness to practise in health and social care through processes of acquiring relevant knowledge and developing the skills and attitudes that are necessary to enable them to behave appropriately in their professional roles. Factors that enable students to develop these abilities include those that primarily reside within the individual – aptitudes, potential, beliefs and attitudes – those that primarily reside within the institution providing the education and training – such as the curriculum, and approaches to teaching and learning – and those that arise out of the interaction of individual and institutional elements. Many of the papers reviewed for this research focus

on the actions that institutions can take to recruit, guide, educate, develop, assess and, where necessary, discipline trainees in order to enable them to be fit for professional practice. The next section of this paper summarises relevant ideas about institutional actions.

This section of the paper brings together relevant published ideas about factors, which may derail students in their progress towards achieving and demonstrating competence to practise. These ideas are mainly drawn from studies of unprofessional behaviour demonstrated by students. The review of the literature showed that using 'risk' as a search term generally did not reveal items related to the risk that students posed, more often focusing on the risks to students from, for example, not being immunised.

As noted in the previous section, views about professionalism (and professional suitability) variously embrace both the idea that it is a characteristic rooted in personality (integrity, honesty, empathy etc) and the idea that it may only be judged by behaviour in specific cases and circumstances (eg Curren, 2009). This range of views naturally impacts on opinions about factors that give rise to unprofessional behaviour.

Ginsburg et al (2000) argue that the traditional approach to evaluating professionalism implies that professionalism represents a set of stable traits, but that this disregards research into personality psychology, which shows that the presence of specific traits does not predict behaviour. The writers argue that there are many grey areas in the idea of 'unprofessional behaviour' and that an evaluation of professionalism should focus on behaviours, and the individual's reasons for behaving in certain ways in specific situations. They highlight ethical challenges that require professionals to reconcile equally worthy opposing values, such as the imperative to tell the truth, and the imperative to protect patient confidentiality: 'these values may occasionally come into conflict, and the ultimate choice the student makes will depend on the specifics of the situation' (Ginsburg et al, 2000: S6).

Examples of dilemmas of this nature from Lucey and Souba (2010: 1021) include:

'Should I leave at 12 noon after being up all night, thus avoiding fatigue-related errors (excellence), or should I stay and continue to care for my patient at this critical juncture in his case (altruism)?'

'Should I demonstrate compassion by spending extra time with this patient who just received bad news, or should I demonstrate respect for the next patient by staying on schedule?'

An exploration of ethical dilemmas experienced by social work students in a small international study, found that situations reported as ethically difficult were: challenging service users and colleagues; the power and responsibility of the worker; and defining the boundaries of the professional relationship (Banks, 2005).

In a study of ethical dilemmas experienced by physical therapy students during clinical placement, Geddes et al (2004) found that students frequently reported ethical issues arising in the clinical setting; the issues were mainly related to the students' relationships with clients and co-workers and with their exploration of their roles as developing health professionals. Three main themes were: respect for the uniqueness of individuals, responsibility and behaviour as a member of the profession, and interaction with and

respect for health professionals. More minor themes included: allocation of resources, advocacy for client, society and/or health policy, and informed consent.

Arnold (2002) builds on the idea that unprofessional behaviour is likely to be situation specific, rather than arising from a stable trait of character. As students may be expected to develop their ability to behave professionally in different sets of circumstances as they progress through training, she suggests: 'Perhaps a matrix should be developed to indicate which levels of assessment will be applied to which elements at which career stage [during training].' (p509)

Some studies identify pressure on students to achieve good grades in coursework as a factor that gives rise to academic misconduct (eg Hilbert, 1987; Rennie and Rudland, 2003; Postle, 2009). Dyrbye et al (2010) identify stress and fear of poor evaluations as factors that may lead to unprofessional academic and clinical behaviours.

In a study of cheating and academic misconduct among business studies students enrolled at a US university, Stone et al (2009) found Ajzen's (1991) theory of planned behaviour provided a useful framework for understanding the influencing processes. As applied by Stone et al, the theory argues that three factors influence individual intentions, justifications and behaviours, which are:

- individual attitudes toward the behaviour - beliefs about a behaviour or its consequences, which in this case relates to whether a particular behaviour amounts to misconduct, and/or whether it is harmful.
- subjective norms - the individual's perceptions of the expectations of other people regarding the behaviour. Even where individuals believe a particular behaviour amounts to misconduct, they may perceive that it is common among colleagues - 'everyone is doing it'.
- perceived behavioural control - the perceived ease or difficulty of performing the behaviour, which in this case relates to opportunity, to the likelihood of being found out, and to the consequences of being caught.

The combination of these factors influence individual intentions and justifications (or rationalisations - cf Brown et al, 2011), and these in turn influence behaviours.

There is some support from other studies for the application of this framework to unprofessionalism in health and social care training. Where students question the value of certain behaviours (such as obtaining a signature for a certain clinical procedure) this may lead to dishonest behaviour, such as forging signatures (Rennie and Rudland, 2003). A study by Hilbert (1987) found that the common reason for engaging in unethical clinical behaviours was that the behaviour did not seem to the individual to be unethical, and that this perception could be influenced, for good or ill, by the actions of educators. Studies by Baingana et al (2010) and by Anderson and Obenshain (1994) found a decline in attitudes towards ethical issues in medicine as students progressed through training, which Baingana et al (2010: 4) suggested 'may relate to loss of idealism and the impact of the hidden and/or informal curriculum.' A study by Self and Baldwin (1998) showed no development in moral reasoning among 598 medicals students over four years of study, leading the authors to suggest 'there may be something in the structure of medical education that appears to inhibit the expected [natural] growth' (ppS92-93).

The range of actions that institutions can take to develop professional behaviours and attitudes is the subject of the next section. A failure in any one of these actions may be a factor that at least partly gives rise to unprofessional behaviour on the part of students.

In summary, studies addressing the factors giving rise to unprofessional behaviour among students tend to favour a behavioural/situational approach to evaluating professionalism. Different studies have focused on a variety of influential factors. Behaviour that is considered 'unprofessional' may arise out of attempts to resolve conflicts of values. The ability to take difficult professional choices is a capability that may be expected to develop over time. Ajzen's (1991) theory of planned behaviour, as modified by Stone et al (2009), appears to provide a relevant and useful framework, which incorporates individual, social and institutional factors influencing misconduct or unprofessional behaviour.

3.3 Educational institutions and student fitness to practice

Introduction

This section addresses literature on what educational institutions that provide professional training and education (usually HEIs) can do to develop the abilities of students so that they practise at the required level. This includes not only academic tuition and assessment, but also the development and assessment of clinical skills and of professionalism. It is worth noting at this point that the literature has little to say about the role of regulators in promoting fitness to practise and tends to focus on what educational institutions can do. We look at the implications of the findings for regulators in the next section.

In a recent editorial Reid (2010) calls for medical schools to manage students 'in a way that places equal value on both the academic and non-academic aspects of fitness to practise.' A number of studies address different aspects of this issue. Whilst the focus of some studies reported in the literature is on learning and development, and the focus of other studies on assessment and evaluation, there is agreement that both types of activity are needed. As Bailey (2001) notes, in a study on academic misconduct among student nurses, there is a need for both proactive and reactive measures, including an ethical focus in the curriculum, clarity about the standards to be met, and clear policies and practices that are consistently applied by all staff.

This section discusses the themes in the literature in three parts – those that are primarily about development, those that are about assessment, and those that are about investigating and managing disciplinary matters. In practice there are overlaps between the three areas, but it is useful to explore each topic one at a time.

In approaching development, assessment and discipline, the literature emphasises a need for agreement between staff as to what constitutes acceptable and unacceptable behaviour, as a precursor to communicating clear expectations to students.

For example, Hilbert (1985) recommends that staff need to develop a consistent approach about what is and is not unethical and to take a stand when unethical behaviour is detected. Papadakis et al (1999) and Korszun et al (2005) provide examples to clearly identify desirable and undesirable behaviours, and van Mook et al (2009a) found that standardised checklists, written comments and reports were commonly used to assess professionalism.

Agreement on what constitutes professionalism is unlikely to occur without discussion and dialogue, and may not be easy to achieve. For example, Teherani et al (2005), in a US medical study, found that there was no consistent agreement amongst faculty about which behaviours were unprofessional. Boon and Turner (2004) argue that, in a culture that emphasises evidence-based medicine, it may be difficult to convince students and 'hard-headed colleagues' that 'ethics, professionalism, and humanism... go to the heart of the practice of medicine.' As a previous section in this report noted, there is not universal agreement about the meaning of key concepts such as 'professionalism' or 'suitability' - or how they may be assessed.

On the other hand, Goldie (2008) argues that the development of a model of professionalism by the Scottish Deans' Medical Curriculum Group demonstrates that it is possible to get agreement on what constitutes professional behaviour, across institutions, and even between quite different styles of curricula. Smith et al (2007) report on actions taken to create a campus-wide culture of professionalism in one US medical school: the actions included creating a charter and mission statement, putting in place a variety of measures to develop an understanding of professionalism, and mechanisms to intervene where unprofessional behaviours were observed.

The literature in this area indicates that the consequences of not achieving agreement within an HEI can be mixed messages to students about the nature of, and the need for, professional behaviour, difficulties in assessing fitness to practise, and confusion and difficulty in investigating and dealing with alleged failures.

Fitness to practice: development

The process of development of fitness to practise is emphasised by Kasar and Muscari's (2000: 43) point that 'Professional behaviours mature through a natural developmental process; a process that requires careful nurturing on the part of educators, student clinical supervisors, and clinicians themselves'. Wear and Castellani (2000) equate the development of elements of professionalism with the development of clinical skills, such as clinical reasoning – that is students need to be educated in them, they are not unchanging and they do not develop automatically.

There is broad agreement that an essential part of the process of helping students to learn this aspect of fitness to practise is setting clear expectations, defining what is acceptable and unacceptable, and setting out responses to unprofessional behaviour (eg Hilbert, 1985, 1988; Anderson and Obenshain, 1994; Hall, 2004; Stern and Papadakis, 2006; Cruess and Cruess, 2006; Howe et al, 2010).

A number of papers set out the diverse means by which professionalism is learned. In a review of the history of educating students in medical ethics, Fox et al (1995) observe that the traditional model of education focused on development of relevant knowledge and cognitive skills, taught as a separate course. Over time 'a wealth of different methods' emerged to promote ethical development, with more focus on emotional and behavioural dimensions of ethical behaviour. Stern and Papadakis (2006) set out the proactive steps that need to be taken to promote professionalism – by educators, by healthcare organisations and by regulators. They suggest that the teaching of core values needs to be contemplated not only as taking place through lectures, small group discussions etc, but through a much

wider range of activities, including informal activities, that occur during a student's education.

Stern and Papadakis (2006) refer to the importance of what Hafferty and Franks (1994) called the 'hidden curriculum', an idea that has been adopted by a number of other writers (eg Fox et al, 1995; Masella, 2006; Smith et al, 2007; Goldie, 2008; Baingana et al, 2010; Karnieli-Miller, 2010). The hidden curriculum consisted of tutorial processes, experiential learning, and learning during placement activities, and may contain learning that contradicts the formal teachings - in lectures - about professional behaviours. Brainard and Brislen (2007), reflecting on experiences in medical schools, argue that many students struggle with the contradiction between the explicit professional values they are taught in the formal curriculum and the implicit values of the hidden curriculum.

A number of papers emphasise the importance of coordinating, throughout the whole curriculum, teaching and learning about professionalism (eg Hilbert, 1988; Daniel et al, 1994; Stern and Papadakis, 2006; Smith et al, 2007; Elliott et al, 2009; van Mook et al, 2009b) and professional suitability (Holmström and Taylor, 2008) including on a longitudinal basis, ensuring that 'instruction and opportunities for self-reflection appropriate to the stage of training' are provided in all elements of the programme (Crues and Crues, 2006: 206). Goldie (2008) calls for integration of medical professionalism across the entire curriculum with significant interaction between formal teaching and professional practice.

Role modelling is seen as an important component of conveying professional values and behaviours (eg Daniel et al, 1994; Gaberson, 1997; Korszun, 2005; Hilton and Slotnick, 2005; Ratanawongsa et al, 2006; Stern and Papadakis, 2006; Weissmann et al, 2006; Whiting, 2007; Fowler, 2008; Hughes et al, 2009; Howe et al, 2010; Morrow et al, 2011). Stern and Papadakis (2006: 1797) suggest that educators should design clinical experiences that will allow students observe how 'seasoned practitioners' manage dilemmas of practice, such as conflicts between the ideal time to spend with patients as compared with the clinic time available. They note that 'role modelling needs to be combined with reflection on the action to truly teach professionalism' (cf also Stockhausen, 2005) and point out that 'faculty need to be trained to promote a kind of role modelling that is essential to a student's professional development' (p1796). The potential for negative role models, in academic and practice-based settings, to influence student attitudes and behaviour is noted by a number of writers (eg Brainard and Brislen, 2007; van Mook et al 2009b).

The use of 'honour codes' is described by Hughes et al (2009) in the context of education for dentistry. Hughes et al (2009) advocate honour codes in order to define cheating, raise awareness among students of the seriousness of cheating, and clarify the implications. Barlow and Coleman (2003) found that a number of Canadian social work schools use a Code of Conduct to clarify expectations and to permit assessment of the student's suitability during the programme. They found that codes could include issues such as respecting the confidentiality of clients; treating colleagues, tutors, clients, staff and supervisors with respect; demonstrating honesty, courtesy, fairness and good faith; and upholding the Social Work Code of Ethics. The development and use of codes of conduct / ethics by regulators is discussed in chapter 4.

Values and attitudes are components of most definitions of professionalism and suitability, and some studies address how these values may be developed within the curriculum. Whiting (2007) explores the ethical and practical issues of seeking to change 'morally

inappropriate attitudes' evidenced by students, which may give rise to questions of fitness to practise. He argues that it is appropriate to do so on a consensual basis, and that inappropriate attitudes may, first of all, arise from a lack of understanding, and that this can be challenged. Where cognitive challenges are ineffective, exposure to situations where patients are in need of support, or modelling certain forms of behaviour, such as those relating to compassion, may be successful. However, Whiting notes that changing attitudes is 'a notoriously difficult challenge' (p669) and accepts that this may not be achievable in every case. Issues discussed above, in the section on the meaning of 'professional suitability' and the meaning of 'good character' are relevant here. Sellman (2007) and Banks (2010) both discussed, in different disciplines, the difference between adherence to the values expressed in a code of practice, on the one hand, and real ownership of relevant values on the other hand. It is assumed that ethical judgment, and the ability to act ethically can be developed during professional education (eg Banks, 2005; Hilton and Slotnick, 2005; Sanders and Hoffman, 2010). The development of certain values and attitudes, relevant to the profession (eg Lafrance and Gray, 2004), and the ability to apply critical thinking to 'those assumptions, beliefs and values which have been uncritically assimilated and internalized during childhood and adolescence' (Goldie, 2008: 521) is seen as a key part of the development of professionalism.

Activity – undertaking clinical experiences – is regarded as an essential component of learning professionalism (eg Hall, 2004; Price, 2006; van Mook et al, 2009b). Cruess and Cruess (2006) emphasise that faculty need to teach the principles that underpin professionalism and also enable reflective experiential learning through providing opportunities to act and reflect.

Mentoring student performance is another key activity to support development. In this way mentors can enhance student development by reinforcing appropriate professional behaviour (Stern and Papadakis, 2006), as well as providing informed formative assessment.

Self-assessment is a component of reflective learning, and a number of studies advocate it as a structured element within formative evaluation (eg Hall, 1994; Korszun et al, 2005; Whiting, 2007). In a UK study, however, Rees and Shepherd (2005a: 30) found that students had difficulty in accurate self-assessment, and feedback was crucial in helping them to gain this understanding (found also in Hodges et al, 2001).

Cleland et al (2005) found that a cohort of students who had failed their final clinical examinations showed low self-awareness in relation to their previous performance. The authors recommended that 'students would benefit from support in developing self-reflection skills in such a way to support life-long learning' (p504).

In summary, literature in the area of actions that HEIs can take to develop fitness to practise encourages staff to have regard to a wide range of activities, both formal and informal, that constitute teaching and learning, and to seek to coordinate teaching and learning across all these activities. There appears to be broad agreement that important elements of teaching and learning include: clear communication of principles and procedures; role modelling and explanation of desirable behaviours by staff; opportunities to practise, and to reflect on and receive feedback on practice; monitoring performance, reinforcing good practice and providing extra support where necessary; and helping students develop the skills of self-reflection.

Fitness to practise: assessment

The literature in this area on the whole advocates the assessment of professionalism and professional suitability, both formatively and summatively. A number of papers suggest a range of methods should be used for assessment, and provide specific examples. There is also a theme in the literature of the difficulties that supervisors and other staff experience giving critical feedback to students.

Assessment of professionalism, or suitability, may be expected to take place: a) on application to a programme of professional education, b) formatively, during the programme, to aid learning and assess progress, and c) summatively at certain points during the programme.

Assessment for selection

Assessment of the suitability of applicants to a programme has been addressed at greater length in recent years in studies of social work education than in other professions, perhaps due to the Department of Health requiring HEIs to assess all shortlisted applicants for social work degree courses through group or individual interviews involving employers and people who use services and their carers (Department of Health, 2002). Manthorpe et al (2010) in a survey of English HEIs, found that staff take their responsibilities in this respect very seriously, and that the task is resource-intensive and time-consuming.

In a review of literature, Lafrance and Gray (2004: 329) found that most attention at recruitment was paid to academic qualifications; and that: 'although the personal qualities and characteristics formed prior to arriving at the portals of the profession are of critical importance for the practice of social work, these criteria are the least attended to in the admission process.'

Dillon (2007), in a study of recruitment in the context of a policy of widening participation, suggests that more robust selection processes may reveal more about applicants' suitability for social work education, whilst acknowledging that this may not be enough to assess their 'emotional and psychological readiness' for social work.

The survey of social work programmes across Canada carried out by Barlow and Coleman (2003) found that a range of tools were used for selection, including academic grades, information from assessment interviews, references, curricula vitae, criminal record checks, and screening questionnaires. They note that a key challenge is 'to develop admissions criteria that are equitable in order that diverse groups are not excluded' (p152). In England, Furness and Gilligan (2004) found that the selection of prospective social work students usually involves some combination of role-plays, discussion groups, written tests and interviews.

In medical education, Self and Baldwin (2000) supported the use of standardised tests of moral reasoning as part of the admission process, but subject to the results of further research. In a retrospective cohort study, Stern et al (2005) found there were no consistent, significant correlations between any information assessed at admission and any of the outcomes of professional behaviour in Year 3 of medical school education. However, in the UK, a systematic review study by Ferguson et al (2002) found previous academic performance to be a reasonable predictor of achievement in medical training, and indicated that a particular learning style was also associated with success.

An extensive literature analysis of assessment of suitability for admission to social work education in the context of changing policy in England (Holmström and Taylor, 2008) concludes that it is very difficult to assess at this point factors other than prior educational attainment, and agrees with Madden (2000: 141): 'with the exception of the obviously unsuitable students, there is little evidence that students who will not succeed can be identified in advance.' Holmström and Taylor (2008) argue that admission criteria should be clearly defined, but that HEIs should not rely solely on assessment of suitability at this stage, and that there should be regular assessment points of 'non-academic' performance during the education programme.

Overall, assessment of suitability at the point of admission appears to have been subject to the compound difficulties of a) demonstrating the clear links between non-academic characteristics and subsequent lack of fitness to practice, b) accurately assessing non-academic factors during admissions, and c) agreeing on the appropriate level of potential that applicants should possess, prior to professional education, as a threshold for admission. It is perhaps particularly problematic in relation to the social work profession, where there are strong values of providing individuals with opportunities to improve and develop.

Assessment during education

A review of methods of assessment of medical professionalism over 20 years, argued that 'although assessing professionalism poses many challenges, gauging and ascertaining growth in professionalism is impossible without measurement' (Lynch et al, 2004: 366).

Van Mook et al (2009a: 90) similarly argue that medical professionalism must be assessed: 'assessment ... is a mechanism by which medical faculties signal that they value certain subject areas. The lack of formal assessment may undermine the impact of teaching.' The Royal College of Physicians (2005a: 3.37) recommended that 'each student's professional values should be assessed throughout their training to ensure their fitness to practise'.

In a study in a medical school, Goldie et al (2002) found evidence to suggest that a lack of formal assessment of ethics teaching in years 2 and 3 of the programme was felt to contribute to its lack of impact on medical students, compared to those years where it was assessed, whilst Howe (2002) concluded that summative assessment of professionalism is necessary, in order to ensure competence and to motivate learning.

Formative assessment may be used to identify at an early stage those students who need extra support (Hilbert, 1985; Cleland et al, 2005; van Mook et al, 2009d; Reid, 2010). Yates and James (2010: 6) suggest that where students are found to be performing poorly, they should receive additional support and mentoring. Lynch et al (2004: 369) also argue that 'professionalism should be formatively assessed. This means that assessment should begin early...be conducted frequently, be implemented long term, and provide learners with opportunities to change.'

A theme in the medical literature is the advocacy of the use of a range of methods for assessing professionalism. Arnold (2002) provides a review of methods of assessing professionalism, including peer or teacher assessment, surveys, critical incident techniques, Objective Structured Clinical Examinations (OSCEs), methods also advocated by Whiting (2007). Bogo et al (2011) report favourably on the use of an adaptation of a medical OSCE

for use in social work education. Lynch et al (2004) reviewed 88 different methods of assessment of medical professionalism. A number of writers advocate the use of a range of tools to assess medical professionalism, including the use of a professionalism mini-evaluation exercise (P-MEX) (Crues et al, 2006; Wilkinson et al, 2009; van Mook et al, 2009a and 2009c).

Assessment of professionalism and professional suitability may be guided by such tools, but ultimately rests on the judgement of experienced and qualified tutors and supervisors. However, a number of studies note the difficulty supervisors can face in giving critical feedback (Burack et al, 1999; van Mook et al, 2009d; Cleary and Horsfall, 2010), and the reluctance of tutors, supervisors, practice educators or mentors to fail students (Barlow and Coleman, 2003; Duffy, 2003; Duffy and Hardicre, 2007a and 2007b; Cleland et al, 2008; Basnett and Sheffield, 2010; Carr et al, 2010; Dean 2011), to tell them that their performance is inadequate (Cleland et al, 2005), to address academic dishonesty (Kolanko et al, 2005; Fontana, 2009), to challenge matters of attitude and conduct (Korszun et al, 2005; Boon and Turner, 2004), or to label a student unprofessional for minor lapses in professional behaviour (Ginsburg et al, 2000). Studies that focus on this difficulty emphasise the need for clear policies and for training, and support for mentors, supervisors and assessors to enable them to undertake this difficult task (eg Furness and Gilligan, 2004; Hickson et al, 2007; van Mook et al, 2009d) 'empathically and effectively' (Cleland et al, 2005: 507).

In a study of clinical teaching and supervision in Australian nursing, Cleary and Horsfall (2010) found that many students were resistant to critical feedback, and were inclined to respond aggressively rather than constructively. The study highlights the need for clear policies and procedures for the placement experience (ie about expected behaviours, and the processes to be followed if students fail to meet expectations) and identifies relevant interpersonal skills and approaches to giving feedback that were needed by the clinical educators in this situation.

The strategy Cleary and Horsfall (2010) suggest is to discuss the identified problem and repeat key points with the aim of working with the student to improve the situation; behave, speak and reiterate calmly without conveying frustration or anger; have firm evidence and documentation and formal support from colleagues and academic bodies responsible for overseeing a student's failure to meet clinical objectives.

Duffy and Hardicre (2007b) also put forward advice to mentors in such situations:

- highlight areas of concern about performance as early as possible
- provide feedback in time for students to show improvement
- offer verbal and written feedback so that students are never surprised by the details of a failed final clinical assessment
- do not pass a student if there is any doubt that patients would be put at risk
- do not avoid the issue of failing a student who does not meet the standards.

In summary, literature reviewed in this area concerns assessment prior to admission to a programme as well as formative and summative during the course of professional education. There are doubts about the accuracy of assessment for selection, other than as a means of excluding the 'obviously unsuitable' candidates. The literature advocates formative and summative assessment during education, with formative assessments giving

rise, where appropriate, to better understanding, more support and further development. A range of different methods of assessment is advocated. The challenge to staff of giving critical feedback on matters of practice and attitude is the focus of a number of papers, indicating that this is an area where clear guidelines should be developed and communicated to students and staff, and where staff will benefit from training and support.

Fitness to practise: investigation and discipline

Failure to pass assessments of professionalism, or professional suitability, may give rise to the need for the educational institution to exercise sanctions. Allegations or incidences of misconduct will also give rise to the need to investigate and, where the allegations are proven, to take appropriate action. Misconduct may include poor clinical/professional practices related to the student's specific area of study, and also academic practices - plagiarism and other forms of cheating – which may equally be committed by students not studying to qualify as a health or social care professional.

There is little available data about incidence of student fitness to practise problems across the health and social care professions in the UK. In most of these professions student problems are handled by the education provider, not the regulator, so aggregate data is not available. Just two regulators – the General Optical Council and the General Social Care Council – register (and discipline) students. Statistics relating to these two student groups are provided in chapter 4, but need to be treated with caution because of the different policies and thresholds for referral to the regulator that may therefore under-report the prevalence of (less serious) poor professional or academic practice. Some of the regulators who do not have systems of student registration often receive about individual students who have been dismissed from programmes, but they do not necessarily receive details of other students where fitness to practise has been called into question but handled remedially by the education provider.

Educationalists from many disciplines are interested in understanding (and preventing or managing) academic misconduct, and the literature reviewed includes studies that give indications of the prevalence of this among health and social care students. Whilst there appear to be no sector-wide studies, a number of more limited surveys have been undertaken. In one survey of US medical students, with 2459 respondents, concerning academic cheating, it was found that 39% of respondents had witnessed cheating and 4.7% confessed to doing it (Baldwin et al, 1996). Another study of cheating, in academic and in clinical activities, in a US medical school, using a self-report survey, found that of over 300 graduating students, 23% admitted to academic cheating in some form, including a similar figure reporting cheating in clinical activities, such as by recording tasks not performed (Dans, 1996). In another US study, survey returns from 571 postgraduate medical residents reported observing medical students falsifying patient records (17%), mistreating patients (29%), working when in an impaired condition (31%), and taking credit for the work of others (11%) (Baldwin et al, 1998).

Academic dishonesty is not limited to students of course; a survey of over 2700, conducted by the British Medical Journal, found that 13% of UK based scientists or doctors had witnessed colleagues intentionally altering or fabricating data during their research or for the purposes of publication (Tavare, 2012; cf also Dyer, 2012). As a result of a Freedom of Information request, the HPC reported in 2011 that it had investigated seven cases involving

plagiarism (although that may not have been the only issue investigated). Of the three cases which to the date of reporting had received a final hearing, two registrants had received a one-year caution order and the other was suspended from the register for 12 months².

The actual incidence of cheating may be under-reported: two survey studies of medical student attitudes towards reporting academic misconduct by their peers found that, whilst respondents recognised academic misconduct as wrong, only a small percentage said they would report unprofessional behaviour of this kind (Rennie and Crosby, 2002; Elzubeir and Rizk, 2003).

The remainder of this section addresses literature on managing the academic misconduct of health and social care students, the operation of fitness to practise policies in HEIs, and the exercise of judgement about fitness to practise.

Four studies address the suitability of HEIs' general policies regarding academic misconduct for cases involving health or social care students. A study of UK HEIs by Unsworth (2011) found that general policies addressing academic misconduct 'will lack specific detail about how professional suitability and fitness to practise issues should be addressed' (p 468). Unsworth therefore recommends special, robust policies for handling such issues.

In a social work context, Currer and Atherton (2008: 282) found that 'the seriousness of certain issues and behaviours were not always shared by colleagues in other disciplines - as seen in University policy documents' or 'in the comments of university (as opposed to faculty) personnel involved in the Fitness to Practise procedures'. Similarly, in a nursing context, a study by Semple et al (2004) considered dishonesty among nursing students and what standards should be expected of these students. Semple et al (2004: 279) argue that honesty and integrity are 'paramount for members of the profession'. Therefore nursing students 'must demonstrate these values throughout their training, so that at the point of registration with the NMC they can be deemed to be of "good character". The treatment of pre-registration students... may need to be different to that meted out to other students within the same university'.

In the context of the education of clinical psychologists, Sofronoff et al (2011: 128) also argue that clinical training programmes should not rely on general university rules in order to terminate the education of students who are deemed unfit for professional practice because: 'in general university rules and policies regarding academic progression and the granting of degrees do not deal with issues of professional suitability or fitness to practise.'

There are a number of relevant studies of fitness to practice procedures within HEIs. On procedures for investigating and dealing with student misconduct, there is agreement that there is a need for timely, robust, documented policies and procedures (eg Hughes et al, 2009; Howe et al, 2010) which are followed (Fiesta, 1998), and that there should be reliable systems for documenting concerns and identifying and managing students whose behaviour is problematic (Reid, 2010). David and Ellson (2010) emphasise the importance of ensuring student fitness to practise policies and procedures are fair; their paper indicates that although numbers of miscreant students may be small, the scale of the task of dealing with them properly should not be underestimated.

² Available on the HPC website at: <http://www.hpc-uk.org/assets/documents/10003624FR01285Fitnessstopracticescasesinvolvingplagiarism.pdf> (last accessed 23/01/12)

A common pattern of fitness to practise procedures in HEIs is for a series of graduated interventions, such as, informal conversations (for single incidents), more formal meetings (for serious misconduct or where there are patterns of behaviour), formal action plans if patterns persist, and imposition of disciplinary processes if the plans fail (eg Hickson et al, 2007; Parker et al, 2008; Howe et al, 2010; Stegers-Jager et al, 2011).

Parker et al (2008) report that in one Australian medical school 19% of students (567 out of 2630 in the study period) were referred to the university's Personal and Professional Development Committee for behaviour giving rise to concerns for further support and advice, with only four referred to the next stage of the process for disciplinary action (Parker et al, 2008). Howe et al (2010) report that over a six-year period in one UK medical school, approximately 15% of students (118/803) were reported for professional behaviour problems; 5% (41) of the students had more than one issue raised about their professionalism (typically from separate incidents); and 3% (25) of the students reached the level of informal or formal warning. Only one student was dismissed from the course on the grounds of fitness to practise. The authors note the similarity of their findings to those of Parker et al (2008).

Four studies of fitness to practise policies and procedures across a number of HEIs found variation in approaches.

Aldridge et al (2009) found that all 31 UK medical schools with undergraduate programmes had a fitness to practise committee to investigate cases where there were concerns about students' fitness to practise. The study found variations in governance structures for the committees, which could in part be explained by variations in University structures, and the extent to which Universities co-manage undergraduate medicine with other courses such as dentistry, nursing, midwifery, physiotherapy, dietetics, social work, pharmacy, psychology, audiology, speech therapy, operating department practice, veterinary medicine and education. The authors note that with the support of the General Medical Council, medical schools continue to work towards achieving greater consistency in student fitness to practise policies and procedures. They also reflect on the fact that the numbers of medical students who are 'irretrievably unsuitable for a career in medicine' are very low, but that such cases are the 'tip of an iceberg of students whose health or behaviour cause concern about their fitness to practise', which they say confirms the importance of educating students about professionalism and of having systems to deal with problem individuals (Aldridge et al, 2009: 3).

A survey of 15 Australian medical schools found that 12 schools reported using a fitness to practise policy. There was wide variation in the criteria used in individual policies, and this, together with the variations in the numbers of students excluded by different schools for reasons of unprofessional behaviour, led the researchers to suggest there were variations in the medical schools' abilities to detect and manage students with problems of professionalism. They called for an Australia-wide consistent approach in this area (McGurgan et al, 2010; as do Parker and Wilkinson, 2008).

Unsworth (2011) reviewed fitness to practise policies of 44 HEIs providing nursing education and found that almost all of these policies could be improved. The main areas for improvement were:

- the inclusion of a clear threshold for referral to a full hearing

- explicit reference to a duty to give reasons at each stage
- making clear the system for appeals
- making explicit that action should be taken against students thought to be professionally unfit to practise in order to protect the public and to uphold the standards of the professions and to maintain the public's confidence.

Unsworth argues that failure to strengthen the policies could leave the HEIs open to challenge. Where students who are unfit to practise are allowed to register because they successfully appeal on technicalities, 'the entire process of self regulation could be called into question' (p 471).

In a study focusing on a new integrated fitness to practice framework in one HEI, Tee and Jowett (2009: 443) reported that the components included:

- *'A...MoU [Memorandum of Understanding] that identifies a threshold for criminal or unprofessional activity against which judgments about fitness to practice can be made at admission to or throughout the professional programme. All placement providers signed up to this arrangement to allow admission decisions to be made as rapidly as possible.'*
- *'A shared protocol for reporting concerns about a student's behaviour in the practice setting.'*
- *'A fitness to practice panel established, with membership drawn from service providers and HEI which would assess severity and implications of data received and make judgements and recommendations about a student's continued progress on the programme.'*
- *'A self-declaration of criminal activity process for completion by students at programme re-enrolment (annually) and at completion of their programme, which was unambiguous, easy to complete, confidential and reliable.'*

However, just as there are disagreements about the meaning and nature of professionalism and suitability, there may be disagreements about approaches to assessment and to sanctions. In a study on social work education in Canadian HEIs, Barlow and Coleman (2003: 153) noted that faculty in this profession have often opposed formal policies for screening out 'unsuitable' students, as such policies 'are thought to contradict the social work values and beliefs of self-determination, capacity for change, and non-judgemental acceptance'. They add: 'In addition, faculty members who oppose screening-out see students as developing professionals who will mature and learn over the educational cycle ...' (ibid). Accordingly, Barlow and Coleman (2003) encountered arguments from colleagues that faculty should do their best to build 'bridges to success' for struggling students, and that suitability policies may discriminate against students from diverse backgrounds. Lafrance and Gray (2004: 326) express this concern as: 'In a profession [ie social work] that espouses the basic value that all people are capable of growth and change, can we justify excluding people who may be unready rather than unsuitable?' In the UK context, McLaughlin (2010: 80) argues that assessment of suitability should only take place at appropriate times in the student's development, and should be fair, transparent and congruent with 'social work's avowed commitment to social justice'.

Returning to the details of what a process might include, a UK study by Brockbank et al (2011) found that members of the public judged misdemeanours among medical students more harshly than did medical students and medical professionals. The authors recommended that views of lay members should be sought by medical schools when promoting professionalism and considering cases of medical student misconduct.

A number of studies discuss a range of penalties, depending on the degree of misconduct. This requires the institution to define degrees of misconduct and set out appropriate actions to be taken if they occur. Anderson and Obenshain (1994) suggest a list of options for action, depending on the severity of the breach. Howe et al (2010) report on one medical school's approach to monitoring and assessing aspects of unprofessional behaviour, which included a seven-point scale of response, from taking no action to suspension and/or a misconduct inquiry, depending on the degree of misconduct.

In a study carried out by Roff et al (2011) the authors developed a 41-item inventory of unprofessional behaviours, based on an analysis of the literature on academic integrity in the health professions, and surveyed 57 faculty and 689 students from a Scottish College of Medicine, Dentistry, Nursing and Midwifery, asking what sanction they thought should be applied for each type of misconduct.

Items included:

- plagiarising work from a fellow student or purchasing work from a supplier
- claiming collaborative work as one's individual effort
- altering or manipulating data (eg adjusting data to obtain a significant result)
- coercing faculty members into providing copies of papers prior to exam through bribery or intimidation
- intentionally falsifying test results or treatment records in order to disguise mistakes
- failing to follow proper infection control procedures
- examining patients without knowledge or consent of supervising clinician
- sexually harassing a university employee or fellow student
- engaging in substance misuse (eg drugs)
- drinking alcohol over lunch and interviewing a patient in the afternoon.

The scale of potential responses range from 1 (ignore) to 10 (report to professional regulator). The authors found that the same sanctions as were proposed by the faculty were indicated by the students in 26 of the 41 items, while some of the other behaviours were regarded more severely and some viewed less severely by students than by faculty.

In summary, procedures for handling fitness to practise cases may vary across institutions, but strong arguments are expressed that professional fitness to practise policies and procedures are required in addition to an HEI's general academic misconduct policies, as general university policies do not deal with issues of professional suitability or fitness to practise. The introduction, amendment and application of fitness to practise procedures may give rise to disagreement and debate about issues of fairness.

Differences may be expected between the procedures in different HEIs, arising from different histories and different structures, but the literature recommends characteristics

that could be embedded within procedures (such as those identified by Unsworth, 2011, above). Scales of unprofessional conduct, with corresponding scales of severity of penalty, are put forward by some papers, similar to those set out by some of the UK healthcare professions regulators discussed in the next chapter.

3.4 Regulatory bodies and student fitness to practise

There is limited literature that refers directly to the role of regulators in setting the parameters of, and assuring, student fitness to practise. From the literature that does exist on the regulators' role, the themes that emerge relate to questions about the consistency of educational institutions' policies and practices, the need to include lay perspectives on student fitness to practise panels, the lack of published data about the outcomes of student fitness to practise policies, and the values about public protection conveyed to students by regulators' practices.

In a comparison of university procedures to assess the professional suitability of students for social work, Currer found that the procedures in different universities varied 'in relation to a number of factors, such as whether professional suitability is an academic or disciplinary matter; the name of the procedure and rationale; its focus and scope; the personnel involved and possible outcomes' (Currer, 2009). McLaughlin in an article designed to promote a debate about whether social work should have a system of student registration argues that registration is inappropriate for students as they are still in the process of developing their knowledge and skills to meet the code of practice and that this situation is compounded by a current lack of knowledge of 'whether these processes are being operated in a fair and just manner' or 'whether they are being operated equitably across England' (McLaughlin, 2010).

Unsworth (2011) found similar discrepancies in an examination of the student fitness to practise policies in 44 of 56 HEIs providers of pre-registration nursing programmes with 16 of the institutions using general student discipline policies for the purpose and 28 institutions having specific fitness to practise policies. There was also considerable variation in the content of the policies, particularly in the areas of defining impaired fitness to practise and thresholds for referral to full hearings. McGurgan et al (2010) reporting on an Australian study of medical schools also found variable policies lacking in an evaluation of effectiveness. All of these authors reach similar conclusions that there is a need for regulators to develop a nationally consistent approach in order to protect the public and provide consistency of outcome for students.

As a result of a pilot cross-sectional survey of the public, medical students and doctors in the UK on the judgments they made on 10 hypothetical examples of student misconduct, Brockbank et al (2011) concluded that the views of lay people as well as those of doctors and students should be included in student fitness to panels as lay people tend to be more stringent in the sanctions they seek. By inference this conclusion suggests that regulators should consider whether lay people should be included as a requirement on educational institutions' student fitness to practise panels to mirror what happens for professional registrants.

David and Ellson (2010) from a UK study on medical student fitness to practise hearings note that while all UK medical schools now have student fitness to practise procedures in place,

there is a dearth of published outcome data. A point also noted by Rubin (2002). David and Ellson also note that standard textbooks on healthcare regulatory law, education law, and disciplinary and regulatory hearings 'make no detailed reference to student FTP procedures, which differ significantly from cases involving registered professionals'.

The effect of the whole healthcare environment on students is a concern of Stern and Papadakis (2006). They suggest that the environment, including the actions of regulators, sends powerful messages to students about cultural values. They conclude to promote the development of professionalism, regulators 'need to take swifter action against unprofessional behaviour because public safety and the public's trust of our profession are at stake'. To support this point, Kelly and Miller (2009) found from a US study of the perceptions of first and fourth year medical students that both groups had 'overwhelmingly negative perceptions of the medical malpractice system' (ie legal remedies and procedures regarding medical malpractice).

In addition to the specific studies which consider the role of regulators, most, if not all, of the outcomes of the literature review discussed in the first three sections of this chapter have implications for regulators, such as in relation to the requirements they set for, and the guidance and advice they issue to, education providers.

The review of the literature has provided evidence of benefits in the following areas that are of relevance to regulators:

1. describing both what is meant by fitness to practise as well as examples of unprofessional behaviour / behaviours that would cause concern about an individual's fitness to practise
2. requiring educational institutions to have both proactive measures (such as embedding an ethical focus across the curriculum, clarifying to students the standards to be met, role modelling, high quality practice placements, and clear policies and practices that are consistently applied by all staff) as well as reactive measures (such as consistently addressing unprofessional behaviour when it occurs, investigating and dealing with student fitness to practise issues)
3. staff discussing, developing and agreeing behaviours that would and would not constitute fitness to practise and consistently applying them – suggesting staff development and appraisal systems
4. assessing student fitness to practise both formatively and summatively.

3.5 Conclusions about the findings from the literature

There is a relative dearth of substantive literature about student fitness to practise concerning the professions regulated by the HPC, or indeed about social work. The field is dominated by material about medicine. There is limited empirical work in this area and much of what there is reports small-scale studies within single professions. The body of literature is dominated by small-scale surveys, qualitative studies and critical reviews, discussions and opinion pieces. There is a lack of information about the risks posed by students or, more specifically, about student registration in managing those risks.

Through their professional education, students acquire the knowledge, skills and attitudes that enable them to demonstrate fitness to practise. The main focus of the literature relevant to fitness to practise and students concerns the development and assessment of non-cognitive abilities, variously described as 'professionalism' or 'suitability' or 'good character'. There are numerous definitions of these terms, put forward by different professional bodies, practitioners and researchers.

Because of the potential for ambiguity, it is generally agreed that there are benefits in describing what is meant by this component of fitness to practise. There are also benefits in specifying examples of behaviour that are unprofessional, or that indicate unsuitability, or a lack of good character.

There is little evidence about the risks that students pose beyond descriptions of unprofessional behaviour, such as poor practice by students resulting in harm to patients or service users - a risk potentially mitigated by supervision. There are also the risks of poor practice after registration: some studies found that disciplinary action by a medical board was strongly associated with prior unprofessional behaviour in medical school. Behaving with a lack of integrity and honesty in academic matters (such as by plagiarising others) may be considered a breach of a code of professional ethics in itself, as well as potentially an indicator of a propensity to behave unethically in other contexts.

Some studies found a range of judgements on the degree to which a particular unprofessional behaviour indicates a lack of fitness to practise. Issues to take into account in making such a judgement include the nature of the misconduct and the stage of the individual's education. Certain behaviours may be considered unacceptable from the first day of study, whereas some situations may pose very difficult ethical dilemmas, challenging even to experienced practitioners

There is general agreement that the capability to behave professionally develops over the course of a student's education, with professional understanding and wisdom only being acquired over time, with experience and learning, alongside a developing knowledge base. It is generally assumed that it is possible to develop values and attitudes relevant to the profession including ethical judgment, during professional education.

The effects of health impairment and disability on fitness to practise, and the danger of unfair discrimination in this area, are subjects only lightly touched upon in this review: they could warrant a literature review in their own right. In this area the literature we have considered argues that HEIs need to balance the rights of students with health difficulties or disabilities with the rights of the public, service users and patients

There is a considerable literature on different aspects of the role of HEIs in developing and assessing the professionalism component of fitness to practise.

The literature emphasises a need for agreement among staff - academic tutors and practice supervisors - as to what constitutes acceptable and unacceptable behaviour, as a precursor to communicating clear expectations to students. This agreement on what constitutes student fitness to practise/professionalism is unlikely to occur without discussion and dialogue, and may not be easy to achieve. However, the literature in this area indicates that the consequences of not achieving this agreement within an HEI can be mixed messages to students about the nature of and the need for professional behaviour, difficulties in

assessing fitness to practise, and confusion and difficulty in investigating and dealing with alleged failures.

The literature on the actions that HEIs can take to develop fitness to practise encourages staff to have regard to a wide range of activities, both formal and informal, that constitute teaching and learning, and to seek to coordinate teaching and learning across all these activities. The concept of the 'hidden curriculum' - the learning that students take from placements, and from informal interactions with their tutors and peers - is widely cited as a strong influence on student behaviour and development.

There appears to be broad agreement that important elements of teaching and learning include: clear communication of principles and procedures; role modelling and explanation of desirable behaviours by staff; opportunities to practise, and to reflect on and receive feedback on practice; monitoring performance, reinforcing good practice and providing extra support where necessary; and helping students develop the skills of self-reflection.

Role modelling is seen as a particularly important component of conveying professional values and behaviours, including potentially learning from experienced professionals how they handle ethical dilemmas. Similarly, negative role models may have significant effect on student understanding and behaviour.

Self-assessment and reflective practice is a component of reflective learning, and a number of studies advocate it as a structured element within formative evaluation, whilst advocating feedback and support in order to attain accurate self-awareness, and to develop self-reflection skills.

The literature on the whole advocates the assessment of professionalism and professional suitability. Assessment of professionalism, or suitability, may be expected to take place on application to a programme of professional education, and both formatively and summatively during the programme.

Overall, assessment of suitability at the point of admission appears to be subject to a number of difficulties and there are doubts about its accuracy of assessment, other than as a means of excluding the 'obviously unsuitable' candidates.

The literature advocates formative and summative assessment during education, with formative assessments giving rise, where appropriate, to better understanding, more support and further development. A range of different methods of assessment is proposed. The challenge to staff of giving critical feedback on matters of practice and attitude is the focus of a number of papers, indicating that this is an area where clear guidelines should be developed and communicated to students and staff, and where staff will benefit from training and support.

Allegations or incidences of misconduct will give rise to the need to investigate and, where the allegations are proven, to take appropriate action through the use of sanctions. Misconduct may include poor clinical/professional practices related to the student's specific area of study and also to academic practices, such as plagiarism. It is difficult to determine the incidence of student fitness to practise issues across the health and social care professions in the UK as the extent to which this is reported and / or dealt with by a centralised body, such as a regulator, is dependent on the systems and practices in that profession.

Strong arguments are expressed that professional fitness to practise policies and procedures are required in addition to an HEI's general academic misconduct policies, as general university policies do not deal with issues of professional suitability or fitness to practise.

There is general agreement that policies and procedures should be timely, robust, fair and clearly documented, that they should be followed, and that there should be reliable systems for documenting concerns and identifying and managing students whose behaviour is problematic.

A common pattern of fitness to practise procedures in HEIs is for a series of graduated interventions and this can be seen to parallel the definition and illustration of thresholds of concern with related sanctions, which have been set out by some of the UK healthcare profession regulators (see next chapter).

Studies show that differences may be expected between the procedures in different HEIs, arising from different histories and different structures, but the literature recommends characteristics that could be embedded within procedures. Regulators are seen to have a role in ensuring consistency of educational institutions' policies and practices as well as conveying values about public protection by their practices.

Chapter 4: Regulators and student fitness to practise

This chapter reviews literature on student fitness to practise from the health and social care professions regulators in the UK and also in some other countries.

4.1 The UK health and social care profession regulators and their approaches to regulating student fitness to practise

In its document on healthcare regulators quality assuring undergraduate education, CHRE emphasises that:

‘patient safety and public protection are at the heart of healthcare professional regulation and consequently underlie all work in quality assurance. The weakest student who passes a programme has to be fit to enter the register and fit to practise.’ (CHRE, 2009)

It recommends that:

‘All regulators must be willing and able to demonstrate how their processes link proportionately to patient safety and public protection, maintaining the focus on the issue of being fit to join the register, or making further progress towards this point, is essential.’ (CHRE, 2009)

To provide an overview, Table 3 summarises and compares the position of each of the UK health and social care professions regulators’ key policies concerning student fitness to practise. This shows that the majority of UK health professions regulators have produced specific standards / guidance on student fitness to practice and / or student ethics and conduct.

Table 3: Overview of the approaches and guidance of the UK health and social care profession regulators for student fitness to practise

Regulator	Student Registration	Student Fitness to Practice Guidance	Code of Conduct / Ethics for Students	Other / comments
General Chiropractic Council (GCC)				No specific Student FtP documents Reference to the need for student FtP policies and related student learning in its Degree Recognition Criteria, 2010.
General Dental Council (GDC)		GDC, April 2010, Student fitness to practise – covers both dentists and dental care professionals plus aspects related to disability and health of students		Acknowledges similarity to GMC document and that it drew from it in its development
General Medical Council (GMC)		General Medical Council and the Medical Schools Council, March 2009, Medical		

Regulator	Student Registration	Student Fitness to Practice Guidance	Code of Conduct / Ethics for Students	Other / comments
		students: professional values and fitness to practise		
General Optical Council (GOC)	<ol style="list-style-type: none"> 1. Registering with the GOC: A guide for students (no date) 2. Registration of students in optometry and dispensing optics: A guide for training providers (no date) 		Code of Conduct	Code of Conduct applies to full registrants and student registrants.
General Osteopathic Council (GOsC)		GOsC, 2011, Student fitness to practise Guidance for Osteopathic Education Institutions - Draft	GOsC, 2011, Student fitness to practise Guidance about professional behaviours and fitness to practise for osteopathic – Draft	
General Pharmaceutical Council (GPhC)		GPhC, 2010, Guidance on Student Fitness to Practise Procedures in Schools of Pharmacy	GPhC, 2010, Code of Conduct for Pharmacy Students, 2010; Code of Conduct for Pre-registration Pharmacy Technicians	
General Social Care Council (GSCC)	Student register – no specific guidance. Covered in: GSCC, Sept 2010, Arrangements for the funding of Practice Learning – Social Work Degree			
Health Professions Council (HPC)			HPC, Guidance on conduct and ethics for students, 2009	No specific Student FtP guidance document. References to requirements for this in, Standards of education and training guidance 2009; An introduction to our

Regulator	Student Registration	Student Fitness to Practice Guidance	Code of Conduct / Ethics for Students	Other / comments
				education processes, 2011 HPC, 2009, Guidance on Health and Character
Nursing and Midwifery Council (NMC)	<i>Plans to introduce a student index in Spring 2012</i>	NMC, 2010, Good health and good character: Guidance for approved educational institutions (Amended November 2010)	NMC, 2011, Guidance on professional conduct for nursing and midwifery students 3rd edition	The Good health and character document has Student FIP policies and practices as one element of a larger document
Pharmaceutical Society of Northern Ireland (PSNI)		Signposts to: GPhC's Guidance on Student Fitness to Practise Procedures in Schools of Pharmacy, 2010	Signposts to: GPhC's Code of Conduct for Pharmacy Students, 2010; Code of Conduct for Pre-registration Pharmacy Technicians, 2010	

The chapter proceeds by looking in greater detail at the standards and guidance on student fitness to practise produced by these regulators. It then goes on to describe the approaches of those regulators that have adopted other methods, or that have not to date undertaken specific work in this area.

4.2 UK healthcare profession regulators who have produced guidance relating to student fitness to practise

The GMC was the first UK healthcare profession regulator to initiate developments related to student fitness to practise (including consideration of whether it should use a system of student registration).

In 2001, Universities UK and the Council of Heads of Medical Schools commissioned the law firm Eversheds to consider fitness to practise issues from the viewpoint of higher education institutions (HEIs) in England and Wales. Under the Medical Act (1983), HEIs are responsible for the education and training of doctors up to full registration by the GMC, including having a duty to ensure that those who graduate from undergraduate courses and complete their initial training are fit to practise.

Eversheds recommended principles for university student fitness to practise procedures that would be fair to individuals, reflected legislative requirements and allowed for detailed procedures to be determined by individual institutions against some broad principles. The criteria that Eversheds defined as the basis of student fitness to practise procedures related

to: legality (eg common law of natural justice and fairness, Human Rights Act 1998), actual and perceived fairness, effectiveness, consistency, efficiency, and fit with the wider structure of regulation of the health professions and of universities.

These broad criteria and the proposals outlined by Eversheds (2001) are evident in the guidance produced by the GMC and the Medical Schools Council – *Medical students: professional values and fitness to practise* (2009). The guidance is aimed at medical students and anyone involved in medical education and covers: the professional behaviour expected of medical students; the scope of student fitness to practise; the threshold of student fitness to practise; making decisions; and the key elements in student fitness to practise arrangements.

The influence of the GMC guidance on student fitness to practise is evident in the guidance produced by the GDC, the GOsC and the GPhC. There are also some commonalities between these documents and the publications of the HPC and the NMC.

Table 4 uses the broad headings within the GMC guidance as a means of comparing the content of the guidance that has been produced by the other regulators. It shows that there is considerable similarity between the student fitness to practise documents of the regulators who have produced specific guidance (ie the GDC, GMC, GOsC and the GPhC). There are also substantial areas of commonality between the NMC and HPC documents and the documents of the other four regulators, although overall the NMC and HPC publications cover fewer areas.

The GDC produced its guidance on student fitness to practise in 2010 for all of the professional groups in its remit (ie for dentists and for all dental care professionals such as dental nurses, dental technicians, dental hygienists and dental therapists). The guidance covers aspects of student fitness to practise relating to disability and health, which is in contrast to other regulators who have tended to produce separate documents. The GDC guidance acknowledges its similarity to the GMC guidance from which it was developed.

The GPhC published guidance on student fitness to practise procedures, a code of conduct for pharmacy students and a code of conduct for pre-registration pharmacy technicians in 2010. The content of these codes and guidance on student fitness to practise broadly covers the same subjects as that of the GMC and the GDC. The purpose of the guidance is to provide advice on how to develop and apply consistent fitness to practise procedures for students. The relevant student codes of conduct are based on the GPhC's Standards of conduct, ethics and performance and apply to all students studying to enter the pharmacy or pharmacy technician professions. The documents state that students 'must abide by the code of conduct at all times and demonstrate professional conduct in the same way as they will be expected to once they qualify'.

The Pharmaceutical Society of Northern Ireland (PSNI) signposts students to the GPhC's guidance on conduct and ethics. It has not produced guidance on student fitness to practise procedures.

The GOsC consulted in 2011 on two draft publications related to Student Fitness to Practise – one for Osteopathic Education Institutions and one for students. The consultation document noted that additional development work was being undertaken to produce more focused guidance on disability and health impairment for the same primary audiences. The draft guidance on student fitness to practise from GOsC broadly covered the same subjects

as that of the GMC and the GDC although it appears to emphasise more strongly that the expectations on students' behaviour would increase as students progressed through the programme and developed their knowledge, skills and attitudes. At its meeting on the 11 October 2011, the Council of GOsC noted the positive response that had been received to the draft guidance and recommended that it should be published as soon as possible. The implementation of the guidance is to be supported by an implementation strategy and an evaluation of its effectiveness³.

Table 4: An overview of the content of the guidance on Student Fitness to Practise of the UK healthcare regulators (where such guidance has been produced) as at December 2011

CONTENT AREA / BODY	GDC	GMC	GOsC	GPhC	HPC	NMC
1 PROFESSIONAL BEHAVIOUR LINKED TO REGISTRANT REQUIREMENTS	X	X	X	X	X	X
COMMON PRINCIPLES agreed by the regulators						
Be open with patients & respect their dignity	X	X	X	X	X	X
Respect patients' rights to be involved in their treatment and care	X	X	X	X	X	X
Be honest and trustworthy to justify public confidence	X	X	X	X	X	X
Provide a good standard of practice and care	X	X	X	X	X	X
Protect from risk of harm	X	X	X	X	X	X
Cooperate with colleagues	X	X	X	-	X	X
Teaching and training, appraising and assessing	-	X	-	-	-	-
2 REGULATORS ROLE IN RELATION TO STUDENT FTP ARRANGEMENTS						
Purpose of guidance from the regulator	X	X	X	X	<i>No specific guidance on FtP policies and practices - certain Standards for Education and Training (SETs) apply referenced below.</i>	X
Specific FtP requirements made by regulator	X	X	X	X	SET 6.5 SET 3.16	X
Health and fitness to practise	X	X	X	X	SET 2.4 <i>A disabled person's</i>	X

³ At the time of writing the finalised guidance was not available on the Council's website – last accessed 23/01/12.

CONTENT AREA / BODY	GDC	GMC	GOsC	GPhC	HPC	NMC
					<i>guide to becoming a health professional. & Guidance on Health and Character</i>	
Relationship to registration and/or qualifications	X	X	X	-	SET 3.16	X
Requirements on disclosure of FtP when an individual seeks to join the register	X	X	X	X	X	X
Requirements for education providers to inform the regulator	X	X	X	X	X	X
3. THRESHOLD OF STUDENT FITNESS TO PRACTISE						
Meaning	X	X	-	X	-	-
THRESHOLD FOR STUDENT FtP DECISIONS						
Defining the threshold	X	X	X	X	-	X
Illustrating the threshold	X	X	X	X	-	-
Categories of concern	X	X	X	X	X	X
4. ASPECTS OF STUDENT FITNESS TO PRACTISE PROCEDURES						
Admissions	X	X	X	X	SET 2.3	X
Communication and awareness	X	X	-	X	-	X
Education	X	-	X	-	SET 4.5 SET 5.12	-
Confidentiality and disclosure	X	X	X	X	-	-
Pastoral care and student support	X	X	X	X	-	-
FITNESS TO PRACTISE CASES						
Overview	X	X	-	X	-	-
Investigation	X	X	X	X	-	-
Fitness to practise panel - purpose and role	X	X	X	X	-	X
Fitness to practise panels – make-up	X	X	X	X	-	X
Fitness to practise panels – training	X	X	-	X	-	X
Possible outcomes	X	X	X	X	-	-
Timescales	X	X	-	X	-	-
Hearings	X	X	-	X	-	-
Support for students in hearings	X	X	X	X	-	-
Appeals	X	X		X	-	-

The NMC produced guidance for educational institutions on good health and good character in 2010 – this contains guidance on student fitness to practise policies as one element of a larger document. The NMC has also produced guidance for nursing and midwifery students on professional conduct (2011). The NMC plans to introduce a student indexing system in 2012.

The HPC has produced guidance on conduct and ethics for students. It warns that in very serious circumstances students' conduct may affect programme completion, the award of a final qualification, or registration with the HPC. It also explains that educational programmes have processes for dealing with concerns about students' behaviour (HPC, 2009). The HPC sees this guidance as setting 'useful principles for prospective registrants around the expectations of a professional' but notes that it will not enforce it.

The HPC has not to date produced specific guidance on student fitness to practise approaches but makes reference to requirements for this in other documents, specifically within its *Standards of Education and Training (SET) Guidance (2009)*. There are six standards of education and training relating to student fitness to practise and each standard has guidance attached. The relevant SETs and related guidance are shown in table 5 below.

Table 5: HPC Standards of Education and Training (and related guidance) relating to student fitness to practise

SET 2.3 The admissions procedures must apply selection and entry criteria, including criminal convictions checks (normally at an 'enhanced' level disclosure or equivalent).

SET 2.4 The admissions procedures must apply selection and entry criteria, including compliance with any health requirements.

Guidance

These requirements could include vaccinations and occupational health assessments. Requirements vary across the professions and we will want to see that providers give applicants clear information.

Providers must take all reasonable steps to keep to any health requirements and make all reasonable adjustments in line with equality and diversity law. 'Health' does not mean people who are 'healthy' or in 'good health'. Our guidance document, 'A disabled person's guide to becoming a health professional', provides information for disabled people applying to approved programmes, and for admissions staff considering applications from disabled people.

The HPC Guidance on Health and Character (2009) states:

We consider the effect that a health condition may have on someone's ability to practise safely and effectively. We look at each case and make our decision based on the particular circumstances of the case. When making a decision about an applicant or a student with a health condition, there are a number of factors providers might want to look at: how they currently manage their condition; whether they have shown insight and understanding of their condition; whether they have got medical or other support⁴.

SET 3.16 There must be a process in place throughout the programme for dealing with concerns about students' profession-related conduct.

Guidance

The purpose of this SET is to make sure that education providers play a role in identifying students who may not be fit to practise and help them to address any concerns about their conduct in relation to their profession. The process should focus on identifying and helping to address concerns, but should also allow an appropriate range of outcomes, including providing for an award which does not provide eligibility to apply to the Register (please see SET 6.8 for more guidance on this issue).

We will want to see evidence to support your choice of process, which must be appropriate to the programme and how it is delivered. It is important that you are able to justify, and be responsible for,

⁴ The HPC website (accessed 23/01/12) states that this document is currently under review and the HPC has removed the requirement for a health reference prior to entry to its Register.

any decision you make, and that the process is thorough, fair and open.

We will want to see the process of communication between you, practice placement providers and practice placement educators. It will be important that you show the process is fair, that you have made every effort to allow the student to address any issues relating to their conduct, and that you can justify clearly all the decisions you have made.

To show that you meet this SET, you could refer us to where the process is laid out, and how you communicate it to students. You might include this, for example, on your website or in your student handbook. You may want to use our standards of conduct, performance and ethics to inform your process.

SET 4.5 The curriculum must make sure that students understand the implications of the HPC's standards of conduct, performance and ethics.

Guidance

The standards of conduct, performance and ethics are broad standards that everyone on our Register must keep to. These standards must be taught and met throughout a programme. For example, they could be covered as part of a module on ethics or could be built into the curriculum as a whole. We will want to see that the curriculum refers specifically to the standards of conduct, performance and ethics, and that students understand these standards, including how and when they apply. We recommend that you include the standards of conduct, performance and ethics in your reading lists.

SET 5.12 Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.

Guidance includes:

We will want to see information about how students learn about the behaviour expected of them on their placement.

SET 6.5 The measurement of student performance must be objective and ensure fitness to practise.

Guidance includes:

We will want to see information about how you monitor and measure student performance, and what criteria you use to assess students who are at different stages in their learning. We will also want to see how you use your guidelines or criteria to make sure students are fit to practise. A student who completes a programme must meet the standards of proficiency. The term 'fitness to practise' is specific to the process that professionals who are registered have to maintain. This includes the standards of proficiency, the standards of conduct, performance and ethics, and the health and character requirements of registration.

Although the detail of the other regulators' student fitness to practise policies have not been produced in the same way, it can be seen from the information in table 5 and table 4 above that the HPC does provide guidance on some aspects of student fitness to practise that are in common with most of the other healthcare regulators. Through its standards of education and training, the HPC ensures that student fitness to practise is included as a key component within its educational programmes leading to registration. However the SETs and related guidance do not cover the same breadth or depth as the guidance from other healthcare regulators, such as in relation to:

- threshold for student fitness to practise decisions
- all areas of managing fitness to practise cases including:
 - confidentiality and disclosure

- pastoral care and student support
- fitness to practise panels – purpose, roles, make-up and training
- hearings
- outcomes
- appeals.

As regards the threshold at which student fitness to practice procedures should be initiated, although the HPC describes professional conduct it does not give specific examples of unprofessional conduct which might help illustrate the types of behaviour that would be a matter of concern.

Drawing on the policies of the other regulators, the threshold tends to be defined broadly and relates to conduct that does not justify the trust placed in the professional, or concerns behaviour that may have harmed patients / clients / users or that has put them at risk of harm.

All of the regulators that have covered this area tend to use the same broad questions first set out by the GMC and which are to be applied on a case-by-case basis. They are:

- *‘Has a student’s behaviour harmed patients or put patients at risk of harm?’*
- *Has a student shown a deliberate or reckless disregard of professional and clinical responsibilities towards patients or colleagues?’*
- *Is a student’s health or impairment compromising patient safety?’*
- *Has a student abused a patient’s trust or violated a patient’s autonomy or other fundamental rights?’*
- *Has a student behaved dishonestly, fraudulently, or in a way designed to mislead or harm others?’*

(GMC & MSC, 2009)

The categories of concern used for criminal conviction appear to be broadly similar across the regulators included in table 4. However the regulators that have produced specific guidance on the subject also include other aspects of behaviour such as:

- drug or alcohol misuse
- aggressive, violent or threatening behaviour
- persistent inappropriate attitude or behaviour
- cheating or plagiarising
- dishonesty or fraud including outside the professional role
- unprofessional behaviour or attitudes
- health concerns and insight or management of these concerns
- placing inappropriate photographs or postings on social media or social networking sites such as Facebook, Twitter etc.

The definitions and illustrations of the threshold used by the regulators are consistent with the four key elements for assessing good character identified by the CHRE (2008) and described in chapter 3.

In terms of managing fitness to practise cases, most regulators do not prescribe the approach and process to be adopted but set out broad principles that education providers should include in their policies and procedures – for example the separation of roles between course tutors, investigators and fitness to practise decision makers; proportionality of the approaches; timeliness and good record keeping.

The CHRE says that in the interests of public protection, fitness to practise sanctions against an individual student should be shared with regulators, preferably by both the student and by the education provider at a point determined by each regulator. It also recommends that through their quality assurance programmes, regulators should collect aggregated data on student fitness to practise and use this to improve their standards and guidance, and work with education providers to share good practice in managing student fitness to practise (CHRE, 2010).

We have been unable to find any published information about the effectiveness of regulators' student fitness to practise guidance, which may simply reflect the relatively recent development of guidance and implementation of formalised policies and procedures.

In conclusion, it can be said that the regulator guidance reviewed is broadly consistent with the approaches first suggested by Eversheds in 2001, with the duty to comply with relevant legislation, and with the need to accommodate the variety of education institutions in which student fitness to practise policies and procedures are applied.

4.3 Other approaches to student fitness to practise used by the health and social care professions regulators, including student registration

No specific guidance or other measures yet in place – the GCC

The General Chiropractic Council does not currently have specific guidance relating to student fitness to practise, but it does make reference to the need for relevant policies and procedures in its Degree Recognition Criteria, 2010. We understand that the GCC is currently in the process of undertaking work in this area. It has addressed the possibility of complaints being made in relation to students in an advice note on supervision and delegation in chiropractic undergraduate education (GCC, 2010a). The advice outlines the roles and responsibilities of educational institutions and the GCC in different scenarios, and it notes that a chiropractic student might be referred to an education institution's student fitness to practise procedures for investigation. The GCC requires education institutions to inform it of the outcomes of any student fitness to practise cases considered.

The introduction of student indexing – the NMC

The NMC plans to (re)introduce a student index in the spring of 2012 following a consultation in 2011⁵. The index is designed for use by the NMC and the nursing education

⁵ Information obtained from NMC website on consultations / student indexing modified date 01/09/2011 and student indexing, modified date 31/08/2011 (both last accessed 23/01/12).

institutions – it will not be publicly available. The student index will be formed from a database of every student enrolled on a pre-registration nursing or midwifery education programme at an NMC approved education institution (AEI).

The NMC says the primary purpose of the index is to enhance public protection and cites ‘programme hopping’ as one of the reasons for its introduction. It says the student index will enable AEIs to identify whether students who have enrolled on a programme at their institution had previously been dismissed from another programme for serious concerns or misconduct. Other benefits identified by the NMC include access to the contact details for every student – enabling the regulator to communicate directly with students on a variety of subjects; enable the NMC to build a picture of the fitness to practise decisions taken by AEIs; and for use in analysing trends in nursing and midwifery education programmes for quality assurance purposes.

In its response to the NMC consultation, the CHRE noted that ‘the consultation paper does not describe the extent of the risks involved, or examine whether there might be more proportionate means than the proposed index to tackle those risks successfully’ (CHRE, 2011). We have not found any evidence published by the NMC about the size of the ‘programme hopping’ problem in nursing and midwifery, nor have we found any evidence in the published literature. The CHRE also emphasises its view that the introduction of a student index, described by the CHRE as a list of students, ‘would not be a targeted solution to the problem, nor would it be in line with right-touch regulation’ (CHRE, 2011).

Actively engaging students in the work of the regulator and giving consideration to student registration – the GMC

In 2008, the GMC undertook an impact assessment as part of a consultation to review its then extant publication *Tomorrow’s Doctors, 2003* (GMC, 2008). The impact assessment noted that the Council had a number of options open to it including: doing nothing and keeping the existing publication; introducing amendments to the 2003 edition; preparing a new edition building on the previous one and pursuing other options such as a national examination near the start of medical practice; a UK-wide register of medical students and a strategy to engage students fully in professional and regulatory matters. The discussion within the impact assessment notes the GMC’s intention to continue to work with the Kings Fund and the Royal College of Physicians to engage students in the concept of professionalism. It also reports that the GMC was not persuaded that the potential advantages of student registration would outweigh the disadvantages.

Feedback from the 2008 consultation was reported as being largely supportive of the proposals but emphasised the need for greater clarity about responsibility for fitness to practise and managing trainees in difficulty, and the respective roles of the GMC, postgraduate deaneries, foundation schools and medical schools. In 2009, the GMC produced and published its revised guidance (referred to above) entitled *Medical students: professional values and fitness to practise* and its Postgraduate Board noted that the GMC had developed an ongoing work stream to promote the work of the GMC and engage students with their professional values early on in their medical training (GMC, 2009).

In 2009 – 10, a series of events on medical professionalism was held with medical students (Levenson et al, 2010), continuing the work reported in *Understanding Doctors: Harnessing*

professionalism (Levenson et al, 2008). The authors note that the findings were encouraging and included affirming the importance of medical professionalism in the personal and professional lives of medical students, as well as the need for students to engage in the process of defining professionalism and its teaching and assessment. They also concluded that medical students needed a fuller understanding of the regulatory role of the GMC and how it will affect their lives.

The review of medical education by Lord Patel (Patel, 2010) returned once more to the issue of student registration and its potential for contributing to the development of a sense of professionalism in students, as well as helping medical schools to deal robustly with fitness to practise issues. The Patel review noted that there was some evidence that by introducing the *Medical Students: Professional Values and Fitness to Practise* guidance, medical schools were better able to adapt their procedures to deal with student fitness to practise issues (although the nature and robustness of the evidence was not cited). The review went on to recommend that the GMC should evaluate the effectiveness of its existing arrangements for engaging with students as well as considering other ways of supporting the development of professional behaviour, values and identity.

Following the Patel review, the GMC's 2011 Business Plan (as noted in an Undergraduate Board paper – GMC, 2011a) stated that the GMC 'will provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career' including an evaluation of the case for establishing student registration. The key test for student registration was noted as 'whether it (student registration) will contribute positively to the promotion of professional values and to supporting a smoother transition to practice (rather than merely being a mechanism for addressing serious fitness to practise issues amongst a very small minority of students)'.

However with the publication of the Government's Command Paper *Enabling Excellence* in 2011 – which made clear the government's view that statutory regulation should be deployed only if there is no other means of achieving the same aim – and following a preliminary discussion with senior counsel on the legislative implications of introducing student registration, the GMC modified the aim of the evaluation of student registration to: 'identify the most effective ways of enhancing our relationship with medical students, so that we can promote a deeper understanding of professional values, responsibilities and behaviours and thereby enabling an effective transition to practice' (GMC, 2011b).

Having considered the options for consultation on student registration and the costs of introducing such a scheme, the GMC Council took the view that mandatory registration of all or some students was not viable and that it should not form part of the consultation process; rather, it should focus on voluntary student registration, or a less formal system of student affiliation/association with the GMC (the then preferred GMC position), or the extant position. It appears that given the changing economic and regulatory context, the GMC did not proceed with the proposed consultation. On 25 October 2011, GMC web news reported that:

'The GMC considered its position on medical student registration at its Council meeting on 27 September 2011 and decided that it will not introduce either mandatory or voluntary registration of medical students. Instead we will continue to work to strengthen engagement with medical students, and will bring forward the point at which medical students engage formally with the GMC.' (GMC, 2011c).

This announcement also included information that GMC reference numbers would be issued to students at an earlier date in order to make provisional registration more straightforward.

The main reasons behind the GMC decision not to proceed with a further exploration of student registration related to: cost, there being no compelling case on the basis of a public safety risk, and because a voluntary register would have the potential to confuse the public.

The GPhC has stated publicly that it does not intend to register students at this stage, noting that it is:

'the Government's view that education and training providers are ideally placed to identify and deal with student fitness to practise by carrying out pre-education checks to discover any factors which might either indicate prospective students' unsuitability for training as a pharmacist or pharmacy technician, or which might identify areas where they may need extra support' (GPhC's website FAQ section, 2012).

The CHRE reached similar conclusions to those of the the GMC when it produced advice on student registration in 2007:

'Much of the evidence for the need for a closer relationship between the student and RB (regulatory bodies) which has been presented to CHRE has been experiential and anecdotal. ... In conclusion, on the basis of the survey of opinion it is our view that registration of students for the purpose of developing a working knowledge of professional behaviour, ethics and values is not necessarily achieved through registration with a Regulatory Body. On balance a stronger relationship between the HEI, RB and student through Codes of Conduct and guidelines for fitness to practise might be a more pragmatic way to proceed that would provide protection for the patient whilst the individual is a student plus better preparation for entry into professional practice on qualifying.' (CHRE, 2007)

Since that time the CHRE has introduced the concept of 'right touch' regulation (CHRE, 2010). From this perspective student registration might be considered the imposition of a further layer of administration for few, if any, perceived benefits. In essence, it is clear that the CHRE has concluded that there are other, more proportionate, ways of developing professional behaviour, ethics and values and of addressing student fitness to practise issues.

A system of student registration not linked to funding or other administrative duties - the General Optical Council

The GOC is the only UK healthcare profession regulator to register students. It is required to do so this under section 8A of the Opticians Act 1989 (amended 2005). It is a criminal offence under section 28(1)(cc) of the Act for anyone to hold themselves out as a student registrant while not being registered with the GOC.

The GOC Code of Conduct applies to all its registrants (ie those who are fully qualified and those in training). It has produced two guides relating to student registration – one for students and the other for training providers. The latter describes the purpose of student registration as follows:

‘Student registration is intended to make students personally accountable for their conduct and to ensure that they do not pose a threat to the safety of the public while training. Requiring students to register with the GOC helps them develop a working knowledge of professional behaviour, ethics and values, as they are bound by the same GOC Code of Conduct as full registrants.’ (GOC, undated)

The GOC states in its guidance to students that ‘the patients you treat and the customers you work with need to be protected to avoid problems’ (GOC, undated). Students are advised that if they are not registered they are breaking the law, will not be able to sit assessments or participate in clinics or training, or advance to professional practice. The guidance for training providers additionally notes that students who are not registered will not be covered by any indemnity insurance policy.

New students must apply for registration with the GOC using the relevant forms. The information is usually supplied by the education provider. Registration occurs annually, so students must remember to submit a registration retention form after the first and subsequent year of a programme. The student registration fee is £20 for the academic year 2012 – 2013.

Students must inform the GOC of anything that might affect their fitness to train and work with the public, such as a past criminal conviction, disciplinary action, or serious health condition. They are advised that if they have anything to declare then the form should be submitted well before the course has begun. All criminal convictions, cautions and disciplinary proceedings have to be declared on the registration and retention forms, including minor misdemeanours (but not road traffic offences dealt with by a fixed penalty notice). The training provider with whom the student is enrolled must validate a student’s form. Student registrants are also required to inform the GOC as soon as possible of any change in their circumstances that might affect their fitness to train (ie rather than only doing this at the point of retention). All declarations are reviewed by the Registrar in confidence and on a case-by-case basis in line with a set protocol (GOC, 2009 amended 2010).

The registration number a student receives is not necessarily the one they will retain when they become fully registered with the GOC. Similarly, if a practitioner leaves the GOC register they may receive a different registration number when re-registering – although all registration numbers are unique.

Training providers assist the GOC in the student registration process by:

- providing registration forms to students and signing and stamping their applications
- reminding students of the need to renew their registration annually and to keep their contact details up-to-date
- ensuring that all students remain registered throughout their studies
- dealing with students who have been removed from the GOC registers until they are reinstated.

Both sets of GOC guidance on student registration focus on the mechanics of the system and what individuals and organisations need to do to maintain registration. The GOC does not appear to have produced specific guidance on student fitness to practise, but it does make reference to guidance documents (for example about matters such as the supervision

of students) available through professional bodies. We understand that this reflects the particular circumstances of eye-care professional training and the respective roles of the GOC and the professional bodies in that process.⁶

We were unable to find specific information on the risks posed by students in the optical profession, nor the policy rationale for student registration. However published statistics do show that the GOC received 184 complaints against members of its 24,656 registrants in the calendar year reported in its last annual report (GOC, 2011), of which 16 were against students (11 student optometrists and 5 student dispensing opticians). This equates to approximately 9% of the fitness to practise complaints received. However the data does not reveal the nature of the complaints against students nor the extent to which they were upheld. The GOC has started to review how students should be regulated, the risks that students pose and how the risks can best be mitigated.⁷

Student registration related to the funding of practice placements – the General Social Care Council and other UK social care regulators

The GSCC regulates the social work profession in England – the other three UK countries each have their own social work regulator. The standards and approaches used by the four social work regulators in the UK have to date been broadly similar, so this review has concentrated on the GSCC and draws on literature from the other UK social care regulators only where it adds to the analysis.

Since its inception the GSCC has registered social work students. Registration is voluntary but is linked to the GSCC's role in administering funding for student practice placements. Funding for student practice learning is only provided for those individuals who are registered as a student on the Social Care Register. Whilst each student is responsible for their own registration and for payment of the registration fee, HEIs are responsible for providing evidence of the registration of each student to the GSCC each year. The GSCC is able to recoup funding paid out in respect of any students who have not been registered by the required deadline GSCC (2010b).

In 2009-10, 6,113 students enrolled on social work degrees across 278 approved programmes in 83 HEIs, many offering several different routes to qualification (such as full-time, part-time, undergraduate, Masters degrees) (GSCC, 2010c).

In social work education student registration appears to be inextricably linked to the way in which the system has developed since the decision to regulate social workers was taken by Government in the early years of the 21st century. The social work profession is unusual in that the requirements for social work education and training are not only laid down by the four professional regulators, but also by the Government (Department of Health, 2002). In deciding to abolish the GSCC and to vest responsibility for regulating the social work profession with the HPC, the Government has also indicated its intention to give the HPC

⁶ The relationship is evident in a news item on the GOC website: in 2009 the GOC felt it necessary to remind optical businesses, students and supervisors to ensure that their current arrangements for professional supervision continued to meet the standards outlined by the GOC following a case in which an optical business was found to have failed to take reasonable and proportionate steps to prevent a student from dispensing spectacles to a patient under the age of 16.

⁷ See GOC website: Stakeholder community contribute ideas at feedback event which can be found at: <http://www.optical.org/en/newsletter/stakeholder-update/srqs-help-goc.cfm> (Accessed 27/01/12)

legislative powers to enable it to establish a voluntary register of students if it (the HPC) considers it appropriate to do so. The GSCC has made its views clear and argues that the HPC should register student social workers. The GSCC has said that:

- *‘Social work students have access to vulnerable service users, in their own homes, often without direction supervision.*
- *Education providers may not be best placed to monitor students’ conduct on placements as systems to do so are not ‘universally effective and consistent’. Concerns expressed by employers and external examiners indicate that programmes are reluctant to exclude unsuitable candidates because of the financial penalties involved.*
- *Registration brings to students’ attention their responsibility for high standards, enhancing public protection.*
- *Registration means the code of practice is binding. The code is often used to initiate debates about ethical issues or used by education providers as the basis of a contract with a student. This is important for the professionalisation of social work.”*

(HPC, 2011b)

The remainder of this section examines this debate in more depth.

GSCC – suitability, fitness to practise and risk

The GSCC has not to date used the term ‘fitness to practise’. The social work profession tends to refer to the concept of suitability (see chapter 3) so it is not surprising that the GSCC has not published guidance on student fitness to practice. However it does refer to parallel concepts and processes within its accreditation criteria. The GSCC requires HEIs to: ‘develop effective procedures for ending a student’s involvement in the social work degree, where appropriate, to make sure that unsuitable people do not have the qualification to allow them into the profession’ and ‘make sure that all graduates are fit for social work practice’; and it says that procedures developed by HEIs ‘must give the student the right to challenge evidence against them and the right to be accompanied or represented at any hearing’ (GSCC, 2002a). This is reinforced to students in the GSCC’s student booklet, which states that: ‘it is the university’s responsibility to ensure that only people who are competent and suitable enter the profession’ (GSCC, 2008).

In 2007 the GSCC and the Joint University Council Social Work Education Committee (GSCC/JUCSWEC) produced guidance entitled *Suitability for social work: Ensuring the suitability of social work students to access and continue their training* (GSCC & JUCSWEC, 2007). Its purpose was to clarify the roles and responsibilities of HEIs and the GSCC in making decisions about the suitability of social work students to enter the social work profession. The guidance states that HEIs are responsible for determining suitability by: selecting students onto programmes, including requiring self-declaration forms for criminal convictions; ensuring that all students are subject to enhanced CRB checks; and having an agreed process to make decisions on a one-to-one basis where declaration and/or checks identify convictions or health issues that raise concerns about suitability. The GSCC assesses suitability to join the student register by confirming that individuals on social work degree courses are of good character, good conduct and are physically and mentally fit; and registers students with or without conditions and can refuse or withdraw registration when suitability is brought into question.

One way in which the GSCC establishes good character is by assessing any criminal offences declared at the application stage (GSCC & JUCSWEC, 2007). It uses three risk categories for offence type as follows:

High risk – offences that suggest the offender is likely to pose a risk to the safety and wellbeing of service users and social care (eg offences against children and abduction of a child, offences involving the abuse of trust; offences involving violence or cruelty).

Medium risk – offences that suggest the offender may pose a risk to the safety and well-being of service users, and may therefore be unsuitable to work in social care (eg drink driving, failure to provide a breath test, theft, possession of class A drugs, repeated low risk offences).

Low risk – offences that suggest the offender is unlikely to pose a risk to the safety and wellbeing of service users, and therefore is likely to be suitable to work in social care (eg shoplifting offences as a teenager, possession of cannabis, minor motoring offences).

Beyond criminal offences, consideration of unsuitable conduct can extend to behaviour in any sphere of a student's life – it is not confined to the programme of learning within the HEI or to practice placements, but could also concern behaviour during employment or in a student's private life. The guidance does not offer specific examples of behaviours considered suitable or unsuitable (except for plagiarism, where it is noted that in some circumstances this may call the student's suitability into question if it involves questions about the student's honesty and integrity) but it does indicate that the concept of reasonableness is to be applied in the assessment of any conduct which calls into question a student's suitability.

The Department of Health (2002) document on social work training requirements also uses the same broad concept with reference to applicants being '*suitable for admission to the General Social Care Council register of social workers*'. To help establish suitability, it requires HEIs to assess all shortlisted applicants through group or individual interviews involving employers and people who use services and their carers.

In contrast to the widespread use of the concept of fitness to practise among the health professions, in social work the concept of suitability is reinforced by reference to the notion of 'gatekeeping'. In a report on the quality assurance of education, the GSCC refers to it as follows:

'Higher education institutions see themselves as gatekeepers to the profession through their selection procedures and, once on the course, to end training if a student is found to be unsuitable. Twenty-five students had their training ended on the grounds of unsuitability during this reporting period. However, it is not clear how many students either withdrew voluntarily or were counselled out when suitability was questioned. These matters, and the need for clarity about the interface between the GSCC and universities in making decisions about suitability, have been considered by a joint working group of GSCC and JUC-SWEC representatives and guidance has been issued.' (GSCC, 2007)

It is clear that the notion of suitability is considered crucial in student selection and social work education and training, and that this is rooted in a concern to protect the public, not

least because social work clients are often extremely vulnerable. Yet it has proven difficult to find evidence about the risks posed by social work students or about the extent to which they pose a greater or more serious risk than students in other professions who are not registered. It has been suggested that a particular risk from social work students arises because they have direct and unsupervised contact with vulnerable service users (GSCC, 2011), but we have been unable to find evidence of this in GSCC publications or in the research literature.

Data submitted by the GSCC to the HPC shows that of 160 conduct hearings in 2010-2011, eight (5%) were students. These cases involved fraud, dishonesty, abuse or convictions for violent behaviour (HPC, 2011). The GSCC refused registration to nine social work students, and registered another seven with conditions, between 2005 and 2011⁸. Reporting on professional conduct between 2009-2010, the Care Council for Wales noted that out of 155 referrals to the Council, 20 were about students (but no information was provided about the nature of the issues concerned).

Since the majority of other regulators do not register students and place initial responsibility for checking criminal convictions and standards of student conduct with education providers, no comparisons can be made to help determine whether rates of student misconduct in social work are atypical or comparable to other professions. We understand that the majority of student cases heard by the GOC (which does register students) relate to criminal convictions (but we have no specific data on this).

In 2011 the GSCC published additional guidance on professional boundaries because 'of those social workers who have been taken through conduct proceedings, a considerable proportion of cases have arisen due to breaches of professional boundaries' (GSCC, 2011). The guidance takes a broad view of the concept of professional boundaries which it takes to include not only direct relationships between social worker and the service user, but also the standards of behaviour expected of social work professionals inside and outside work which could potentially damage the reputation of the profession. Some of the examples provided in the guidance relate to social work students, implying that the same standards of conduct apply through every stage of professional development. Indeed the GSCC reported that allegations of inappropriate relationships between social workers and people who use services have been a consistent theme in complaint referrals between 1 April 2003 and 31 March 2007. Analysis by the GSCC revealed that the most common areas of misconduct relate to breaching the trust and confidence of service users and the public in relation to section 2 of the Code (honesty, trust, reliability, adhering to policy and procedures and declarations of issues), and section 5 of the Code (abuse, exploitation, boundaries, and placing people who use services at risk) (GSCC, 2008).

GSCC – quality of practice placements

In reviewing publications from the GSCC and other organisations, we noted a recurring theme relating to concerns about the quality of practice placements; and in particular the extent to which they are capable of preparing or assessing social work students' suitability for practice. Despite using the student registration system to fund placements, the issue appears to have been a longstanding concern (at least since the GSCC came into being and

⁸ From GSCC website – latest news GSCC: Registration of social work students should continue in the future

probably before it was established). Indeed this is one of the reasons that the GSCC puts forward in its reasons for retaining student registration (HPC, 2011b).

The GSCC has noted pressures across the country to provide appropriate 'practice learning opportunities with appropriately skilled and qualified practice educators and assessors' (GSCC, 2007). The problem was further highlighted in a report of two student forum events in the north and south of England in which the GSCC engaged directly with students.⁹ The negative practice learning experiences reported by students included: inadequate preparation both of the student and/or the placement provider; inconsistent standards of practice teaching and assessment; discouraging work place cultures that were experienced as uninterested in the presence of a student or which used them as unpaid workers; and a lack of basic resources such as desks or telephone (GSCC, 2007). The GSCC reported that it was in the process of developing and piloting a set of criteria for practice placements as a response to the concerns.

Concern about the quality of practice placements was once again highlighted by the national Social Work Taskforce (established by the Secretaries of State for Health and for Children, Schools and Families in response to the challenges faced by the social work profession). Its report recommended that there should be: 'more transparent and effective regulation of social work education to give greater assurance of consistency and quality', and that 'new arrangements be put in place to provide sufficient high quality practice placements, which are properly supervised and assessed, for all social work students' (Social Work Task Force, 2009). The Government accepted all of the Task Force recommendations (DH & DCSF, 2009).

In responding to the Social Work Task Force Review, the GSCC welcomed its recommendations and started on a process of transforming its monitoring, inspection and approval regime as in the reporting period 2008 – 2009, 58% of programmes had had conditions set (61 courses across 24 HEIs), most often in relation to the areas of fitness to practise procedures and policies and a lack of quality assurance of practice placements. (GSCC, 2009).

To address the lack of quality assurance of practice placements and to help HEIs, the GSCC worked with Skills for Care and the Children's Workforce Development Confederation to produce a quality assurance of practice learning (QAPL) benchmark statement and associated evaluation tools. The benchmark statement identifies what needs to occur in the planning and provision of a high quality practice placement such as: systems for assuring the quality and suitability of placements; the allocation of students to placements; commencing the placement; support arrangements, accountability and role clarity; the learning and assessment programme; and evaluation and feedback (Skills for Care et al, 2010, 2nd edition).

In September 2009 the GSCC confirmed that from September 2010, HEIs would be formally required to report annually on how practice placements meet the QAPL benchmark statement (GSCC, 2009). This reporting requirement was followed up by the GSCC in its annual monitoring of practice placements in 2010, which revealed that 94% of HEIs always applied the auditing tool when quality assuring placements and that 57% of HEIs had rejected placements as unsuitable. 12 HEIs reported that they had had to use inappropriate

⁹ We have not found any similar reports of student engagement activities undertaken by other regulators (aside from the GMC).

placements because of shortages, although the absolute number of placements involved was small. A qualified and experienced social worker had assessed the final placement in 99% of cases. This was seen to be a significant improvement from previous years (GSCC, 2010c).

In 2011 the Social Work Reform Board (SWRB) looked again at social work education to assess the extent to which the recommendations of the Social Work Task Force had been implemented, including improving practice placements. As a consequence it further strengthened the requirements set out in the QAPL by adding aspects related to: partnerships between employers and universities; agreed thresholds for progression and the outcomes required at the end of each placement; a new practice educator framework from 2013-14 requiring practice educators to be qualified to a specific level; and a requirement that all programmes use a consistent model of practice learning (SWRB, 2011). The SWRB indicated that the College of Social Work would further develop and oversee the implementation of these arrangements (although it is not clear how this is to relate to the role of the HPC).

The proposal for a new practice educator framework is similar to the NMC's development of standards for mentors, practice teachers and teachers (NMC, 2008) and to the GMC's consultation (ongoing at the time of writing) on recognising and approving trainers (GMC, 2012). This area of regulation is beyond the scope of this research but is highlighted here as an area that might be of interest to the HPC in its wider deliberations on measures to promote student fitness to practise.

The SWRB also returned to the issue of student suitability and expressed its concern about 'inconsistency between programmes with some passing students who were either not competent and/or not suitable to become a registered social worker' (SWRB, 2011) noting that it was a challenging area:

'The SWTF called for greater consistency in the quality of social work qualifying education. Here, there is a clear gap in the literature in terms of what we know about the effectiveness of differing methods of assessing students and the operation of professional suitability procedures. We also know very little about the process of accrediting programmes beyond how many programmes are considered to be operating satisfactorily.' (SWRB, 2011).

The SWRB report also notes that the:

'HPC will require providers to have in place a process throughout the programme for dealing with concerns about students' profession-related conduct, SET 3.16. It is therefore proposed that programmes should retain their procedures for considering student's suitability to practise, and should have in place procedures to end a student's social work training if there are concerns. The existing GSCC requirements about suitability for practice have served the profession well, but will no longer apply.' (SWRB, 2011).

This review of how the GSCC has addressed issues related to student suitability shows that there are a number of longstanding issues in social work education, such as the quality of practice placements, which have become intertwined with the issue of student registration.

4.4 Other regulated professions in the UK

A web search revealed a dearth of information about student registration or student fitness to practise among other professions. Two examples illustrate approaches that have been adopted by other professions in the UK.

In England the General Teaching Council (GTC) keeps a register of those training to become teachers. These provisionally-registered trainee teachers are subject to the GTC's *Code of Conduct and Practice*, which sets out standards for the behaviour and competence of teachers generally (GTC, 2009). Any trainee can be referred to the GTC following a conduct matter that has led to their leaving a teacher training course. Rules referring to competence come into force only after 'qualified teacher status' (QTS) has been awarded and following full registration with the GTC. However these arrangements are soon to change following recent legislation abolishing the GTC and transferring some of its functions to a new Teaching Agency. The GTC will close on 31 March 2012¹⁰. Teachers must continue to register with the GTC until then but after that date it appears that the Teaching Agency will hold only a record of teachers who have been awarded QTS, and the trainee register will cease to exist.

The second example concerns the professional element of legal training to become a solicitor. Students are required to enrol with the Solicitors Regulation Authority (which regulates qualified solicitors) before they start a Legal Practice Course (LPC), the professional element of legal training. The enrolment includes written confirmation of completion of the academic stage of training (usually a law degree), and includes a 'suitability test', which has replaced previous character and 'suitability guidelines'.

We concluded that there was little to be learnt by further exploring these arrangements, not least because trainee teacher registration is soon to cease, and that there was little to be gained by continuing to search for evidence of student registration in other professions, many of which have no regulatory interest in the undergraduate education that precedes entry to professional training.

4.5 Non-UK health and social care professions regulators

As a supplement and comparator to the detailed analysis of UK health and social care professions regulators described above, we also reviewed a convenience sample of non-UK English speaking health and social care regulators. The review below provides no more than an indication of the extent to which regulators elsewhere intervene directly to assure student fitness to practise. It is by no means comprehensive, not least because there are:

'potentially thousands of Regulators and Professional Bodies who may be involved in the regulation of health care workers operating in over 190 countries, 30 dependant territories and 200 smaller regional administrative areas such as states and provinces.' (HPC, 2011)¹¹.

Furthermore, there is a lack of detailed policy information in published sources or on regulator websites about student fitness to practise and student registration, and there is a

¹⁰ GTC website section: The future of the GTC dated 01/12/11 (last accessed 23/01/12).

¹¹ HPC website 'Health Regulation Worldwide' accessed 14 December 2011 at: <http://www.hpc-uk.org/aboutregistration/regulators/worldwide/>

dearth of information about the extent to which regulators use other means to engage with students or to regulate their practise. The scope of the commissioned research did not extend to making a direct approach to other regulators – but rather to reviewing published and grey literature – so, for the purposes of this review, in some instances a regulator’s policy position about student conduct and fitness to practise has been inferred from material about related regulatory policies and functions, such as educational standards and education quality monitoring.

It is evident that the majority of regulators operate from the principle that student conduct is largely a matter for the institutions approved to provide education and training for first registration and entry to the profession. While regulators may set standards and provide advice about the conduct expected of students, managing student conduct and fitness to practise appears to be viewed by many as a devolved regulatory function best undertaken by education providers. Among the many jurisdictions in which health and social work professionals are statutorily regulated – and it is important to note here that although the registration of medical professionals is near universal, this is not the case for other health professions or for social work – it appears that only a small minority register students. The examples below illustrate some of the different approaches adopted.

Australia

Australia is one jurisdiction where student registration is being introduced for a number of health professions. Recent legislation (Health Practitioner Regulation National Law Act 2009) established the Australian Health Practitioner Regulation Agency (AHPRA), a statutory body responsible for implementing a national registration and accreditation scheme across Australia which, for the first time, brings the regulation of 10 health professions under nationally consistent legislation. A further four health professions are to join the national registration and accreditation scheme in July 2012.

The AHPRA supports the National Health Practitioner Boards established for each profession by managing the registration processes for practitioners and students, and by administering investigations into their professional conduct, performance or health. Nine of the ten National Health Practitioner Boards¹² that fall within the AHPRA’s remit started to introduce mandatory student registration during 2011. The purpose and scope of the scheme has been described as follows:

‘Ministers for Health have been guided by the principle of public safety and determined that the impact of registration on students should be as limited as is necessary to achieve this. They agreed the National Scheme would enable National Boards to act on student health impairment matters or when there is a criminal conviction of a serious nature that may adversely impact on public safety. However, the National Boards have no role to play in the academic progress or conduct of students.

¹² The nine Boards are: the Chiropractic Board of Australia, the Dental Board of Australia, the Medical Board of Australia, the Nursing and Midwifery Board of Australia, the Optometry Board of Australia, the Osteopathy Board of Australia, the Pharmacy Board of Australia, the Physiotherapy Board of Australia, and the Podiatry Board of Australia. The Psychology Board of Australia does not register students who must apply for provisional registration at the beginning of their 4+2 internship or their higher degree pathway.

The Student Register is confidential therefore the Australian Health Practitioner Regulation Agency cannot provide validation of student enrolment to health services that are not the designated education provider.

The National Law states that a National Board may request information from an educational body where the Board requires the information to exercise its functions under this Law. An educational body receiving such a request is expressly authorised to give the information to the National Board.’ (AHPRA, 2011).

A number of features of this development are noteworthy. There are no fees for student registration. The register is not in the public domain, nor is information on the register accessible to health service providers. Education providers are required under law to notify the AHPRA if they believe a student has an impairment that, in the course of the student undertaking clinical training as part of the programme of study, may place the public at substantial risk of harm; or if a student is found guilty of an offence punishable by 12 months imprisonment or more; or if a student has contravened an existing condition or undertaking (AHPRA, 2011). When a National Board suspends a student, imposes conditions on their registration, or accepts an undertaking from a student, it is required to give written notice to the education provider who must, as soon as practicable, give notice to any organisation with whom the student is undertaking clinical training (AHPRA, 2011). In the year 2010-2011, there were seven mandatory notifications received in relation to just under 100,000 students registered (AHPRA, 2011).

The AHPRA makes it clear that neither it nor the National Boards have any other role to play in the academic progress or conduct of students, and that it is education providers that remain responsible for managing the academic progress and disciplinary pathways for their students. So in this instance student registration appears to be a vehicle to enable the regulator to deal with a limited range of (more serious) student health and conduct issues without usurping the responsibilities of education providers to assure appropriate standards of student conduct and handle instances of (less serious) misconduct – a distribution of responsibilities which it might be argued implies the potential for duplication of effort and double jeopardy for students.

In contrast to medicine, nursing and other health professions, there are no legal registration requirements for social workers in Australia. Social work is not currently included in the national registration and accreditation scheme described above. Representatives of the profession have formally expressed their disappointment about this and indicated their intention to pursue registration in the future (AASW, 2009). Nevertheless, most employers require that social workers be members of the Australian Association of Social Workers (AASW). The AASW is a professional association which, among other things, accredits social work degrees, the successful completion of which confers eligibility for membership. Students enrolled on an AASW accredited degree, and those already eligible for AASW membership and undertaking full time Masters or Doctoral social work studies, are eligible for student membership.

The AASW operates in a quasi-regulatory role, not least, as Wilson (2005) observes, by setting education and accreditation standards (AASW, January 2010) and, for example, by establishing practice standards for social workers (AASW, 2008) and publishing a Code of Ethics. Significantly, the latter calls upon both practitioners and students ‘to account for their practice in the event of complaint or investigation regarding unethical conduct’ (AASW,

2010). However, while the AASW has a formal system for receiving and responding to complaints about the alleged unethical practice or behaviour of its members (including students), because it is not compulsory for Social Workers to be members, the AASW can only receive and deal with complaints about those who are.

New Zealand

In New Zealand the Health Practitioners Competence Assurance Act 2003 provides a framework to regulate health practitioners in order to protect the public where there is a risk of harm from professional practice. The Act – which came into force in 2004 and is administered by the Ministry of Health – repealed 11 occupational statutes governing 13 professions. Not all health professions are regulated under the Act – some because they have been judged to pose little risk of harm to the public, some because they work under the supervision of a regulated profession, and some because they are regulated in other ways, for example through their employers. Each of the regulated professions has a Council or Board which works to the common regulatory standards of the Act.¹³ In contrast to the Australian health professions legislation discussed above, there is no duty or power in the Act for Councils or Boards to register students; and we could find no evidence of (non-mandated) student registration among the regulated health professions in New Zealand.

The New Zealand Social Workers Registration Act 2003, which introduced registration on a voluntary basis, ‘arrived rapidly and without huge contest’ (Beddoe, 2007). It established the Social Workers Registration Board (SWRB), a Crown agency which seeks to protect the public by ensuring that social workers are competent to practise. The SWRB established a register, a Code of Conduct, and policies and procedures for complaints and discipline. In addition it ‘recognises’ social work qualifications awarded by 18 institutions – there is no indication that it inspects or monitors, perhaps reflecting Beddoe’s (2007) observation that social work education ‘has long been a site of struggle in New Zealand, with the nature of educational qualification being the focus of the registration debates’. Furthermore, while the Code of Conduct ‘covers the minimum professional standards of behaviour, integrity and conduct that apply to registered social workers’, it might be inferred that it also applies to students insofar as the standards ‘should apply generally in the social work profession’ (Social Workers Registration Board, 2008). However the SWRB’s complaints and disciplinary procedures apply to registered social workers only. In the context of voluntary registration, the absence of a Code of Conduct explicitly encompassing students, and given the apparently weaker form of education quality assurance implied by the notion of ‘recognition’, it is not surprising that we were unable to find any evidence of the registration of social work students in New Zealand.

South Africa

South Africa is one jurisdiction where student registration appears to be more commonplace, with nursing, social work and some – but not all – health professions students being required to register. However the purpose of registration and the extent to

¹³ The professions regulated under the Act are: chiropractic, dentistry, dental hygiene, clinical dental technology, dental technology and dental therapy, dietetics, medical laboratory science, anaesthetic technology, medical radiation technology, medicine, midwifery, nursing, occupational therapy, optometry and optical dispensing, osteopathy, pharmacy, physiotherapy, podiatry, psychology, psychotherapy.

which regulators intervene directly appears to vary between professions. For example the South African Nursing Council registers all nursing students as well as qualified nurses. Its statistical bulletin (South African Nursing Council, undated) indicates that it can and does take action against students accused of professional misconduct, reporting that between 2003 and 2008, 11 students were the subject of professional misconduct hearings concerning physical assault (1), medication related misconduct (9) and fraud/forgery (1).

The South African Council for Social Service Professions (SACSSP), which is the statutory body that regulates social workers, also registers students; but whereas its nursing counterpart publishes statistics reporting disciplinary action against students, we have found no such publications or any other confirmatory evidence of regulatory body intervention in respect of social work students. However Sewpaul and Lombard (2004) assert that 'social workers and social work students are required to abide by the SACSSP's code of conduct and failure to do so may result in disciplinary proceedings'.

The Health Professions Council of South Africa, which was established to protect the public and which provides guidance to registered healthcare practitioners covered by 12 Boards¹⁴, also registers students in some – but not all – of the professions that fall within its regulatory ambit. It publishes statistics about the numbers of students registered but it is not clear whether it intervenes in respect of student misconduct (although the Act establishing the Council gives it powers to do so). Its misconduct statistics distinguish professions but do not differentiate practitioners from students (if indeed the latter are subject to proceedings), so here too it has not been possible to determine whether student registration serves anything more than administrative purposes.

Canada

In the Canadian federal system the regulation of the health professions is a matter for each Province. A number have umbrella legislation. For example in Ontario there are 23 regulated health professions, each with a governing body (a college) which sets standards for the profession but which must work to a common regulatory framework. Similar legislation exists in, for example, Ontario, British Columbia and Alberta. As in other jurisdictions the position varies from profession to profession in the same province. For example in Alberta, while medical students are required to register and are subject to conduct and fitness to practise requirements similar to those which apply to fully qualified medical registrants, as elsewhere in Canada student registration does not apply to other health professions.

Guidance to employers in Alberta encapsulates an apparently common understanding and policy position that seems to hold true for a number of provinces and for a number of health professions. The guidance states that:

'While students may practice in a regulated health profession and perform restricted activities, they are generally not restricted as regulated members. They are considered to be under the control of their educational institution.'

¹⁴ The professional Boards cover dental therapy & oral hygiene, dietetics, emergency care, environmental health, medical & dental (and medical science), medical technology, occupational therapy, medical orthotics / prosthetics & arts therapy, optometry & dispensing opticians, physiotherapy, podiatry & biokinetics, psychology, radiography & clinical technology, speech, language & hearing professions.

When students, like other unregulated practitioners, perform restricted activities, they do so under the supervision of regulated members and are authorized by the supervisor's regulation. College Regulations specify how members of the college are to supervise students (and unregulated workers) in the performance of restricted activities. These regulations must identify who can provide restricted activities under supervision, and the nature of that supervision. While students are not normally regulated, they can use the name of the profession in combination with the title "student" while undertaking activities within the program.'

(Alberta Health and Wellness, 2004, p28)

In Canada the regulation of social workers is also a provincial matter. Some provinces have protected title and require registration; some have a qualifying examination provided and managed by the Association of Social Work Boards (a not-for-profit association of social work licensing boards in Canada and the United States). The Association of Social Work Boards does not create or enforce licensing or registration requirements for individual jurisdictions; rather, it maintains the licensing examinations used by its members in respect of 600 social work degrees accredited by the Canadian Association of Social Work Education and in the United States by the Council on Social Work Education. The Association of Social Work Boards maintains a database which records and compares the Laws and Regulations concerning the social work profession in each of the 62 States, Provinces and Territories it covers.¹⁵ The database comprises information about Board structure and statutory provisions; levels of practice regulated; experience and supervision requirements; miscellaneous features of laws and regulations; administrative and licensure fees; continuing education requirements; and social work practice and related definitions. A search of the database of levels of practice regulated by the 62 licensing (registration) jurisdictions across Canada and the United States failed to reveal any that have a student category.

United States of America

The regulation of health professionals in the United States is also largely a matter for each State or territory but regulation is distributed across a number of bodies, with education provision, education accreditation, examination, and licensure undertaken by different organisations. For many professions States co-operate and work to common standards. For example, each State or territory is responsible for licensing nurses and protecting the public in its territory, and each has a Nurse Practice Act enforced by a State Nursing Board, but operations are harmonised through the National Council of State Boards of Nursing (the Federation of State Medical Boards serves the same functions for medical doctors, who must be licensed by a State Medical Board). A qualifying licensure examination (NCLEX) is a national requirement for licensure as a nurse (the United States Medical Licensing Exam is the equivalent requirement for medical doctors). Accreditation of nursing education programmes is undertaken by several autonomous agencies (which have to be recognised by the US Secretary of Education). They provide confirmation – not least for State Boards of Nursing – that education is of a satisfactory standard and is an appropriate preparation for students wishing to enter the NCLEX. Thus, a student nurse will undertake undergraduate

¹⁵ The database can be accessed by following the links to Social Work Laws and Regulations Comparison Guide at <http://www.aswb.org/SWL/licensingbasics.asp>.

education in a university with a course accredited by an independent agency, sit a national examination provided by another body, and apply for licensure to a State Nursing Board. Similar State licensure arrangements apply to other health professions.

As a consequence of these distributed responsibilities, the prime responsibility for undergraduate health professional conduct and fitness to practise rests with education providers. Licensing authorities are concerned with regulation from the point at which a student seeks a license to practice (or as the prelude to that, when applying to take the national examination). Regulator involvement in student conduct is therefore minimal and student registration with, for example, a State Board does not occur until the student is approaching the end of their education and begins the process of seeking licensure, when they register to take a national qualifying examination.

Republic of Ireland

As in the UK there are several health and social care professions regulatory bodies in the Republic of Ireland. Under the Health and Social Care Professionals Act 2005, a new body CORU (from an Irish word, 'cóir' meaning fair, just and proper) has been established as an umbrella organisation responsible for protecting the public by regulating both health and social care professionals. This is the first time in Ireland that a single statutory body has been given responsibility for the regulation of multiple professions. Nurses and doctors continue to have their own regulatory bodies. Operating under the aegis of the Department of Health, CORU is in the process of establishing criteria for the registration of members of the designated professions, codes of professional conduct and ethics, and standards of professional performance as a basis for determining fitness to practise. There is no evidence that it currently has any interest in registering students.

In contrast, An Bord Altranais, which regulates the nursing profession in Ireland, does have a register of "candidates admitted to nurse training programmes" (An Bord Altranais, 2008). Once on the register students receive a Candidate Registration Card, identifying the holder as "a candidate member of a professional body which advocates high standards" (An Bord Altranais, 2008). The only purpose cited is that the card may be requested for identification on clinical practice placements – although by way of a reminder as to expectations regarding standards of conduct, students are referred to the provisions of Section 28 (5) of the Nurses Act, 1985 which states that: 'nothing ...shall operate to prevent the Board from refusing to register the name of any person, who is otherwise entitled to be registered, on the grounds of the unfitness of that person to engage in the practice of nursing' (An Bord Altranais, 2008). However questions about a student's fitness to practise can be addressed only at the point of application for registration. Decisions cannot be made at the point of entry to a nursing education programme or at any time during a nursing education programme (An Bord Altranais, 2008).

International perspectives - conclusion

A number of general points emerge from this limited review of student fitness to practise arrangements, including student registration, in countries other of the UK:

- student registration – as a vehicle to enable regulators to intervene directly in respect of fitness to practise – is by no means commonplace among health and social

care professions regulators; the majority of regulators devolve responsibility for assuring student fitness to practise and managing misconduct to education providers

- in the jurisdictions and professions where student registration has been adopted, it serves different purposes in different cases, including a largely administrative function (for example to collect accurate workforce data about enrolments and completions), as a means of encouraging appropriate standards of conduct (for example by promoting ethical behaviour by binding students to a Code of Conduct to encourage a developing sense of professionalism), and as a vehicle to impose the same or similar expectations and sanctions in respect of conduct and fitness to practise as apply to qualified registrants (enabling the regulator to intervene to investigate misconduct, to take disciplinary action, and to impose sanctions)
- in respect of managing misconduct, some constructions of student registration appear to yield limited benefit (as in Ireland where nursing student misconduct cannot be considered by the regulator until the point of registration), and in others there appears to be a risk of duplication (as in Australia where both the regulator and education provider run parallel disciplinary machinery applied differentially according to the nature of the misconduct)
- transparency about whether, and if so why, student registration has been adopted (or rejected) is lacking, with very limited information available from regulators about the policy rationale, and none about costs and benefits (obtaining this – if it exists – would require a direct approach to individual regulators)
- there is very little information about students generally on regulator websites, conveying the strong impression that for many, regulatory responsibilities and interventions start at the point of first registration and entry to the profession (although of course many regulate students indirectly by setting standards for education and operating systems to accredit, approve or recognise education programmes leading to registration or licensure).

4.6 Summary and conclusions

This chapter has reviewed the position of UK health and social care regulators in respect of student fitness to practise. It has also examined the position in some other countries by way of comparison.

The GOC and the GSCC (together with the other social care regulators) are the only UK health and social care professions regulators that currently register students. The NMC is planning to introduce a quasi-registration in the form of student indexing. It is notable that the GMC has considered and rejected the case for student registration and is currently pursuing a strategy to better engage with medical students to promote professionalism.

A number of regulators provide guidance about student fitness to practise and associated procedures, and / or a code of ethics that applies to students. There is evidence of a good deal of commonality in the content of these policies and guidance documents, particularly in terms of the specification of standards of professional behaviour expected of students, and the behaviours that give cause for concern. Much of the guidance is consistent with principles established in 2001 for the GMC by the law firm Eversheds.

A considerable level of responsibility for the management of fitness for practise procedures rests with education providers, operating in accordance with guidance about standards and requirements from the regulator.

The GSCC student register is closely linked to its role in administering payments for clinical placements, yet there is evidence that the availability and quality of placements is a matter of longstanding and continuing concern in the social work profession. In social work the issues of suitability (rather than fitness for practise) and gate-keeping (entry to the profession) are considered important priorities.

In general, the guidance provided by most regulators is consistent with the advice from the CHRE. It concluded that:

- *‘Professionalism and regulation should run as a developing strand of the curriculum throughout the course of study. Measures should be put in place between the Regulatory Body and Higher Education Institution for the student to develop a thorough understanding of professionalism and the purpose of regulation ... so that students enter programmes with the full knowledge of what will be expected of them beyond the straightforward academic achievement.*
- *Students should be made aware of the inherent risks in any learning situation and understand their responsibility in relation to the safety of the patient. The risk to patients from student practice varies from profession to profession and with the circumstances and style of their training. A single approach is therefore not desirable. The different professions expose students to patients to different extents and using different levels of supervision. There is strong support from regulators for professional behaviour being expected of students throughout their course whether working directly with patients or not.*
- *Higher Education Institutions should have formally agreed mechanisms for removing students from contact with patients if their fitness to practise is impaired. One approach would be for Higher Education Institutions to have Fitness to Practise committees that function in accordance with guidance from the relevant regulatory body and with the ability to remove a student from a course on the basis of a finding.*
- *Regulatory Bodies and Higher Education Institutions should agree to a Code of Conduct for students. The common values agreed by the Regulatory Bodies should be used as the core principles for the document.’ (CHRE, 2007)*

An examination of selected regulators in other countries indicates that student registration is by no means commonplace. It appears that the majority of regulators devolve responsibility for assuring student fitness to practise and managing misconduct to education providers (although in some cases they influence this through education standard setting and mechanisms to assure the quality of education and training). In jurisdictions and professions where student registration has been adopted it serves different purposes in different cases, and in some instances appears to yield limited benefits in terms of managing fitness to practise, instead fulfilling largely administrative purposes.

Where student registration has been adopted there is a dearth of information about why it has been judged necessary or how effective it is. No information has been uncovered about costs and benefits. This reflects CHRE’s conclusion that ‘there is insufficient evidence to

suggest that registration of students is necessary to protect patients and the public' (CHRE, 2007).

There is very little information about students generally on the regulator websites in the other countries reviewed, conveying and confirming the strong impression that for many, regulatory responsibilities and interventions start at the point of entry to the profession and first registration or licensure.

Chapter 5: Conclusions and recommendations

5.1 Conclusions

The policy objectives that the HPC has set for developing student fitness to practise regulatory processes, and the effects they are intended to achieve, have formed the focus of this literature review ie

- *'To ensure that the public are adequately protected from the potential risk of harm posed by students.*
- *To ensure that concerns about students are adequately dealt with so that only someone who is fit to practise completes a programme with an award that leads to eligibility for registration.*
- *To ensure that students are aware of the duties, responsibilities and standards expected of them as future registrants.*
- *To ensure consistency and equity of regulatory approach across the HPC register, wherever possible and appropriate.*
- *To ensure that any voluntary register of students is feasible on a self-financing basis, avoiding cross-subsidisation from the HPC's statutory functions.'*

(HPC, 2011b)

Our conclusions are set out below against each of these policy objectives. The literature reviewed has primarily been from the professions of medicine, nursing and social work, as there is a paucity of literature related to the professions that the HPC currently regulates.

The potential risk of harm posed by students

There is little in the literature on the risk of harm posed by students, although there is considerable literature about how students acquire the knowledge, skills and attitudes that enable them to practise the profession at a suitable level. A key component of fitness to practise is variously described as professionalism, suitability or good character. There is general agreement on the benefits of defining this component of fitness to practise, and there is also agreement on the value of specifying examples of behaviour that are unprofessional, or indicate unsuitability. Where risks of harm posed by students are referred to in the literature, they tend to be descriptions of poor practices by students that result in harm to users of services, or the potential for harm to the public after registration. Studies also stress the need for integrity and honesty in academic matters as a key indicator of behaving ethically in professional matters.

The literature indicates that it is often difficult to judge the degree to which a behaviour indicates lack of fitness to practise and that a behaviour needs to be considered in context. There is also a need to take into account the stage of the programme at which the behaviour occurred, although some behaviours may be considered unacceptable from the start.

A review of the practices of the other regulators shows that the four regulators that have developed stand-alone student fitness to practise guidelines (ie the GMC, GDC, GOSc and the GPhC) have all included descriptions of professional and unprofessional behaviours and also in various ways put this in the context of the student's stage of development.

1. The literature indicates that it would be good practice to:
 - a. describe behaviours that indicate fitness to practise in students and those that do not, including in those descriptions examples of academic behaviours which relate to ethical professional practice
 - b. recognise in any guidance produced the complexity of making judgments about behaviour and that such judgments should take into account the context in which they were set and also the stage of the student's development.

Concerns about students are adequately dealt with

This policy objective focuses on managing the instances of individuals' behaviour that raise concerns about fitness to practise. The literature is equally strong on looking at proactive measures to pre-empt such instances arising, an important preventative aspect of regulation, and this is discussed further below.

The literature reveals that it is difficult to determine the incidence of student fitness to practise issues across the health and social care professions in the UK, as the extent to which this is reported and / or dealt with by a centralised body, such as a regulator, is dependent on the systems and practices in that profession.

There are strong arguments for professional fitness to practise policies and procedures being required in addition to an HEI's general academic misconduct policies in order to ensure that fitness to practise is dealt with appropriately, and also to send out clear messages to students that where problems exist they will be dealt with fairly but seriously.

There is general agreement that policies and procedures should be timely, robust, fair and clearly documented, that they should be followed, and that there should be reliable systems for documenting concerns and identifying and managing students whose behaviour is problematic. There is also general agreement that there should be a series of graduated interventions, starting with informal conversations to more formal meetings when there is serious misconduct or patterns of behaviour up to and including formal disciplinary processes with appropriate sanctions. Studies reveal differences in procedures in different HEIs and concerns about consistency. Whilst the number of studies in this area is relatively small, the interventions of regulators are sought to improve consistency and assure public protection. It is also suggested that there should be public involvement at the disciplinary stage.

The four UK health regulators that have developed stand-alone student fitness to practise guidelines have all included thresholds for student fitness to practise cases and set out the specific ways in which they expect concerns about students to be addressed, focusing on the different aspects of student fitness to practise panels.

2. The literature indicates that it would be good practice for regulators to:

- a. require educational institutions to have specific and separate professional student fitness to practise policies and procedures, which have the capacity to remove students from courses if required
- b. require educational institutions to make their student fitness to practise policies and procedures timely, robust, fair, clearly documented, contain reliable systems for documenting concerns and identifying and managing students whose behaviour is problematic, using a system of graduated interventions and to implement the policies and procedures consistently
- c. evaluate the consistency with which student fitness to practise policies and procedures are applied and improve their regulatory approaches as a result.

Student awareness of duties, responsibilities and standards

There is considerable literature on the proactive steps that can be taken to enable students to develop the knowledge, skills and attitudes they need to be fit to practise. The approaches proposed in the literature are much stronger than awareness and include:

- describing both what is meant by fitness to practise as well as the behaviours that would cause concern about an individual's fitness to practise (as described above)
- embedding the development of professionalism across the curriculum
- clarifying to students the standards to be met
- role modelling and mentoring
- high quality practice placements
- assessing student fitness to practise both formatively and summatively
- clear policies and practices related to student fitness to practise that are consistently applied by all staff, including those in placements (implying high quality staff development and appraisal systems)
- consistent messages in every aspect of the student experience not only by the educational institution but also by the health and social care environments in which they have practice placements and by the regulator (such as in relation to dealing with fitness to practise cases).

There is a similar emphasis in the guidance on student fitness to practise from the four UK healthcare profession regulators. These variously have a focus on admissions, communication and awareness, education, and pastoral care and student support. Specific consideration should also be given to the needs of students with disabilities and health conditions to ensure that they get the support they need and are not unfairly discriminated against in the approaches used.

3. The literature indicates that it would be good practice for the regulator to:
 - a. ensure that its approved educational programmes contain a range of proactive measures for developing and assessing student fitness to practise, including the assurance of high quality practice placements

- b. seek evidence from approved educational programmes as to how they ensure consistent application of student fitness to practise policies and procedures
- c. evaluate all of its own approaches, practices and performance over time for the messages that these send to the public, educators and students.

Consistency and equity of regulatory approach across the HPC register

The literature on the procedures within HEIs to assess student fitness to practise has a concern with consistency, to ensure fairness to individual students, as well as clear standards to assure protection of the public. Published studies have generally focused on procedures relating to one profession; however, if the outcomes of these studies are combined with the evidence of risks of harm from students, a different picture might emerge - ie if one group of students is found to pose greater risks to the public than others, it could be argued that differential processes should apply.

The literature in this area indicates that there is remarkable consistency across the professions about behaviours that are seen to be acceptable and unacceptable as indicators of fitness to practise. The proactive approaches for developing student fitness to practise, and addressing poor practice, are also remarkably similar across professions. This finding from the literature is also supported by the approaches generally promulgated by the other profession regulators.

- 4. The literature indicates that it is both appropriate and possible for the HPC to develop consistent and equitable regulatory approaches for all of the professions in its remit.

Any voluntary register of students is feasible on a self-financing basis

The review of the literature, both published and grey, shows that student registration is the exception rather than the norm. The majority of regulators devolve responsibility for assuring student fitness to practise and managing misconduct to education providers (although in some cases they influence this through education standard setting and mechanisms to assure the quality of education and training).

Where student registration has been adopted there is a dearth of information about why it was judged necessary to introduce it, such as increased risks of harm to the public by the students concerned, or its effectiveness in meeting its desired aims. Often the aims appear to be administrative rather than related to public protection. No information has been found on costs and benefits. These findings concur with those of the CHRE, which found 'there is insufficient evidence to suggest that registration of students is necessary to protect patients and the public' (CHRE, 2007).

In the context of 'right touch' regulation (CHRE, 2010) and the evidence found in this literature review as a whole, it is difficult to see the value that student registration in any form would add to the mechanisms described above. In short it might be perceived as a regulatory burden not a necessary regulatory layer.

5. There is insufficient literature to comment on the costs and benefits of voluntary registration, but any decisions on the use of registration for students need to take into account the value that such a system would add to other regulatory mechanisms.

5.2 Recommendations

The conclusions set out above should be reviewed in the context of the larger programme of work that the HPC is undertaking in relation to student fitness to practise. From the evidence found in this review, it appears appropriate that the HPC further consider:

1. the ways in which it can improve its standards for, and guidance to, educational providers in relation to developing and managing student fitness to practise
2. how it can best enhance students' understanding of fitness to practise, and the relationship of fitness to practise to public protection.

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