
Research report

Regulating ethics
and conduct at the
Council for
Professions
Supplementary
to Medicine
– 1960 to 2002

Contents

Foreword 2

Acknowledgements 3

1 Introduction: the origins of regulation 4

- 1.1 The Board of Registration of Medical Auxiliaries 4
- 1.2 The development of statutory registration: the CPSM 4
- 2 Why regulate allied health professionals' conduct and how? 7**
- 2.1 The foundations 7
- 2.2 The three fundamental principles 7
- 2.3 Regulating allied health professionals 8
- 2.4 Possible models of professional regulation 9
- 2.5 The British model of professional regulation 11

3 The CPSM structure and the disciplinary function 12

- 3.1 The statutory foundations of the CPSM and boards 12
- 3.2 The purpose of the legislation 13
- 3.3 Justice, reasonableness and the right to a fair hearing 15
- 3.4 The Investigating and Disciplinary Committees 16
- 3.5 Infamous conduct 17
- 3.6 The investigating and disciplinary 'rules' 18
- 3.7 Protected titles 19
- 3.8 Professional conduct and admission to the Register 19

4 The disciplinary process at the CPSM 21

- 4.1 Allegations 21
- 4.2 The preliminary investigation 22
- 4.3 The effects of low public knowledge of the CPSM 23
- 4.4 The disciplinary hearings 23
- 4.5 The hearing process 24
- 4.6 The Council 25

5 The boards' standards of conduct 27

- 5.1 The Statements of Conduct 27
- 5.2 The Statements of Conduct and registrants 28
- 5.3 Queries and advice 28
- 5.4 1975 to 2002 – a period of radical change 29

6 Individual issues relating to standards of conduct 31

- 6.1 Advertising 31
- 6.2 Professional nameplates 33
- 6.3 Promoting products 34
- 6.4 Professional scope of practice 35
- 6.5 The 'supplementary' status of the professions 37
- 6.6 Delegation to assistants 40
- 6.7 Registrants' responsibilities during industrial disputes 40
- 6.8 Duty of care owed to patients, clients and the public 41
- 6.9 Confidentiality and record keeping 44
- 6.10 Professional indemnity insurance 45
- 6.11 Inappropriate association 46

7 Cases and hearings 48

- 7.1 The very small number of cases 48
- 7.2 Outcome of hearings 49
- 7.3 Competence cases 50
- 7.4 Health cases 50

8 The CPSM and professional conduct, a final word 52

- 8.1 A great step forward in 1960 52
- 8.2 Internal reform and modernisation at the CPSM 52
- 8.3 The need for statutory change 53

Glossary 54

Relevant documents 56

Appendix 1 – The health professions covered by the CPSM and the registrars 57

Appendix 2 – The disciplinary sections of the Professions Supplementary to Medicine Act 1960 58

Appendix 3 – Convention for the Protection of Human Rights and Fundamental Freedoms: Articles 6, 10 and 11 62

Appendix 4 – The basic structure of the CPSM 63

Appendix 5 – Statistical charts 65

Foreword

In the area of conduct, as in all other areas of professional regulation, there has been considerable and significant development since the Health Professions Council (HPC) began in 2002. However, the period of regulation covered by the Council for Professions Supplementary to Medicine (CPSM) and its respective boards was also a time of great significance, and saw equally important development. It is now several years since the Health Professions Council replaced the old boards. As such it is possible to take an objective look back at the efforts of the boards and their conduct committees, to deal with the disciplinary side of regulation, and to map any changes.

Professional conduct and ethics is increasingly topical, and the source of growing discussion, controversy and research. To inform the debate, it is important to be aware that the roots of regulating professional behaviour lie in the past: with the CPSM and earlier still. This report will therefore look at how the CPSM boards and their conduct committees developed their standards of conduct and ethics and accompanying conduct processes, and how they dealt with some of the basic issues of the day.

This account is from the perspective of the history of the CPSM and boards. It does not consider the HPC's own processes, practices and arrangements. It is an historical document only and so does not reflect the policy or views of the current HPC. Although, necessarily, it does on a number of occasions refer to legal issues.

In looking at this period, it is important to recognise that ideas, principles and standards change and develop, and will always do so. Much has changed in the world of all the health professions and wider society since regulation began. As a general observation, it would be unreasonable to expect today that those who set up and worked their systems in a quite different era would have always abided by our own standards, judgments and processes. Indeed, the professionals and their regulators fifty years hence will be looking at today's HPC in the same way that this report looks at the CPSM.

Acknowledgements

This research report was prepared by Tom Berrie, Information Service Manager at the HPC. Tom joined the Council for Professions Supplementary to Medicine (CPSM) in 1984 and was involved in the setting up of the HPC from its shadow form. The responsibilities of his current role include producing historical material and items relating to the foundation and development of the CPSM. This report is therefore a product of that work.

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Views expressed in this report are those of the author and not the HPC.

1 Introduction: the origins of regulation

1.1 The Board of Registration of Medical Auxiliaries

Regulating and registration of non-medical health professions goes back many decades. Between 1960 and 2002 the Council and boards 'Supplementary to Medicine' carried out this function for most of these professions. Before the early 1960s there had been a voluntary register for a few of them, which the Board of Registration of Medical Auxiliaries (the BRMA) had run since 1937. The British Medical Association (BMA) had set up the BRMA in 1935, as a non-profit making company. It published its first register on 26 May 1937. Each profession that it registered had its own committee. There were committees for chiropodists, dietitians, orthoptists, physiotherapists¹, radiographers, speech and language therapists (then simply 'speech therapists') and dispensing opticians. Each registrant paid a yearly fee of 'half a guinea' (10 shillings and sixpence in predecimal money; a guinea was 21 shillings, £1.05) and received a registration certificate.

The BRMA carried on into the early 1960s, when the Council for Professions Supplementary to Medicine (CPSM) and boards replaced it, although the CPSM did not take on dispensing opticians, which went to the General Optical Council (GOC), and did not take on speech and language therapists until 2000. The respective professional bodies, such as the then Society of Chiropodists and the Society of Radiographers were much more directly involved in the BRMA than they were in the subsequent CPSM. They appointed the professional representatives on the professional committees. The committees had no professional conduct functions, relying on the respective professional bodies to deal with allegations.

Therefore, removal from the register on conduct grounds was problematical. Strictly speaking, the BRMA had no 'powers' at all, as it had no statutory basis. As well as the professional bodies, it was very much under the control of medical practitioners and their professional body, the BMA, which subsidised its staff and accommodation. As the article in the *British Medical Journal* in 1982², which although unreferenced was probably written by Brian Donald, stated:

“The Board was effectively under the wing of the BMA, which not only subsidised its staff and accommodation but also kept a fatherly eye on the various groups and tried to help improve their conditions, status, and pay.”

1.2 The development of statutory registration: The CPSM

The BRMA's effectiveness was very limited due to the fact that it lacked statutory backing to its processes and, as stated above, had no role in professional conduct, which was left entirely to the participating professional bodies. For this reason, and because it was dominated by the medical profession, during the 1950s there was considerable discussion within government, the professions, and some consultation with interested parties including various professional bodies, on making registration 'statutory' (giving it legal backing through an Act of Parliament). People were now using 'professions supplementary to medicine' rather than 'medical auxiliary', as they were now professions in their own right. The result was the Professions Supplementary to Medicine Act 1960 (the Act).

¹ However, the physiotherapists dropped out after a few years.

² 'Briefing: Professions supplementary to medicine', *The British Medical Journal*, 284 (27 February 1982), pp 680–681.

The Act set up a supervisory Council, and boards for chiroprodists, dietitians, biomedical scientists (then called medical laboratory technicians), occupational therapists, physiotherapists, radiographers and remedial gymnasts (who were similar to physiotherapists and merged with them in 1986).

Originally, there were to be eight professional boards. But before Parliament passed the Professions Supplementary to Medicine Bill, the speech therapy profession, which had until then intended to seek inclusion, decided against doing so. It did not come within the terms of the Act until 2000. The Orthoptists Board came into being in 1967. For convenience, people usually called the whole structure, collectively, the CPSM, although this was strictly speaking inaccurate, because the initials only referred to the Council.³

Each board had its own register and two kinds of member; the majority being members of the profession. The boards' registrants elected the majority of members by a postal ballot. The Council appointed the rest after nomination by outside bodies. The medical profession in its various branches retained a major role regarding the professions in the early days. For example, the first Chairman of the Dietitians Board was not a dietitian but a medical practitioner, Dr R. J. Allen and continued in this post until the mid-1970s. The Chairman of its Education Committee continued to be a medical practitioner, Dr J. D. Baird, until the mid-1980s. This dominance of the medical profession changed during the last period of CPSM's history, as medical practitioners gradually became less involved in the boards' day-to-day work and activities.

Compared with the previous BRMA system, effective professional conduct powers were a key part of the CPSM system which the Professions Supplementary to Medicine Act 1960 set up. The Act did this through the boards' Investigating and Disciplinary Committees, and the standards that the latter issued through their 'Statements of Conduct'. State registration assured patients, the public and employers that registered members of the profession were appropriately qualified and competent to practise. It was a standard that people could recognise throughout the United Kingdom and beyond. It provided significant public protection from unprofessional or unethical behaviour. An important reason for this was that there was a formal, statutory disciplinary process which began to set some basic standards, and could deal with allegations against members of the profession and remove people from the register where necessary. Nonetheless, the Act was rooted in the 1950s and there were significant limitations to the existing powers.

During the last decade or so of their existence, the Council and boards began to deal with the changing, and increasingly complex issues that were beginning to arise. They did so as effectively as they could within the limitations of their powers. They and the staff had also begun to address and change an organisational culture which was rooted in the past. In particular, for a number of reasons, the increasingly outdated legislation restricted and limited the effectiveness of the powers that the boards had in relation to professional conduct.

³ Whilst acknowledging the importance within the whole structure of the autonomy of the Boards and their conduct committees, we therefore continue this use of CPSM throughout the report.

Two of the most serious limitations were the lack of legal protection of the common titles of each of the professions and the very limited sanctions that the boards' Disciplinary Committees had. The government set up the Health Professions Council (the HPC), amongst other things, to remedy these, by protecting basic common titles and introducing full 'fitness to practise' standards, rules, processes and sanctions, and standardising all of these for all its professions.

The title 'professions supplementary to medicine' was in 1960 a great advance on 'medical auxiliaries' and reflected the movement towards their increasing professional autonomy. However, as the professions developed further, the term itself became outdated. Most of the parties involved, including most of the professions themselves, the NHS institutions and government departments, began instead to use the term 'allied health profession' and 'allied health professional' throughout much of this period. Although its use in practice varied, this report uses this term throughout to cover the professions within the CPSM, shortened to AHP, rather than the term 'supplementary'.

2 Why regulate allied health professionals' conduct and how?

2.1 The foundations

Professional regulation has developed over several centuries and in our society it is arguably now regarded as normal. As a part of this, the CPSM professions have had formal regulation since 1960. Before looking at the development of CPSM's regulation of professional conduct, it is important to look at why regulation of their conduct, including education and training, came about and the basic principles involved.

2.2 The three fundamental principles

British society has arguably long recognised that it cannot control all professional character and behaviour, nor prescribe every detail of behaviour and practice. This would be highly impractical. Nor would it want to do so, because this would be contrary to our Western concept of the liberal professions and professionalism, which has long asserted that it can and should leave professional, day-to-day practice to the individual professional's own judgment. It has largely left the professional to 'get on with the job in hand'. However, it recognises that some regulation is necessary, because of the responsibilities that all health professionals, including AHPs, have regarding their patients and the public in general. We can see three principles which underlie such professional regulation, and are of much more wider application, and existed well before the UK government in the 1950s and early 1960s was preparing and enacting the CPSM and its legislation.

2.2.1 Autonomy

Our society arguably encourages human autonomy, ensuring that all can realise their human potential. Individuals and groups are entitled to live as they believe is appropriate, and to free speech and expression.

People are therefore entitled to earn their living and pursue their ambitions, including the right to pursue the career and profession of their choice, and develop professional groups and associations. Citizens are also free to consult professionals as they see fit.

2.2.2 The common good

The state must protect its public and ensure their safety, and protect them from unprofessional, dangerous or incompetent practice by establishing and enforcing basic professional standards, because it has long believed that it must protect and develop the 'common good'. The wellbeing of each person necessarily relates to the good of everyone. Everyone should do good and avoid harm, and so must control, plan and regulate their behaviour, by following certain basic standards. Society therefore expects health professionals to benefit the public, to contribute to the public or common good, and not to act against it.

2.2.3 Justice and equity

Our society wishes to maintain justice and equity and thus balance autonomy and the common good. This is particularly relevant to professional practice, where health professionals have traditionally sought to earn their living and further their legitimate careers, by serving others and society in general. So, the state must both respect professional autonomy and protect the public, dealing with each individual and group fairly. Justice and equity demand that all be consistent and fair, avoid unfair discrimination and arbitrary directives and decisions. Maintaining standards and treating all fairly have long been a fundamental part of 'being a health professional', whatever the specialism. Therefore, professionals and their institutions must establish good, sound reasons for their practice, actions and standards, related to the empirical evidence and real world.

2.3 Regulating allied health professionals

Historically, within the United Kingdom, all three principles have been equally important in regulating AHPs. They have for fifty years been entitled to real, though certainly not unlimited, professional autonomy. This includes freedom to organise their profession collectively, through associations and groups. The degree of autonomy has developed over time. Professions exist to provide a source of income, satisfaction and personal development for their members, and to serve the public good, and the public is entitled to a good and safe professional service from them. This is why the state started to regulate at least some of the AHPs through the CPSM in 1960, and sought to ensure that they were fit to practise. The public, the AHPs themselves and their employers are entitled to know the standards that the professions are expected to meet and by which they are to be assessed. It has long been accepted that these standards must be reasonable and founded upon coherent principles and an evidence base; that the AHPs themselves must have some involvement in their creation and development; and that within the system, an AHP and profession could expect fair and equitable treatment.

Although essential, statutory regulation has never been the only part of setting and maintaining standards of conduct and ethics. There have always been other significant dimensions, which are essential for effective control and regulation. The regulators have always needed to take into account the much wider dimension within which standards arise and are enforced, and work with them (something that is now often called 'metaregulation'). These are the common

values, customs, ideologies, traditions, history, institutions and life of the society within which the professions and regulators have emerged, worked and developed. AHPs themselves in their associations and groups, both informal and formal, have long played a significant role, each with their own history, ethos and common purpose. The origins of the CPSM professions are very varied⁴. Each developed differently, in different contexts, within their differing specialisms. Some are old professions; for example, chiropody. Chiropodists first developed, a century or more before the foundation of the Chiropodists Board, within the context of independent, private practice. The radiography and dietetic professions developed within a technical and largely hospital context, decades before the establishment of their respective boards. The biomedical and clinical scientists developed within a scientific context. Occupational therapy and speech and language therapy developed within a more one-to-one, person-centred context, in a variety of types of organisation. The paramedic profession is, on the other hand, very new and has developed as 'responders to emergencies'. Each therefore brought an already well-established 'history' upon being given a board, which continued to form their professional values, attitudes and conduct throughout the history of that board. This helps explain the boards' and Disciplinary Committees' choices of the standards which they highlighted and developed, those that they did not, and their attitudes to individual issues and cases.

Other professionals in the working environment have also played their part. The working environment encompasses government policy and the media, employers and the users of the

4 For an early history of these professions see: G. Larkin, *Occupational Monopoly and Modern Medicine*, (Tavistock Publications, London and New York, 1983). Several professional bodies have also produced their own histories for their professions.

service that they provide. All AHPs use their profession as a source of work and their professional practice has an important economic dimension. Their employers and employing organisations, particularly but not exclusively the NHS, and market forces, particularly for the self-employed professional, have always influenced their ethics and conduct.

Education providers have also always been vital in forming all the CPSM professionals in competent and ethical practice. This contribution included practical training and academic institutions, curriculum frameworks, minimum standards, entry requirements, systems of assessment, examination and validation. Setting and enforcing standards of professional conduct has always been closely linked to setting standards of professional education and training. During this period, there were very considerable changes in the setting and context of professional education and training of AHPs, which have all had a major impact on the standards of conduct.

2.4 Possible models of professional regulation

Historically, the United Kingdom has usually incorporated regulation of professional conduct within one single structure, which has also included professional education and training, and has chosen one particular way of regulating professions. This was the structure used for the CPSM professions. However, Parliament could have, in theory, chosen other ways to regulate them. Before setting out the way that the government in 1959–60 chose for the CPSM professions, below are the main possible alternatives.

2.4.1 Using the professional body

It could have given the task to the respective professional body. For example, at the time government was considering regulating the CPSM professions, a professional body (the

Royal Pharmaceutical Society of Great Britain and the Pharmaceutical Society of Northern Ireland) regulated pharmacy. In the case of the CPSM professions, the Society of Radiographers, for example, would have regulated radiographers as well as represented their interests. In fact, many of the professional bodies (including the Society of Radiographers) were (and continue to be) involved in their members' professional conduct, including setting standards and removing membership due to misconduct. However, this did not, in itself, have statutory backing. Governments have used this method of regulation for non-health professions, such as engineers and accountants (and continue to do so), by granting a royal charter to a particular professional body. This is a very old legal process, much older than that of state registration, and gives the body 'charter' powers.

However, the extensive discussion throughout the 1950s produced a consensus that this model was likely to confuse the legitimate role of the professional body as advocate of the profession, with the quite different and potentially conflicting role of protecting the public; this is particularly important to keep separate in the case of professional conduct. Further (though this is less true in many cases now), the respective professional bodies in the 1950s were small and in some cases tiny (some had almost no paid staff at all); in practice most of them were not capable of fulfilling a regulatory role, particularly one which involved considering objectively and fairly disciplinary issues. Finally, regulation by professional body is, essentially, profession-specific and does not provide any opportunity for interprofessional regulation and common standards. Even in the late 1950s and 1960, government considered that a degree of interprofessional regulation and commonality of standards was desirable. These are the main reasons why government, ministers and Parliament did not choose this model in 1959–60.

2.4.2 Direct regulation by government department and decree

Instead, governments have usually set up arrangements for regulating their AHPs that are independent of the profession itself and its professional associations. A significant and widespread alternative to the British method is the European continental tradition of direct regulation within their own legal traditions, for example, through the relevant minister and department, by decree and legal code. Government departments, nationally or regionally, directly control professional education and practice (although they usually do this with the cooperation of, or even through, the relevant professional body). Those who have attended an approved institution and obtained the diploma sanctioned by the relevant government department (in the case of AHPs, the Health Ministry or Department) have the right to practise the profession. Only those so qualified are eligible to practise. They work within the scope of practice and codes of behaviour prescribed by legal decree. This decree is an integral part of the whole legal code. Those who do not are breaking the law and can be prosecuted in the courts. This provides direct accountability of the professions to Parliament or another democratically elected assembly. The decree and code directly enforce professional conduct and ethical standards, and have the full force of law.

However, in the United Kingdom, the Health Ministry or Department has been the ultimate employer of AHPs within the National Health Service as well as the strategic planner for health at the national level, since its establishment in 1948. Those involved in the consultations and in preparing legislation concluded that it would potentially confuse its role and functions if the Ministry of Health also had the quite different, and, potentially conflicting, function of detailed regulation of the professions. Other ministries or departments

would be unlikely to have the appropriate knowledge and expertise to carry out the function. Further, although a legal code gives the profession full legal standing and protection, it is likely to require a change in the law every time a change is needed. This could slow down that natural progress and development which even in the 1950s was regarded as important to any profession. Finally, it is clear from the reports and debates during the 1950s, that the UK government wished to allow the professions a degree of involvement in their own regulation, which would be more difficult in the case of direct regulation by government department. These are the reasons, among others, that in the United Kingdom, governments have not chosen, at least so far, this model of regulation for full professionals, including for the CPSM in 1960 and other subsequent regulatory bodies.

2.4.3 Licensing boards

Another alternative was the licensing board system which is found, for example, in various forms in the United States of America. It is, superficially, similar to the British system, in that a legally autonomous 'board' regulates its designated profession.

The board is directly accountable to the governor or to the state legislature. Boards issue their own codes of ethics, which they enforce by various legal means. Many of these boards are 'profession-specific' like the CPSM boards (except, unlike the CPSM they are often entirely so, there being no overarching Council). Unlike the British tradition however, boards offer a 'licence' rather than 'entry on a register'. The professional therefore has an actual 'licence' which they can place upon their wall. In some cases this 'licence' is also a true 'licence to practise', ie it grants functional closure to the professions, where only those with a licence can practise the profession. In 1960, almost none of the professions had functional closure in the United Kingdom (to

this day, only midwifery, hearing aid dispensing and dentistry in the health area have this) and so far, governments have been very unwilling, to impose functional closure. In the late 1950s this was out of the question for professions still considered 'supplementary' to medicine, when even the medical profession did not have it.

2.5 The British model of professional regulation

The British model for a long time has been the 'statutory registration' model, where the regulatory body holds a register of those who meet its standards, usually accompanied by some form of protection of title for those whose names are on the register (see section 3). This model has developed differently from those outlined above, and countries greatly influenced by Britain also use it. In it, statutory bodies carry out regulation entirely separately from either professional bodies or government departments, and are accountable ultimately to Parliament, not the profession or government.

In the 1950s, the relevant ministries and their ministers, most bodies consulted and Parliament all agreed that this 'registration' model was the most appropriate one for regulation of what they then called the 'professions supplementary to medicine'. They considered that it was the arrangement which best reflected the need to balance legitimate professional autonomy with public protection. When Parliament set up the CPSM, the model had been well established for over a hundred years by the General Medical Council (originally the General Council of Medical Education and Registration). Therefore, the government of the day set up the CPSM squarely in that British tradition of regulation, which had also produced the General Dental Council, the General Optical Council and the other subsequent regulators of health professions, as well as non-health registration bodies such as the Architects Registration

Board. These statutory bodies have been independent of government from the start, but have the legal powers to enforce their standards, including standards of conduct. However, the constitutions of these statutory bodies at that time allowed for participation by the professionals themselves in their own regulation. For example, each of the CPSM boards and their conduct committees (but not the Council) had a majority of one of members who were directly elected by the registrants themselves. The purpose of this was to allow for a direct participation by members of the regulated profession that was independent of their professional body.

3 The CPSM structure and the disciplinary function

3.1 The statutory foundations of the CPSM and boards

3.1.1 The Council

The early consultation documents about regulation on the professions then called 'auxiliary to medicine' acknowledged that professional conduct and an effective disciplinary process was a key feature of any future regulatory body, although they did not explore this in any detail. The report of the Working Party on the Statutory Registration of Medical Auxiliaries in November 1954: the Pater Report, prepared the way for state registration. It, in respect of professional conduct, stated that the "functions which the registration body should be designed to perform" should include the ability "[t]o remove from the register persons who have shown themselves unworthy of retention."

The report advised that the proposed registration boards have this function. The 'Coordinating Council' would hear and determine appeals by people removed from the register against the board's decision. Professional discipline would be the responsibility of each professional board, not that of the coordinating council. The government adopted this policy in the subsequent Professions Supplementary to Medicine Act 1960 (the Act).

The Act set up a Council, and boards for chiropodists, dietitians, biomedical scientists (whose title was then medical laboratory technicians⁵), occupational therapists, physiotherapists, radiographers and remedial gymnasts. Remedial gymnasts were similar to physiotherapists and merged

with the latter in 1986. The Council and boards were legally accountable, not officially to the government or Ministry of Health, but the 'Privy Council', an ancient constitutional arrangement going back to medieval times. The Privy Council retained certain rights to determine appeals, make certain appointments to statutory bodies and to make legislation, known as 'Orders in Council' and 'Orders of Council'. All of these it exercised in respect of the CPSM and boards. In reality this meant the relevant Government Minister or Secretary of State who was a member of the Privy Council. The Council of CPSM appointed the Registrar, who was the chief executive, although the term 'Chief Executive and Registrar' did not appear until the very end of the CPSM. It employed the other staff, collected registration fees, controlled the finances, supervised and co-ordinated matters of common interest, and organised the elections to the boards. However, people began calling the Council, boards and staff, all, together, the CPSM, and normally continued to do so until the end. People did not start to use the term 'fitness to practise' until very late in this period. The professions at that time widely used the term 'discipline', as in 'professional discipline' until the 1990s. At CPSM, people used terms like 'disciplinary procedure', and the committees which assessed and decided upon allegations were 'Disciplinary Committees'.

3.1.2 The boards

Each board was legally autonomous and had its own disciplinary powers. It had two kinds of member. The majority of its members were elected from its own registrants. The Council invited nominations from the registrants of that

5 The Act listed each profession specifically. Not long after, this profession renamed itself 'medical laboratory scientific officers'. However, to change the title of the Board would have required a change in the Act itself, so formally it remained the 'Medical Laboratory Technicians Board' until the end of the CPSM – the whole point of them being 'professions supplementary to medicine' was that they were 'professionals', not 'technicians'. However, the Board used 'medical laboratory scientific officers' in everything but legal documents.

board, who elected from the nominations a prescribed number by a postal ballot. Registrants voted for elected members in pairs: there was the main member and an 'alternate' member who had the right to attend and act on behalf of the main member if they were not attending the meeting. The Council appointed the rest of the Board members, after nomination by outside bodies named in the legislation. The majority of these appointed members were from the medical profession. There would also be someone who was an expert in education. At first they would usually be a college principal, then from about 1990, deans of faculties and professors. Each board had an Investigating Committee and Disciplinary Committee. All members of a board had to be a member of one or the other, but could never be both. The Board Chairman was automatically the Chairman of the Disciplinary Committee. The board also appointed the Investigating Committee Chairman from amongst the membership of that Committee. In some, but by no means all instances, this would, by convention, be the Vice-Chairman of the Board. However, the legislation restricted membership of both committees to board members only and neither could co-opt outsiders.

3.2 The purpose of the legislation

Section 1(2) of the Act stated that each board "shall have the general function of promoting high standards of professional education and professional conduct among members of the relevant professions".

This subsection set out the 'function' of the boards and therefore, by implication, the Council, but it did not specify the ultimate purpose of registration, ie what it was for, precisely why it was to promote high standards and what they were. One should also note that the word 'promoting' is slightly less proactive,

than the later 'establishing' as, for example, in the Health Professions Order 2001. Presumably it was up to the board to determine what 'high' meant in particular circumstances. In those days, unlike in modern legislation, regulatory legislation usually did not actually set out what the ultimate purpose of registration was. The Act was no exception. We have to deduce its purpose from the legislation itself, and its background and context. However, it is clear from the background papers leading to and from the Act, and the debates in Parliament on the preceding Professions Supplementary Bill, that 'state registration' was about promoting standards, with the ultimate purpose of protecting the public. Rod Pickis, in his paper CPSM and Professional Education, Registration, and Regulation⁶, quoted the Minister of Health of 1960, in describing the benefits of state registration.

"Identification of trained and qualified persons with high ethical standards, not only for the purposes of the NHS, or even of other public services, but also in the eyes of the public generally."

Employers and the public needed safe practitioners, but also to have confidence in the professions themselves. Certainly, all the boards and their Disciplinary Committees understood their main purpose was to protect the public. The introductions to all of the Statements of Conduct (see section 5), from the late 1960s, stated that "[t]he purpose of the statement is to enable the Board to fulfil its statutory function of promoting high standards of professional practice. These standards are required, not solely, or even principally for the benefit of the profession, but for the protection of the public."

⁶ See 'Relevant Documents – Other Documents', below.

The Minister in 1960 went on to say elsewhere that the legislation gave the professions a “[f]ull and proper measure of self government and conferred status through the association with the Privy Council.”⁷

Following on from this, we can derive the legislation’s ultimate purpose from those foundational principles which are at the very heart of public life and legislation in the United Kingdom, and has already been covered in section 2 above: maintaining the liberty, both individual and collective to pursue the profession of one’s choice and for the public to consult that professional; the need to protect and develop the welfare of all, and thus the patient and public; and ensuring justice and equity in dealing with all parties and setting basic, consistent standards.

It is clear from the background of debates, discussion and reports of the time that the legislation’s purpose was also to set the boundary between the medical professions and what were then the ‘professions supplementary to medicine’, between the professions and each other, and between the regulated and unregulated sectors. The legislation’s authors and framers clearly saw that, as well as setting and enforcing standards of conduct, the boards’ disciplinary functions of the Investigating and Disciplinary Committees, hearings, and the issuing of the Statements of Conduct were intended to play an important part in this delineating of boundaries. At the time, they were declaring and illustrating that the CPSM professions, were in a broad sense ‘medical’ in the broader sense, but supplementary to medicine itself. Rod Pickis, in his paper, quoted the Editor of the Lancet in 1960, Sir Theodore Fox, as saying that these professions were part of the

‘greater medical family’, with the medical profession clearly implied as the ‘head’ of the family. This is not the way people would see it later. Nevertheless, they arguably continued (and continue to this day) to think of all health professions as forming parts of the whole healthcare team and recognised the need to set some sort of professional boundaries (see section 6.4).

Finally, the previous background to the framing and passing of the Act implies that its purpose was also to provide a standard for employment, including giving employers and potential employers a degree of guarantee of competence and good ethical behaviour. Rod Pickis stated that:

“The final standard is that of the standard for employment. It should be emphasised that state registration is an independent statutory standard of excellence, of professionalism, of ethical behaviour and of true medical activity. It is also, at present, by separate statutory provision [subsequent to the PSM Act], the criterion for employment in the relevant professional capacity in the NHS, in NHS Trusts and in Local Authority Social Services Departments.”⁸

This standard was (and is) applicable to any context in which the professional worked, as not all of them worked or work for the NHS and a number work for themselves or the private sector.

7 Quoted in Rod Pickis’ paper ‘Relevant Documents – Other documents’, below.

8 Quoted in Rod Pickis’ paper ‘Relevant Documents – Other documents’, below

3.3 Justice, reasonableness and the right to a fair hearing

The boards' conduct powers reflected the already well-established legislation of older regulators of health professions. As statutory bodies, all the Committees and boards also had to obey the fundamental principles of natural justice. They could only act within the powers given to them by Parliament, ie they could not act 'ultra vires' and make decisions or act outside the powers that its legislation had given to it. So for example, a Disciplinary Committee could only use the sanctions available to it within the legislation (striking off or not striking off), and could not make up entirely new ones.

Further, a Committee or Board could not misuse its powers by acting 'unreasonably'. The concept of 'reasonableness' is founded upon a substantial body of case law built up over a considerable time. The committees and their officials had to act reasonably, fairly and in good faith throughout all proceedings, and in all of its decisions, directions and actions. This principle goes back a long way and reflects the third fundamental principle in Chapter 2 section 2.2, maintaining justice and equity. It included the duty that all parties involved received a fair hearing, a central part of the CPSM investigating and disciplinary processes. The important case, *Dimes v Grand Junction Canal* [1852], set out the foundational definition of a fair hearing as the principle that "justice must not only be done, but must be seen to be done" and stated that "the maxim that no man is to be a judge in his own cause should be held sacred."

Therefore, the PSM Act, its subsidiary legislation and the processes deriving from them, sought to ensure that the processes and hearings treated all sides fairly and equitably. During the processes, all parties had a right to a fair and impartial hearing of their case, to adequate notice of when the case was to be heard, to consider and challenge the evidence

presented, and reasonable time to prepare their case thoroughly. The persons adjudicating the allegation had to be a disinterested party and therefore not one of the parties in the case.

When someone made an allegation, the registrant whom they were accusing had the right to be fully informed of the accusation or allegation, and be given a fair opportunity to respond. The members of the Investigating Committee and the Disciplinary Committee had to be wholly impartial and unbiased. Therefore, a member of the Disciplinary Committee as set up by the Act, could not also be a member of the Investigating Committee and vice-versa, to ensure that entirely different individuals considered the case at each stage, and both were separate from the Council. Both committees were independent of the registrant, their employer, their professional body, the police, the Courts or the person making the allegation. If a member of the Committee was an interested party, they were required to declare this and could not take part in the proceedings. The principle in those days was that they were being 'judged by their peers', although both committees would also have medical practitioners, educationalists and others from outside the profession. Registrants had the opportunity to be represented during the process, although this was not compulsory. They were entitled to appear at the hearing of the Disciplinary Committee to present their case, but this was not obligatory.

The Human Rights Act 1998, which incorporated the Articles and Protocols of the Convention for the Protection of Human Rights and Fundamental Freedoms, came into effect just before the CPSM ended. The only difference that it made to the boards' conduct procedures was that both the Investigating and Disciplinary Committees were now explicitly required to set out the reasons for their decisions. Before, committees had in fact done so, as this was seen as required by natural justice.

The reasonableness rule does not just include the right to a fair hearing, but is more general, and includes any requirements, standards and directions that the statutory body may make. For example, an item in a Disciplinary Committee's Statement of Conduct (see section 3.5) had to be reasonable and fair, and could not be arbitrary, whimsical or biased. In fact, as is set out in section 6, it was in this area, rather than that of allegations and hearings, where boards and committees occasionally laid themselves open to accusations of unreasonableness and unfairness, for example, in relation to advertising and publicising one's services, and 'inappropriate association'.

3.4 The Investigating and Disciplinary Committees

The relevant sections of the PSM Act are set out in Appendix 2. Section 9 stated that the Investigating Committee's functions would be as follows.

“[T]he investigating committee shall be charged with the duty of conducting a preliminary investigation into any case where it is alleged that a person registered by the Board is liable to have his name removed from the register, and of deciding whether the case should be referred to the disciplinary committee.”

Section 9 of the Act stated that:

“where

(a) a person who is registered by a board is convicted by any court in the United Kingdom of a criminal offence which, in the opinion of the disciplinary committee set up by the board, renders him unfit to be registered; or

(b) such a person is judged by the disciplinary committee to be guilty of infamous conduct in any professional respect; or

(c) the disciplinary committee is satisfied that the name of such a person has been fraudulently entered on the register maintained by the board,

the committee may, if it thinks fit, direct that the person's name shall be removed from the register.”

It also stated that:

“It shall be the duty of each disciplinary committee to prepare and from time to time revise, in consultation with its board and the Council, a statement as to the kind of conduct which the committee considers to be infamous conduct in a professional respect...but the fact that any matters are not mentioned in such a statement shall not preclude the disciplinary committee from judging a person to be guilty of infamous conduct in a professional respect by reference to such matters.”

These statements were therefore called 'Statements of Conduct' (covered in sections 5 and 6). Allegations under (a) came to be called, for convenience, 'conviction cases' and under (b), 'conduct cases', although all involved professional conduct. In the late 1990s, committees included formal cautions as being in the category of 'conviction'. The relationship between the two subsections was not entirely clear. In assessing allegations in the conduct category and giving advice to registrants on matters of conduct, committees and hearings could use the Statement of Conduct, although in the early years they were so short and unsystematic they were likely to be of limited practical value. Although they would refer to the Statement, a hearing did not have any specific equivalent Statement or guidance on conviction cases.

3.5 Infamous conduct

The Act specifically refers to the concept of 'infamous conduct', showing that it was fundamental to all the boards' standards of professional conduct. The Act required that all the Statements of Conduct set out the kind of behaviour which the Disciplinary Committee thought was 'infamous conduct'. Infamous conduct was (and is) conduct that makes the registrant unfit to stay on the Register. The concept of 'infamous conduct' is founded upon a substantial body of case law. The term and concept goes back at least to the very first Medical Act of 1858, which states that:

“If any registered Medical Practitioner...shall after due Inquiry be judged by the General Council to have been guilty of infamous Conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such a Medical Practitioner from the Register.”

Two significant Court cases contain the two classic definitions of infamous conduct.

- *Alinson v the General Council of Medical Education and Registration* (the predecessor to the General Medical Council) 1894 where the court defined it as if a professional “in the pursuit of his profession has done something with regard to it which would reasonably be regarded as disgraceful and dishonourable by his professional brethren of good repute and competency” and
- *Felix v The General Dental Council* 1960, where the judge said that the phrase remained as terms “denoting conduct deserving of the strongest reprobation and indeed, so heinous as to merit, when proved, the extreme professional penalty of striking off”.

'Infamous conduct' is therefore not just 'misconduct'. It is behaviour that brings the profession into disrepute, and / or seriously endangers or adversely affects a patient / client, and / or seriously abuses the registrant's relationship with their patient / client. This was occasionally a problem for the committees, because there were examples of misconduct by registrants with which they wanted to engage, but could not do so because the actions were not 'infamous' and because the only remedy was the very serious one of striking off.

Committees recognised that 'infamous conduct' has several aspects to it. It, for example, includes endangering patient safety. Brian Donald's revised introduction, common to all boards, stated that:

“The Committee will have regard to...the duty on a member of the profession to have proper regard to the welfare of a patient so that the health or safety of the patient is not endangered.”

They also recognised that infamous conduct included 'bringing the profession into disrepute'. Brian Donald's revised introduction also stated that:

“The adoption of such a code of discipline which involves establishing ethical rules and restriction beyond those required of the ordinary citizen by law, sometimes to the personal disadvantage of the professional person, is designed to establish the probity and competence of the profession in the eyes of the public.”

During the CPSM period, the following judgment by the Court of Appeal in *Bolton v Law Society* (1994) supported this view. It held:

“the Solicitors Disciplinary Tribunal’s orders were not primarily directed to punishment but to the maintenance of a well-founded public confidence in the trustworthiness of all member of the profession and the discharge of any professional duty with less than complete integrity would attract severe sanctions... A profession’s most valuable asset is its collective reputation and the confidence which that inspires...The reputation of the profession is more important than the fortunes of any individual member... Membership of a profession brings many benefits, but that is part of the price.”

At that time, the Judicial Committee of the Privy Council was the highest court of appeal in respect of the conduct processes of most the regulatory bodies, including the CPSM. The Judicial Committee confirmed this in respect of health professionals in a number of non-CPSM, appeal cases. As a result, the Registrar of the CPSM wrote in early 2000 to all Board members and alternate members reminding them that in dealing with cases they must have consideration of not only:

“protection of the public [but also]...the wider one of public interest including among other things:

- 1. Preserving public trust in the profession.**
- 2. Registering disapproval of unprofessional conduct.**
- 3. Maintaining high standards of conduct.”**

3.6 The investigating and disciplinary ‘rules’

As soon as the boards began, the Registrar, John Tapsfield, who was a solicitor, drafted their subordinate legislation himself, including the rules for the Investigating Committees and Disciplinary Committees, and the Investigating

Committees’ standing orders.

Within the Professions Supplementary to Medicine Act there were sections and clauses which gave the CPSM Council powers to ‘make rules’. The term ‘rules’ here has a formal, legal meaning, not just as in ‘rules and regulations’ (see Glossary), and they need to be submitted to Parliament. In this case, they prescribed the legal details for disciplinary procedure which were not in the original Act but were outlined there. The CPSM and boards, being corporate bodies, had powers also to set out formal processes and procedures which had a legal status but did not need approval of Parliament. These were the ‘Standing Orders’ (see also the Glossary).

Each board had its own subordinate legislation. Most of the legislation concerned the Disciplinary Committees, not the Investigating Committees. The Investigating Committees did have their own rules, eg the Physiotherapists Board (Investigating Committee) Rules 1964, but these rules were less detailed than those of the Disciplinary Committees. They simply set out their constitutions and did not cover procedures. The Investigating Committees laid these down in their standing orders, which barely changed between the start of CPSM and its end in 2002. A registrant had the right to appeal a decision to the Judicial Committee of the Privy Council. There was no corresponding specific and formal mechanism for the person making the allegation or a body acting on its behalf to appeal a decision as too lenient. However, the Council could challenge a decision under its general supervisory powers in Section 1(3). This rarely happened. Specific powers to challenge decisions on grounds of excessive leniency did not come until the Government created the Council for Healthcare Regulatory Excellence (CHRE), after the end of the CPSM.

3.7 Protected titles

The Act did not protect the common titles of the professions, but there was some, limited protection of title. Anyone could legally use the common title, 'dietitian', etc without being registered. However, they could not call themselves 'state registered', 'registered' and 'state' dietitian, etc. It also sought to prevent people, by their use of language 'making out to be' or implying that they were registered when they were not. Later on the Council arranged for a number of successful prosecutions against people using the above when they were not registered, and publicised the boards' powers in this area and threatened with prosecution. Under separate legislative powers, only people on the boards' registers could be employed in or contracted to the National Health Service or local social services. The original separate regulations had been introduced making registration compulsory for these categories of employees in 1964, for England and Wales, Scotland and Northern Ireland. This was closure of function in the areas where the majority of registrants worked. It did not, however, cover other areas of work such as private practice.

Protection of title was relevant to professional discipline in two ways. First, the respective Board, by definition, only covered the members of its profession who were on its register, not those who were not. This meant that the latter were not subject to any statutory regulation; the Board had no control over members of the profession who were not registered, yet they could still bring the profession into disrepute. So, for example, an allegation may have indeed been against a physiotherapist, but not all physiotherapists were on the Physiotherapists Board's Register. Second, a registrant who was struck off could continue to practise, provided they did not claim to be registered or try to work in the NHS or local social services. Both were major defects of the Act throughout its existence and why, amongst other things, the Health Professions Order replaced it.

3.8 Professional conduct and admission to the Register

The disciplinary powers only applied after registration. A board could not therefore refuse to register or reregister someone who was unsuitable because of serious misconduct or ill-health. They could not take into account any convictions or cautions before they actually entered the Register. Provided they had the right qualifications, the Board had to register them. For most of this period, the boards also did not take into account conduct or convictions during periods when former registrants were off the Register. If they had been registered before, the boards automatically reregistered them. Surprisingly, in respect of the latter, until Mike Hall, Registrars had never put into effect paragraph 13(ii) of the general registration Rules which gave the Registrar powers to require a former registrant wishing to return to the Register after five years or more to establish "to the satisfaction of the Board his identity and good character".

It is not now clear why they did not do so, as this clause provided an important contribution to the boards' responsibilities for public and patient protection. Mike Hall put this clause into effect in early 1998, and from then on until the demise of the CPSM legislation, all former registrants wishing to return to the Register after an absence of five years or more had to provide proper evidence of identity and good character to the Registrar on the Board's behalf.

The Council's Working Party on the Future, in its document "Future Requirements and Opportunities" addressed the issue of conduct before application as early as 1980. It wanted to introduce character requirements for applicants for registration. The Council accepted this recommendation as a part of all the Working Party's recommendations. In 1984, it included the recommendation in its list of recommended amendments to the Act:

“To ensure applicants for first registration and subsequent restoration are free from convictions which would lead to erasure were they registered at the time of conviction.”

When it was clear that a review and replacement of the Act was going to take some time, the Registrar, Council and boards agreed to take remedial action until amending legislation. They used their educational rather than disciplinary or registration powers. In 1998, all boards agreed to inform all of the educational centres which they approved, of the following:

“To protect vulnerable members of the public, the Board requires of academic institutions that all prospective radiography students submit to the institution criminal conviction certificates obtained under the Data Protection Act 1984, Subject Access, (information which every citizen has the right to know), to ensure that there are no convictions and / or cautions resulting from crimes of sufficient seriousness which could bar them from obtaining employment in the National Health Service or its contractors, or obtaining state registration. The production of this certificate will be a condition of acceptance on courses for which they have applied.”

Subsequently, a working party of representatives of all the boards, with the Registrar, produced a document giving education providers advice on dealing with potential students or students on approved courses who had criminal records.

All of this became an actual case in 1999, when an individual with a serious criminal conviction applied for registration with one of the boards. They had been convicted and served a prison term for abuse of elderly patients whilst a nurse. Although the Act did not give the Registrar or boards specific powers to refuse such an application, the

Registrar upon consultation, had, nonetheless, refused the application. He believed that the extreme seriousness of the criminal acts which had a direct bearing on the practice of an AHP, precluded him from accepting the application. He argued that the underlying purpose of all the CPSM legislation was to protect the public and patients, and he believed that he would be failing in his duty to the public if he had allowed the individual to register. He therefore instructed the Registration Department not to register this individual.

4 The disciplinary process at the CPSM

4.1 Allegations

A person made an allegation against a registrant by contacting the Registrar in writing. Telephone and (towards the end) email was insufficient. The Registrar first arranged for the Registration Department to check whether the person complained against, called the 'respondent', was actually on the Register of the relevant board. This was not always the case. Out of ignorance, people would quite often send allegations against professions which were not within the CPSM. Some would be on the registers of other regulators, such as nurses or optometrists (confusing them with orthoptists); others would not be regulated at all. Presuming the person was a registrant, the Registrar then sent the allegation to the Chairman of the Investigating Committee, who 'screened' the allegation ('screened' is a more modern term which the boards' process did not use, but it reflects the basic process which went on).

Although all cases related to professional conduct, because of the way the legislation was set out, cases were divided into two types of case.

4.1.1 Conduct cases

There were two ways of making an allegation within this category. The first was for somebody who was acting 'in a public capacity', which the Standing Orders defined as "an officer of a government department or of a local or public authority, acting as such, or any person holding judicial office or any officer attached to a court."

At first, the Investigating Committees and Registrars interpreted this quite strictly. Much later they interpreted this more broadly to include, for example, the registrant's manager, the personnel manager or someone else in authority in the organisation. This person acting in a public capacity wrote directly to the Registrar setting out their case.

If somebody was a member of the public, it was much more difficult to make an allegation. They could only submit an allegation by making a 'statutory declaration' in the presence of a solicitor and sending it to the Registrar setting out their case. The Investigating Committees' standing orders stated very specifically:

"provided that, except where the complaint or information relates solely to an allegation that a criminal offence has been committed, or has been made by a person acting in a public capacity, the matter shall not proceed further until one or more statutory declarations has been furnished in support thereof, stating the address and description of the declarant and the grounds for his belief in the truth of any fact declared which is not within his personal knowledge."

The solicitor concerned would normally charge them a fee for making such a declaration. There were, therefore, obstacles to a member of the public making an allegation which were not there for an employer or the police. Registrars and Investigating Committee Chairmen interpreted this requirement very strictly. If there was no statutory declaration and the individual was not somebody who was acting 'in a public capacity', the allegation would not proceed. The justification at the time was that it deterred 'frivolous and vexatious' allegations. However, it clearly gave a bias against the public and acted as a barrier to members of the public making legitimate allegations.

4.1.2 Criminal cases

The Committees would also consider criminal cases, where a registrant had been found guilty by a court. The Registrar would present these to the Investigating Committee straightaway, without the need for a statutory declaration or submission by somebody acting in a public capacity. Registrants of all the boards were specifically excluded from the Rehabilitation of Offenders Act 1974. Therefore, in respect of their professional practice, no conviction or accepted police caution was ever 'spent'. For many years there was no formal procedure for finding out about criminal cases against registrants. In 1997, the Home Office agreed to notify Registrar, Mike Hall of all convictions and police cautions involving registrants. The Police Central Computer was updated to enable this to take place. This covered England and Wales. It is possible that a number of criminal convictions against registrants went unnoticed by the CPSM until then. Even after this arrangement, the process would miss a registrant who did not declare their profession to the police or court correctly. As with other allegations, the Registrar would check whether the convicted person was on the specific Register. Again, this was often not the case.

4.2 The preliminary investigation

The Chairman of the Investigating Committee, as 'screener', decided whether or not the allegation should proceed further. There were, in the Standing Orders and Rules, no guidelines or guidance whatsoever for Chairmen on this judgment on whether or not to proceed. Much later, the solicitors which the Council and boards used for the whole disciplinary process – Kingsley Napley – produced such guidance notes in successive versions. Once the Chairman had agreed that the allegation would proceed, the Standing Orders required that the Registrar write to the registrant with full details, including a copy of

any material which the complainant had submitted, inviting them to submit any explanation or observations. The members of both the Investigating Committee and Disciplinary Committee themselves acted as the panel to consider cases. The Investigating Committee always met in private.

The investigation was a preliminary one only. The Committee simply considered whether, with the evidence in front of it, there was a case to answer.

As a part of the question 'is there a case to answer?', Committees considered, first whether the allegation related to infamous conduct in a professional respect, or would in any way bring the profession into disrepute. If the answer was yes, the Disciplinary Committee would examine the case in more detail. Although apparently straight-forward, it was not always easy for either committee to decide this. Even in the case of convictions by a court, it was not always obvious whether or not the crime affected the registrant's suitability to remain on the Register. Was this 'infamous conduct' in the committee's specific terms? Take the example of an offence on which a number of the committees had actually to deliberate, drink-driving. Committee's held that, by and large, outside work hours during a registrant's non-working life, such a conviction would not normally affect their registration. A drink-driving offence, on the other hand, when the registrant was driving between hospitals or on domiciliary visits, they considered was a quite different matter. There might also be circumstances when an employer disciplined a registrant for a particular action, but the Disciplinary Committee did not strike them off. There could also be circumstances when a registrant was not sanctioned by the court but struck off by the Disciplinary Committee. On the other hand, a very serious crime would not necessarily have been committed in relation to a registrant's professional practice at all, but was so serious that a Committee could not help but take it into account. Examples would be grievous bodily

harm, sexual abuse of minors or abuse of vulnerable adults.

In all conviction cases, both the Investigating and Disciplinary Committee presumed that the case had been found and crime proved. In conduct cases, the case had to be proved. According to the standing orders of each Investigating Committee, the Committee could ask for further investigations or get advice from its lawyers, but could not interview the registrant. No reason for this is immediately obvious. However, it may be that the Council and boards did not want Investigating Committees to be tempted to start to assess the case itself, which attendance of the registrant could well encourage. On the other hand, as a part of the further investigations and advice, the Committee could ask the solicitor to interview the registrant, but also the complainant and witnesses from both sides.

4.3 The effects of low public knowledge of the CPSM

When the CPSM and boards first began in the early 1960s, there was a statutory disciplinary system to deal with issues of professional conduct, and administrative and internal arrangements derived from it, which there had not been before. This was a substantial and significant improvement. Nonetheless, it had shortcomings which became more apparent as the century progressed. The general public knew little, if anything about the Council and boards, even at the end in 2002. Indeed, until about 1990, there was very little publicity of their existence or work. At the beginning of the CPSM, the Council had sought advice on publicising its work amongst the general public from public relations consultants. This initiative does not appear to have lasted or have been repeated. By-and-large, the only contacts which the Council, boards and Registrar fostered were with professional bodies and government departments.

After 1990 the Council, Registrars and boards began to put this right, but it required a major and continuous effort, starting almost from scratch. People did not know that the CPSM and boards existed, and therefore did not know to whom they needed to complain if they were dissatisfied with a CPSM registrant in terms of their behaviour. There were also obstacles when they did want to make an allegation. They had to go to the trouble and expense of getting a statutory declaration. They, too, had to have sufficient knowledge and education to be able to submit their case, or resources to employ a solicitor to do so on their behalf. It is likely that legitimate cases never appeared, by default, because the public were largely unaware of the CPSM's existence and many would have been put off anyway by the obstacles in their path. Furthermore, the CPSM or boards or Registrar could not initiate cases themselves, but always had to wait until they received an allegation from elsewhere. Even if they knew of a major cause for complaint against a registrant, they could, in themselves, do nothing about it.

4.4 The disciplinary hearings

The Professions Supplementary to Medicine (Disciplinary Committee)(Procedure) Rules covered the proceedings of the committees. Each board's Disciplinary Committee had its own Rules, for example, the Dietitians Board (Disciplinary Committee) Rules 1964. These Rules set up the committees. The Rules required that:

“Not less than seven clear days before the date fixed for a meeting of the Committee, the Registrar shall send to each member of the Committee a notice in writing of the date, time and place of the meeting, and a programme of business for the meeting, which shall include the particulars of the allegations against registered in every disciplinary case to be considered at the meeting.”

At a formal hearing the Disciplinary Committee used court-like procedures, as it was acting in a quasi-judicial capacity, very like a court of law. Hearings were open to the public. This was an exception for the CPSM, where even Council and Board meetings were held in private and were never open to the public, except for the Council at the very end of its existence. The Committee had to decide whether, from the evidence presented to it, the conduct of which the registrant had been accused took place and, if it did, whether it rendered him / her unfit to be registered. The basic principles and procedures were the same as used in a court. Both sides were given an equal and fair opportunity to present their case. Once the Investigating Committee had decided that there was a case to answer, the Council's solicitor, rather than the person making the allegation, took over and presented the case in the hearing. In the hearing the Disciplinary Committee itself acted as the panel (though this term was not used), over which the Committee Chairman presided. There was a legal assessor to advise the Committee but also ensure that the hearing was legal and fair.

The CPSM never employed its own solicitor for disciplinary purposes, although the first Registrar, John Tapsfield, was a solicitor. Once the boards had set up their professional conduct committees and processes, the Council engaged the firm of solicitors Kingsley Napley to carry out the legal aspects of the work. This involved presenting the case against the registrant, advising the Committees and advising the Registrars. The CPSM, unlike other large regulators such as the General Medical Council (GMC), never had a professional conduct department. Until the late 1990s the Registrar and Registrar's secretary serviced all Disciplinary Committee hearings themselves. The Board secretaries serviced the Disciplinary Committees when meeting as committees rather than hearings and, until the early 1990s, they serviced all the Investigating

Committee meetings. This was only possible because of the very small number of cases involved each year. Neither employees (not even the Registrar), nor Board members involved in the disciplinary processes received any training in this area until towards the end of CPSM. They relied entirely on the professional advice of the Council's solicitors.

4.5 The hearing process

All the Disciplinary Committees over the years devised ways of trying to work the system effectively. The hearing process was fully 'accusatorial'. Both the person presenting the allegation and the respondent (the registrant being complained about) had an equal and fair opportunity to present their case. The Disciplinary Committee had to decide whether to find the registrant either 'guilty' or 'not guilty' of 'infamous conduct in a professional respect' (see section 3.5) or it could defer a decision. A registrant found 'guilty' could have her or his name removed or 'struck off' from the Register, which was their only sanction. The Committee would alternatively issue a warning or caution. The legislation did not specifically give the Committee such powers, but it was taken as a reasonable and just implication from the explicit powers it had. A hearing could decide that a particular act was infamous conduct, but that there were mitigating circumstances. Therefore, and particularly where a registrant had expressed regret and a determination that it would not happen again, it was considered reasonable and in accordance with common justice, that they be given a warning that, should they come before the Committee again, they would be struck off, rather than be struck off there and then. Thirdly, it would remove his or her name, but indicate that it would consider readmission to the Register after a set period, provided proof of good conduct were received.

Again, the legislation did not specifically give the Committee such powers, but it was taken as a reasonable implication in accordance with common justice.

The Professions Supplementary to Medicine Act used the terms ‘guilty’ or ‘not guilty’, terminology which people now regard as inappropriate. Although they were acting in a quasi-judicial capacity, the Disciplinary Committees were not dealing with criminal law, to which the term ‘guilty’ applies, but considering the question as to whether or not a person should be on the Board’s Register. The standard of proof which hearings used was, essentially, that used in civil cases. A hearing sought to balance the probabilities, the standard of proof being higher the more serious the circumstances. A registrant’s livelihood, and professional and personal good name were at stake. On the whole therefore, the standard of proof would be slightly higher than the average civil case in a court of law, and, as R Pickis stated in his unpublished paper⁹ :

“It should be borne in mind here that that the precedents relating to the establishment of sufficient proof of infamous conduct also come into play. In rough lay terms, it is understood that the level of proof in civil cases is that a judge must be satisfied that a case is made on the balance of probabilities. The criminal level of proof is that the case is established beyond reasonable doubt. The level of proof in CPSM cases lie (sic) somewhere between the two. The standard of proof being higher the more serious the circumstances.”

4.6 The Council

Professional conduct was a Board not a Council responsibility, through their Investigating and Disciplinary Committees, except that the Council made the relevant Rules, and employed the staff who organised the hearings and serviced the committees, the legal assessors and the solicitors to present the cases. However, it had quite extensive general supervisory powers. Section 1(3) stated that:

“The Council shall perform its general function of co-ordinating and supervising the activities of the boards

(a) by making to each board, or inviting the board to make to the Council, proposals as to the activities to be carried on by the board or other boards;

(b) by recommending a board to carry on such activities, or to limit its activities in such manner, as the Council considers appropriate after consultation with the board on the proposals aforesaid;

(c) by concerning itself with matters appearing to it to be of special interest to any two or more of the boards, and by giving the boards such advice and assistance as it thinks fit with respect to such matters;

(d) by exercising its powers under the following provisions of this Act in such manner as the Council considers most conducive to the satisfactory performance by each board of the board’s functions under this Act.”

⁹ Quoted in Rod Pickis’ paper ‘Relevant Documents – Other documents’, below.

4 The disciplinary process at CPSM

In the event that the Council did not use these powers proactively in respect of ethical and conduct matters until the 1980s. Until then, by and large, it left the boards and their Disciplinary Committees to their own devices. However, as covered in section 6, a number of general ethical and conduct issues began to arise which applied to all the professions. It made sense that the Council co-ordinate the discussion and consideration of these issues, and proactively introduce them when appropriate. Examples of this are confidentiality of patient data, infection control and 'whistleblowing'. In some instances, a Disciplinary Committee and its Board would consider an issue and then recommend that the Council invite all boards to do so. Examples are registrants' responsibilities during an industrial dispute and for clinical records.

5 The boards' standards of conduct

5.1 The Statements of Conduct

The Act required that each Disciplinary Committee produce its own standards of conduct: the Statement of Conduct. The Committee had to consult its own board and the Council in doing so, but it did not require any other consultation. From the beginning, each statement had an introduction. The introduction explained the purpose of the statement, the powers under which the Committee had produced it and how registrants should interpret it. Most of the committees changed their introductions four times. The first Registrar wrote the introduction to the very first statements, which was common to all professions and the subsequent one. Dr Brian Donald revised it in consultation with the Council's solicitor in the early 1980s. Both wrote before the Plain English Campaign began influencing organisations and their literature and documents. As was then the norm, the language that the introductions and the statements themselves used derived directly from the legislation, from purely legal and administrative perspectives. General attitudes to this changed in the 1980s and early 90s. Therefore, in the late 1990s, following the example of the Occupational Therapists Disciplinary Committee, which rewrote its Introduction in 1995–6, most committees rewrote the Introductions entirely to make them more readable and usable. Some of the committees at that time also rewrote their statements in more user-friendly language.

In the first fifteen years or so, the number of these written standards was very small. Hearings did not need to confine their considerations to the statements when considering allegations. In practice, most 'standards' they used were unwritten and assumed, and provided the committees could broadly demonstrate reasonableness, they were not acting 'ultra vires'.

The committees did not produce their written standards as a result of specific engagement with the ethical issues and principles involved, nor as a coherent whole. It would not have occurred to them to do either because this was not needed in that period of their existence. They were ad-hoc and almost entirely intuitive. Later, although the committees amended them more frequently, largely reactive rather than proactive. They were reactive to issues which disciplinary hearings brought up in individual cases, and subsequently also to general issues which came up in the broader health world or wider society, such as confidentiality of patient data or responsibilities of registrants during an industrial dispute.

Section 9 of the Act stated that:

“but the fact that any matters are not mentioned in such a statement shall not preclude the disciplinary committee from judging a person to be guilty of infamous conduct in a professional respect by reference to such matters.”

All the versions of the introductions to the statements reminded registrants of this. So it was never expected that the statement would set out in detail every possible example of infamous conduct. Nonetheless, principles such as that set out by the Law Lords in 1993 in their judgment in the Tony Bland case (described in greater detail in section 6) that any decision about patient care should “carry conviction with the ordinary person as being based not merely on legal precedent but also upon acceptable ethical values”, began increasingly by the early 1990s to influence all regulators, at least indirectly, including those at CPSM. The Council, boards and committees increasingly recognised that these values needed in future to be more explicit and articulated, and thus be of use as guidance to the average registrant, the overwhelming majority of whom would never have an allegation made against them.

5.2 The Statements of Conduct and registrants

At first, the statements had little impact on the professions, even less on the wider health world. Each board included a copy of the current statement with each application form and required that an applicant sign that they had “read the Board’s statement relating to Infamous Conduct”. The Act required each board to: “send by post to each registered member of the relevant profession, at his address on the register, a copy of the statement for the time being revised.”

In the early days, committees almost never changed their statements (for example the Dietitians Statement did not change between 1966 when the Dietitians Disciplinary Committee issued its first one and 1985 when it issued a second version; in contrast, it then changed six times between 1985 and 2001). Each board included a copy in the front of its annual register, but few people actually bought these. Therefore, the large majority of registrants would never see or refer to a copy of its board’s statement once they had applied for registration. So they were not things which the average practitioner would have had to hand in their day-to-day practice, which in the early days was, by and large, not considered to be their purpose. Much later, the Disciplinary Committees and their boards began using their statements as a means of setting and publicising their standards of conduct and ethics.

Most of the professional bodies had their own statements of professional ethics and conduct procedures. Their statements were often more detailed than the Statements of Conduct. Some of the areas which the professional statements covered were not relevant to the boards, for example scales of fees charged by private practitioners. For most of the CPSM period, there was little, if any, interaction between the boards’ Statements of Conduct

and the professional bodies’ ethical statements. However, towards the end this changed. In assessing allegations and cases, and in giving advice to registrants the Committees and Investigating Committee Chairmen were increasingly using the professional bodies’ ethical statements to clarify points. Some of the Disciplinary Committees therefore added to the Introduction to the Statement of Conduct wording such as that used in the Radiographers Statement from 1999.

“When considering such cases in the light of the Statement, the Committee may take into account the current “Code of Professional Conduct” of the Society of Radiographers.”

5.3 Queries and advice

The statements were a little more widely publicised through the process by which registrants could send in queries relating to conduct and ethics. Registrants would write to the Registrar asking for advice on a particular matter relating to professional conduct. In the early days the queries related to issues like the use of a particular word or phrase in their ‘announcement of practice’ or name plates. Much later they related to issues such as delegation to assistants, record keeping, sterilisation of equipment and control of infection, additional professional responsibilities and post-registration training. The Registrar used the Statements of Conduct as a basis for his advice to give to registrants. They also received requests for advice from employers and the occasional member of the public.

At first this facility was of little importance and there were very few of these enquiries, even from registrants. During the 1980s they increased considerably and became an important part of the professional conduct function. Professions, such as the orthoptists, whose Investigating Committees had almost no cases during the whole of their existence,

nonetheless did receive a number of queries relating to conduct and ethics. Some professions received a regular number from their registrants each year. Originally, the Registrar by himself had responded, as and when appropriate. When the numbers increased, Brian Donald, the second Registrar, with the Council's solicitors, developed a formal process for handling and responding to these queries. Under this more formal process, the Registrar would receive a query from a registrant about some matter of professional conduct. For example, they would set out a proposal that they would delegate a particular task to an assistant and ask whether this was acceptable. The Registrar would then seek the advice of the relevant Investigating Committee Chairman and, where necessary, the Council's solicitor, as well as previous responses to similar queries. The registrant who was enquiring was here asking for practical advice on specific issues, which they could use in their day-to-day practice. The Registrar therefore had to consider and word the advice carefully, and make sure that his advice was consistent. Sometimes registrants wanted a definitive ruling read off a detailed code. This was never possible because, there were never such detailed codes. The advice always had to remind the registrant that the Disciplinary Committee and Board would always allow and expect them to use their professional judgment, and took the circumstances of each individual case into account. Over the years, the Registrars built up a body of precedent in respect of advice given, but would also need to amend advice appropriately in response to changing circumstances, disciplinary cases and statements.

Occasionally, if a number of queries on the same topic arose and there was no clear answer which the Registrar and Investigating Committee Chairman could give, the Registrar or Investigating Committee Chairman or Board

would ask the respective Disciplinary Committee to see if it needed to change its Statement.

5.4 1975 to 2002 – a period of radical change

In the first fifteen years, the boards concentrated their efforts first on setting up their processes and assessing those who had practised the professions before 1963, but had not undergone the approved qualifications, (known then as 'grandfathering'), and later, on establishing and developing their educational powers. They did very little in the area of ethics and conduct. Some had no cases for many years. In a report on likely future developments to Council in October 1974, the then Registrar, John Tapsfield commented as follows:

“In the field of professional conduct, the boards have, with few exceptions, been required to do little beyond publishing statements relating to infamous conduct in a professional respect.”

Later in the report, he even suggested that their professional conduct power could be removed and implied that all such issues could be left to the professional bodies, because “the boards have had little part to play in it.”

This was a decidedly premature judgment and very definitely not the case subsequently; indeed, this began to change not long after he made this comment and suggestion.

In the 1950s and 1960s unwritten codes of behaviour and attitudes which came from a much earlier age were still common. In this context, it could be argued that the CPSM professionals did not need much guidance or articulated standards. The large majority of health professions still looked up to the medical profession, which for many was the ideal, as were the other established professions such as lawyer, accountant and architect. This all radically changed in the 1970s and by the end of CPSM, professional

conduct and the setting of standards of conduct had become increasingly important to the boards and their professions. This period saw major change and development in all the professions, as well as radical changes in wider society. There were some forms of conduct which in the 1960's society and the professions in particular had considered were 'infamous conduct', but no longer considered them to be so by the late 1990's or at the beginning of the new millennium. By way of a general example, until 1967, homosexual acts between men in England were a crime (and the law didn't change in Scotland and Northern Ireland until the early 1980s). Therefore, an openly gay lifestyle was potentially a matter that could have been subject to disciplinary sanctions by a regulator (although at the CPSM there were, actually, no such cases). Since then attitudes have changed, so that later in the CPSM period, AHPs were free to be openly gay and form gay relationships.

However, all of the Disciplinary Committees resisted the opposite temptation of trying to cover every eventuality and eliminate all possible risk by turning their Statements of Conduct into highly detailed 'codes of conduct' which tried to cover every eventuality. Indeed, by and large, they all tried to avoid using the term 'code'. The statements were indicative statements and most remained fairly general throughout. This allowed practitioners the freedom to make their own professional judgments in accordance with their circumstances and their patients' or clients' needs.

The next sections describes this period of radical change in more detail, by using examples of individual issues and principles with which the Disciplinary Committees and their boards had to deal in relation to their Statements of Conduct.

6 Individual issues relating to standards of conduct

6.1 Advertising

6.1.1 Advertising as infamous conduct

A good example of the radical change in attitudes over the decades is over advertising. In the 1960s, all boards considered that any advertising whatsoever was 'infamous conduct'. In fact, the very first allegation against a physiotherapist in 1967 was that he:

“advertised for the purpose of promoting his own professional advantage (a) by a sign attracting attention to his professional skill and services; and (b) by publication of an advertisement in the Bristol Evening Post.”

The Physiotherapists Statement of Conduct stated as follows.

“Physiotherapists should not (a) directly or indirectly canvas for patients; (b) advertise, whether directly or indirectly for the purpose of obtaining patients or promoting their own professional advantage, nor should they, for such purpose, procure, sanction, or acquiesce in the publication of notices commending or directing attention to their professional skill, knowledge, services or qualifications or deprecating the professional skill, knowledge, services or qualifications of others. The Committee, however, would not regard it as a breach of this requirement for a physiotherapist to write to registered medical or dental practitioners in order to draw attention to his name, address and qualifications, and to the fact that his services as a physiotherapist are available.”

The Disciplinary Committee found him “guilty of infamous conduct in a professional respect”. However, he was not struck off. The ban on ‘advertising’ at the beginning did not just cover ‘inappropriate’ advertising as it did in the later CPSM period. The boards’ and their committees’ interpretation of ‘advertising’ was at first very strict indeed.

They considered that you were ‘advertising’ even if you simply told an interviewer in a newspaper or programme that you were ‘state registered’ and allowed that to be published or broadcast. In 1971, the third-ever hearing against a physiotherapist found a physiotherapist guilty of infamous conduct (although he was not struck off in this case) on the grounds that he had:

“Indirectly advertised for the purpose of promoting his professional advantage and for the purpose of his professional advantage acquiesced in the publication of an article in the Sussex Express”.

In the fourth-ever hearing against a physiotherapist as late as 1982, the hearing found her guilty of ‘infamous conduct’ for the same reason. Again, she was not struck off because, according to the Committee:

“On the evidence we have heard we are uncertain that it was [her] deliberate intention to promote her own professional advantage in allowing the publication of the article referred to. Nevertheless, the article directed attention to her skills, knowledge, service and qualifications and we are greatly concerned that a person of her experience was not more circumspect in the conduct of the interview. We regard her as being negligent in not following up the article”.

The Chiropodists Statement of Conduct was slightly more liberal. It stated that:

“No chiropodist should advertise or canvas, directly or indirectly, for the purpose of obtaining patients or promoting his own professional advantage, but it would not be regarded as a breach of this provision for a chiropodist i) to send professional cards or letters to patients who have been attended by him, as a principal, giving notice of a change of address, ii) to notify registered medical practitioners and to put up to four [later 12] announcements under the

heading of ‘professional’, ‘medical’ or ‘personal’ all appearing within a period of four weeks [later six months] in two newspapers circulating in a district where it is proposed to set up a new practice or to take over an existing practice.”

By the 1980s, items in the Yellow Pages of telephone directory became very important to private practitioners. The Chiropractors Disciplinary Committee therefore added a further section to its item on advertising.

“It is considered that a registrant whose name appears in classified telephone or other local directories will not be guilty of misconduct, provided that (i) an individual entry in the general listing does not appear in distinctive type or setting and (ii) an entry in a group announcement carries the designation ‘State Registered...’ and that all registrants in the directory have been offered an opportunity to participate.”

The Committee recognised that its registrants needed to advertise in this new medium, because unregistered chiropractors were already doing so and because the public had a right to know that such services were available. This section of the item on advertising did not last long as a result of the pressure from the Office of Fair Trading described below. All that survived was the attempt to require all its registrants to put ‘State Registered’ at the top:

“all such advertisements must be headed ‘State Registered Chiropractor’; no other material in the announcement may be larger in size or more prominently displayed than the heading.”

It lasted until the end of the Board’s existence, but it is, with hindsight, highly unlikely that the Committee would have been able to enforce this.

6.1.2 Pressure from outside

All Disciplinary Committees changed this strict interpretation, after discussion and consultation with the Office of Fair Trading in the mid-1980s provoked all the Committees and boards to rethink their positions.

The Office regarded such an absolute ban on advertising as an unfair restriction on trade. It threatened to take up the matter further with Ministers under restrictive practice legislation if the Disciplinary Committees did not relax them. Committees and boards began to appreciate that it was particularly unfair to registrants in private practice, as this restriction could not bind the unregistered members of the professions, who could, and did, advertise however they liked. The prime purpose of all the boards was to protect the public, not the professions. The boards and committees discussed and at times agonised over a number of questions. What was wrong in stating to a journalist or interviewer that you were a state registered member of your profession? Indeed, it could be seen as free publicity for the Board and CPSM. Is there anything inherently wrong in promoting your practice for your own professional advantage, provided you do so ethically, fairly and legally? Does the public need protection from registrants publicising themselves or advertising their services? On the contrary, they increasingly recognised that the public and potential users of their services would benefit from the increased access to information on practitioners that would result and also that they may benefit from a degree of competition. On the other hand, they recognised that the public does need protecting from being misled or lied to, and registrants must act fairly in terms of their advertising in respect of the public, but also their fellow professionals. The Office of Fair Trading also accepted this fact. The committees therefore removed any ban on advertising itself, but retained a ban on misleading, false, unfair or exaggerated

advertising. An absolute ban on advertising could well have been challenged, particularly by then, as unreasonable, and subsequently, had it not been changed, as contravening Article 10 'Freedom of expression' of the European Convention on Human Rights (see Appendix 3), whose purpose is to ensure legitimate freedom of expression. The UK signed the Convention in 1951 and so it applied when the boards were beginning in the early 1960s; since the Human Rights Act came into force in 2000, giving the Convention effect in domestic law, such restrictions would have been unsustainable.

6.2 Professional nameplates

In the early decades, the Physiotherapist and Chiropodist Statements were also very strict on the professional nameplates which registrants put up outside their clinics. This was particularly relevant to these two boards, which registered a large number of private practitioners. Nameplates were very important in the days before Yellow Pages, the internet and websites. Because registrants were not allowed to advertise, apart from word-of-mouth or referral by a medical practitioner, a nameplate outside their clinic was the only way a member of the public could know that a registrant's practice existed. The Physiotherapist Statement's wording was that:

“Professional signs should be dignified and restrained in character, and limited to such as are, in position, size and wording no more than are reasonably required to indicate to persons seeking them the exact location of, and entrance to the premises where practice is carried on.”

The Chiropodists wording added 'plates' and 'stationery' to the above:

“Practitioners may describe themselves as State Registered Chiropodists, and may use only their names, decorations, and qualifications for the time being recognised by the Board for inclusion in the Register, their telephone number and hours of attendance. They should not use any other titles or qualifications, and in particular, should not use expressions such as ‘Foot Clinic’.”

The hidden and unwritten assumptions behind this wording reflect values and attitudes of the early period, and show the shift in social attitudes and values since then. It is, for example, not obvious to us now why the term 'foot clinic' was unacceptable. For some time, it has been normal and acceptable both in the NHS and private practice for chiropodists or podiatrists to describe their place of work as a 'foot clinic', 'chiropody clinic' or 'podiatry clinic'. Indeed, examination of the minutes of the Society of Chiropodists' Council confirms that this objection to the term 'clinic', and especially 'foot clinic', was taken very seriously and goes back a long way (before the Board began). It appears that the profession in its early days took its cue on such matters from the usage of the medical profession, which had 'practices' and 'surgeries', but for some reason regarded the term 'clinic' as inappropriate or even unacceptable. This ban on the term 'foot clinic' or similar terms was still in the 1987 Statement.

However, by 1989 it had been removed and incorporated the item on nameplates into the one on advertising, and simply stated that “[p]rofessional signs should be dignified and professionally restrained.”

6.3 Promoting products

Boards did not approve of their registrants promoting products for gain. Most Statements of Conduct had items on this. Some were stricter than others. Most simply banned all such promotion. For example, the Orthoptists Statement stated as follows.

“No registered orthoptist should accept commission on the sale of goods or in respect of any action arising out of the practice of his/her profession.”

The Physiotherapists Statement allowed the supply of dressings and appliances in connection with the treatment given, as follows.

“Physiotherapists should not either personally or as agents or employees of any person, firm or corporate body, sell or accept commission on the sale of goods to the public in connection with occupation as physiotherapist, nor should they in any way directly or indirectly be associated with the sale of such goods. This would not preclude them from supplying dressings and appliances in connection with the treatment of a particular condition for which they have been consulted.”

The Chiropodists Statement had the same wording. Whether or not the registrant was allowed to sell these items is unclear. Presumably they were allowed to do so to cover their cost. The Dietitians Statement was not so strict. The first version gave as an example of infamous conduct:

“improperly promoting the sale of any product in connection with her profession as dietitian or for her own personal advantage”

This was somewhat unclear. Dietitians, particularly those who work for commercial companies, have always to some extent been involved in the promotion of products, by the very nature of their professional practice. The Dietitians Disciplinary Committee later expanded and clarified the item as follows.

“A state registered dietitian must not 4 a) make or support unjustifiable statements relating to particular products, b) use a single brand name as the sole description of a product when giving therapeutic advice to individuals or groups. It is important that a range of products is described. 5) be involved in the promotion of dietary products in other than a professionally restrained manner. When working for commercial organisations, whether employed or contracted, dietitians should not be personally identified in product advertising material and must ensure that their scientific knowledge and clinical skills are used in an accurate and professionally responsible manner in any promotional activity.”

Even the new boards included an item on this. The Prosthetists and Orthotists Statement said:

“No prosthetist-orthotist shall compromise his/her professional judgment in the prosthetic-orthotic management of a patient/user for the purposes of commercial gain, either personally, or as an agent, or employee of any person, firm or corporate body.”

Both the Paramedics and Arts Therapists Statements had strict bans on promotional activity for gain. Undoubtedly, in the early days, some of this reflected older attitudes to being a ‘professional’. However, when they reviewed this ban later on, committees appreciated that there was (and still is) an important public protection aspect to the question of promotional activity. This is why the new boards created in 2000 retained an item on it. The committees recognised that a registrant must not abuse their reputation as a professional and their superior knowledge and expertise. A member of the public could easily be misled into believing that a particular product is superior on the recommendation of a health professional, who, in fact may be doing so simply because they are being paid

to do so and not from any intrinsic merit. Registrants therefore had and have a duty to ensure that any recommendations or promotions are made disinterestedly.

6.4 Professional scope of practice

6.4.1 The significance of professional scope of practice

One of the purposes of the boards' disciplinary function was, jointly with their educational function, to help boards determine what their registrants could and could not do professionally. As explained in Section 3.2, an implied requirement of the Act and the statements was that they protect the boundary between the medical profession and the 'professions supplementary to medicine', between the professions themselves, and between the regulated and unregulated sectors. This is the complex area of scope of practice, ie what a professional can and cannot do; it is the area or areas of their profession in which they have the knowledge, skills and experience to practise lawfully, safely and effectively. Although there was no formal definition as such at that time, this was what 'scope of practice' was in the CPSM period.

6.4.2 Scope of practice, competence and proficiency

Scope of practice is a subject in its own right and too complex to discuss here in detail. It is worthy of a separate study of its own.

However, it does relate closely to professional conduct and discipline, and did so at the CPSM. Although all boards had Statements of Conduct, not all developed formal standards of education and training. None specifically developed the equivalent of the HPC's standards of proficiency. Some, such as the

Radiographers Board, were very reluctant to do so, because they wished to avoid rigidity, be as flexible and non-prescriptive as possible in their approach, and to encourage innovation. Until the degree programmes replaced the old diplomas, the large majority of boards simply approved the core-curriculum of their respective professional body as being the 'benchmark' of proficiency and competence. These were in effect the standards of proficiency, although none actually used that term. So, one determined each profession's scope of practice almost entirely by drawing from other organisations' documents, by implication and by unwritten consensus and agreement, rather than by formal definition. When most of the CPSM professions developed preregistration degree programmes, boards were involved in the Quality Assurance Agency's development of benchmarks for each profession and used them as points of reference. In effect, the scope of practice of all the professions expanded considerably between 1960 and 2002.

6.4.3 The Chiropodists Board and Disciplinary Committee and scope of practice

With one or two exceptions, Statements of Conduct in this respect set out what a registrant could not do, rather than what they could do. Only the Chiropodists Statement clearly laid down what the scope of practice for the 'chiropodist' actually was:

“Chiropody comprises the maintenance of the feet in health condition, and the treatment of their disabilities by recognised chiropodial¹⁰ methods in which the practitioner has been trained. Chiropodists should confine themselves to this field of work.”

¹⁰ Strictly speaking chiropody is a noun and therefore the Board often used the term 'chiropodial' as an appropriate adjective.

In the 1980s there was considerable debate and controversy over chiropodists carrying out foot surgery, both within the profession and with the medical profession. A number of chiropodists were expanding into foot surgery and aroused the suspicions of members of the medical profession, particularly orthopaedic surgeons. Some of this related to protection of the public issues and some to simple demarcation issues, partly relating to the 'supplementary' status of all CPSM professions (covered in section 6.5). The Board and its Disciplinary Committee were, for a period, caught between a small but vocal 'avant-garde' of the profession, who were pushing the professional boundaries, and the orthopaedic surgeons who were deeply suspicious of any change to the status-quo and had several representatives on the Chiropodists Board. There was particular pressure on the Board from two specialist chiropody associations The Podiatry Association and The British College of Podiatry¹¹ to permit the use of designatory letters in its Register indicating that the registrant had obtained qualifications in 'foot surgery'. This, by implication, meant that they wanted the Board and its committees to give, at least tacit, acceptance to expansion by its registrants in to the area of foot surgery.

These specialists were also pressing for the acceptance of the term 'podiatrist' to mean a chiropodist who had gained postregistration training and qualifications in foot surgery, which further complicated matters. In the event they failed in this and the term became, and now is, simply an alternative to chiropodist. However, on the question of chiropodists practising foot surgery, all agreed that, whatever the Board

and Disciplinary Committee accepted, tacitly or otherwise, its registrants would always need to keep their practice within the competence they had gained in their education and training, either pre- or postregistration. The Disciplinary Committee therefore made no addition to its item in the Statement on scope of practice, but added a footnote to it.

“Ambulatory foot surgery, which is becoming an established procedure in chiropodial¹² practice, is surgery performed by Chiropodists at a level sufficiently minor as to be carried out on a day-case basis and which would not normally warrant in-patient admission, the patient being ambulant with or without assistance immediately after surgery. It should be subject to the limitations of the operator’s skills and training, and the facilities available.”

6.4.4 The other boards

The Physiotherapists Statement simply said “A physiotherapist should confine himself¹³ to treatment in those fields of physiotherapy in which he has been trained.”

It made no attempt to define what physiotherapy actually was. The other statements had similar items.

This reluctance to define formally and legally a profession’s scope of practice was deliberate. The committees and boards increasingly recognised that, whilst professionals need much more than just vague implications and unwritten assumptions, strict definitions will tend to make change and development difficult. In the modern world, all professions are continually growing and developing, and

11 Both these associations later merged with the Society of Chiropodists and Podiatrists.

12 See footnote 10.

13 Statements often followed the contemporary practice of using 'he' to mean 'he or she', even though most of their respective professions were female.

need to do so. The view that the boards and committees by and large took was that it is the regulator's role to watch and guide this development, not to dictate to its professions how and whether or not they should so grow.

6.5 The 'supplementary' status of the professions

6.5.1 Professions 'supplementary to medicine'

In the early days, apart from chiropractors, the two things the professions could definitely not do were either 'diagnose' or receive individuals without first getting a 'referral' from a medical practitioner. In later years, these two prohibitions were more and more difficult to define and enforce, and in most cases eventually disappeared. Both prohibitions reflected that in 1960 the professions were 'supplementary' to medicine, by legal definition and provide good examples of this status. However, what exactly did it mean? 'Supplementary' was clearly more than 'auxiliary' (the former term) and 'subordinate', but was not 'equal to'.

6.5.2 Diagnosis

In the early years of CPSM, the terms 'diagnose' and 'diagnosis' or 'clinical diagnosis' had, throughout the medical world, specific and restricted meanings. The issue of whether or not an AHP could 'diagnose' was an important part of this relationship between the professional and the medical practitioner, and the status and exact meaning of 'supplementary'. For many years only a registered medical practitioner (and dentist) 'diagnosed'. If appropriate, he¹⁴ then passed an aspect of this diagnosis to a professional supplementary to medicine to act upon within their own expertise. Professions

supplementary to medicine only 'assisted' the medical practitioner or, at most, 'treated under his supervision'.

For most of the CPSM professions at the beginning and for about two decades afterwards this was presumed and assumed within the requirement for 'referral', see below. However, for two professions, their Statement spelt it out in a separate item. The first example is the Radiographers Statement which stated in the first Statement in 1964 that "No registered radiographer should: Hold himself out as a person who by training and experience is professionally qualified to diagnose or treat injury or disease."

Although the Disciplinary Committee gradually added and developed exceptions to this, this was more relevant to diagnostic radiography; therapeutic radiographers had been involved in the treatment of patients from the beginning. Presumably, in the case of therapeutic radiographers, it meant that they were not to claim that they could treat someone by themselves, but only under medical supervision. Relating to diagnosis, the particular issue with diagnostic radiographers was whether they could 'report' on a medical image which they had produced such as an X-ray, ie interpret what they saw.

For many years this was seen as 'diagnosis' and therefore forbidden. They merely produced the image and gave it to the medical practitioner (usually but not always a radiologist) to interpret. Gradually, as radiography education and training developed, the statements allowed for greater involvement of the radiographer in interpreting and commenting upon the images which they had themselves produced, particularly in emergencies. This reflected the changing arrangements and formal working procedures,

14 In most cases in the early days it was a 'he'.

and relationships between radiographers and radiologists ‘on the ground’ in individual hospital departments, especially since many radiographers were (and are) working in accident and emergency departments, where a radiologist may not be immediately on hand.

Similarly, the Medical Laboratory Scientific Officers Statement stated, too, that:

“No registered medical laboratory scientific officers should: Hold himself out as a person who, by training and experience, is professionally qualified to diagnose or treat disease in man or animal,”

But it gave no exceptions.

Over the years, the CPSM registrants became better trained and took greater responsibility for their patients’ treatment; and, unlike in some other countries, there was often a shortage of medical practitioners, and continual restriction on funds to train and pay them. Therefore, what the medical practitioner did and what the other AHPs did became increasingly blurred. And what exactly was a ‘diagnosis’ and why was what the medical practitioner did ‘diagnosis’ and not the CPSM professional? As professionals, the CPSM professions were moving from ‘supplementary to medicine’ to ‘allied to medicine’. The later changes to the Statements of Conduct reflect this.

6.5.3 Referral from a medical practitioner

A part of this change in status was the gradual relaxing and then final removal of the requirement that a registrant could only advise and treat a patient or client if they had first been referred to them by a medical practitioner. Until the late 1980s, boards and their Disciplinary Committees took this requirement very seriously in their Statements of Conduct. With the exception of the chiropodists, no registrant could advise or treat a patient if they simply arrived at their clinic or

place of work. The patient had to have consulted a medical practitioner (or dentist but the number of dentists referring to CPSM professional must have been very small) first, who then formally ‘referred’ them to a registrant with a diagnosis and instruction as to what was required. If a member of the public simply turned up, the registrant (apart from a chiropodist) would have to send them to their general practitioner or another medical practitioner for a diagnosis and referral before they could do anything. For example, the 1966 Occupational Therapists Statement of Conduct stated that:

“No registered Occupational Therapist should: Undertake the treatment of any patient, unless that patient has been referred to him for treatment by a registered medical practitioner.”

The 1967 Physiotherapists Statement of Conduct added “except in emergency or for some other exceptional reason.”

The Dietitians Statement was less strict. From the beginning, the item stated that the Committee would consider “[h]abitually treating any patient therapeutically without regard to instructions given by a registered medical or dental practitioner” as infamous conduct; it did not define what “habitually” meant. In 1986 it added “[t]he Committee would not regard the giving of general nutritional and dietary advice to groups as a breach of this provision.”

However, the 1988 Dietitians Statement was apparently more restrictive, stating that:

“No registered dietitian should: advise a patient therapeutically unless that patient has been referred to her/him by a registered medical or dental practitioner except in emergency or for some other exceptional reason or unless she/he consults with the patient’s doctor about such advice”.

Although it did have a footnote which stated that “the giving of general nutritional and dietary advice would **not** be regarded as a breach of this provision”

Times have now changed, but in the early decades of CPSM, registrants were very much ‘supplementary’ to medicine and only a registered medical practitioner would know enough about the patient and his / her overall health, and the breadth of medical conditions. A registrant only knew their own specialist area. In the early days, their qualifications were not at degree level. Some were considerably below degree level. For example, the early form of the Diploma of the College of Radiographers was only two years long. However, by the late 1980s this was no longer true and by the mid-1990s, almost all of the profession were graduate entry, and some were developing Masters degrees within their own professional expertise and a few obtaining doctorates.

In the 1950s and 60s, the medical profession had dominated all health professions and the health service, and were heavily represented on the Council and boards. Undoubtedly, in a number of instances they were resistant to greater professional autonomy for the professions. Most medical practitioners and the medical professions wanted to maintain control over these professions, for a variety of reasons, some of them out of self-interest.

Further still, most CPSM registrants were women and most medical practitioners then were men, which is likely to have influenced their view at first, that is, until later in the CPSM period, when some of the medical appointees on the boards and Council itself were themselves women.

6.5.4 Removal of dependency

Some boards and their Disciplinary Committees changed what was, in effect, a ‘dependency’ requirement and therefore their ‘supplementary’ status more quickly than others. In reality, although still legally ‘supplementary’, by the end of CPSM, all the professions were in practice better described as ‘allied’ to medicine, as professions in their own right. The Physiotherapists Board and Disciplinary Committee began debating this issue in the mid-1980s. By the late 1980s, the 1989 Physiotherapists Statement of Conduct simply stated that:

“A physiotherapist shall communicate and co-operate with registered medical or dental practitioners in the management of patients.”

By the end of all the boards’ existence, all the wording was the same in essence to that of the Physiotherapists Statement.

Almost all of this was at the general level. In practice, if one looks at the outcomes of all the CPSM disciplinary hearings for all boards, there was only ever one case in the area of referrals. This was against a biomedical scientist in 1990. He was found guilty of infamous conduct for requesting an item “for the purpose of diagnosis knowing that request was not by a Registered Medical Practitioner”. He was not struck off, but the Committee stated that it the Committee “continues to hold a serious view of the circumstances that led to this charge of which he was faulty on his own admission”.

In fact, as the graph in Appendix 5(14) shows, even in the more general area of ‘practising outside of scope of practice’ (which would also include allegations that a registrant carried out a treatment for which they were not properly qualified), only four per cent of cases could be classified as such.

6.6 Delegation to assistants

In the other direction, a number of the CPSM professions were, by the 1980s, increasingly delegating relatively simple tasks to assistants and helpers who were directly responsible to them. By the end of CPSM, most of the professions had helper / assistant grades working to them. At that time, the Council, and some boards and committees were very aware that their registrants were often under pressure within the NHS and from other employers to cut costs by delegating tasks to personnel who were not trained for them. It must be admitted that not everyone outside the professions themselves was able to distinguish between professional protectionism (which certainly could be a factor at times) and legitimate protection of the public from unqualified or underqualified individuals carrying out practices and techniques beyond their competence. Some people, particularly in the late 1980s and 1990s, presumed, often wrongly, that professional staff, when expressing their concerns regarding inappropriate delegation, were simply protecting and serving their own interests, when there were also important public protection issues. Like some of the other professions (for example the physiotherapists, radiographers and occupational therapists), the chiropody profession developed and begun to train footcare assistants during this period. The Chiropodists Statement therefore included an item on this in its Statement (although it is very likely that most of the others would soon also have included similar items if they had continued). In it the Committee was acknowledging that delegation of simple tasks was necessary and even desirable, but wanted to avoid inappropriate delegation to footcare and other such assistants, which it recognised was not to the benefit of the patient. Employers who forced registrants to delegate

tasks and treatment to individuals who were not properly trained for them, could endanger these patients. If things went wrong, it was the registrant who would, at least in part, receive the blame. The Statement stated as follows:

“A state registered chiropodist who improperly delegates to a person who is not a state registered chiropodist duties or functions requiring the knowledge and skill of such a chiropodist is liable to disciplinary proceedings. This statement is not intended to restrict the proper training of chiropody and other health students or the use of other registered health staff who have been trained to perform specialised functions or to carry out treatment of procedures falling within the proper scope of other registered professions.”

6.7 Registrants' responsibilities during industrial disputes

The major socio-economic and cultural changes which began in the 1960s and 1970s, which included the changes in employment patterns of professional workers and the large increase in the size of almost all of the CPSM professions (see Appendix 4(1)), had a major impact on professional practice, ethics and behaviour. Increasingly, the professions drew from a much wider social background, one which had not been brought up or formed in the traditional ethics of the old professions. Many younger members of the health professions saw themselves as 'workers' and 'employees', certainly not 'professional men', and became increasingly unionised (for example, the Society and College of Radiographers has been a member of the Trades Union Congress for a long time).

During the late 1970s the industrial disputes characteristic of those years spread into the health service. A number of key health

personnel went on strike or took other industrial action. This was largely a new phenomenon, one which people associated with miners and car workers, not ‘professional men’. However, in practice, their pay and working conditions were now essentially the same as other organised workers. This nonetheless raised some major issues of principle. On the one hand, members of a union, whatever their work, would maintain a loyalty to that union and their fellow members. On the other, for workers who were AHPs, such loyalty could never be absolute, because each also had responsibilities to their patients’ care and safety. Ethically, registrants could not use engagement in a legitimate and official industrial dispute as a reason for abandoning or endangering their patients, and thus could not automatically absolve themselves from allegations of infamous conduct.

The Medical Laboratory Technicians Board and Disciplinary Committee began the debate on this in 1980, after the events of 1978 and the ‘Winter of Discontent’ of 1978–79. In particular, a medical member of the Board had reported that as a part of an industrial dispute, medical laboratory scientific officers in the laboratory in which he also worked, had withdrawn from emergency duty rosters. The Council took the initiative to urge all the other boards and their committees to discuss this, and took legal advice. The Council consulted more widely than was normal for the time and sought the views of trade unions as well as the professional bodies and employers’ representatives. The Council and all the boards and their Disciplinary Committees came to basically the same conclusion. The area was extremely sensitive. Committees had to exercise a great deal of caution and diplomacy. On the one hand, all agreed that some sort of reference to this would need to be included in the boards’ statements. They did not wish the

public or employers to think that they were automatically condoning any action carried out during a dispute. On the other hand, after the Winter of Discontent and the election of Margaret Thatcher’s government in 1979, circumstances and industrial relations were highly charged emotionally and parties significantly divided. Boards and the Council did not therefore want the parties to potential disputes to think they were taking sides. After they sought and received Counsel’s opinion, the committees did not add an item to their statements themselves, but added a footnote to the Introduction to each Statement, as follows:

“The question of the relationship between the requirements of the statement and action taken in an industrial dispute has been raised on a number of occasions. It would not be proper for a Disciplinary Committee to be involved in the merits of any industrial dispute concerning registrants and their employers and the participation by registrants in industrial action would not be regarded as within the statement of conduct. The statement of conduct is concerned only with infamous conduct in a professional respect; the principles of conduct against which that will be judged are set out in the introduction to and the contents of the statement. The Disciplinary Committee will consider any allegations referred to them irrespective of whether or not the conduct complained of has arisen in the course of industrial action, or in any other circumstances.”

6.8 Duty of care owed to patients, clients and the public

6.8.1 Safe and effective practice

The complex issue of where a registrant’s responsibilities lay in an industrial dispute

opened up the whole issue of the duty of care that they had to their patients.

Health practitioners have always recognised that they have a responsibility in relation to their patients, but until this period it had not been considered necessary to specify or codify this. The political and industrial climate changed again in the late 1980s and 1990s, and the emphasis was more on safe and effective practice in general, rather than the more specific issue of the consequences of an industrial dispute (one which had become less topical by then). A number of Disciplinary Committees added the warning that their registrants must not exploit or abuse their relationship with their patients or clients.

During the 1990s there were several high-profile cases where medical practitioners had covered up serious incompetence and mistakes by their colleagues, and other practices which endangered the health and safety of patients, and where individuals who had reported them had been ostracised and discriminated against. The latter came to be known as ‘whistle-blowers’. The CPSM Investigating and Disciplinary Committees had not received any such cases, but certain other regulators had been criticised, rightly or wrongly, for either ignoring ‘whistleblowers’ or being ineffective in such situations. They had also been accused, again, whether or not this was actually justified, for appearing to ‘protect their own’, and for acting as if their role were to defend their registrants and their interests, rather than protect the public. In response, a number of other regulators, including, for example, the General Dental Council, now required that their registrants report to the appropriate authority a colleague’s conduct or behaviour or condition which threatened the well-being of their patients or clients. A CPSM registrant could also conceivably find themselves in a similar predicament. At the CPSM Council’s recommendation, in 2001 all

the Disciplinary Committees, after discussion with their respective boards, inserted similar items into their statements of conduct.

The items not only laid down this obligation, but asserted that the safety of patients or clients must come first at all times and should override personal or professional loyalties.

6.8.2 Registrants’ responsibilities in relation to withdrawal of treatment and care

In 1992 and 1993, dietitians became involved in a challenging ethical question which lies at the point where duty of patient care meets the exact moment of death, and still provokes much thought and discussion today. This is the issue of a ‘persistent vegetative state’. The Law Lords on 4 February 1993 had issued a legal ruling in relation to the Tony Bland case. He had been in a coma since being deprived of oxygen during the tragedy in 1989 at the Hillsborough football stadium. The judges in the Court of Appeal in early December 1992 had upheld the previous decision to allow the medical staff to end the artificial feeding of Tony Bland. The Law Lords had also upheld this decision. They had recommended that in future, cases of patients like him should each be referred to the High Court. They described such patients as ‘insensate with no hope of recovery’. They raised a number of major ethical issues surrounding patients in this state, which they believed needed clarifying by Parliament. They believed that the diagnosis was a medical matter, but that any legal decision about their care should “carry conviction with the ordinary person as being based not merely on legal precedent but also upon acceptable ethical values.”

The particular issue in this case was whether the health team, which included and still includes dietitians, could legally and morally stop parenteral and tube feeding, and thus allow the patient to die. Formerly, as professions supplementary to medicine,

dietitians would likely have relied upon and deferred to the decisions of medical practitioners. However, the Dietitians Board believed that, as they were fully professionals in their own right, a dietitian had their own professional contribution, and:

“should not in any way abrogate responsibility towards her/his patient. The Board emphasised that it was not the responsibility of the dietitian to carry out all discussion her/himself, but it would be wise for her/him to assure her/himself that adequate discussions had occurred before her/himself concurring with an intention to cease feeding such a patient.”

The case had initiated a lively and at times heated debate nationally. One of the crucial questions was at what point in practice could a team declare that a patient was ‘insensate with no hope of recovery’ and was this actually death? In the case of Tony Bland, his brain was irreparably damaged. However, in other, albeit rare, cases people in a persistent coma have, nonetheless, come out of it, sometimes years later. Another question was whether tube feeding could be classed as treatment or feeding. A third was, whether or not it was feeding or treating, was this in anyway benefiting a patient whose brain could even be described as hardly existing. As it was a complex issue where it was difficult to lay down hard-and-fast rules, the Disciplinary Committee did not include an item in its Statement of Conduct, but the Board itself produced guidelines for all of its registrants. The Dietitians Board looked at a consultative document which the British Medical Association had previously produced in September 1992, “Discussion paper on treatment of patients in persistent vegetative state”, and produced its own guidelines, in consultation with the British Dietetic Association. Overall, this particular issue is a very good example of how CPSM registrants were developing increasing professional responsibilities.

6.8.3 Control of infection

A growing concern during the 1980s and 90s was the danger of cross-infection during treatment. Because chiropodists frequently use instruments such as scalpels which cut the skin, the Chiropodists Board and its Disciplinary Committee began considering this in the mid-1980s. Until then, the profession had believed that cold sterilization using strong disinfectant was sufficient. However, the Board now believed, after considering expert evidence which it had sought, that this was not sufficient to ensure that instruments were truly sterile, and therefore took the view that only heat sterilization via autoclave provided adequate prevention of cross-infection. The Board had therefore issued the requirement that all schools of chiropody provide heat sterilization of all instruments. However, the Disciplinary Committee did not make this requirement of all the board’s registrants through its Statement of Conduct, which it considered would have been too specific.

For the other boards, the issue was largely first raised in relation to AIDS / HIV. This in itself caused concern with some boards. They observed that, during the 1980s and early 90s there was growing public and media attention regarding AIDS, in some cases, they believed, disproportionate to other infection issues. The Department of Health produced guidance in the early 1990s, with covering instructions about the requirement for healthcare staff to disclose details to their employers on whether they were HIV positive or if their life-style might put them at risk. The boards were asked to consider if this had implications for them. Having received and considered copies of the guidance from the Department of Health on this, all boards produced their own advice. However, several boards and their Disciplinary Committees expressed concern that the advice only dealt with only one aspect of the whole issue of

infection control – one usually associated in the public's mind with a particular minority group – and that it had partly arisen only because the media had drawn attention to it. The Occupational Therapists Board, for example:

“expressed concern that such guidance concentrated on only one, well publicized aspect of cross infection, commenting that there were other, more likely sources of cross infection which were wholly ignored by the guidance documents and were in practice of much greater danger to patients/client.”

The Disciplinary Committees did not add an item to their Statements of Conduct, but, rather, the boards produced advice themselves. Some committees refused even to attach this advice to the Statement of Conduct. From the beginning, the Chiropractors Board entitled its advice on this ‘Cross Infection’ and worded it accordingly. With hindsight, we can see that the boards’ and committees’ concerns had validity. If they had incorporated an item exclusively on AID / HIV into their formal Statements, boards and their Disciplinary Committees would have been drawing attention to only one aspect of a major, much broader issue. Subsequently the much broader nature of the issues involved relating to cross infection became clear.

6.9 Confidentiality and record keeping

6.9.1 Confidentiality

Just as some issues, such as advertising and referral, declined in importance between 1960 and 2002, so other issues arose which had not been significant at the beginning. Some of these arose from the fact that registrants’ professional responsibility and therefore the expectations of employers and the public had grown. Some arose from the wider changes in society, professional behaviour and the health

service and provision. One of the most important issues which reflected both was the development of data protection and confidentiality law and requirements between the mid 1980s and the 2000s. Health practitioners have always needed to respect their patients’ confidentiality and data. However, until the 1980s, nothing in most of the statements specifically set out or clarified what this meant in practice. Because of the nature of their practice, both the Radiographers and Medical Laboratory Scientific Officers Statements of Conduct were exceptions to this. Both had an item on confidentiality from the beginning. Both statements said that registrants should not knowingly:

“disclose to any patient, or to any other unauthorised person, the result of any investigation or any other information of a personal or confidential nature gained in the course of practice in his profession.”

The first data protection legislation was in the mid-1980s and covered the, by then extensive, use of computerised records. Upon the advice of the then Department of Health and Social Security, all Disciplinary Committees added an item to their statements of conduct which said that a registrant should not:

“in the course of professional work seek, keep or store and disclose health information about a patient other than solely for the purpose of that patient’s continuing care.”

They thus extended the requirement to all records rather than just computerised ones. The Data Protection Act 1998 replaced the previous legislation, in response to the European Directive on data protection, and came into force in 2000. The committees modified their statements accordingly, to include reference to obtaining patients’ or clients’ consent.

6.9.2 Record keeping

Record keeping is a closely related to confidentiality. Considering how important keeping good clinical notes and records is to any professional, it is perhaps surprising that none of the statements referred to it throughout the history of the CPSM. However, two boards did address the question, the Dietitians Board and the new Prosthetists and Orthotists Board. The Dietitians Disciplinary Committee considered two cases in 1995 and 1998 respectively, relating to allegations of inadequate clinical record-keeping. In both instances the Committee hearing declared that the case was well-founded and in the second case the registrant was struck-off. Partly as a result of this, the Board produced a joint guidance document on record keeping with the British Dietetic Association.

Arising from a recent query to its Investigating Committee Chairman and general discussion within the profession, the Prosthetists and Orthotists Board also began discussing clinical note-keeping in 1999. The Board in October 1999 agreed formally, as a matter of principle, that failure by a registrant to keep clinical notes on patients treated would be likely to be considered infamous conduct in a professional respect and so informed the Disciplinary Committee. The Disciplinary Committee then began to consider how to take this into account in its Statement and any possible hearings.

At the board's suggestion, its Chairman recommended at the next Council meeting that the boards and Council consider jointly the question of clinical note keeping by all registrants. Other boards (for example the Radiographers Board) recognised that this was an important item which needed further discussion. However, none of them were able to progress this much further before the HPC replaced them. In the meantime, the Prosthetists and Orthotists Board produced

some draft guidelines, and consulted the British Association of Prosthetists and Orthotists and other interested parties on this. Unusually for then, it also sent a consultation letter and the draft guidelines to all of its registrants. A number of registrants replied and the Board Chairman, Colin Peacock, analysed them. The replies supported the proposal, but stated that, for notekeeping to be effective, employers would need to give practitioners enough time to complete the notes. However, the Board was unable to finish this consultation before the HPC replaced it in April 2002. The Disciplinary Committee would have almost certainly included an item in its Statement referring to the guidelines if it had continued, as would, undoubtedly, other committees. Nonetheless, the Shadow Conduct and Competence Committee took the Board's draft guidelines into account when discussing and drafting an item on record keeping in the Standards of Conduct, Performance and Ethics.

6.10 Professional indemnity insurance

Some regulators (for example the GMC, General Optical Council (GOC) and General Dental Council (GDC)) require their registrants to take out professional indemnity insurance. At the CPSM, only the Chiropractors Statement referred to professional indemnity insurance and only in a footnote, which it introduced in 1986. By and large, boards and their committees did not believe that it was appropriate for them to lay down requirements regarding insurance cover and left such things to the professional bodies, who often incorporated insurance cover in their membership fees. However, because many chiropractors worked in private practice, alone or in partnership, the Disciplinary Committee believed it appropriate at least to mention it. The Statement included it as a general footnote, as follows:

“It would not be proper for a Disciplinary Committee to be involved in questions of professional negligence and the adequacy of registrants’ insurance cover under which patients could be paid for damages suffered. However, other aspects of the practitioner’s relationship with patients might become the subject of complaint and the fact that a professional relationship remains impaired because a practitioner has failed to pay damages for want of adequate insurance cover might be taken into account when other matters are considered.”

6.11 Inappropriate association

Throughout the Chiropodists Board’s existence there was a category of ‘infamous conduct’ which was peculiar to that Board, called ‘inappropriate association’. It arose because, unlike most of the other CPSM professions, there were two distinct sectors within the profession, the registered and unregistered. The Chiropodists Board and its Disciplinary Committee wanted to stop its registrants from associating with chiropody institutions which ‘were not recognised by the Board’:

“Chiropodists should not teach or take part in the conduct of examinations in chiropodial¹⁵ subjects, or be in any way associated with any school or institution which has not been recognised by the Board.”

The early version added “unless they have permission from the Board to do so,” which the Committee dropped somewhat later, but added exemptions for training students of other health professionals, post-registration training of chiropodists (presumably registered ones) or foot-care assistants.

Many chiropodists were not registered with the Board and, if they were in private practice, did not need to be. There were several educational and training institutions which trained chiropodists, but were not approved by the Board. Those who successfully completed their courses could not register with the Board, but could work in private practice.

The physiotherapy profession also had very distinct registered and unregistered sectors, but did not attempt to include such a restriction. The Chiropodists Board was trying to avoid a blurring of the distinction between the two sectors. It wanted to stop registrants from giving even an occasional lecture or talk to an unapproved school of chiropody. It was not an idle threat. During the history of the Chiropodists Board, the Disciplinary Committee found two registrants guilty of infamous conduct for associating “with an institution... which has not been recognized by the Board without the permission of the Board to do so,” the second being as late as 1989. In 1983, the Committee struck the first registrant off the register, the second it did not.

This was a significant example of the consequences of unprotected titles. However, since 2005 legal protection of the titles chiropodists and podiatrist, the two former sectors of registered and unregistered have merged through the grandparenting process. This issue is therefore no longer relevant. In retrospect, could the Board’s Disciplinary Committee have enforced such a restriction, even before the Human Rights Act 1998 came into force? On the common law grounds alone of fairness and reasonableness, was it seriously unethical behaviour? Was it unethical at all? If the two individuals above had pressed the matter further and taken the Committee to the Judicial Committee of the Privy Council or

¹⁵ See footnote 10.

judicial review, would the former or a court have upheld the view that such behaviour was 'infamous conduct in a professional respect'? This is perhaps unlikely, particularly as the language which the item in the Statement used was ambiguous. The PSM Act nowhere used the term 'school' or 'recognised', so what exactly did they mean? It did use the word 'institution', but this could also mean any form of institution. Article 11 of the European Convention on Human Rights, 'Freedom of assembly and association'¹⁶ protects the rights of all to join and be associated with lawful and peaceful associations. Since 2000, it is very unlikely that the Committee could have defended this item successfully in the light of this Article.

¹⁶ See Appendix 3.

7 Cases and hearings

7.1 The very small number of cases

The graph in Appendix 5(2) compares the total number of registrants with the number of cases reaching the Disciplinary Committees. As we can see, this stayed very small indeed throughout the time they existed. In some years, there were no cases at all, ie in 1975–6, 1976–7 and 1985–6. The graph in Appendix 5(3) shows the proportion of cases per 1,000 registrants, for all registrants. In fact, the highest proportion was right at the beginning in 1965–66. Professions varied slightly. The Orthoptists Disciplinary Committee never had a case to consider. The new boards, ie those formed from 1997 onwards, did not last long enough to produce enough cases to indicate significant patterns. The graph in Appendix 5(4) shows that the Chiropodists Board's Disciplinary Committee considered cases throughout its existence, but even here there were very few. The appendices show, by way of example, a profession which had very few cases (dietitians), through to those which had a number of cases throughout, (chiropodists). As the graphs in Appendix 5(6) and 5(7) highlight, the Dietitians Disciplinary Committee did not consider a case until 1991–92. The CPSM did not collect data on gender of registrants against whom an allegation was made or who had been through the disciplinary process. Indeed, it did not collect gender data at all, but it was nonetheless clear that during much if not all of its history the majority of registrants were women. However, from an examination of the outcomes of the very small number of hearings held, the majority of registrants who went through a hearing were men.

Why were there so few cases? From the minutes of the Investigating Committees, there is no evidence that these Committees were receiving large numbers of cases and not

referring them. For example, the Occupational Therapists Board's Investigating Committee (see Appendix 5(12)) did not receive a case until 1976–7, which it referred to the Disciplinary Committee. For many of the years between then and 2002, it again did not receive any cases. Apart from 1999–00, when it received seven cases, of which it referred only one, when it did receive cases, it received 1, 2 or 3. Another example, the Medical Laboratory Technicians Board follows basically the same pattern. In accordance with normal procedure in terms of confidential personal data, the CPSM (and its successor the HPC) has not kept copies of allegations received during the CPSM days and which did not proceed to the Investigating Committees, nor is there an extant record of what or how many the Registrars received, but there is no evidence, either, that large numbers of people were making allegations which the Registrars or Investigating Committee Chairmen were screening out.

There are several reasons for this tiny number of cases for every profession. Until the last few years of the CPSM, very few people, whether employers or the public, knew that the boards or their disciplinary processes existed; and, until the mid 1990s convictions involving registrants rarely reached the CPSM. Even if the public knew they existed, they knew little if anything about what they did. The requirement that members of the public always had to make a statutory declaration was an obstacle, too.

However, even in the case of the GMC, which always had a much higher profile than the CPSM, the number of allegations received is very small compared to registrant numbers, albeit larger than for CPSM. The GMC figures for allegations and enquiries received for the same period as the last five years of CPSM are as follows¹⁷.

Year	GMC allegations and fitness to practise enquiries
1998	1,503
1999	2,687
2000	4,470
2001	4,504
2002	3,937

According to the GMC's Annual Report of 2003 "by the end of 2002 over 200,000 doctors held provisional, full and limited registration"¹⁸. 3,937 registrants involved in an allegation / enquiry out of 200,000 registrants is under two per cent.

There is no evidence to suggest a conspiracy by all regulators to avoid looking into and to cover up most allegations against registrants. Instead one can legitimately come to the conclusion that there continue to be so few allegations largely because the vast majority of registrants are committed to their job and vocation to help others and contribute to their well-being as AHP, and therefore maintain their competence, continue to develop professionally and do not misbehave.

7.2 Outcome of hearings

As we can see from the graphs in Appendix 5(13), very few registrants indeed were ever struck off during the whole CPSM period. From all the cases where committees found that a registrant was 'guilty of infamous conduct' (see graph in Appendix 5(14)), the reasons fall into the following categories:

- standards of conduct
 - theft / fraud
 - drug abuse
 - alcohol abuse
 - violence
 - verbal abuse
 - sexual misconduct
- bringing the profession into disrepute
- record-keeping issues
- confidentiality issues
- scope of practice issues
 - practising outside of scope of practice
 - referral issues
- acting against patients' best interests
 - health and safety of patients
 - incompetence
- advertising issues
 - inappropriate advertising
 - inappropriate promotion of products
- sterilization issues
- supervision and delegation issues
- fraudulent entry to the register

¹⁷ From GMC annual reviews.

¹⁸ See page 4 of the GMC Annual Report of 2003.

Some reasons for imposing sanctions were more common than others and some professions were more susceptible to some kinds of misconduct than others. For example, chiropodists¹⁹ were apparently susceptible to theft and radiographers²⁰, alcohol abuse. However, the figures are so small that we can in no way see them as representative of the profession.

7.3 Competence cases

Although strictly speaking Committees could not take competence into account, in practice they could do so partially by classifying it as acting against the patient's best interest. If a registrant acted incompetently, this is clearly acting against the patient's best interest. However, because the only category was 'infamous conduct' and 'bringing the profession into disrepute', and the only sanction was striking off, this could only cover very serious or 'gross' incompetence. The Council and boards for some time, from at least since 1980, had wanted to extend the range of sanctions, and take into account health and competence issues. There was no way of dealing with practitioners who, although not grossly incompetent, regularly fell short of minimum standards of competence. For these, striking off is usually not the most appropriate sanction, because it means that the professional drops out of the system. Rather, committees wanted to bring their practice up to an acceptable standard so that they can continue to make a contribution as a health profession.

7.4 Health cases

The CPSM Disciplinary Committees also could not take into account health issues as such. Again, they, where possible, used the categories which were open to them, particularly 'acting in the patient's best interest' or not doing so. A registrant whose ill-health seriously impaired their competence and practice, and endangered the health and safety of patients should not remain on the Register. However, this was rather stretching the plain meaning of 'infamous conduct' and only covered serious ill-health. Furthermore, as with normal incompetence, striking off was usually not the appropriate remedy.

Committees, boards and the Council increasingly recognised that 'impairment of competence due to ill-health' is quite different from something like theft, violence or sexual abuse. Indeed, informing the world that someone is 'guilty of infamous conduct' under these circumstances would give an entirely wrong impression and could make their condition even worse. In one particular instance, a registrant, who was an occupational therapist had, as a result of a serious episode of mental illness, set fire to her place of work on two occasions. The Occupational Therapists Disciplinary Committee realised that for the moment she was a danger to the public and should not be allowed to practise whilst still seriously mentally ill. Setting fire to her place of work on two occasions was, objectively 'infamous conduct'. They were, nonetheless very aware that she had acted purely as a direct consequence of her illness, not with malice, and whilst not fully responsible for her actions. Simply striking her off and declaring her "guilty of infamous conduct" would give a false impression of her motives and impair her full recovery.

19 Appendix 5 (15).

20 Appendix 5 (16).

Nonetheless, they could only use the legal powers currently available. The Committee therefore formally declared: The Committee had:

“heard the facts of the case sympathetically. They would have wished to be in a position to consider a conditional suspension whilst she received appropriate treatment but they were not empowered to do so. Therefore in respect of the matters to which the charges relate the respondent [registrant against whom the allegation has been made] is guilty of infamous conduct in a professional respect and her name should be removed from the Register. However the Committee hope that she will consider applying for restoration of her name at a suitable time in the future when she can produce appropriate evidence to support her application. The Committee feel that it is in her best interests to be relieved of the responsibility of practising in the present circumstances.”

Given the serious limitations, the Committee in this instance dealt with this particular registrant in as sympathetic a way as was possible.

Partly as a result of this case and more general discussion, the Council’s Working Party on the Future, in its report ‘Future Requirements and Opportunities’ in 1980, considered the question of allegations involving physical and mental health rather than conduct. During its consultation, it had found that the majority of those responding to its discussion document, were in favour of the Working Party’s proposal.

The Working Party favoured a joint health committee to deal with this, as, even then, it recognised that the number of such cases was likely to be small. It therefore recommended that the Council support a change in the legislation allowing a ‘joint Council / boards medical cases committee be set up with a power to suspend registration and / or restrict practice’, which would involve members who

would be specialist medical practitioners. The Council included in its list of recommended legislative changes, which would it produced in 1984, as follows:

“To provide Boards with powers and organisation to suspend the registration of or impose restrictions upon the practice of a registrant whose health may impair his competence or affect his conduct. The same powers of suspension and restriction should also be available to Disciplinary Committee for us in conviction and misconduct cases.”

All reference to a joint committee has been dropped as this was an idea that was arguably not politically opportune at the time.

8 The CPSM and professional conduct, a final word

8.1 A great step forward in 1960

The CPSM, boards and their committees were products of the 1950s and early 1960s (as the HPC is a product of the early 2000s).

The boards set themselves up and developed their disciplinary powers and standards in their early years within the ethos of that era, one which was, in many respects, very different from what came later. The world in which they handed over to HPC had in many senses changed very considerably since their beginnings and, although legally the same entities, they themselves were, actually, in many senses quite different.

Inevitably, how the boards, their Investigating and Disciplinary Committees and the CPSM executive exercised these powers varied from time to time and from board to board.

Nonetheless, the statutory registration which the Professions Supplementary Act achieved was a great step forward in 1960.

An important contribution to this was that it included what were, for the time, real and effective powers relating to professional conduct. It provided a 'kitemark' analogous to that used by the British Standards Institute since 1903, showing that registrants (and the courses and institutions which educated and trained them) met a certain standard of practice and behaviour for the protection of the public. This in turn provided a real and effective standard for employment.

8.2 Internal reform and modernisation at the CPSM

All the professions within the CPSM grew considerably over the period it existed. In 1965 the number of registrants was 25,950, in 2002 it was 137,014. In the 1960s, apart for the position of Registrar, the first of whom was a lawyer and the Assistant Registrar who carried out some accounting and administrative functions, the only staff which CPSM needed were a small number of clerical and

administrative staff; (see Appendix 4 for a diagram setting out the staff structure until 1984). A registration department, with a manager, known as the Registration Officer, and registration clerks, carried out the registration function itself. Two administrative assistants ran all the boards and the Council as committee clerks, entirely unaided. Apart from the actual registration function itself and the Disciplinary Committee hearings, they did everything relating to regulated professions: preparing and sending out agendas; minuting meetings; dealing with all matters arising from the meetings; advising boards on professional, educational and other matters; liaising and communicating with outside bodies; running each board's approval and monitoring, overseas application and grandparenting schemes. The Council appointed an additional administrative assistant in 1984, but all three worked unaided until the early 1990s. There was almost no specialisation of tasks. Individual members of staff provided what input there was in all areas in which the Council, boards, Investigating and Disciplinary Committees were involved, on an ad-hoc basis. For example, until the mid-90s, the Registrar's secretary provided the administration of disciplinary cases.

When it computerised the registers, the Council had greatly helped modernise the registration process, but the other administrative processes and arrangements did not change until the early 1990's. In 1989, the organisation fundamentally remained the same as in the early 1960s in its ethos; yet it was facing radical changes within the professions and professional practice, health service, educational world and general social change. Upon his appointment as Registrar in 1989, Roderic Pickis began tackling the large backlog of urgent internal change needed that had built up over more than two and a half decades, and of bringing the internal administration, management and ethos from the early 1960s into the 1990s, including the

processing of professional conduct matters. Michael Hall, his successor, continued this until the HPC took over (see Appendix 4 for a diagram setting out the staff structure in 2001).

8.3 The need for statutory change

For some time the Council and boards had recognised the legal shortcomings of the PSM Act, as did many outside CPSM. Several of these shortcomings related to their professional conduct powers. Section 6.3 sets out why this was the case: as well as general concerns, the lack of protection of common title was relevant to professional conduct. As section 7 highlights, the disciplinary powers and sanctions which were available to the Disciplinary Committees were very crude. Their powers only related to ‘infamous conduct in a professional respect’ and could not take into account ordinary misconduct, or competence and health issues, and the only sanction was striking off, when a more subtle and appropriate sanction was often required.

Further, there was the fact that each board had its own professional conduct committees. In the CPSM’s Working Party on the Future, in 1980 its report ‘Future Requirements and Opportunities’, had floated the idea of a joint disciplinary committee of the Council rather than one for each board. This would have required a change in legislation. The Working Party’s discussion document had commented:

“For such little use, in some professions robbing the Board of any experience of the operation of the disciplinary powers whatsoever, the provision of eight separate arrangements seems inept and cumbersome. The merging of committees in a Council disciplinary committee to be joined by, say, three assessors from each Board, seems a practical alternative.”

This had aroused some vehement opposition in some quarters, particularly those who wished to retain professional differences and were jealous of professional autonomy. In respect of existing powers which related to conduct and conviction cases, the Working Party had subsequently recommended that the Council leave well-alone. Nonetheless, there was also support for this proposal and it could be argued that, by the end, twelve separate Investigating and Disciplinary Committees was not only administratively inefficient, but could encourage excessive bias towards the profession and individual professional, reinforced by the fact that none of the committees could legally open its membership to outsiders, including lay members.

The fact that CPSM or boards or Registrar had no powers to initiate cases at all themselves, but always had to wait until they received an allegation from elsewhere meant that cases may well have got missed (although there is no actual statistical evidence for this). Even if they knew of a major cause for complaint against a registrant, they could, in themselves, do nothing about it.

Any significant changes required changes to the Act itself. In 1980 the Council began to draw up a list of changes which it and the boards wanted implemented. It was not until 1995 that the government began to prepare for a major review of the PSM Act, which ultimately resulted in its replacement by the Health Professions Order 2001.

Nonetheless, despite all the limitations of the legislation, on balance the boards and their Investigating and Disciplinary Committees accomplished a great deal, particularly in two periods: in their first two or three years when they were setting themselves and their processes up; and within the last ten to twelve years of CPSM.

Glossary

AHP	Allied health profession or allied health professional, a term commonly used during this period for those previously called ‘profession supplementary to medicine’
Applicant	A person applying to join the Register
BRMA	Board of Registration of Medical Auxiliaries
CPSM	Council for Professions Supplementary to Medicine
DHSS	(former) Department of Health and Social Security, subsequently separated into the Department of Health and Department of Social Security
Discipline / disciplinary	Term used for the formal powers relating to professional conduct exercised by the CPSM boards (and certain other regulators)
Fees	The fees payable by registrants for admission to the Register, or re-admission or renewal of registration; fees were the CPSM’s, and are the HPC’s, main source of income
GDC	General Dental Council, one of the UK statutory regulators of healthcare professionals, which regulates dental professionals (dentists, dental nurses, dental technicians, dental hygienists, etc)
GMC	General Medical Council, one of the UK statutory regulators of healthcare professionals, which regulates medical practitioners
GOC	General Optical Council, one of the UK statutory regulators of healthcare professionals which regulates optometrists, dispensing opticians, student opticians and optical businesses
Grandparenting	Process by which people without approved qualifications apply for registration if they practised before the opening of the Register, both for the CPSM boards and HPC, previously called ‘grandfathering’
HPC	Health Professions Council
Health Professions Order	The Health Professions Order 2001 which set up the Health Professions Council
Member	Member of Council or a Board, either appointed or elected
NHS	National Health Service
Professional body	Organisation which aims to further a particular profession and the interests of professionals such as registrants.
PSM Act	Professions Supplementary to Medicine Act 1960 which set up the CPSM and boards
Protected title	Professional titles which a regulator protects by law (eg occupational therapist, paramedic, physiotherapist, radiographer)

Register	The record of professionals who meet the standards
Registrant	An individual whose name is currently on the Register
Registrar	A person appointed by the Council under the PSM Act, then Health Professions Order 2001, who has certain functions as directed by the Council
Regulator	In this context, any organisation which is responsible for regulating professional workers and their professions
Rules	Legal documents which prescribe in more detail how the organisation will run, and set out procedures for statutory committees, work in relation to professional conduct, procedures for registration and the level of fees
Sanction	Decision reached as a result of a disciplinary hearing; for CPSM this was whether or not to strike off
Scope of practice	Procedures and processes undertaken by a registrant, which includes what they actually do, what they can do and what they are entitled to do
Standing orders	Document which sets out the formal procedures for running Council, Board and committee meetings; they dictate how the members and officers, including the chairman and vice-chairman, will act and behave
Statutory	Set up, required or enforced by the authority of an Act of Parliament
Statutory committee	A committee which the legislation requires be established to carry out certain statutory functions
Statutory Instrument	Secondary legislation which is made under the authority of Acts of Parliament (primary legislation)
Statutory regulation	Regulation of a profession in accordance with a piece of legislation
Striking off	One of the possible sanctions in a disciplinary case, for the CPSM the only one; the registrant's name will be removed from the Register
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting (the predecessor of the NMC)

Relevant documents

The sources for this report include the minutes of the relevant meetings of boards and committees, reports to meetings, standards documents, government reports and Council reports.

Reports

Z. Cope, 'Cope Report', *Reports of the Committees on Medical Auxiliaries*, 1951.

J. E. Pater, 'Pater Report', *The Working Party on the Statutory Registration of Medical Auxiliaries report*, 1954.

'The report of the Council's Higher and Further Education Working Party', *The Next Decade*, 1979.

'The report of the Council's Working Party on the Future', *Future Requirements and Opportunities*, 1980.

K. Melvin, A. Richardson, 'A Report to the Council for Professions Supplementary to Medicine', *Revising the Professions Supplementary to Medicine Act 1960*, Nuffield Institute for Health, 1995.

'Report of JM Consulting Ltd to the Department of Health on the future of the Professions Supplementary to Medicine Act 1960', 1996.

Other documents

The Professions Supplementary to Medicine Act 1960 and relevant subsidiary legislation (all now repealed)

The Statements of Conducts in their various editions of all former boards

The minutes of the CPSM boards and their Disciplinary Committees

European Convention for the Protection of Human Rights and Fundamental Freedoms

Papers for the Professions Supplementary to Medicine Bill and Act, then in the Department of Health Archive at the Elephant and Castle.

R. Pickis, as Registrar 1989–95, unpublished paper 'CPSM and Professional Education, Registration, and Regulation', explains the purpose of registration, and the boards' educational and professional conduct functions, and sets out the background, foundational principles theses.

G. Larkin, *Occupational Monopoly and Modern Medicine*, Tavistock Publications, London and New York, 1983.

A Wilcock, *Occupation for Health: A Journey from Self-Health to Prescription Volumes 1 and 2*, British Association of Occupational Therapy / College of Occupational Therapists, 2001.

J. Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994*, Butterworth-Heinemann Ltd, Oxford, 1994.

I. Moodie, *The Society of Radiographers 50 Years of History*, Society of Radiographers, London, undated.

'Briefing', *British Medical Journal*, 284, (27 February 1982), pp. 680–81.

Appendix 1: The health professions covered by the CPSM and the registrars

The professions which the CPSM covered were as follows, in date order.

From the beginning

Biomedical scientists (formerly medical laboratory technicians then medical laboratory scientific officers)

Chiropodists (since 2005 also called podiatrists)

Dietitians

Occupational therapists

Physiotherapists

Radiographers

Remedial gymnasts (merged with physiotherapists in 1986)

From 1967

Orthoptists

From 1997

Prosthetists and orthotists

From 1998

Art, music and drama therapists (collectively arts therapists)

From 2000

Clinical scientists

Paramedics

Speech and language therapists (formerly speech therapists)

CPSM Registrars

John Tapsfield 1960 – 1976

Brian Donald 1976 – 1985

Frank Whitehill 1985 – 1989

Roderic Pickis 1989 – 1995

Michael Hall 1995 – 2002

Appendix 2: The disciplinary provisions of the Professions Supplementary to Medicine 1960

Disciplinary provisions

Investigating and Disciplinary committees

8.–(1) Each board shall set up two committees, to be known as the investigating committee and the disciplinary committee respectively, of which –

- (a) the investigating committee shall be charged with the duty of conducting a preliminary investigation into any case where it is alleged that a person registered by the board is liable of deciding whether the case should be referred to the disciplinary committee; and
- (b) the disciplinary committee shall be charged with the duty of considering and determining any case referred to it by the investigating committee and any other case of which the disciplinary committee has cognisance under subsection (5) of the next following section.

(2) The provisions of Part 1 of the Second Schedule to this Act shall have effect with respect to the constitution of investigating and disciplinary committees, and provisions of Part II of that Schedule shall have effect with respect to the procedure of disciplinary committees.

Removal of names from register for crime, infamous conduct, etc

9.–(1) Where –

- (a) a person who is registered by a board is convicted by any court in the United Kingdom of a criminal offence which, in the opinion of the disciplinary committee set up by the board, renders him unfit to be registered; or

- (b) such a person is judged by the disciplinary committee to be guilty of infamous conduct in any professional respect; or
- (c) the disciplinary committee is satisfied that the name of such a person has been fraudulently entered on the register maintained by the board,

the committee may, if it thinks fit, direct that the person's name be removed from the register.

(2) When the disciplinary committee directs that a person's name shall be removed from the register, the committee shall cause a notice of the direction to be served on that register.

(3) The person to whom such a direction relates may, at any time within twenty-eight days from the date of service on him of the notice of the direction, appeal against the direction to Her Majesty in Council in accordance with such rules as Her Majesty in Council may by Order prescribe for the purposes of this subsection; and the board concerned may appear as respondent on any such appeal and, for the purpose of enabling directions to be given as to the costs of the appeal, shall be deemed to be a party thereto whether or not it appears on the hearing of the appeal.

The Judicial Committee Act, 1833, shall apply in relation to a disciplinary committee as it applies to such courts as are mentioned in section three of that Act (which provides for the reference to Judicial Committee of the Privy Council of appeals to Her Majesty in Council).

(4) A direction for the removal of a name from the register shall take effect—

- (a) where no appeal under this section is brought against the direction within the time limited for the appeal, on the expiration of that time;
- (b) where such an appeal is brought and is withdrawn or struck out for want of prosecution, on the withdrawal or striking out of the appeal;
- (c) where such an appeal is brought and is not withdrawn or struck out as aforesaid, if when the appeal is dismissed and not otherwise.

(5) A person whose name is removed from the register in pursuance of a direction of a disciplinary committee under this section shall not be entitled to be registered in that register again except in pursuance of a direction in that behalf given by the committee on the application of that person; and a direction under this section for the removal of a person's name from the register may prohibit an application under this subsection by that person until the expiration of such period from the date of the direction (and where he has duly made such an application, from the date of his last application) as may be specified in the direction.

(6) It shall be the duty of each disciplinary committee to prepare and from time to time revise, in consultation with its board and the Council, a statement as to the kind of conduct which the committee considers to be infamous conduct in a professional respect, and the board shall send by post to each registered member of the relevant profession, at his address on the register, a copy of the statement as for the time being revised; but the fact that any matters are not mentioned in such a statement shall not preclude the disciplinary committee from judging a person to be guilty of infamous conduct in a professional respect by reference to such matters.

Section 8.

Second Schedule

The Investigating and Disciplinary Committees

Part I

Constitution of the Committees

1.—(1) The board by which an investigating committee and a disciplinary committee are set up shall, in consultation with the Council, make rules regulating the membership of each of the committees, and the times and places of the meetings, quorum and mode of summoning members of the disciplinary committee; but subject to paragraph (b) below, a person shall not be eligible for membership of either committee unless he is a member of the board.

(2) Such rules shall secure that—

- (a) no person who acted as a member of the investigating committee with respect to any case shall act as a member of the disciplinary committee with respect to that case; and
- (b) where a case against a person who resides and practises the relevant profession in Northern Ireland is before either of the committees, at least one member of that committee at any meeting thereof shall be a member of the board who resides and practises as aforesaid or (where no member of the board satisfies that requirement or no member who satisfies that requirement is available to act on the committee) a registered member of the relevant profession residing and practising as aforesaid and appointed by the board to be a member of the committee for the purposes of the case in question.

(3) Rules under this paragraph shall not come into force until approved by the Privy Council.

Part II

Procedure of Disciplinary Committees

2.—(1) For the purposes of any proceedings before a disciplinary committee in England or Wales or Northern Ireland the committee may administer oaths and any party to the proceedings may sue out writs of subpoena ad testificandum and duces tecum, but no person shall be compelled under any such writ to produce any document which he could not be compelled to produce on the trial of an action.

(2) The provisions of section thirty-six of the Supreme Court Act 1981 shall apply in relation to any proceedings.

Schedule 5, Supreme Court Act 1981.

(3) For the purpose of any proceedings before a disciplinary committee in Scotland, the committee may administer oaths and the Court of Session shall on the application of any party to the proceedings have the like power as in any action in that court to grant warrant for the citation of witnesses and havers to give evidence or to produce documents before the committee, and for the issue of letters of second diligence against any witness or haver failing to appear after due citation, to grant warrant for the recovery of documents, and to grant commissions to persons to take the evidence of witnesses or to examine havers and receive their exhibits and productions.

3.—(1) Subject to the next following subparagraph, the Council shall make rules as to the procedure to be followed and the rules of evidence to be observed in proceedings before disciplinary committees, and in particular—

- (a) for securing that notice that the proceedings are to be brought shall be given, at such time and in such manner as may be specified by the rules, to the person alleged to be liable to have his name removed from the register;
- (b) for determining who, in addition to the person aforesaid, shall be a party to the proceedings;
- (c) for securing that any party to the proceedings shall, if he so requires, be entitled to be heard by the committee;
- (d) for enabling any party to the proceedings to be represented by counsel or solicitor or (if the rules so provide and the party so elects) by a person of such other description as may be specified by the rules;
- (e) for requiring proceedings before the committee to be held in public except so far as may be provided by the rules;
- (f) for requiring, in cases where it is alleged that a person is guilty of infamous conduct in any professional respect, that where the committee judges that the allegation has not been proved it shall record a finding that the person is not guilty of such conduct in respect of the matters to which the allegation relates.

(2) As respects proceedings for the registration of a person whose name was previously removed from the register by direction of a disciplinary committee, the Council shall have the power to make rules with respect to all or any matters mentioned in the foregoing subparagraph, but shall not be required to do so; and separate rules under this paragraph may be made as respects such proceedings.

(3) Before making rules under this paragraph the Council shall consult the boards for the time being established under this Act, and before entering into consultations with the Council under this subparagraph a board shall consult such bodies representing members of the relevant profession as the board thinks fit.

(4) Rules under this paragraph shall not come into force until confirmed by order of the Privy Council.

4.-(1) For the purpose of advising a disciplinary committee on questions of law arising in proceedings before it, there shall in all such proceedings be an assessor to the committee who shall be a barrister, advocate or solicitor of not less than ten years standing.

(2) The power of appointing an assessor for a disciplinary committee shall be exercisable by the Council after consultation with the board concerned, but if no assessor appointed by the Council is available to act in any particular proceedings the committee may itself appoint an assessor qualified as aforesaid for those proceedings.

(3) The Lord Chancellor may, by statutory instrument, make rules as to the functions of assessors appointed under this paragraph, and in particular such rules may contain provision for securing—

(a) that where an assessor advises a disciplinary committee on any questions of law as to evidence, procedure or any other matters specified by the rules, he shall do so in the presence of every party or person representing a party to the proceedings who appears thereat or, if the advice is tendered while the committee is deliberating in private, that every such party or person as aforesaid shall be informed what advice the assessor has tendered;

(b) that every such party or person as aforesaid shall be informed if in any case the committee does not accept the advice of the assessor on such a question as aforesaid,

and may contain such incidental and supplementary provisions as the Lord Chancellor considers expedient.

(4) Except in the case of an assessor appointed by the committee itself under subparagraph (2) above, an assessor may be appointed under this paragraph either generally or for any particular proceedings or class of proceedings, and shall hold and vacate office in accordance with the terms of the instrument under which he is appointed.

(5) The relevant board may pay to an assessor appointed under this paragraph remuneration at such rates as may be determined by the Council with the consent of the Lord Chancellor.

Appendix 3: Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention on Human Rights)

Article 6. Right to a fair trial

1 In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2 Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3 Everyone charged with a criminal offence has the following minimum rights:

- a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;
- b) to have adequate time and facilities for the preparation of his defence;
- c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;
- d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;
- e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

Article 10. Freedom of expression

1 Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.

2 The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.

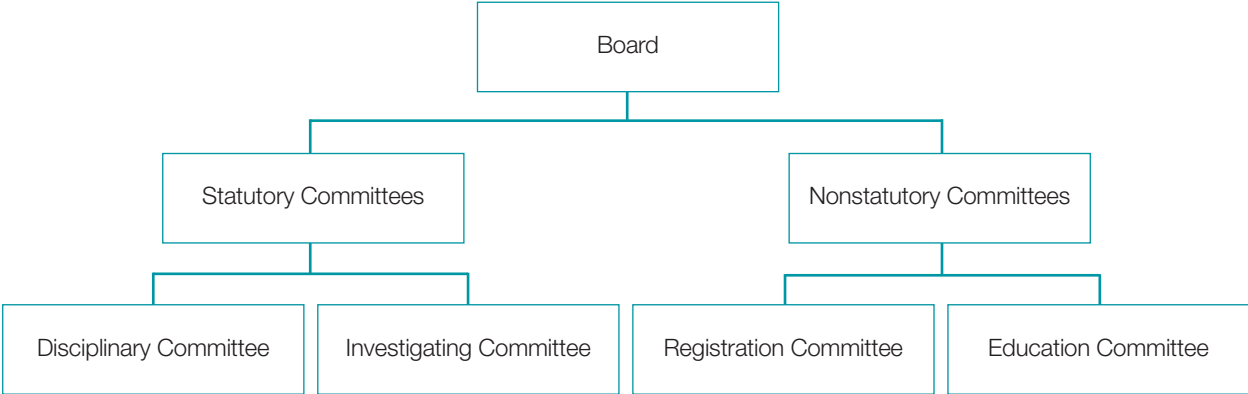
Article 11. Freedom of assembly and association

1 Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests.

2 No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others. This Article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces, of the police or of the administration of the State.

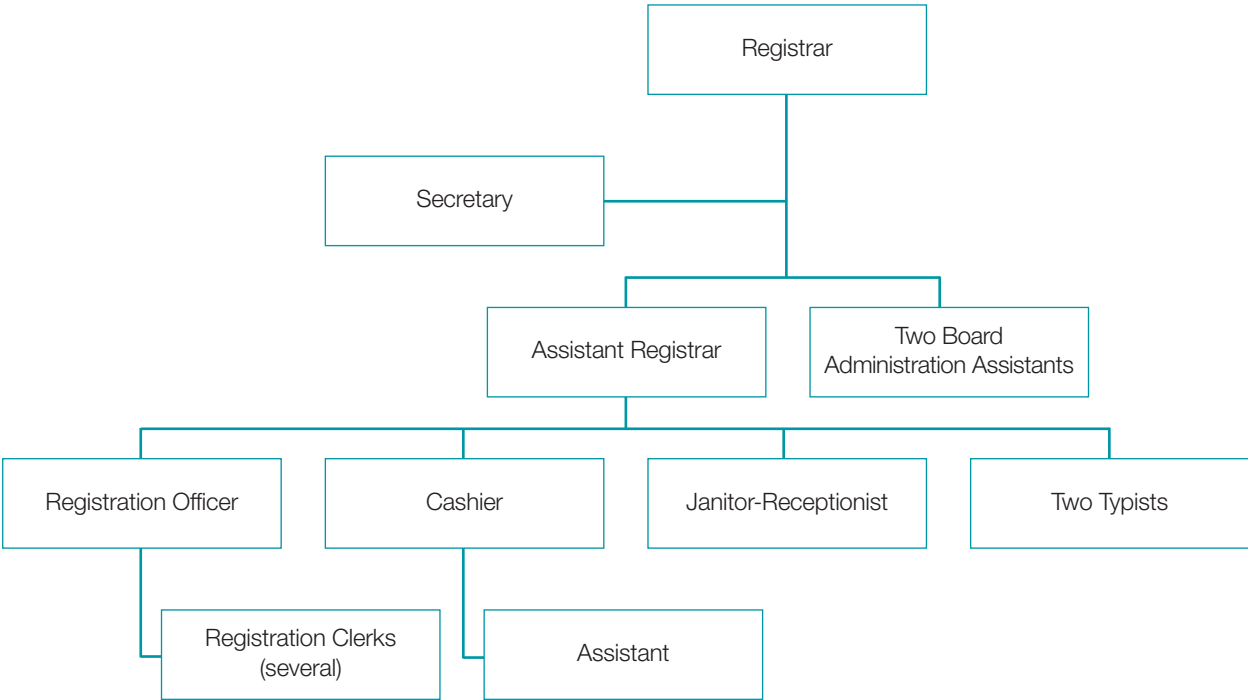
Appendix 4: The basic structure of the CPSM

A typical Board with its committees before the late 1980s

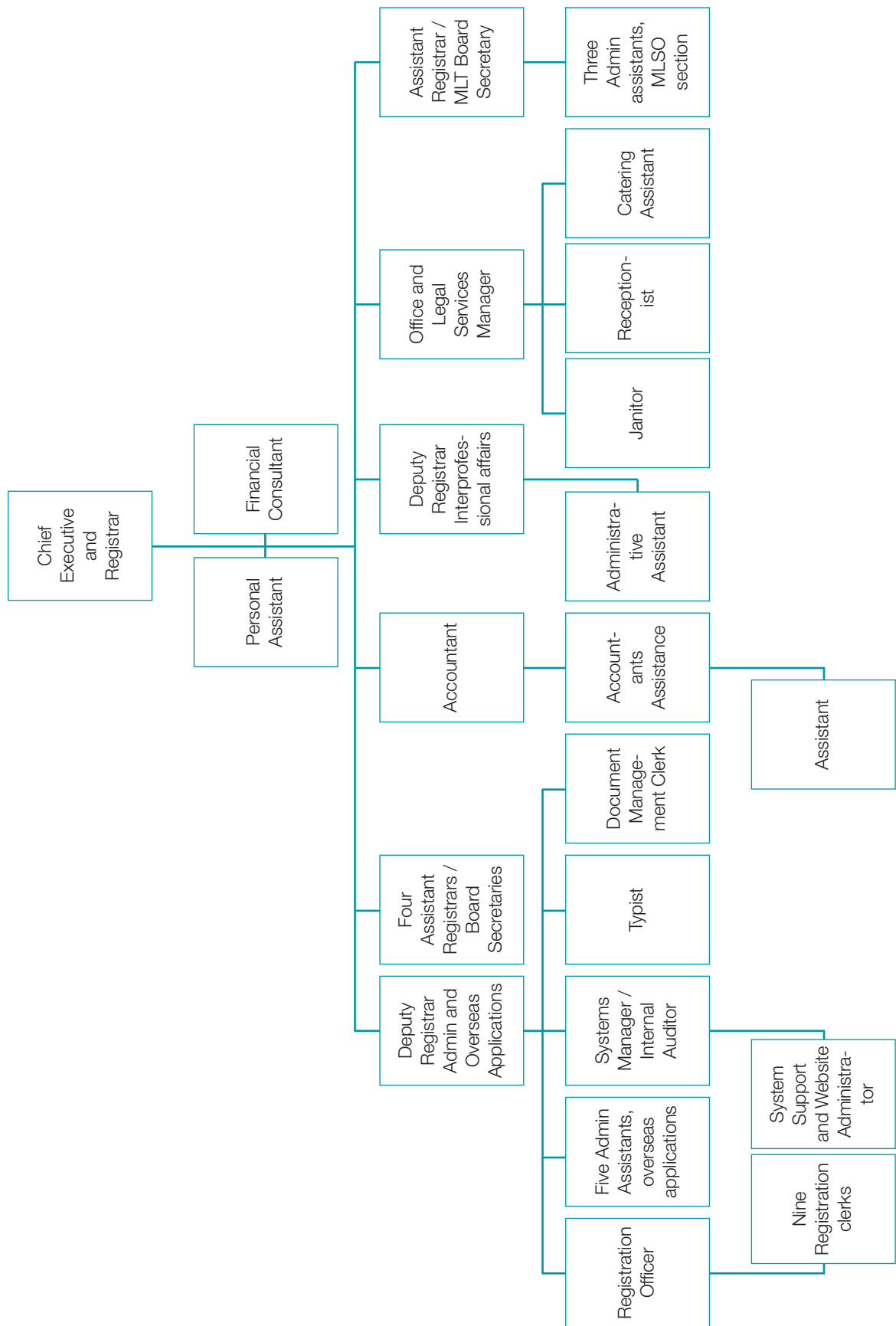


For one or two boards, the title of the nonstatutory committees was different. Later, several boards replaced their education committees with joint committees with their respective professional bodies.

Organisational structure before 1984



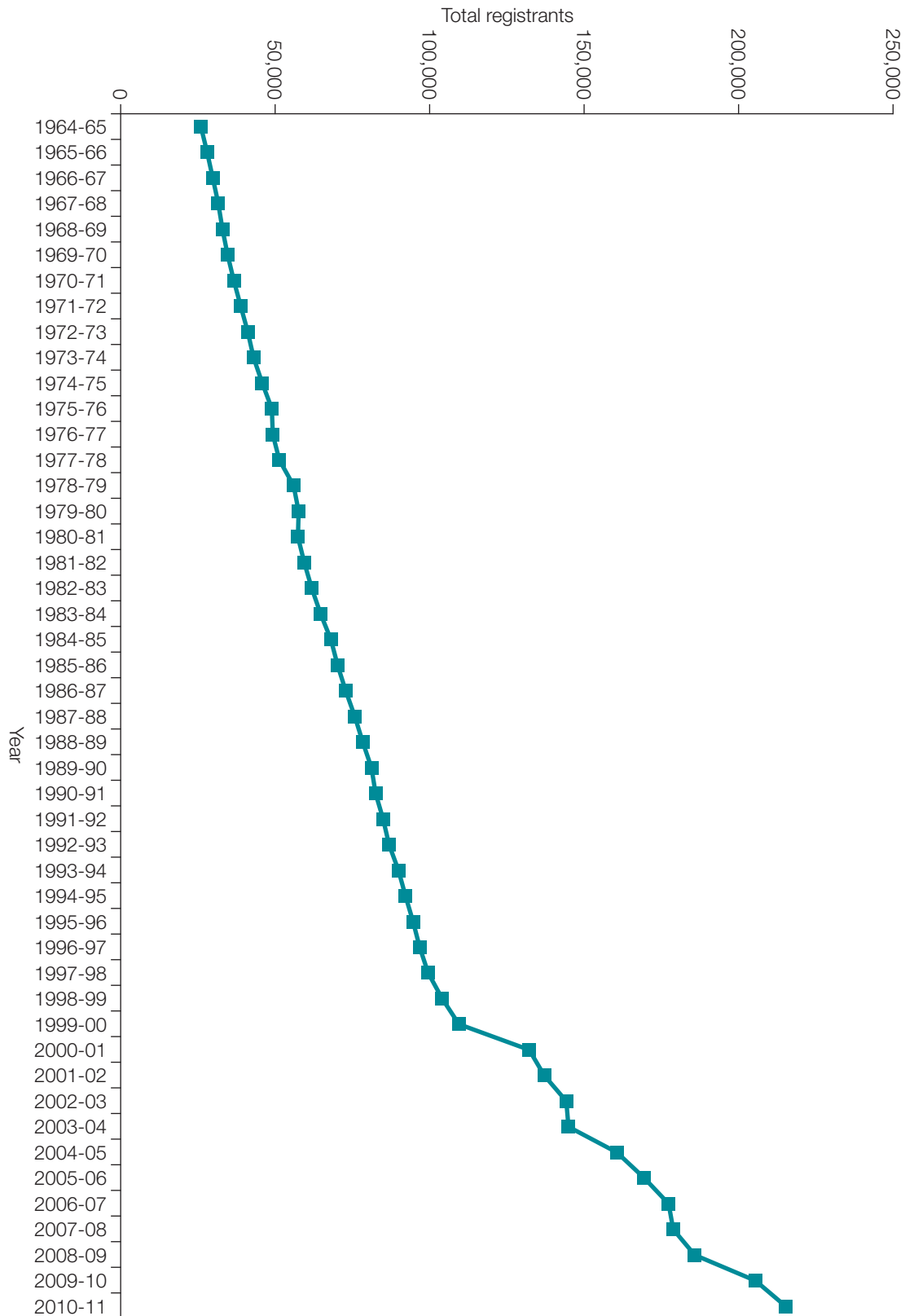
Organisational structure in 2001



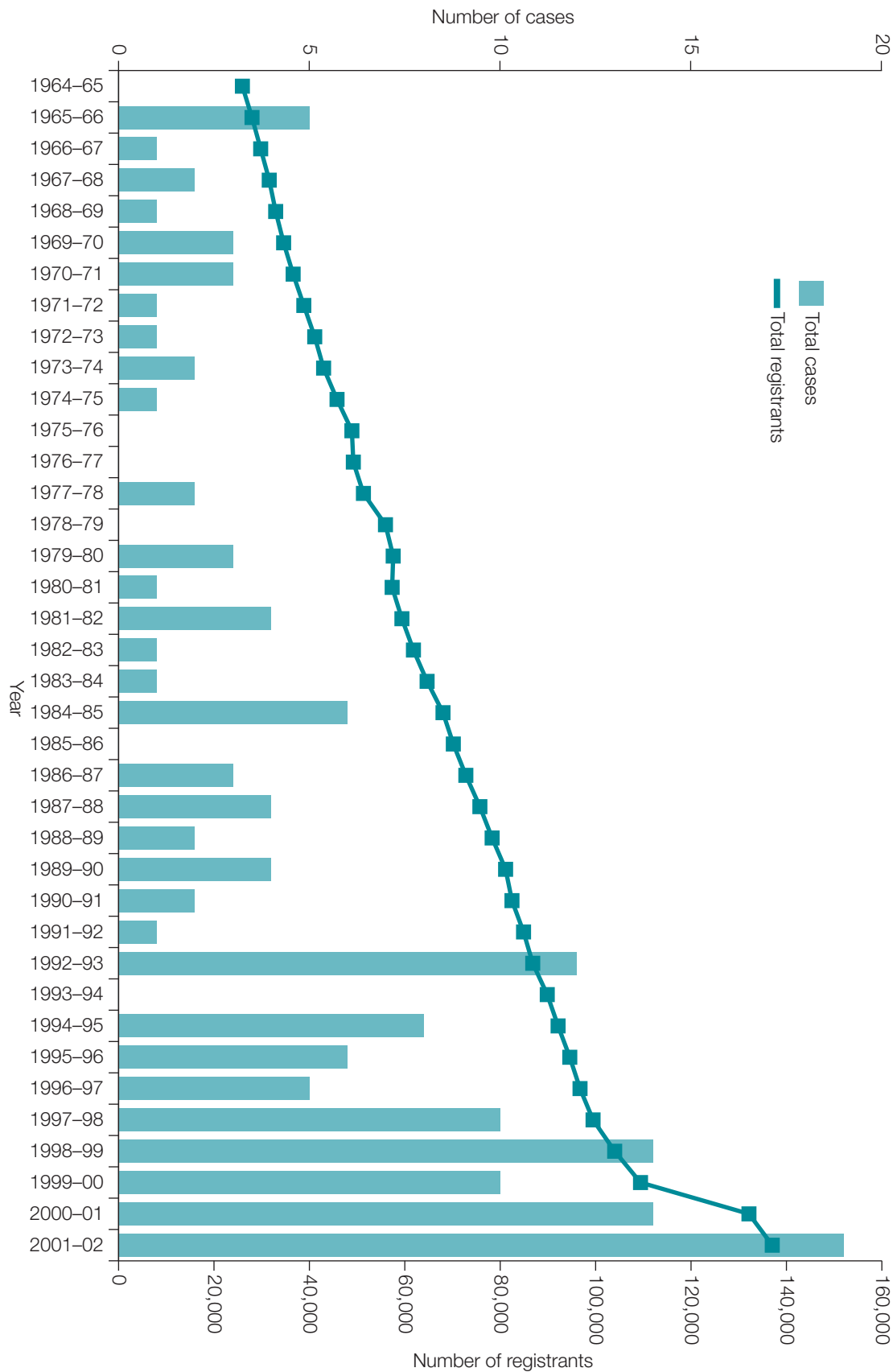
Appendix 5: Some statistical charts

In the next few pages are some charts illustrating the work of the CPSM disciplinary process.

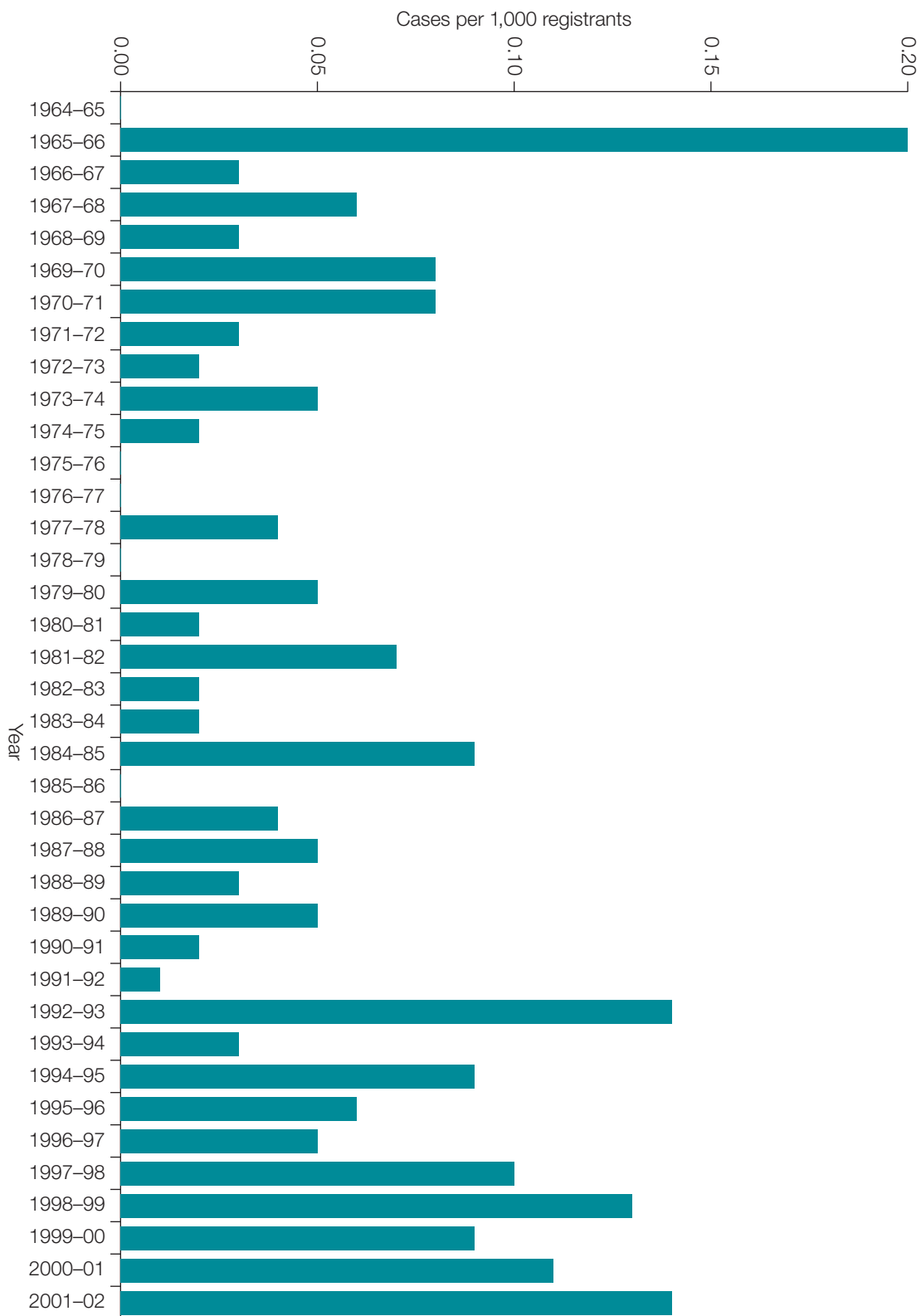
Appendix 5 (1) Total registrants 1964-5 to 2010-11



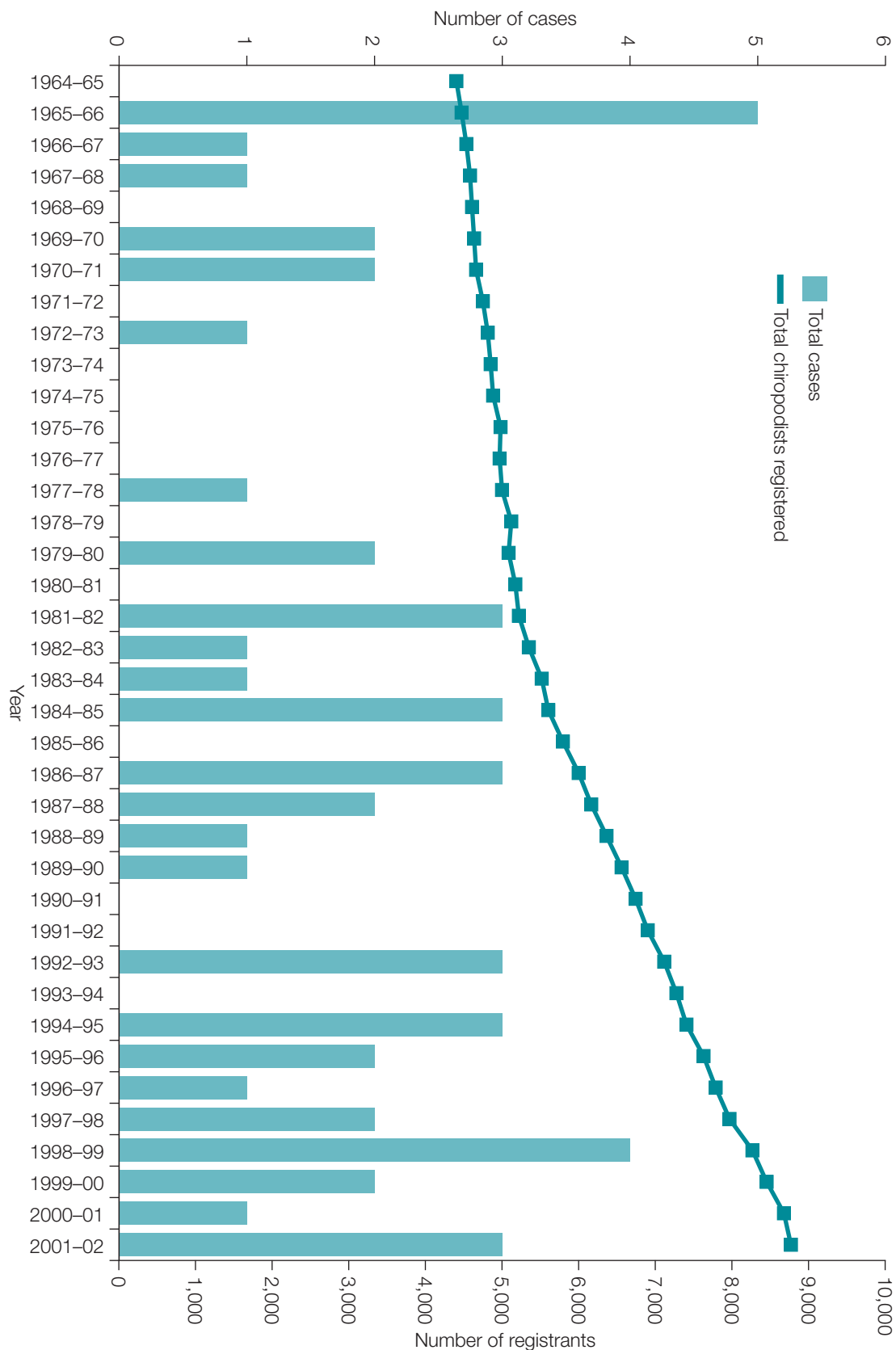
Appendix 5 (2) Total registrants and total cases 1965 to 2002



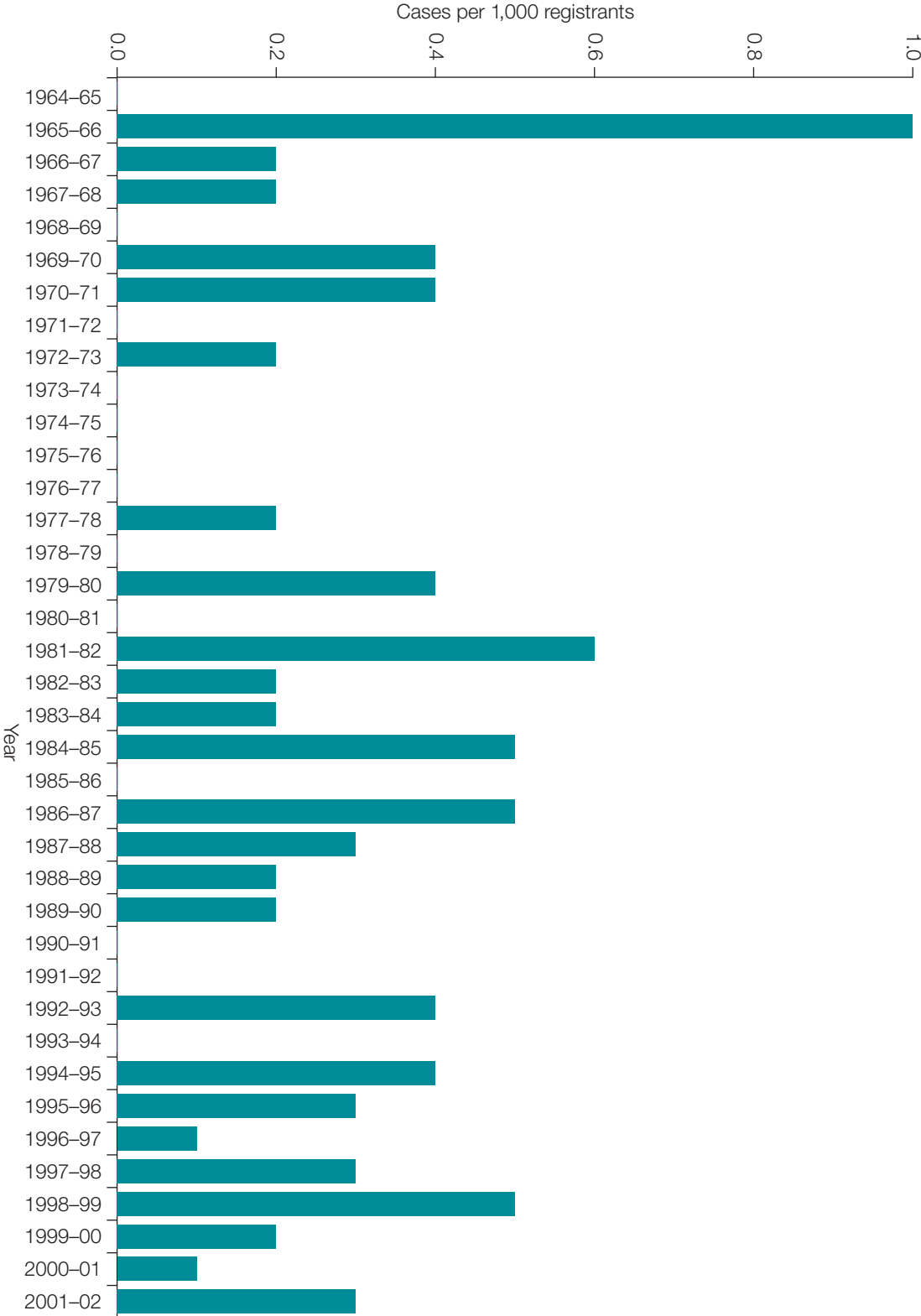
Appendix 5 (3) All professions: cases per thousand registrants 1965 to 2002



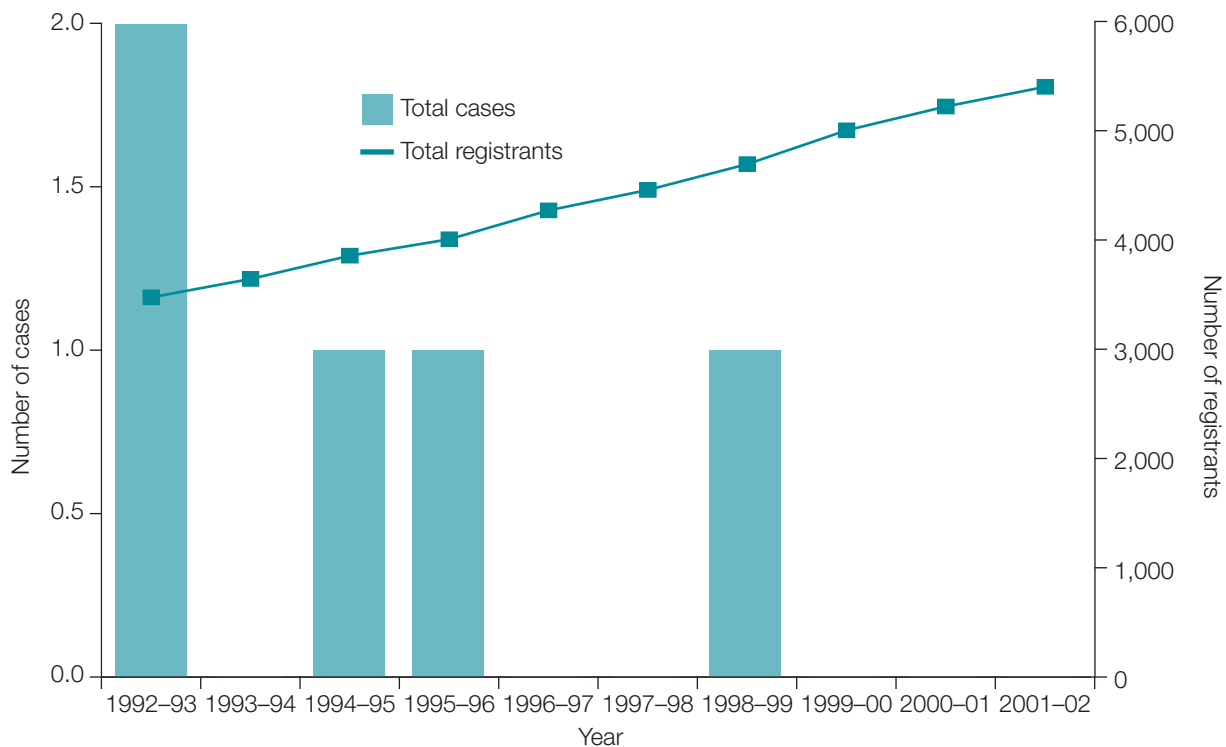
Appendix 5 (4) Chiropractors: total registrants and total cases 1965 to 2002



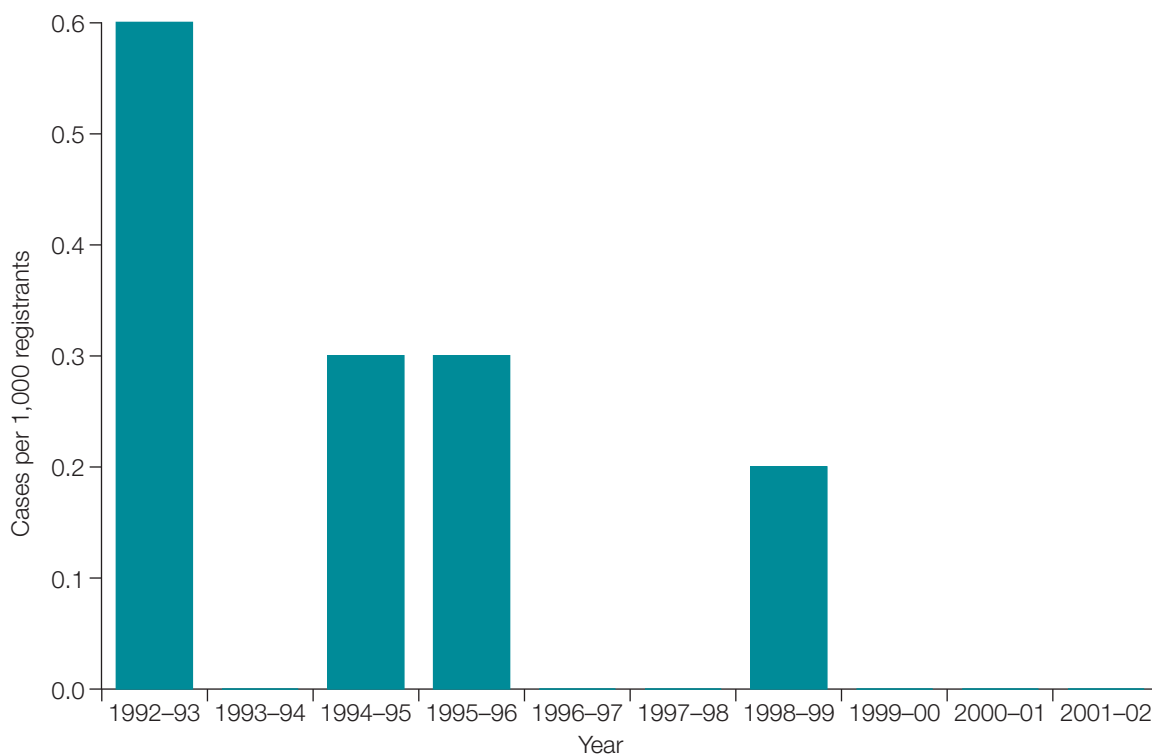
Appendix 5 (5) Chiropody cases per 1,000 registrants 1965 to 2002



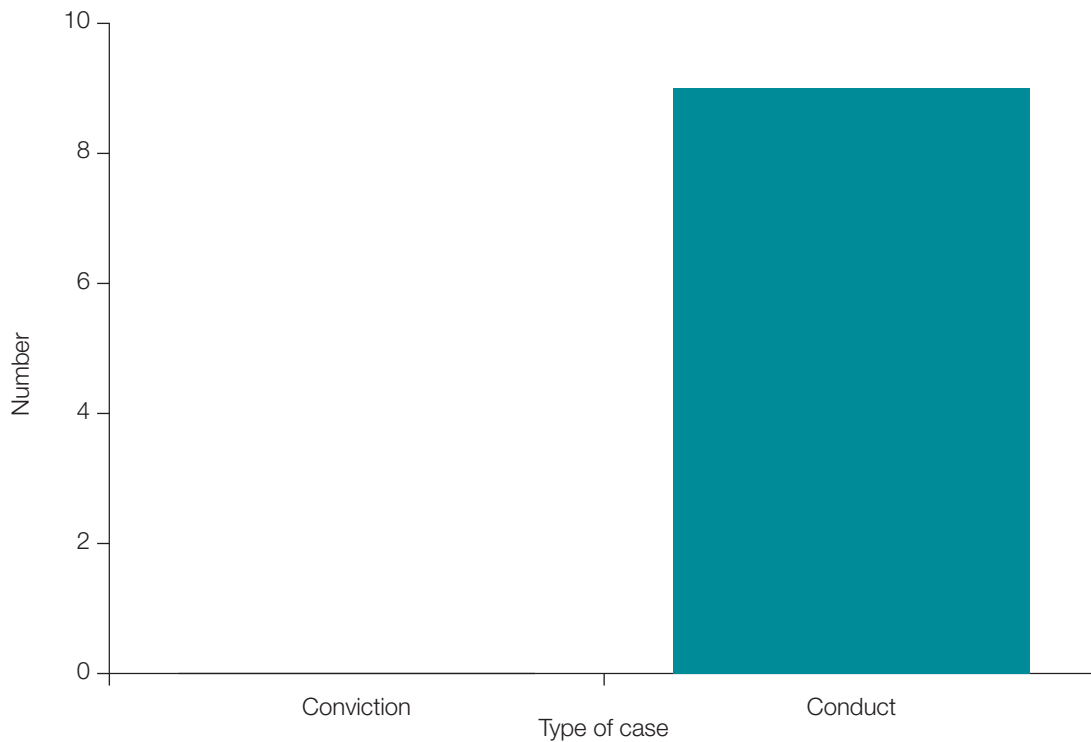
Appendix 5 (6) Dietitians total registrants and total cases 1992-3 to 2001-2 (no cases before 1992-93)



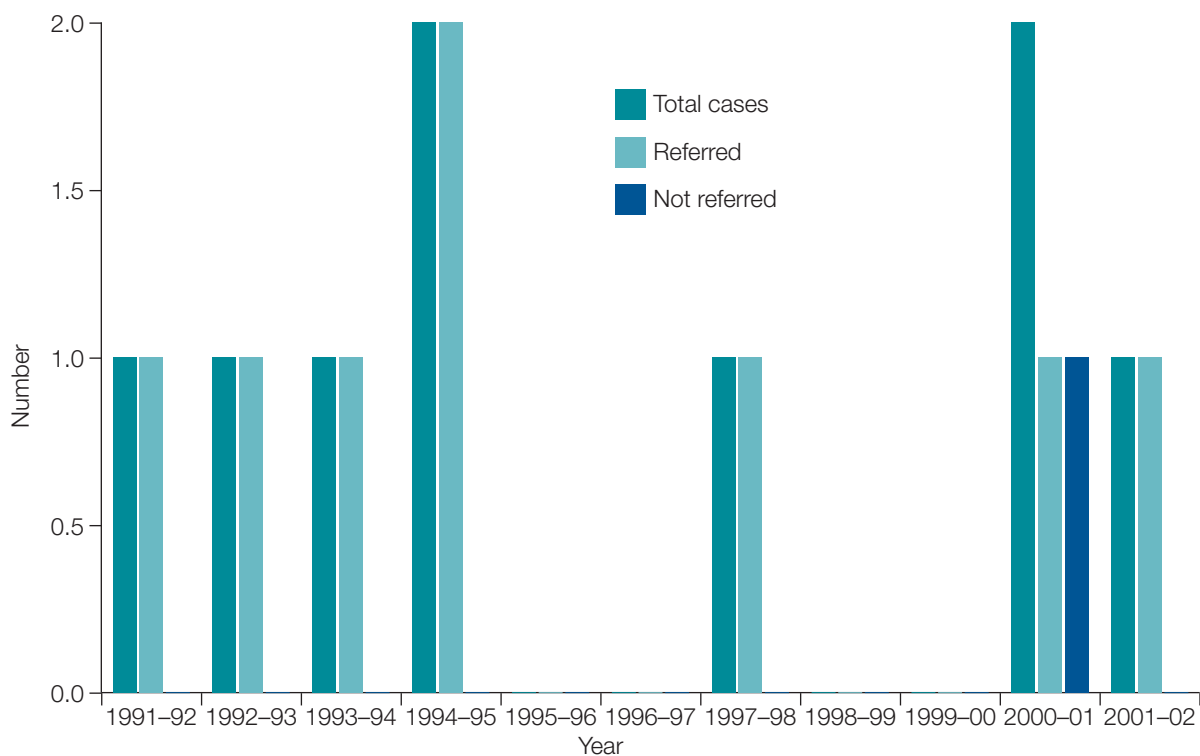
Appendix 5 (7) Dietetic cases per 1,000 registrants 1992-3 to 2001-2 (no cases before 1992-93)



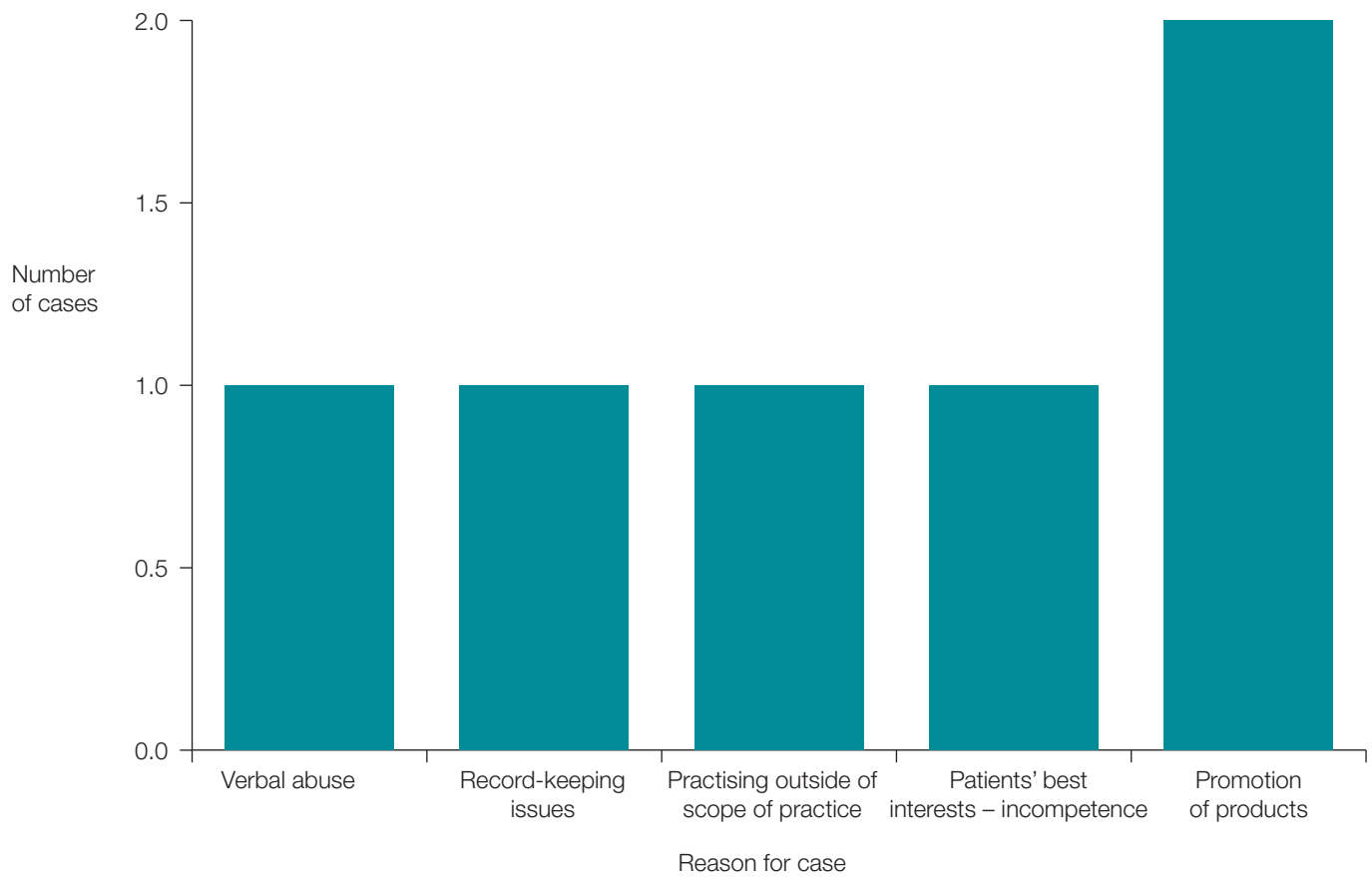
Appendix 5 (8) Dietetic conviction and conduct cases throughout the boards existence



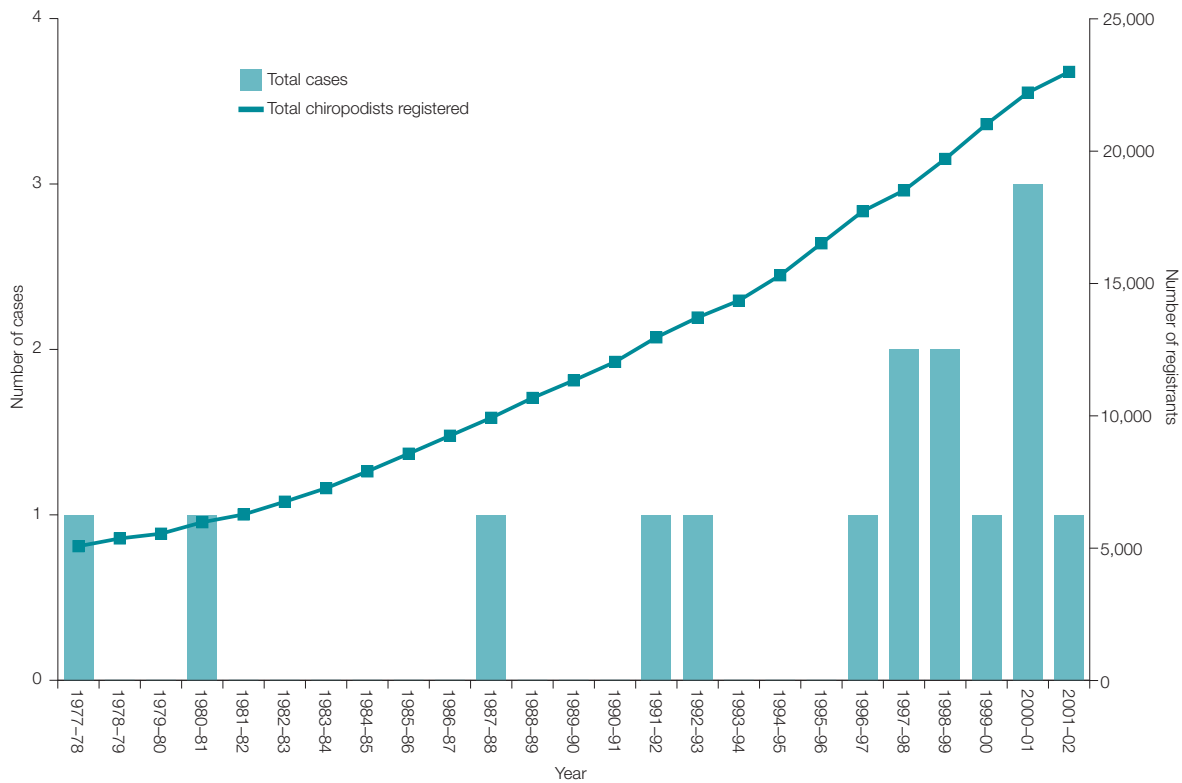
Appendix 5 (9) Dietitians Investigating Committee referral of cases



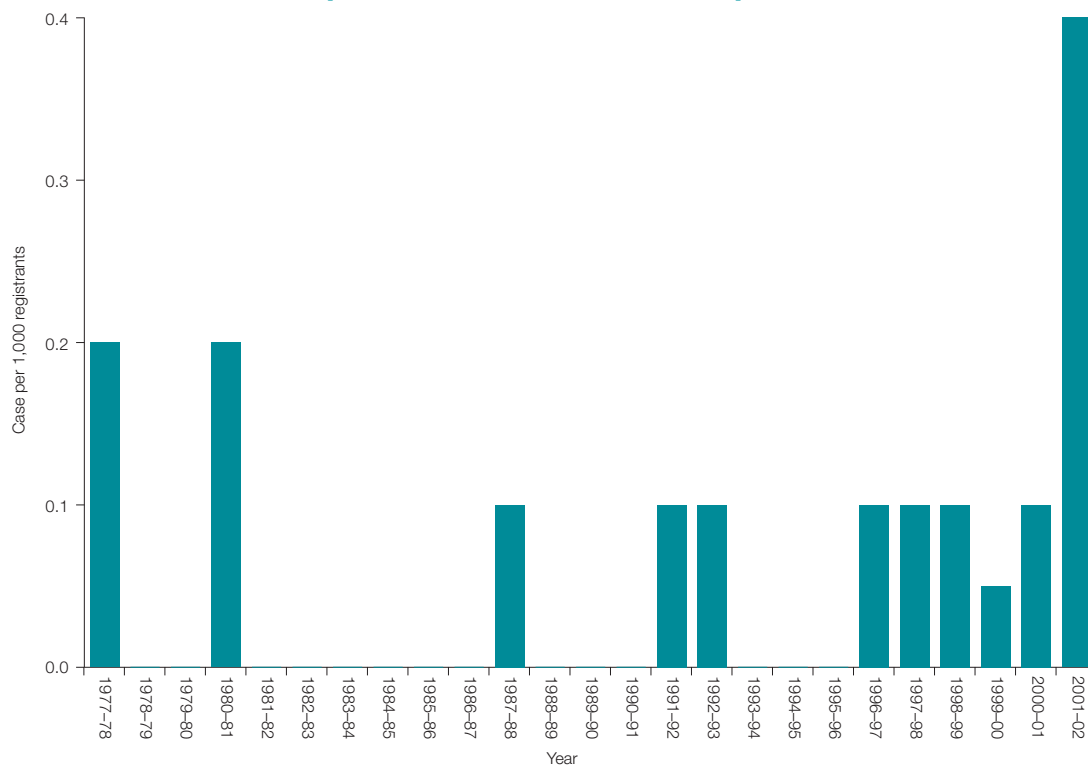
Appendix 5 (10) Dietetic cases: categories of reasons for case found



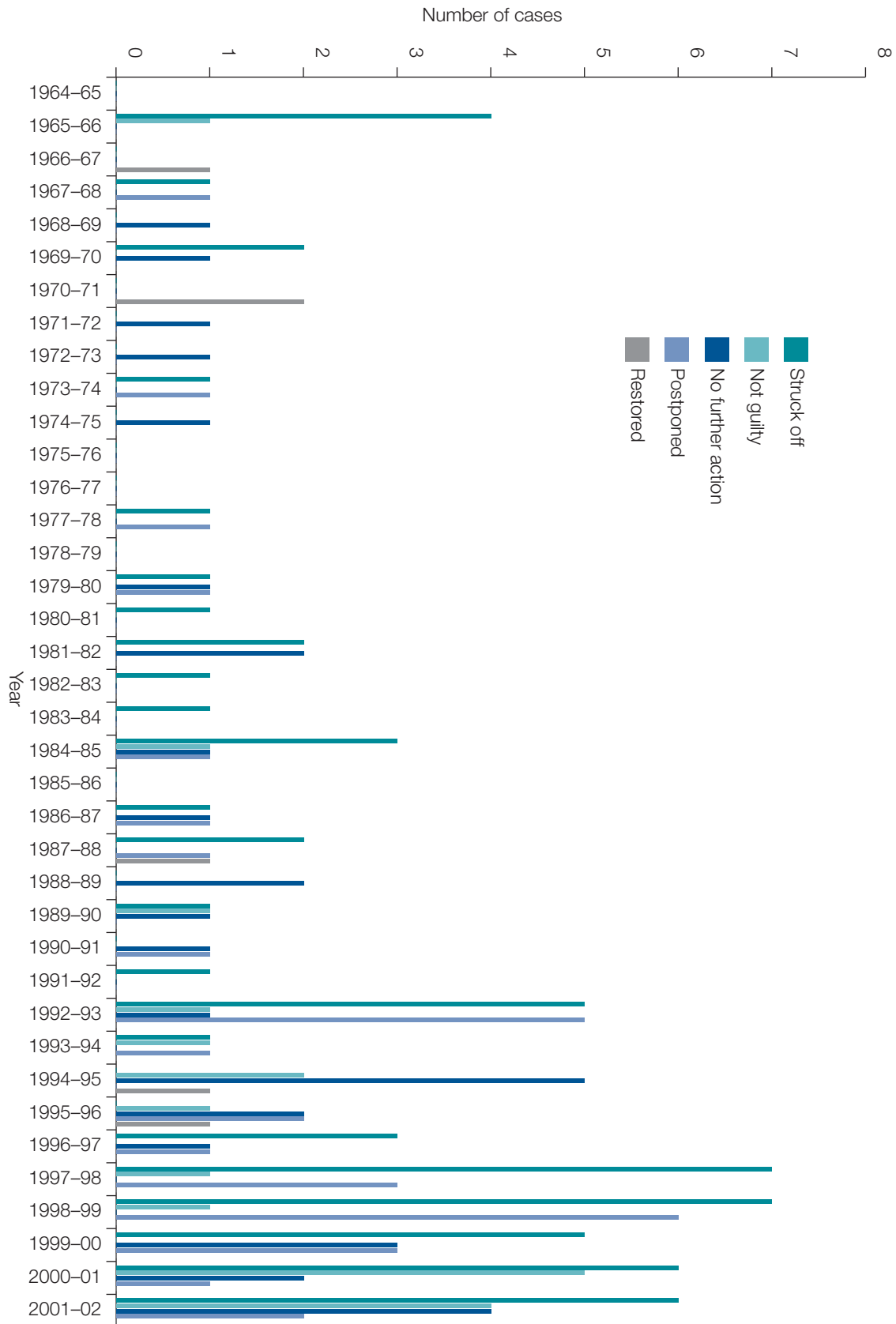
Appendix 5 (11) Occupational therapists total registrants and total cases 1977-78 to 2001-2 (no cases before 1977-78)



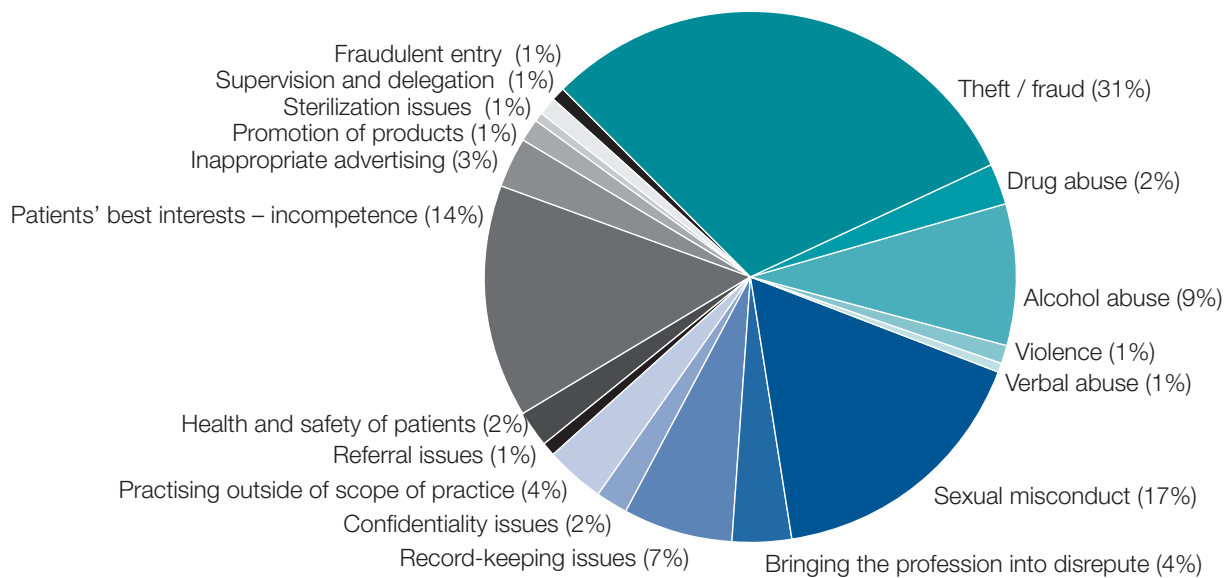
Appendix 5 (12) Occupational therapy cases per 1,000 registrants 1977-78 to 2001-2 (no cases before 1977-78)



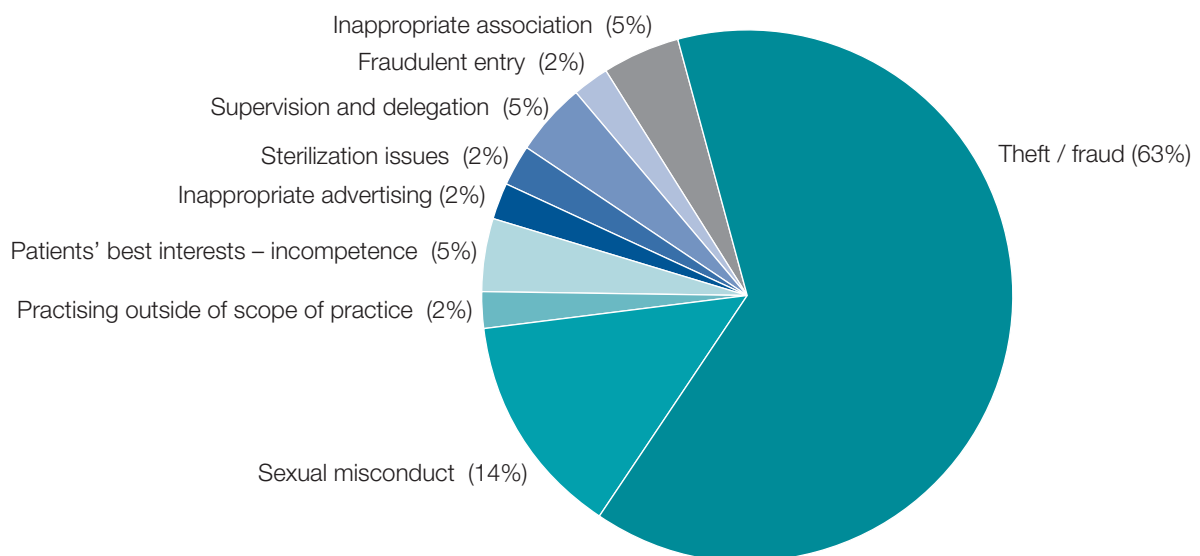
Appendix 5 (13) Outcome of all cases 1964–65 to 2001–2



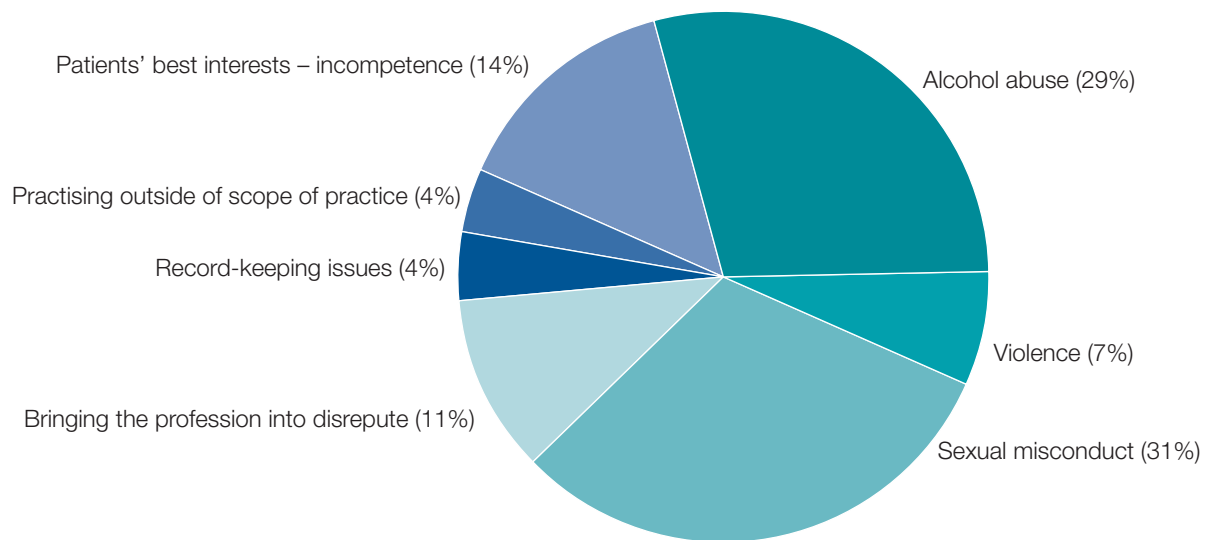
Appendix 5 (14) Categories of reasons for finding “guilty of infamous conduct” for all Boards for whole period 1964–2002



Appendix 5 (15) Chiropody categories of guilty findings from 1964–5 to 2002



**Appendix 5 (16) Radiographers: reasons for guilty findings 1979–80 to 2002
(no cases before 1979–80)**



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