



Accountability &
Professionalism

in Nursing
& Healthcare



Marc
Cornock

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BEING A PROFESSIONAL

What it means to be a professional healthcare practitioner is the focus of Chapter 3, those aspects of practice and accountability that relate to becoming a professional and maintaining professional status. Initially, the chapter considers how someone can attain professional status in healthcare, including registration requirements. It then examines the concept of competence and how this is maintained, and how a healthcare practitioner can update their knowledge and skills, before looking at the ways in which a healthcare practitioner's competence can be assessed and how a healthcare practitioner can prove that they are fit to practise. The chapter then moves to look at the professional standard that all healthcare practitioners must achieve, and how codes of conduct are related to this. The chapter closes by discussing the role of professional organisations.

Although the main focus is from the point of registration, student issues such as academic integrity and whether there should be a transition period between being a student and a registered practitioner are addressed.

QUESTIONS COVERED IN CHAPTER 3

- How does registration relate to being a professional?
- Why do I pay a registration fee?
- Is there a transition period from being a student healthcare practitioner to becoming a registrant?
- How is an indemnity arrangement related to registration?
- What is clinical competence?
- What is the relationship between professional accountability and competence?
- Are standards of proficiency different to competence?
- Once I am registered do I need to maintain my competence?
- How up to date do I need to be?
- What is continuing professional development?

(Continued)

- Does reflective practice maintain and develop competence?
- Is clinical supervision related to competence?
- What is appraisal?
- How is revalidation different to appraisal?
- Why is the professional standard important to a healthcare practitioner?
- What is a code of conduct?
- Do codes of conduct have legal status?
- What constitutes professional conduct?
- Why is academic integrity important to professional accountability?
- What is the association between professional support organisations, accountability and being a professional?

Q A

How does registration relate to being a professional?

In the context of professions, registration has been discussed at several points in this book, notably in **What is a profession?**, **What is being regulated?** and **How does regulation affect the healthcare practitioner?** Registration is one of the key features in an occupation achieving recognition as a profession.

Registration for healthcare practitioners means to be on the list of those practitioners who are entitled to use a registered title that is under the protection of one of the statutory healthcare regulatory bodies (see **Who regulates healthcare practitioners?**, **How does regulation affect the healthcare practitioner?** and **Is it important to restrict the use of titles?** for discussion on the nature of registration and its purpose).

Healthcare practitioners can apply for and attain registration with the relevant statutory healthcare regulatory body after they have completed an approved programme of pre-registration education and training, as discussed in **Why is pre-registration education a professional issue?** and **How does regulation affect the healthcare practitioner?** The completion of a pre-registration programme will not in itself allow the healthcare practitioner to achieve registration. There are also requirements regarding being in good health and having a good character. These are usually achieved through self-declaration and through a reference/statement supplied by the institution proving the pre-registration programme of study.

It is also possible to achieve registration with a statutory healthcare regulatory body if an individual meets the good character and good health requirements, along with successful completion of a programme of study from an overseas institution which is deemed to be equivalent to the education requirements of the relevant United Kingdom statutory healthcare regulatory body.

The various statutory healthcare regulatory bodies maintain their registers in different ways, albeit with the same purpose of having a register of those who are entitled to practise in the area of healthcare that they regulate. For instance, the

General Medical Council maintains a register of those healthcare practitioners who currently hold a license to practise, that is, who are registered medical practitioners (this being the legal title for those entitled to practise as a medical doctor as explained in **Is it important to restrict the use of titles?**). However, it also has further parts to its register, one for those who meet the requirements for specialist registration, and another for those who are able to work as a general practitioner.

Further examples showing the difference in approach between the various statutory healthcare regulatory bodies include the Health and Care Professions Council which maintains a single register of all its registrants regardless of their specific professional grouping, while the Nursing and Midwifery Council until 1 August 2005 had fifteen parts which differentiated whether a registrant was a level one or level two registrant (that is registered or enrolled) and their area of speciality, for instance, a children's nurse or an adult nurse. Currently, the Nursing and Midwifery Council has four parts to its register for nurses, midwives and specialist community public health nurses and, since 12 July 2018, a part for nursing associates.

For healthcare practitioners, registration is the main way in which their practice is regulated. If a healthcare practitioner is not on the register maintained by the relevant statutory healthcare regulatory body, they are not able to practise in that area of speciality at the professional level, that is, where the title is protected. It does not prevent the individual from working at the non-professional level because no register is kept at this level, but it does mean that an individual could not work, for example, as a paramedic or a registered nurse.

As such, registration with a statutory healthcare regulatory body is an indication that the individual has achieved professional status and is working to the requirements of their professional occupation group.

Q A

Why do I pay a registration fee?

In short, a registration fee is the annual fee payable by a healthcare practitioner to be able to practise in their chosen area of practice. If a healthcare practitioner does not pay their registration fee, they would lose their registration and at the same time lose their licence to practise their occupation at the professional level.

The healthcare practitioner would still be able to practise in the healthcare arena just not at the professional level, and they would also lose their right to use any protected title (as seen in **How does registration relate to being a professional?**).

Some see the registration fee as a form of occupational tax. However, this is not a useful analogy as the registration fee does not go to the government but instead goes directly to the relevant statutory healthcare regulatory body and is used by them. It may be more accurately stated that the registration fee is the payment a healthcare practitioner pays to be recognised as a professional in their chosen healthcare speciality and for the privilege of using a protected title.

The fees are necessary because, as seen in **Who regulates healthcare practitioners?**, the statutory healthcare regulatory bodies do not receive state funding, except in exceptional circumstances. Therefore, they need to raise money for their operational costs to achieve their purpose of promoting and protecting patient safety

as determined in **What is being regulated?** Registration fees are the mechanism by which the statutory healthcare regulatory bodies raise the money they require.

AS AN ASIDE: ANNUAL REPORTS OF THE STATUTORY HEALTHCARE REGULATORY BODIES

If you are interested in seeing how the various statutory healthcare regulatory bodies use the money they raise through registration fees, you can read their annual reports which detail their accounts.

These can be quite interesting reads as they provide detail of the money raised and how it is spent, but also provide detail of challenges they have faced and how they operate, as well as information on their registrants and their plans for the future. For instance, the latest Health and Care Professions Council annual report notes that they were 286,914 registrants on 31 March 2021 with prosthetists and orthotists being the smallest occupational group of the 15 groups regulated with only 1,113 registrants and occupational therapists being the largest occupational group with 41,231 registrants (Health and Care Professions Council, 2021 at page 9).

Total income for the Health and Care Professions Council in 2021 was £27,162,000 (Health and Care Professions Council, 2021 at page 26) raised from 286,914 registrants.

There is a vast difference in the fees that the various statutory healthcare regulatory bodies charge their registrants. Some of the statutory healthcare regulatory bodies charge an annual fee, while others may charge for a two-year period.

The current highest annual charge (for the period covering 2022) is made by the General Chiropractic Council which charges £800 per year. The lowest is charged by the Health and Care Professions Council at £98.12 per year but paid for two years at a time.

There may also be fees charged for initial registration and for issuing certificates of registration or for other administrative purposes such as being restored to the register after a period of not being on the register. These fees also vary between the statutory healthcare regulatory bodies.

Q

Is there a transition period from being a student healthcare practitioner to becoming a registrant?

A

As can be expected, there are different approaches to how the statutory healthcare regulatory bodies approach the transition from being a student healthcare practitioner to becoming a registrant with them.

Three main approaches can be identified. Some of the statutory healthcare regulatory bodies make no distinction between their registrants, and on registering with them, the student healthcare practitioner becomes a full registrant. Others do not

have any formal conditions but provide guidance and recommendations for a transition period once the student healthcare practitioner has achieved registration with them. Others have a period of conditional registration.

Two examples will illustrate these latter two approaches to the transition from student to registrant.

The Nursing and Midwifery Council does not have a formal transition period for its new registrants. All registrants are full registrants at the point of registration. However, the Nursing and Midwifery Council does recommend a preceptorship period for new registrants.

The Nursing and Midwifery Council has stated *‘that the experience a newly registered nurse, midwife or nursing associate has in the period directly after initial registration is significantly important and can positively influence their journey to becoming a confident professional. . .the preceptorship period provides the basis for the beginning of a lifelong journey of reflection, and the ability to self-identify continuing professional development needs, as the nurse, midwife and nursing associate embarks on their career and prepares for revalidation’* (Nursing and Midwifery Council, 2020 at page 5).

Preceptorship is not obligatory and is not offered by the Nursing and Midwifery Council itself. Rather, it is a period of time when the new registrant receives additional support through a structured programme provided by their first employer. This programme may include working with an experienced nurse (preceptor) who can help them transition to the demands of their new role, protected time for the new registrant to meet with their preceptor to discuss progress and achievement of objectives, meetings between groups of new registrants, formal teaching or developmental sessions.

For the Nursing and Midwifery Council, *‘the objectives of preceptorship are to welcome and integrate the newly registered nurse, midwife and nursing associate into the team and place of work, help them grow in confidence, and begin their lifelong journey as an accountable, independent, knowledgeable and skilled practitioner’* (Nursing and Midwifery Council, 2020 at page 3).

The General Medical Council provides students who become new registrants with provisional registration. Provisional registration means that the medical practitioner is registered with the General Medical Council and so subject to all the regulation that every registrant would be subject to; however, because they do not have full registration, they cannot take any role that a full registrant could. In effect, it means that they can take a job that acts as a bridge between being a student to being a full registered medical practitioner who can take any job anywhere. The roles and jobs available to those with provisional registration are ones that provide support and guidance and have been approved as providing the necessary training to allow medical practitioners to gain the skills and competencies they need for their future careers.

At the successful end of the period of provisional registration, the medical practitioner is issued with a ‘certificate of experience’ that allows them to apply for full registration with the General Medical Council.

The General Medical Council limits the period of time that a medical practitioner can be provisionally registered, the norm maximum is three years and 30 days, although this can be extended in certain circumstances (General Medical Council, 2022).

While it has been seen that the Nursing and Midwifery Council uses preceptorship and the General Medical Council conditional registration, as an example, the General Optical Council has no transition between student and fully registered professionals.

Q A

How is an indemnity arrangement related to registration?

Indemnity is defined as ‘*security or protection against contingent hurt, damage or loss*’ by the *Shorter Oxford English Dictionary* (Stevenson, 2007). While an ‘*indemnity arrangement is one that will indemnify the person who holds it from expenses incurred or suffering a loss*’ (Cornock, 2020 at page 6). In the healthcare context, an indemnity arrangement can be likened to having insurance cover in case of an incident during a healthcare practitioner’s professional practice.

If an incident were to occur, the indemnity arrangement pays for any legal costs the healthcare practitioner were to incur in defending themselves against a claim, as well as any compensation awarded to the person bringing the claim against the healthcare practitioner.

An indemnity arrangement is an aspect of professional accountability as it is a way of demonstrating that if something were to go wrong within a healthcare practitioner’s practice, they have ensured that their patient will receive the appropriate compensation.

As to why indemnity arrangements are linked to registration, this is because it is a legal requirement that healthcare practitioners have an indemnity arrangement in place in order to register and maintain their registration with a statutory healthcare regulatory body. It is a legal requirement because the laws which govern statutory healthcare regulatory bodies and their functions specifically mention the need for an indemnity arrangement.

For example, article 12A(1) of The Nursing and Midwifery Order 2001 states ‘*Each practising registrant must have in force in relation to that registrant an indemnity arrangement which provides appropriate cover for practising as such*’. While article 12A(93) defines ‘*appropriate cover*’ as ‘*cover against liabilities that may be incurred in practising as such which is appropriate, having regard to the nature and extent of the risks of practising as such*’. The other statutory healthcare regulatory bodies have similar wording in their legislative provisions. Failure to have or to maintain an indemnity arrangement can result in the registrant being removed from the professional register (The Nursing and Midwifery Order 2001 article 12(A) (8a)) or may be treated as misconduct and referred to a fitness to practise committee (article 12(A) (8b)).

Indemnity arrangements have not always been required, and it was only relatively recently that it was made a part of the registration requirements. The Health and Care Professions Council made it compulsory in April 2014; the General Medical

Council followed in August 2015, with the Nursing and Midwifery Council making it a compulsory requirement for registration in April 2016.

If a healthcare practitioner works solely for the National Health Service, their indemnity arrangement will be provided by their employer. This is through NHS Resolution, formerly the NHS Litigation Authority, which manages a number of indemnity schemes for NHS employees for which the employer pays a fee.

The cover provided through NHS Resolution is a basic indemnity arrangement which satisfies the requirements for registration of the statutory healthcare regulatory bodies. It provides cover for claims of clinical negligence (see **What is clinical negligence?**) made against healthcare practitioners.

Those healthcare practitioners who work outside of the NHS may have their indemnity arrangement provided by their employer, or they may be required to have their own arrangement in place. Those healthcare practitioners who are self-employed will need to make provision for their own indemnity arrangement.

There are various organisations that provide indemnity arrangements, such as professional organisations, trade unions and specific organisations that exist for this purpose. The indemnity arrangements they provide vary, and some provide assistance to the healthcare practitioner beyond the basic arrangement offered for NHS employees. This additional cover may include assistance for disputes with employers, such as grievances the employee may bring against their employer or complaints made against the employee, and even cover for fitness to practise investigations and hearings undertaken by the statutory healthcare regulatory bodies. This additional cover is also available from these organisations to NHS employees for the appropriate fee.

Most healthcare practitioners do not need to take out their own or additional indemnity cover for their NHS work to satisfy the statutory healthcare regulatory bodies registration requirements, unless they have additional work or duties outside of their NHS employment. Because the NHS indemnity arrangement will only provide cover for their NHS work. It is generally only the self-employed and those working outside the NHS who need their own indemnity arrangement in place.

The various statutory healthcare regulatory bodies provide information on indemnity arrangements, and these can be obtained from their respective websites (see Table 3.1 Statutory regulatory body websites).

Q
A

What is clinical competence?

The issue in determining what clinical competence means is that it is very often left undefined and there seems to be an assumption that everyone knows that it means without the need to define or explain it.

For instance, several of the codes of conduct of the statutory regulatory bodies (see **What is a code of conduct?** for a discussion of codes of conduct) mention competence without defining what they mean by their use of that term in that document. For example, see Good Medical Practice (General Medical Council, 2020), Standards of Conduct, Performance and Ethics (Health and Care Professions Council, 2016) and/or The Code (Nursing and Midwifery Council, 2018).

Table 3.1 Statutory regulatory body websites

Statutory regulatory body	Website
General Chiropractic Council	https://www.gcc-uk.org/
General Dental Council	https://www.gdc-uk.org/
General Medical Council	https://www.gmc-uk.org/
General Optical Council	https://optical.org/
General Osteopathic Council	https://www.osteopathy.org.uk/home/
General Pharmaceutical Council	https://www.pharmacyregulation.org/
Health and Care Professions Council	https://www.hcpc-uk.org/
Nursing and Midwifery Council	https://www.nmc.org.uk/
Pharmaceutical Society of Northern Ireland	https://www.psni.org.uk/

The *Shorter Oxford English Dictionary* defines competence as ‘*having adequate skill*’ and ‘*being properly qualified*’ (Stevenson, 2007). On this definition, at the point of registration with one of the statutory regulatory bodies, the healthcare practitioner would be competent to undertake their professional role. Indeed, as discussed in **How does registration relate to being a professional?** and **Why is pre-registration education a professional issue?** this is one of the reasons for the registration of healthcare practitioners, and why one of the requirements for registration is that the prospective registrant has undertaken an approved pre-registration programme of education and training, to prepare them for their role when registered with a statutory regulatory body.

Helpfully a previous version of the Nursing and Midwifery Council code of conduct allows the definition provided by the *Shorter Oxford English Dictionary* to be applied to a healthcare context, as it did define what was meant by competence. In 2004, the then current version of the Nursing and Midwifery Council code of conduct defined competence as ‘*possessing the skills and abilities required for lawful, safe and effective professional practice without direct supervision*’ (Nursing and Midwifery Council, 2004 at section 6.2).

From these two definitions, it is possible to state that clinical competence is concerned with having skills, abilities and knowledge to undertake a particular role and that this is initially achieved through a period of pre-registration education. Also, that competence refers to healthcare practitioners being able to practise in their own right, that is, without the need to be supervised as, for example, a student or unregistered healthcare practitioner requires.

Q
A

What is the relationship between professional accountability and competence?

Using the definition of competence from **What is clinical competence?**, that competence is related to the healthcare practitioner’s ability to be able to perform a specific role, for example nurse or physiotherapist, allows its relationship to a

healthcare practitioner's accountability to be explored by noting what a healthcare practitioner's accountability requires of them for their role.

Several commentators have noted that competence is a key aspect of the regulation of healthcare practitioners and is fundamental to patient protection and safety. For Montgomery, *'the relationship between patients and health care professionals is based largely on trust that the latter are competent. Membership of the profession should indicate a level of training and expertise which enables the public to rely on the skill of the practitioner'* (2003 at page 133). While the Kennedy Report goes further to state that *'professionals should be able to do that which they profess they can do. From the patient's point of view, it is shocking to think that this might not be the case. Indeed, the need for healthcare professionals to acquire and maintain appropriate levels of competence is so obvious that it would seem unnecessary to refer to it'* (Kennedy, 2001 at page 323).

The healthcare practitioner is only able to register with the relevant statutory regulatory body because they have demonstrated that they have achieved the necessary competence to do so.

The healthcare practitioner is professionally accountable, based on the discussion of professional accountability in **Why is professional accountability a key concept in professionalism?**, for their competence because, as Montgomery and Kennedy noted above, competence is one of the measures that the statutory regulatory bodies can use to restrict access to their respective professional registers and is a key aspect of ensuring patient safety.

Specifically, the healthcare practitioner who is not currently competent needs to recognise this and, as part of their professional accountability, raise this with the relevant individuals in their organisation to ensure that they do not put patient safety at risk.

This is a vital aspect of professional accountability, and a hallmark of professional practice, so it is worth repeating. Being competent means knowing when to act and when not to act. Professional accountability is a way of ensuring that healthcare practitioners pay due regard to their competence.

Competence is not based on a notion of being 'time served', that once you have X number of years as a healthcare practitioner, you are seen as being competent. It is the ability to apply the knowledge and experience gained to different situations. So that the whole of the healthcare practitioner's ability and knowledge and skills can be used for the benefit each of their patients: different patients with different problems and needs in different circumstances.

The healthcare practitioner who acts outside of their competence is failing the professional standard and is professionally accountable for that.

Q
A

Are standards of proficiency different to competence?

As discussed in **What is the clinical competence?** competence is concerned with having skills, abilities and knowledge to undertake a particular role.

It was also noted that achieving competence is a requirement for attaining registration with one of the statutory regulatory bodies. Standards of proficiency are not used by all of the statutory regulatory bodies but by those that do they are a measure of the ability, knowledge and skills that need to be demonstrated by a healthcare practitioner in order to attain registration with them.

In this way, there is an overlap between competence and standards of proficiency as both relate to what a healthcare practitioner needs to demonstrate to achieve registration with a statutory regulatory body.

The Health and Care Professions Council and the Nursing and Midwifery Council have both issued standards of proficiency for the professions they regulate. These can be viewed on their respective websites (see **How is an indemnity arrangement related to registration?** for their website addresses). In addition to using these standards of proficiency to assess whether a healthcare practitioner has attained the necessary abilities, knowledge and skills to attain registration, both also state that they use their respective standards of proficiency to assess whether individual registrants registered with them should remain on their respective registers.

For those statutory regulatory bodies that use them, standards of proficiency are the standard by which a healthcare practitioner registered with a statutory regulatory body is judged in terms of their professional role and their professional values and behaviours. Those who are judged to fall below the standard of proficiency can be removed from the professional register.

It was noted above that there is an overlap between standards of proficiency and competence, and this is indeed so as both relate to specific characteristics of a professional healthcare practitioner. The difference between the two is that standards of proficiency relate to the healthcare practitioner and their ability to be registered with a statutory regulatory body. Whereas competence goes beyond mere registration and is concerned with the capability of the healthcare practitioner to perform their role effectively and safely.

In reality, the terms are used interchangeably, and this does not generally pose an issue as both are concerned with the ability, knowledge and skills of a healthcare practitioner.

Q
A

Once I am registered do I need to maintain my competence?

The simple short answer to this is yes you do. Though this was not always the case.

In the not too distant past, indeed less than 30 years ago, it was possible to just have to demonstrate competence at the point of initial registration. That is that you undertook a period of training and at the end of that training undertook an examination which included assessment of practical skills and on passing these were deemed to be competent for your health care role. There was no need to undertake any form of continuing professional development or to prove your

competence further, unless you wanted to take on an additional expanded role. Once you had achieved this initial competence you were set for life. (Cornock, 2016 at page 8)

This is no longer the case and, after achieving the competence needed to register with a statutory regulatory body, a healthcare practitioner has to maintain their competence in order to maintain their registration.

Part of a healthcare practitioner's professional accountability is their commitment to maintaining their competence, throughout their professional career and certainly beyond the point of initial registration. By maintaining their competence, the healthcare practitioner is helping protect the public and patients from incompetent practitioners, that is, those healthcare practitioners whose knowledge or skills are out of date.

The various codes of conduct from the statutory regulatory bodies all have statements or sections that outline the registrant's responsibility to maintain their professional competence. The General Medical Council have a section titled '*develop and maintain your professional performance*' (General Medical Council, 2020), the Health and Care Professions Council have subsection in their code called '*maintain and develop your knowledge and skills*' (Health and Care Professions Council, 2016), while the Nursing and Midwifery Council state that registrants must '*keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance*' (Nursing and Midwifery Council, 2018 at section 22.3).

It should be noted that the statutory regulatory bodies not only require healthcare practitioners to maintain their competence, but there is an expectation that they will develop and improve their competence.

As to how a healthcare practitioner maintains their competence, this is addressed in the following questions:

- How up to date do I need to be?
- What is continuing professional development?
- Does reflective practice maintain and develop competence?
- Is clinical supervision related to competence?

Q

How up to date do I need to be?

A

It was discussed in **Once I am registered do I need to maintain my competence?** that the various statutory regulatory bodies require their respective registrants to maintain their competence. Here it can be further stated that all the codes of conduct mentioned there use the phrase 'up to date' when stating the requirement to maintain and develop competence (General Medical Council, 2020 at page 6, Health and Care Professions Council, 2016 at page 7 and the Nursing and Midwifery Council, 2018 at section 22.3).

Unfortunately, there is no indication of what ‘up to date’ means, or how up to date a healthcare practitioner needs to be.

Obviously, *‘it would be the ideal situation if every healthcare practitioner was fully up to date; had read every article relevant to their subject; attended, or had feedback on, every seminar in their field; and was aware of every research finding appropriate to their clinical area’* (Cornock, 2021 at page 56).

Ideal but not feasible and not an expectation of the statutory regulatory bodies. Rather, there is an expectation of reasonableness in the updating a healthcare practitioner undertakes. Reasonableness has two elements to it: what would it be reasonable for the healthcare practitioner to achieve and what would a reasonable healthcare practitioner achieve in the same circumstances.

Is it reasonable to expect that you have read a research paper that only came out last week? Is it reasonable for you to attend every course that provides updates for your area of clinical practice? Probably neither of these is reasonable. However, it is reasonable to expect that you are aware of major changes and updates in your area of specialism.

Q A

What is continuing professional development?

There are a variety of terms used by the statutory regulatory bodies to encompass the need for healthcare practitioners to engage with learning throughout their professional careers. Some of these terms are profession specific, while others go in and out of favour, continuing professional development seems to be both current and commonplace and so is used here.

For Peck et al. continuing professional development is *‘the process by which health professionals keep updated to meet the needs of their patients, the health service, and their own professional development. It includes the continuous acquisition of new knowledge, skills, and attitudes to enable competent practice’* (2000 at page 432).

Continuing professional development is related to the fact that the attainment of competence does not end at the time of initial registration with a statutory regulatory body but that it must be maintained throughout the healthcare practitioner’s professional career. It is continuing professional development that meets the requirements of the statutory regulatory bodies for the maintenance and development of a healthcare practitioner’s competence (as stated in **Once I am registered do I need to maintain my competence?**). It is learning and education that goes beyond the requirement for initial registration.

There is no requirement that healthcare practitioners undertake a specific type of activity to fulfil their continuing professional development requirement. Instead, many type of activities will fulfil the requirement. The key aspect of continuing professional development is that the healthcare practitioner is either maintaining or developing their competence in their area of practice. It is a systematic approach to

career-based lifelong learning. Continuing professional development can include activities such as:

- Article reading
- Conference attendance
- Conference presentations and the associated preparation
- Discussion with colleagues, for example about clinical techniques
- Formal training courses
- Informal training
- Practice reflection
- Programmes of study leading to new qualifications
- Research
- Study days or individual sessions

As well as meeting the requirements of the statutory regulatory body requirement for maintaining competence, continuing professional development can also be utilised to acquire new skills and to prepare for new roles.

It is useful for healthcare practitioners to make and update a log of their CPD activities and achievements, which can be referred to for appraisal and revalidation purposes.

Continuing professional development can be summarised as the way that healthcare practitioners keep their skills, knowledge and abilities up to date and continue to learn about their area of practice throughout their professional career. It assists healthcare practitioners with their professional accountability in relation to maintaining their competence as noted when discussing **Once I am registered do I need to maintain my competence?**

It is worth noting that *'there are two aspects to continual professional development, the first is actually undertaking some form of formal or informal education training or learning. The second is the recording of that experience'* (Cornock, 2016 at page 9).

Q
A

Does reflective practice maintain and develop competence?

Reflective practice is a way of learning from experience by actively reflecting (thinking) about the experience to determine what happened, what your role was in the experience, what went right, what did not go as expected and what could be changed for the future. In some ways it is a way of learning through experience but where the experience is reviewed and considered rather than just having taken place.

There is no single way of undertaking reflective practice as each person will have a different way of approaching their own reflection, and what may work for one person may not work for another.

Reflective practice is not a form of goal setting. That is, the aim is not to find an answer to a specific problem but rather to engage in a continuous way of reflecting

or observing your own practice to determine where practice is going well and where change could be beneficial.

There are two main forms of reflection according to Schön (1991). These are reflection in action and reflection on action. Reflection in action is also described as reflection or thinking while doing. For a healthcare practitioner, an example of reflection in action would be when they reflect upon how their interaction with a patient is affecting the patient's ability to make a treatment decision. The healthcare practitioner may reflect that their interaction needs to be less, or more, direct to accommodate the patient's needs and circumstances.

Whereas reflection on action is when reflection or thinking takes place after the event has happened. In the example above, the healthcare practitioner may reflect that, although their approach is generally effective, there are patients for whom a different approach and style of communication is needed, and then further reflect on what these approaches may be and who they would be most effective with.

The common element in the two approaches is that the healthcare practitioner considers their own practice so that they can maintain or improve it in the future. Through reflective practice, the healthcare practitioner not only considers a specific experience but is able to understand their role in that experience and, over time, will develop a greater insight into their practice and their attitude and approach to their practice. This allows the healthcare practitioner to change, adapt and improve their practice according to their reflections.

Reflective practice does not have to be an individual event and can be undertaken with a colleague or as a group activity. Though whether an individual activity or with a colleague or as part of a group, it must be a method that the healthcare practitioner is comfortable with otherwise they will be unlikely to gain from the reflection.

Competence is maintained and developed through the insights into their practice that the healthcare practitioner gains from the reflections they undertake and the actions they take as a result of these insights.

Q A

Is clinical supervision related to competence?

Clinical supervision is not a new phenomenon and has been a statutory requirement for midwives since the Midwives Act 1902 (although the current authority arises under The Nursing and Midwifery Order 2001 (SI 2002/253), particularly articles 41–43).

Butterworth et al. describe clinical supervision as '*an exchange between practising professionals to enable the development of professional skills*' (1998 at page 12). It is a formal arrangement where a healthcare practitioner meets with another more experienced healthcare practitioner with the purpose of developing the practice of the first healthcare practitioner. The role of the supervisor is to act as a coach or mentor to the healthcare practitioner to assist them with their practice. The supervision can be one to one or occur in groups.

For Midwives clinical supervision, being statutory in origin is more formalised, and the supervisor is appointed by a Local Supervising Authority after undergoing specific training for the role. A midwifery supervisor will usually be responsible for a group of midwives and must meet each midwife at least annually, although a midwife may request to meet their supervisor at any time for their assistance or advice or guidance. The supervisor's role encompasses two duties, one to the pregnant woman and the other to the midwife. As such, the supervisor is able to monitor the midwife's practice and investigate any allegations against the midwife and even suspend the midwife from practice.

Moving away for midwives, Butterworth and Faugier note that clinical supervision '*should not be confused with simple managerial oversight ... [and] ... its purpose is to facilitate reflective practice and push toward a patient-centred focus*' (1994 at page 1). The role of clinical supervision, although encompassing many aspects of midwifery supervision, does not usually have the oversight function or the ability of the supervisor to investigate or suspend the healthcare practitioner.

Various approaches to clinical supervision exist but most involve training for the supervisors, include meetings between the supervisor and the healthcare practitioner being supervised, with these meetings taking place in the workplace, and the supervision is centred around the healthcare practitioner's practice with the aim of developing their competence through attaining new knowledge or skills. Some clinical supervision also involves the supervisor having a more pastoral role in supporting the healthcare practitioner's wellbeing.

In some ways, clinical supervision can be likened to preceptorship (as discussed in **is there a transition period from being a student healthcare practitioner to becoming a registrant?**) for healthcare practitioners who are more experienced.

Although midwives are the only group of healthcare practitioners who are statutorily required to have clinical supervision, it has been long recognised that it is a mechanism of patient protection, and it has been suggested that '*the exploration of the concept of clinical supervision of practitioners other than midwives, should be further developed so that it is integral throughout the line of practice*' (Department of Health, 1993 at page 10). Despite this, to date, it is only midwives who are statutorily required to have clinical supervision.

Clinical supervision allows the healthcare practitioner to maintain and develop their competence via a formal arrangement that allows them to receive support in relation to practice and professional issues from a more experienced healthcare practitioner.

Q
A

What is appraisal?

Interestingly, one of the definitions of appraisal in the *Shorter Oxford English Dictionary* is '*able to be valued or assessed*' (Stevenson, 2007). In some ways, this accurately sums up the purpose of an appraisal as it suggests that what is being

appraised is being assessed on its value to the appraiser. For the healthcare practitioner, appraisal is an assessment of their competence to perform their role.

The more usual definition of appraisal provides the detail on the what as well as the how, with appraisal being a '*regular formal review of an individual's work performance, an interview or meeting with this purpose or to establish objectives*' (Stevenson, 2007).

Healthcare practitioners are generally required to have an annual appraisal. However, an employer's appraisal process may require that more than one meeting takes place during the year. These meetings will be structured around a process of initially setting objectives, checking on the progress of the objectives throughout the year, with an end of year assessment of how the healthcare practitioner has achieved the agreed objectives. The process then repeats itself for the next annual cycle.

Conlon sees appraisal as being a '*structured process of facilitated self reflection*' (2003 at page 389). As reflection was seen as being one method of maintaining and developing competence (see **Does reflective practice maintain and develop competence?**), having a formal process whereby the reflection is facilitated through a structure that requires time to be set aside for it and links it to objectives that are useful for the healthcare practitioner, their practice and their development moves appraisal from being a management checking process to one that is effective and useful for the organisation and the healthcare practitioner.

Gatrell and White (2001) have stated that appraisal has three purposes in a healthcare context. These are: as a developmental tool where the healthcare practitioner's needs can be identified and a means of attaining them be planned (though the setting of mutually agreed objectives); an annual assessment of performance by which the healthcare practitioner can faithfully judge their performance and be appraised of how others assess their performance; and as a management tool by which the healthcare practitioner can be assessed against their job description and any organisational objectives.

It should be noted that the first two of Gatrell and White's purposes are based around the needs and abilities of the healthcare practitioner, and it is only the third purpose that is employer focused, in that it meets the needs of the organisation. However, it should be acknowledged that all healthcare organisations should see the development of their healthcare practitioners as an organisational need.

The setting of objectives for the healthcare practitioner's needs is key to an effective appraisal. If the outcome of an appraisal cycle is a set of objectives that the healthcare practitioner does not engage with, the appraisal will not be effective and the objectives unlikely to be achieved.

For many individuals, appraisal is just a compulsory set of meetings to check on their performance, a list of objectives to achieve, and not something that they are engaged with. However, it does not have to be like this, and healthcare practitioners should see their appraisal as part of their professional accountability. Appraisal can be a mechanism by which the healthcare practitioner can reflect upon their practice over a defined period, and put in place any developmental needs to maintain the standard of their practice, thereby maintaining patient safety and meeting the

demands of professional accountability as defined in **Why are healthcare practitioners professionally accountable?**

Appraisals can also be used by both the healthcare practitioner and the employing organisation to move beyond current needs to incorporate developmental needs for the healthcare practitioner's career goals and aspirations, and to set objectives for the healthcare practitioner to gain knowledge and skills outside of the demands of their current role. In this way, the healthcare practitioner develops, and the organisation meets future staffing needs.

Q
A

How is revalidation different to appraisal?

It was said in **How does regulation affect the healthcare practitioner?** that it was the case in the past that registration with a statutory regulatory body was for life, unless the healthcare practitioner was removed from the professional register as a result of a fitness to practise proceedings. There was certainly no requirement for the healthcare practitioner to prove their competence to practise on a regular basis.

This is not the case anymore with the arrival of revalidation to the healthcare professions.

If, as discussed in **What is appraisal?**, appraisal is about the healthcare practitioner and a reflection on their practice and setting objectives to meet their developmental needs and also about how well they are undertaking their role, then revalidation is a system that goes beyond the individual's needs to consider how a healthcare practitioner can show that they are fit to practise in their chosen area of practice. It is about the healthcare practitioner demonstrating that they are up to date in their practice and that their competence has been maintained, that the public trust in them is still justified.

Revalidation is not a new concept, and the General Medical Council was considering introducing it as far back as 1998. However, it was the healthcare scandals in the 1990s, such as that involving children's heart surgery at the Bristol Royal Infirmary and those involving Harold Shipman and Rodney Ledward, that led to calls for reform which in turn led to government consultations on the regulation of healthcare practitioners (Department of Health 2006a, 2006b) that ultimately led to a government White Paper. It was this White Paper that set out proposals to reform the regulation of healthcare practitioners including the introduction of revalidation (Secretary of State for Health, 2007).

Revalidation is administered by the statutory regulatory bodies. At present only the General Medical Council, the General Pharmaceutical Council and the Nursing and Midwifery Council have revalidation requirements for their respective registrants.

The General Medical Council was the first to introduce revalidation in December 2012, having initially been set to commence in March 2005, the Nursing and Midwifery Council was next in April 2016, with the General Pharmaceutical Council introducing revalidation in March 2018. It is to be expected that the other statutory regulatory bodies will introduce revalidation for their registrants, as the

2007 White Paper *'sets out new proposals to ensure that all the statutorily regulated health professions have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise'* (Secretary of State for Health, 2007 at page 6).

Although the purpose is the same, each of the statutory regulatory bodies administers revalidation in a different way. The General Medical Council has a five year process while the General Pharmaceutical Council and the Nursing and Midwifery Council have three-year processes.

As an example of revalidation requirements, the Nursing and Midwifery Council requires a registrant to have achieved the following:

- 450 practice hours
- 35 hours of CPD including 20 hours of participatory learning
- Five pieces of practice-related feedback
- Five written reflective accounts
- Reflective discussion
- Health and character declaration
- Professional indemnity arrangement
- Confirmation (a signed declaration of meeting the revalidation requirements) (Nursing and Midwifery Council, 2021)

Revalidation is the pinnacle of professional accountability as it is the mechanism by which a healthcare practitioner demonstrates that they are competent to continue to practise effectively and safely. It is a continuing process with a formal review every three or five years depending upon the statutory regulatory body. Failure to either engage with the revalidation process or to meet its requirements can result in the removal of the healthcare practitioner from the relevant professional register.

Q

Why is the professional standard important to a healthcare practitioner?

A

In various questions within Part 1 of this book, the importance of a professional standard has been raised and discussed. Part of the reason for the importance of the existence of a professional standard in healthcare is, as noted in **Does it matter if an occupation is a profession or not?**, that it is one of privileges granted to professions. Only professions are given permission to set their own standards for entry and for continued membership of the profession, the professional standard.

The professional standard reflects the values that are held by a particular profession. Professional values are a way of setting out the behaviours expected by a member of that profession as noted in **Do professional values differ from ethics?** It is against the professional standard that the healthcare practitioner can be measured to determine if they have upheld the profession's values.

As discussed in **How do morals, ethics and professional values relate to being a professional?**, those healthcare practitioners who do not adhere to their profession's

standard are acting outside of the profession's norm for behaviour and not practising according to the profession's values. It may even be said that those healthcare practitioners who act outside of their professional standard may be said to be acting unprofessionally and failing to uphold the status of the profession within society and putting its professional status in jeopardy, as well as possibly risking harm to their patients. This puts the healthcare practitioner at risk of censure by, or even expulsion from, their profession.

There is then a need for healthcare practitioners to work to the agreed standard as part of their professional accountability, as noted in **Is there a hierarchy to responsibility, accountability and liability?** Indeed, the need for a standard for professionals to work to is one of the reasons for having professional accountability in the first place, as noted in **Why are healthcare practitioners professionally accountable?**

One possible problem with requiring healthcare practitioners to work to a professional standard is how does the individual healthcare practitioner know what that professional standard that they must work to and achieve is?

In **What is being regulated?** it was stated that standards for performance were one of five elements of regulation that need to be achieved for public protection and patient safety to be achieved; while in **How does regulation affect the healthcare practitioner?** it was stated that producing and maintaining standards for registrants is one of the roles that the statutory regulatory bodies undertake on behalf of society as part of their regulatory role.

Each of the individual statutory regulatory bodies set its own standard for their registrants, although there is considerable commonality between the standards as to what is expected of each of the healthcare professions and in what they contain. This is only to be expected as each of the healthcare professions is working towards the same goal of providing a service to individual patients and, therefore, the public as a whole.

The professional standard is provided to registrants by their statutory regulatory body through the code of conduct that they issue (Codes of conduct are discussed further in **What is a code of conduct?**). The code of conduct is an expression of the profession's values as set by the statutory regulatory body that represents that profession.

A code of conduct can be said to have three main purposes. Firstly, it sets the professional standard for registrants and acts as a guide for their practice. Secondly, it allows the statutory regulatory body to judge a registrant's performance against the professional standard. Finally, it communicates the professional values of the profession, that is, being regulated by the statutory regulatory body, to those who are external to the profession, thereby allowing them to know what they can expect from those professionals.

Q
A

What is a code of conduct?

In **Why is the professional standard important to a healthcare practitioner?**, it was determined that healthcare practitioners who are members of a profession must work to an agreed standard, the professional standard, and that this professional

standard is necessary for the status of the profession as well as for fulfilling the profession's duty to protect the public, specifically by maintaining patient safety. Also, that it is the statutory regulatory bodies that set the professional standard for their respective professions as part of their duty to society. The statutory regulatory bodies communicate their professional standard by issuing codes of conduct to their registrants.

Codes of conduct are, therefore, an expression of professional values that allow individual healthcare practitioners to know what standard they should be working to, and the ethical principles and concepts that underpin professional values. This is affirmed by Burnard and Chaman who state that '*many codes claim to be based on ethical principles ... others do not overtly make that claim but nevertheless have ethically based statements within their pages*' (1993 at page 4).

Because they represent the values of a profession at a specific point in time, and indeed of the society they are serving, codes of conduct are not static but evolve. These evolutions can be traced through the new editions of their codes that the statutory regulatory bodies periodically issue to their registrants.

The codes of conduct issued by the healthcare statutory regulatory bodies can be said to have an ethical basis and incorporate the ethical principles of autonomy, beneficence, non-maleficence and justice as discussed in **What ethical principles are relevant to healthcare practice?**

Using nursing as an illustration, the first code of conduct issued for nurses by a statutory regulatory body was in 1983 and was titled 'code of professional conduct for nurses, midwives and health visitors based on ethical concepts' (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1983). The latest version was issued in 2015 but updated in October 2018, when the Nursing and Midwifery Council commenced regulation of nursing associates. It is titled 'the Code', with a subtitle of 'professional standards of practice and behaviour for nurses, midwives and nursing associates' (Nursing and Midwifery Council, 2018).

The title of the current code recognises that the code of conduct represents the professional standard for midwives, nurses and nursing associates. It also clearly states that the professional standard relates not only to the nurse's practice but also their behaviour.

The 1983 version of the nurse's code of conduct was eight pages long, but only three actually contained the code. The code consisted of 12 paragraphs that the nurse needed to adhere to and was preceded by a paragraph which stated that the nurse had to justify their professional standing and maintain public trust in them and serve the interests of the public as well as their patients. There were also three explanatory notes.

The current version of the nurse's code is 24 pages long, of which 18 contain the code. The code has expanded to 25 clauses, but all of these have multiple, up to 10, subclauses.

Reading a code of conduct from 40 years ago and comparing it to its current successor is most likely going to feel as if you are reading two very different codes that, although they share some features and themes, have very different content and underlying philosophy.

AS AN ASIDE: HISTORICAL CODES OF CONDUCT

Reading old codes of conduct can be quite illuminating in terms of understanding the professional values of a profession through time. They can also show how an occupation or profession is viewed by society, and of the values of society. For instance, the issuing of the first code of conduct by a profession may represent when the profession was first elevated from being viewed as an occupation to a profession, or when an occupation is seeking to raise its status to that of a profession.

The purpose of codes of conduct is to provide an overarching framework within which healthcare practitioners can practise. They provide an indication of what acceptable behaviour is. They are not, and do not, provide an answer for every ethical dilemma or problem that the healthcare practitioner encounters. Neither are they rule books to be followed. This has both negative and positive connotations. Negatively it means that the healthcare practitioner needs to interpret the code of conduct for any practice issue or situation they face. Positively it means that the healthcare practitioner has the professional freedom to practise their profession as they wish without having to follow rules, so long as it is within the overall professional standard.

The authority for the statutory regulatory bodies to issue codes of conduct for their registrants arises out of their establishing legislation. For instance, for nurses, the Nursing and Midwifery Council was established by The Nursing and Midwifery Order 2001 which provides that *'the principal functions of the Council shall be to establish from time to time standards of . . . conduct and performance for nurses and midwives'* (article 3(2)).

Although the Nursing and Midwifery Council code of conduct sets out the professional standard that nurses must adhere to, the Nursing and Midwifery Council published supplementary guidance on their website (<https://www.nmc.org.uk/>) which provides additional guidance for specific groups of nurses, or areas of practice, or for nurses with additional competences beyond those attained at initial registration.

One interesting point about codes of conduct for healthcare practitioners is that the various healthcare statutory regulatory bodies all issue their own codes. There is not a shared code of conduct issued on behalf of all the statutory regulatory bodies, even though the various healthcare professional groups share many of their professional values and standards and the ultimate aim of providing safe and effective patient care. On reading the various codes of conduct for healthcare practitioners, it can be seen that there are more commonalities between them than there are inconsistencies, suggesting that a shared code would not be that difficult to produce.

Codes of conduct are not without their issues, and some commentators do not see them as being effective as professional standards as they are written in statements that are too simplistic and general. While others, for instance Stone (2002), believe that they are not effective because, instead of being applicable to the healthcare

practitioner's practice, they instead represent an idealised version of healthcare practitioners and what they can achieve, and that this is not attainable.

Q
A

Do codes of conduct have legal status?

Codes of conduct, as described in **What is a code of conduct?**, are not legally binding, that is, they do not have the status of being legislation, and they are not laws that have to be followed with failure to do so resulting in an appearance in a criminal or civil court.

While legal action does not directly result as a consequence of not following a code of conduct, they do have a legal status that relates to their being accepted as the professional standard of practice. This means that, if a healthcare practitioner needed to defend their practice in a court hearing, failure to follow their code of practice could be seen as evidence of failing to meet the required standard for their practice.

Being accepted as the recognised standard of practice also has potential implications for the healthcare practitioner's registration with their statutory regulatory body.

Codes of conduct as standards of practice, as noted in **What is a code of conduct?**, mean that they are indicative of the behaviour that a healthcare practitioner should exhibit in their practice. By not following the principles in the code of practice from their statutory regulatory body, the healthcare practitioner is not adhering to the accepted standard and as such is acting outside of the norm expected. This may result in the healthcare practitioner having their practice investigated through a fitness to practise process (see **What is a fitness to practise investigation?**) to determine if their practice meets the required standard. If the healthcare practitioner's practice is judged to have fallen below the required standard, they face the possibility that they will be removed from the professional register and no longer able to practise.

Q
A

What constitutes professional conduct?

Being a professional is about upholding the values of a profession and meeting its professional standard. In **What is a code of conduct?** it was seen that the statutory regulatory bodies, who are responsible to society for ensuring that the professional standard is maintained, set the professional standard by issuing codes of conduct for their registrants to follow.

The reason behind issuing codes of conduct is to protect the public from poor practice and performance from healthcare practitioners who are not meeting the professional standard. To meet the professional standard, the healthcare practitioner follows the guidance in their code of conduct. It is in this way that the healthcare

practitioner registered with one of the statutory regulatory bodies exhibits the conduct expected of them as a member of their profession.

Professional conduct is, therefore, to simply adhere to the standard set by their profession, outlined in the relevant code of conduct. Where the healthcare practitioner does not adhere to their code of conduct, this is known as professional misconduct.

A healthcare practitioner demonstrates professional conduct by their approach to, and actions in, their practice. In this way, professional conduct is the embodiment of the relationship between the purpose of regulation in healthcare, the reason for regulation of healthcare practitioners (as noted in **Why are healthcare practitioners professionally accountable?**), the professional accountability that individual healthcare practitioners have and the actual care that patients receive from those healthcare practitioners.

Having a professional conduct requirement for registration with one of the healthcare statutory regulatory bodies allows the healthcare practitioner to be held to account for their actions in their professional practice.

For healthcare practitioners, ensuring that professional conduct is at the heart of their practice means that they will be adopting the values and standards of their profession, as well as addressing their professional accountability.

A failure by a healthcare practitioner to meet their professional conduct requirements, by not adhering to the code of conduct of their statutory regulatory body, can lead to a fitness to practise investigation by that statutory regulatory body. As a point of interest, fitness to practise processes used to be termed professional conduct processes.

Using professional conduct to adhere to the professional standard as embodied in a code of conduct should not be done just to avoid a fitness to practise investigation. It should be an integral part of the healthcare practitioner's approach to their practice. After all, the professional standard means doing it the professional way even when no-one is looking.

Q
A

Why is academic integrity important to professional accountability?

To be a registered healthcare practitioner, you will have to complete a pre-registration programme of education and training. When the healthcare practitioner is registered, if they want to develop their area of competence and/or extend their area of practice, it is likely that this will, in part, require them to participate in a formal programme of study.

Academic integrity is used to mean good practice during a course of academic study, essentially being a good, conscientious student while at college or university. A student who acts professionally towards their learning if you will.

An example of lack of academic integrity would be the student who plagiarises the work of another student and submits it as their own. This will not have happened in a clinical setting but in a university setting and so for many appear to be outside of the remit of the statutory regulatory bodies.

It would be wrong to assume this, for two reasons. Firstly, if the student was on a post-registration course, they will be expected to exhibit professional standards and conduct in the maintenance of their competence or the attainment of new competences. Many individuals are surprised to learn that a failure to uphold academic integrity could lead to the statutory regulatory body initiating a fitness to practise investigation against the registrant, even when the alleged incident occurred in their role as a student and not in a clinical practitioner role.

Secondly, students who are undertaking a pre-registration programme of education and training are not subject to the fitness to practise proceedings of a statutory regulatory body. Educational establishments providing programmes of study will be required to have their own fitness to practise proceedings as part of the approval for the programme by the statutory regulatory body. This means that there can still be a fitness to practise investigation for allegation of failure to maintain academic integrity. The result of which could include suspension or removal from the educational establishment or lesser sanctions of resitting assessments or a whole module, or even having to retake a whole programme of study.

Additionally, as part of the approval given to them, educational establishments are required to provide the statutory regulatory bodies with details of students who have had sanctions imposed as a result of an internal fitness to practise investigation. In extreme cases, this could lead to the statutory regulatory body declining to admit the individual to the professional register on the basis of professional misconduct. It is in this way that academic integrity is an aspect of professional accountability.

Q What is the association between professional support organisations, accountability and being a professional?

A There are many organisations that provide support to healthcare practitioners in undertaking their professional practice. Unlike the requirement to be registered as a member of a profession through a statutory regulatory body in order to practice as a healthcare professional, membership of the professional support organisations is voluntary.

Some of these support organisations act as a trade union for their members, a trade union being '*an organized association of the workers in a trade, group of trades, or profession for the protection and furtherance of their interests, rights and working conditions*' (Stevenson, 2007). Trade unions use the collective voice of their membership to gain collective benefits for their members. Other professional support organisations are more of a professional support group, while others still combine the role of a trade union and a professional support.

Two examples illustrate the roles of professional support organisations.

The Royal College of Nursing states that it is '*is the world's largest nursing union and professional body... [and that it represents] close to half a million nurses, student nurses, midwives and nursing support workers in the UK and internationally*' (Royal College of Nursing, 2022).

According to its website (available at <https://www.rcn.org.uk/>) some of the activities that the Royal College of Nursing undertake include:

- Representing nurses' professional interests
- Negotiating pay and terms of conditions
- Providing health and safety representation in workplaces
- Protecting and supporting members regarding employment matters
- Providing free advice to members on legal and employment issues
- Campaigning to influence and develop patient care policy
- Providing advice to parliament and political parties and organisations on healthcare and healthcare policies
- Maintaining a library for their members
- Undertaking research into nursing and patient care
- Assisting members with lifelong learning goals and career development

On the other hand, the College of Paramedics does not have a trade union function but undertakes the professional support functions. *'The College of Paramedics [states it] is the recognised professional body for all paramedics in the UK, whose role is to promote and develop the paramedic profession across England, Northern Ireland, Scotland and Wales'* (The College of Paramedics, 2022).

The College of Paramedics states on its website that its activities include:

- Advising members
- Providing advice to those considering becoming a paramedic
- Providing learning resources to members for continuing professional development purposes
- Publishing curricula for undergraduate and postgraduate education
- Establishing a career framework for postgraduate practice
- Shaping policy and working with various stakeholders to maintaining patient care standards
- Advising government and other interested parties regarding paramedic practice
- Publishing a journal
- Acting as media representative for paramedic practice
- Providing legal representation to members for Health and Social Care Professions investigations (The College of Paramedics, 2022).

As can be seen, there is considerable overlap between the two organisations and the activities they undertake on behalf of their respective members. Both have an education role and provide advice to their members and act as representatives for their members' area of practice, nursing and paramedicine, acting as a collective voice and promoting their views on healthcare. The main difference between the two being the trade union activities which the Royal College of Nursing undertakes.

As to their role in professionalism and professional accountability, professional support organisations can act as a peer group through which new members of the

profession can be socialised into the profession's values and norms. Through their educational and standard setting activities, they promote the ideal accepted view of what a healthcare practitioner should be. Membership may provide healthcare practitioners with an opportunity to undertake continuing professional development and to gain understanding of current thinking on areas of their practice. Although, obviously, all of these opportunities are only available to those who are members of a professional support organisation.

SUMMARY

- Registration with a statutory healthcare regulatory body is an indication that the individual has achieved professional status and is working to the requirements of their professional occupation group.
- Registration fees pay for the operational costs of the healthcare practitioners' statutory healthcare regulatory body. For the individual healthcare practitioner, the registration fee is the payment they pay to be recognised as a professional in their chosen healthcare speciality, for the privilege of using a protected title and to be able to practise in their chosen area of speciality.
- Most statutory healthcare regulatory bodies do not have a formal period of transition from student to full registrant. The General Medical Council is one exception to this and has a period of provisional registration. The Nursing and Midwifery Council is an example of a statutory healthcare regulatory body that recommends a formal non-obligatory period of transition from student to full registrant through a preceptorship programme.
- An indemnity arrangement is a requirement for registration with the statutory healthcare regulatory bodies, and failure to have one in place or to maintaining it may result a fitness to practise investigation or in removal from the register for misconduct.
- Clinical competence is concerned with having skills, abilities and knowledge to undertake a particular role.
- Individual healthcare practitioners are professionally accountable for their own competence and for ensuring that they maintain their competence.
- Standards of proficiency and competence are both concerned with a healthcare practitioner's abilities, knowledge and skills. The difference between the two is that standards of proficiency relate to registration with a statutory regulatory body, and competence is more concerned with the healthcare practitioner's capability to perform their role.
- The achievement of competence is not a single event, but an ongoing process and healthcare practitioners need to maintain their competence throughout their professional practice. It is a requirement of continued registration with a statutory regulatory body that competence is maintained and developed.
- In order to maintain registration with a statutory regulatory body, in addition to maintaining their competence, a healthcare practitioner has to demonstrate that

they are up to date within their area of practice. There is no definition of how up to date a healthcare practitioner needs to be, but there is an expectation that they will be reasonable in their approach to ensuring they are up to date.

- Continuing professional development is a requirement of the statutory regulatory bodies and is the way that healthcare practitioners keep their skills, knowledge and abilities up to date and continue to learn about their area of practice throughout their professional career.
- Reflective practice is a way of learning from experience by actively reflecting (thinking) about the experience. Competence is maintained and developed through the insights into their practice that the healthcare practitioner gains from the reflections they undertake and the actions they take as a result of these insights.
- Clinical supervision allows the healthcare practitioner to maintain and develop their competence via a formal arrangement that allows them to receive support in relation to practice and professional issues from a more experienced healthcare practitioner.
- Appraisal is a process by which a healthcare practitioner can demonstrate their professional accountability and reflect upon their practice, and set objectives to maintain and develop their practice as well as those for their career goals.
- Appraisal is for the benefit of the individual healthcare practitioner and their employing organisation; revalidation is for the benefit of society. At present only the General Medical Council, the General Pharmaceutical Council and the Nursing and Midwifery Council have revalidation requirements for their respective registrants. They administer revalidation in a different way, although for each, it is a formal process by which the healthcare practitioner demonstrates that they are competent to continue to practise safely and effectively.
- Healthcare practitioners must practise to a professional standard that is set by the statutory regulatory body that they are registered with. The statutory regulatory body sets out the professional standard that they expect their registrants to adhere to through a code of conduct that they issue.
- Codes of conduct are issued by the statutory regulatory bodies for their registrants and set the professional standard for their respective professions. They provide an overarching framework within which healthcare practitioners can practise.
- Although codes of conduct are not legally binding, they are indicative of accepted practice and thus are binding on healthcare practitioners, who need to adhere to their principles or face the possibility of being removed from their professional register.
- Professional conduct is the way in which a healthcare practitioner undertakes their practice in accordance with the professional standard of their statutory regulatory body, as outlined in the code of conduct.
- A failure to uphold academic integrity could result in a fitness to practise investigation. Either by the educational establishment for those students on

pre-registration programmes of study or by the statutory regulatory body for students on post-registration courses.

- Professional support organisations can act as a support organisation, a trade union or a combination of both for a defined group of professionals. Through their activities, they can assist healthcare practitioners to adapt to their new profession, meet their continuing professional development needs and to keep current with developments in their area of practice.

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