

Professional regulation

The system of professional regulation in the United Kingdom is designed to ensure that if a patient is seen by a health care professional, such as a doctor or a midwife, the patient can trust that the care they receive will meet certain minimum standards of safety and quality. However, a number of high-profile cases of substandard practice and (in the case of Harold Shipman) murderous behaviour by doctors has raised questions about whether the present system, based on self-regulation, is fit for purpose.

After commissioning two reviews of current arrangements for the regulation of all health care professionals, the government has concluded that the public's trust in a doctor's continuing fitness to practise throughout their career must now be 'underpinned by objective assurance'.

In February 2007, the government published a White Paper entitled *Trust, Assurance and Safety: The regulation of healthcare professionals in the 21st century* (Department of Health 2007b). This set out significant reforms to the system of professional regulation, which, if implemented, will introduce new checks and assurances for the safety and quality of professional performance and make the regulatory councils more accountable.

This briefing outlines the current system of professional regulation in the United Kingdom; describes the criticisms of this system; details the government's proposals for reform; and discusses the potential strengths and weaknesses of the proposed changes.

The current system of professional regulation in the United Kingdom

There are a number of components to the regulation of health care in the United Kingdom: the regulation of organisations; the regulation of individuals as employees of organisations; and the regulation of individuals as members of professions. Due to differences in the way that health policy is made in England, Scotland, Wales and Northern Ireland, the regulation of organisations and employees of organisations differs between the four countries. However, the regulation of individuals as professionals is UK-wide.

The report of the Bristol Royal Infirmary Inquiry usefully defined 'professional regulation' as measures designed to 'ensure that healthcare professionals acquire and maintain professional competence' (The Bristol Royal Infirmary Inquiry 2001). For the regulation of health professionals in the United Kingdom, the system is largely one of state-sanctioned self-regulation. Professionals wishing to use titles such as 'registered medical practitioner' or 'physiotherapist' must be registered with the respective professional council. In the United Kingdom it is illegal to present yourself as a registered medical practitioner, or any other health care professional subject to statutory regulation, unless you are registered by the relevant council. In order to be registered, professionals have to

meet certain standards set by the councils. The councils set and police standards of practice for their respective profession and the state underwrites the councils' disciplinary procedures and polices the law against individuals who falsely present themselves as registered practitioners.

There are nine councils in total: the General Chiropractic Council (GCC); the General Dental Council (GDC); the General Medical Council (GMC); the General Optical Council (GOC); the General Osteopathic Council (GOsC); the Health Professions Council (HPC); the Nursing and Midwifery Council (NMC); the Pharmaceutical Society of Northern Ireland (PSNI); and the Royal Pharmaceutical Society of Great Britain (RPSGB).

Although there are some differences between the councils (*see Allsop et al 2004* for a full account of these differences), their structures and functions are broadly similar. The councils are tasked with protecting the public from unsafe or poor-quality practice. For example, the GMC's purpose, established in statute, is to 'protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine' (General Medical Council 2007). Councils currently do this by setting standards for relevant education and training; maintaining registers of those who are appropriately qualified to practise by virtue of having completed the correct training and in some cases by also being of 'good character'; setting standards for good practice for registered practitioners; and investigating and prosecuting practitioners when they are found to fall short of those standards.

The councils themselves comprise a combination of professional members, who are elected by other members of the profession, and lay members appointed by the Privy Council on the advice of the United Kingdom's health departments.

The Council for Healthcare Regulatory Excellence (CHRE) was established in April 2003 to oversee the nine statutory regulators. The CHRE conducts annual performance reviews of how the regulators carry out their functions; recommends changes to the rules of regulators when necessary; and has the power to refer judgements made by the regulator in disciplinary cases to the courts if they judge that the regulator's decision showed 'undue leniency'.

Criticisms of the current regulatory system

The GMC, which regulates doctors, has been the focus of concerns about whether the United Kingdom's system for professional regulation is adequate and how it should be reformed.

In the 1970s, the GMC came under fire from doctors on the register (including GPs) who felt that the Council was dominated by senior doctors from London, the Royal Colleges and academia. They also objected to the introduction of an annual fee for remaining on the Council's register.

The Royal College of GPs (a self-governing association of GPs that encourages high standards in practice and represents the interests of GPs in education and training) also criticised the GMC for not implementing their proposals for initiatives to address poor performance. Protests by GPs culminated in some GPs withholding the new annual GMC retention fee and the GMC eventually threatening to strike these members from the register. Faced with the prospect of losing a large number of doctors, the government intervened by commissioning a public inquiry to examine the existing arrangements for professional regulation and the constitution and functions of the GMC.

The committee of the inquiry was chaired by Alec Merrison and reported in 1975. The inquiry made a number of recommendations that included increasing the size of the GMC; giving the profession the right to elect the majority of council members (whereas previously the majority were appointed by the Royal Colleges and universities); and giving the GMC statutory responsibility for promoting high standards of professional conduct. All of these recommendations were implemented in the following five years.

In spite of these changes, the GMC came under further pressures in the following decades, and in 2005 the government announced a full-scale review of the make-up and functions of all nine regulators of health care professionals.

The impetus for reform derived from three key pressures: criticism of the GMC's lack of transparency and accountability from a number of high-profile commentators in the 1980s; the emergence of a stronger sense of consumerism in health care; and, perhaps most powerfully, national media coverage of a number of high-profile cases of substandard care and abusive, even murderous, behaviour by doctors.

A number of the cases prompted public inquiries and two of these proved particularly influential. One was the case of Bristol Royal Infirmary where substandard care and an unusually high number of deaths among children receiving heart surgery during a ten-year period failed to raise alarms or be addressed. The other was the case of Harold Shipman – the GP who murdered more than 200 of his patients during the course of 20 years. The inquiry into the Bristol case was chaired by Professor Ian Kennedy and published its results in 2001. These prompted the government to introduce a series of measures, which included: setting up a single national system for reporting and analysing any adverse events and near misses that occur in the NHS; and establishing the CHRE to oversee the work of the nine regulators of health professionals.

In the meantime, the GMC had introduced a number of its own reforms, which included: establishing a set of standards defining acceptable performance (General Medical Council 1995); developing a framework for ensuring standards in medical education (General Medical Council 1993); and, in 2002, reducing the overall size of the GMC and increasing the proportion of lay members, although still leaving a clear professional majority (currently 21 doctors to 14 lay members).

In 2000 the GMC also proposed introducing a system of revalidation that would make each doctor's right to practise contingent on being able to demonstrate every five years that they were fit to practise and up-to-date in their knowledge. However, the proposals were eventually diluted to a requirement that doctors should participate in annual appraisals conducted by their employers, who should issue a statement every five years to confirm the absence of significant concerns. When the fifth and final report of the Shipman Inquiry was published in 2004, these proposals were criticised by the Inquiry's chair, Dame Janet Smith, who concluded that: 'the GMC had, in effect, delegated responsibility for revalidation of GPs to appraisers, who were not expected and were not equipped to carry out an evaluation of the doctor's fitness to practise' (The Shipman Inquiry 2004).

Dame Janet's report recommended further reforms to the GMC. She said that the election of professionals onto the Council reinforced a perception that the GMC was there to represent the interests of doctors, rather than to protect the public, and recommended that all the Council's members should in future be appointed. She also pointed out that the Human Rights Act (1998) demands that the functions of prosecutor and judge should be clearly separated within professional bodies that hear complaints, and recommended that the GMC's adjudicating powers should be transferred to a separate, independent body. Her report further concluded that the existing criminal standard of proof required for the GMC to act on a doctor's registration – that is, 'beyond reasonable doubt' – should in most cases be lowered to that used in civil legal proceedings – that is, 'on the balance of probabilities'. This would make it easier to find a practitioner guilty of misconduct and so could offer the public greater protection. However, Dame Janet said that in cases where the allegations amounted to a criminal offence, the criminal standard should still be used.

Following the publication of Dame Janet's final report on the case of Harold Shipman, the then Secretary of State for Health John Reid announced in January 2005 that he had commissioned the Chief Medical Officer Sir Liam Donaldson to conduct a review of professional medical regulation. This was

with a view to re-evaluating the GMC's plans for revalidation; strengthening procedures for ensuring patient safety where there is professional misconduct; and changing the role, structure and functions of the GMC.

Up to this point, criticisms of professional regulation and proposals for reform had focused on doctors and the GMC. With the notable exception of the nurse Beverly Allit, who was convicted in 1993 of murdering four children in her care and injuring a number of others, there have been fewer high-profile cases of misconduct among non-medical health care professionals. However, in March 2005, John Reid announced that an accompanying review was to be launched into the regulation of non-medical professionals on the grounds that 'lessons emerging' from Donaldson's review would also have implications for the regulation of other non-medical health care professionals. He said that running both reviews would enable the government 'to put in place comprehensive and consistent measures to ensure all professionals treating patients remain fit to practise' (Department of Health 2005). This second review was led by Andrew Foster, then head of workforce at the Department of Health.

The Donaldson and Foster reports (Chief Medical Officer 2006; Department of Health 2006) were published in July 2006 and followed by a consultation period. The government then set out its programme for reform in the White Paper *Trust, Assurance and Safety: The regulation of healthcare professionals in the 21st century* published in February 2007 (Department of Health 2007b). The reforms cover six principal areas: the composition and accountability of professional regulators; revalidation; complaints and 'fitness to practise'; education; English language testing; and the regulation of new professional roles.

The government's proposals for reform

Composition and accountability of professional regulators

The government's White Paper recommended changes to the composition of professional regulatory bodies in order to 'ensure that the regulators are not only independent in their actions but, just as critically, that they are seen to be independent in their actions' (Department of Health 2007b). To counter the perception that councils act in the interests of professionals rather than the public, the government will now require that each council has at least equal numbers of lay and professional members – if not a lay majority – and that all the professional members of councils are appointed rather than elected by doctors. All councils currently have a professional majority – although a very small one in the cases of the NMC and the HPC.

At present, the term 'lay' indicates only that the person is not currently registered to practise by that particular council. For example, a lay member of the GMC could be a recently retired doctor. The Department of Health is going to consult on developing a clear definition of lay membership in order to protect against the practice or perception of lay members being drawn from groups that might be 'naturally sympathetic to professional interests' (Department of Health 2007b).

The government has followed Donaldson's recommendation that professional members, like their lay colleagues, should be appointed rather than elected in future. The task of making these appointments will fall to the NHS Appointments Commission, who will select members on the basis of a (yet to be established) set of competencies. The government has recommended that members of the CHRE should also become more independent. The regulatory councils will no longer nominate the CHRE's members and its chair will be appointed rather than elected.

The White Paper also states that the regulatory councils should be smaller; more consistent in their size and role; and more accountable to parliament – to which they should have to present annual reports.

Revalidation

'Revalidation' is a broad term used to refer to the policy of pro-actively ensuring that practitioners who are registered to practise are still safe and competent to do so. This contrasts with the policy of investigating competence only when complaints are made or concerns are raised.

Although doctors are regularly assessed during undergraduate and postgraduate training, the Donaldson report, *Good Doctors, Safer Patients* (Chief Medical Officer 2006), noted that a doctor could go on to have a 30-year career without any further formal assessment of their continued competency. Public opinion research conducted by MORI for the Donaldson report found that almost half of those asked thought that doctors were already subject to regular assessments, with one in five saying that this happens annually (Chief Medical Officer 2006).

The government has concluded that because of changes in public and professional opinions, it is no longer sufficient to assume that a professional continues to be up-to-date in their knowledge and fit to practise throughout their career; this trust must now be 'underpinned by objective assurance' (Chief Medical Officer 2006). In the White Paper (Department of Health 2007b), the government proposes that all health care professionals should be subject to some form of revalidation. There will be two main components to revalidation: 'relicensing' under which all professionals will have to demonstrate that they remain fit to practise; and, as proposed by the Chief Medical Officer, an additional process of 'recertification' for specialist doctors and GPs, who will need to demonstrate that they remain competent in their specialism.

Under this system, all doctors in the United Kingdom will require a license to practise and, crucially, will have to successfully complete a relicensing process every five years in order to remain eligible to practice. The process will be based on: 'agreed generic standards of practice' (Department of Health 2007b) set by the GMC; a revised system of NHS appraisal that must include 360-degree feedback and a positive affirmation of entitlement to practise rather than just the absence of concerns; and any concerns known to medical directors or GMC affiliates.

Specialist doctors and GPs will undergo an extra 'recertification' process. This will be based on standards set by the Royal Colleges in consultation with stakeholders and assessed using information from knowledge tests, patient feedback and/or observation of practice. The White Paper adds that: 'Ideally, recertification will be supported by information that shows how clinically effective each doctor's treatment of his or her patients has been'. A doctor's place on the specialist or general practitioner's register would depend on the relevant Royal College giving a positive statement of the individual's continued fitness to practise to the GMC at least every five years. Where possible this process will be synchronised with relicensing.

Those professionals who fail the relicensing or recertification processes would either be suspended from practice, or have to undergo a period of supervision while an assessment and rehabilitation plan were put in place.

While the government has in principle agreed with the Foster report that non-medical health care professionals should also be subject to revalidation, the extent to which this will go beyond a basic relicensing process has yet to be established. The Department of Health is set to discuss arrangements for each non-medical profession with the relevant regulators in order to establish processes that are proportionate to the potential risk posed by members of the profession.

For employees of the NHS or other licensed independent sector providers offering care to either NHS patients or private patients, revalidation should form part of existing appraisal and clinical governance structures. For self-employed practitioners, the government recommends the following: 'for those, including self-employed contractors, performing services commissioned by NHS primary care organisations (such as dentists or optometrists), the revalidation processes will be carried out under

the supervision of either the NHS commissioning organisation or, particularly where it is necessary to take an overview of both NHS and private work, the regulatory body, but in either case with appropriate collaboration between the two bodies; and for all others, for example, osteopaths, their regulatory bodies will develop direct revalidation arrangements' (Department of Health 2007b).

The White Paper did not provide further details of how regulation of these self-employed professionals might work in practice. For example, if commissioners are supervising the revalidation of self-employed contractors, who is conducting the revalidation itself? However, it is stated that the ability of providers and commissioners to carry out revalidation procedures will be a core standard against which organisations will be judged by the new regulator (a merger of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission).

Complaints and 'fitness to practise'

The Foster report recommended that there should be a single portal through which all complaints can be made, irrespective of whether they are ultimately dealt with through the NHS Complaints system, civil or criminal legal proceedings, or referred to the relevant professional regulator (Department of Health 2006). The White Paper does not deal in any detail with the issue of the complaints system for patients and the public. However, *Safeguarding Patients*, the government's response to the fifth report of the Shipman Inquiry and three other inquiries into abusive behaviour by doctors, which was published alongside the White Paper, announces that a consultation paper containing proposals for a new complaints system will be issued shortly (Department of Health 2007a).

Developing a mechanism through which complaints can be dealt with at a local level so that they are only referred to a national regulatory body in serious cases was recommended by both the Foster and Donaldson reports. In the White Paper, the government has recommended that for the medical profession, a network of local GMC officers – called GMC affiliates – should be established, apparently in line with proposals from the Donaldson report. However, whereas Donaldson had envisaged an affiliate in every organisation containing doctors, the White Paper recommends that affiliates should only be based at a regional level in England (one for each strategic health authority) and at a national level in the devolved administrations in Scotland, Wales and Northern Ireland. Affiliates will be employed by and accountable to the GMC. Together with their support teams they will provide support and advice to employers dealing with concerns about a doctor's practice as well as examining the relicensing procedures in a sample of local organisations. The job of overseeing local revalidation processes will fall to medical directors and their equivalents.

Also in line with Donaldson's proposals, the White Paper indicates that affiliates will be given the power to agree 'recorded concerns', which would appear on a professional's record. Following a complaint or safety incident, a written agreement with the professional concerned would detail the nature of the occurrence and any remedial actions that have been agreed. The intention is that these will 'facilitate proportionate local responses to problems and allow patterns of misconduct or behaviour to be tracked over time and place' (Department of Health 2007b). The concern could be removed from the professional's record if they have successfully completed an appropriate programme of rehabilitation. The details of how this mechanism will work in practice and the range of people to whom the concern would be visible on the professional's record have still to be established.

The government has said it will consult on whether similar local-level mechanisms are appropriate for other non-medical health care professionals.

At a national level, evidence of substandard practice by a doctor is currently investigated and adjudicated by the GMC. It is the role of the GMC's 'fitness to practise panel' (whose members are appointed by but are not themselves members of the GMC) to judge whether a doctor's fitness to practise has been 'impaired' by ill health, incompetence or inappropriate behaviour. The panel has the power to issue a warning that stays on the doctor's record and is accessible to inquirers for five years;

to place conditions on a doctor's right to practise; or to prohibit the doctor from future practice in the United Kingdom.

The government has followed the recommendations of Dame Janet Smith and Liam Donaldson in recommending that adjudication of doctors' fitness-to-practise cases must be carried out by a separate, independent body if impartiality is to be secured and be seen to be secured. The task of investigating and prosecuting in fitness-to-practise cases will remain with the regulator – the GMC. While it will not be compulsory for the other professional regulators to relinquish their adjudication function to this new body (something Foster had invited comments on), the government is encouraging them to do so, and has anyway recommended that the members of adjudication panels in the other regulators must be chosen by the Appointments Commission in future.

Fitness-to-practise cases for all health professionals will have to use the sliding, civil standard of proof rather than the criminal one. This is broadly in line with recommendations by Dame Janet Smith, Donaldson and Foster and means that the burden of proof required to find the professional guilty can vary depending on the seriousness of the case. The government claims that in cases where a health professional could lose their livelihood, the standard used could be 'virtually indistinguishable' (Department of Health 2007b) from the criminal standard of 'beyond reasonable doubt.' A sliding civil scale is already used by two-thirds of the existing councils; only the GMC, the NMC and the GOC currently use the criminal standard.

Education

In the White Paper the government asserted that 'the standards of conduct, ethics and clinical excellence set by the curricula for health professionals' (Department of Health 2007b) are central to the regulation of health care professionals. The government recommended that responsibility for setting educational standards for non-medical professionals should remain with their respective councils. Donaldson had recommended that responsibility for inspecting medical schools and setting the curriculum for medical undergraduate education should be moved from the GMC to the (already established) independent Postgraduate Medical Education and Training Board. However, the government has said that while it may in theory be desirable to have a single body responsible for setting the standards for undergraduate and postgraduate education and continuing professional development for doctors, 'change should be introduced in such a way as to preserve the expertise and experience of the present organisations that undertake its role' (Department of Health 2007b). The government has therefore recommended that the Postgraduate Medical Education and Training Board is maintained as a separate legal entity and undergraduate education and continuing professional development are looked after by two separate boards within the GMC. This is termed 'the three-board approach'.

English language testing

The government reports that the consultation revealed serious concerns among patients and professionals about the ability of some professionals for whom English is not the first language to perform their duties to an acceptable standard. All recommendations on English language testing have to comply with European Union law, which prohibits the introduction of language testing as a pre-requisite for entry to a professional register for EU nationals (the restrictions don't apply to non-EU nationals).

The Department of Health has recommended that regulatory bodies should work with NHS employers to develop arrangements for selective pre-employment tests. The Department suggests that the level of competence required is likely to vary, depending on the role in question. They have proposed that an English test for European applicants would only be appropriate if the applicant has not qualified in an English-speaking environment; has not demonstrated language competence in their application or interview; or has not previously practised professionally in the United Kingdom. Since concerns have

been raised about the abilities of some professionals already practising, this last condition would not seem to be sufficient in itself to assure suitable English language skills.

Regulating new professional roles

The government announced in the White Paper that it plans to introduce statutory regulation for applied psychologists, psychotherapists, counsellors, other psychological therapists and several groups of health care scientists on the grounds that these professions are ‘well established and widespread ... and what they do carries significant risk to patients and the public if poorly done’ (Department of Health 2007b). There is already a working group examining the practicalities of regulating acupuncturists and practitioners of herbal medicine and traditional Chinese medicine.

A new UK working party will be set up by the Department of Health to establish criteria ‘to determine which roles should eventually be statutorily regulated’ (Department of Health 2007b). As suggested by the Foster review, these criteria will be broadly based on those already established by the HPC. These include the requirements that a profession has a discrete area of activity, a defined body of knowledge, evidence-based practice, a voluntary register with defined entry routes, and a code of conduct and disciplinary procedures for registrants. The White Paper adds that these criteria will need to be ‘adapted’ but does not offer further detail on how or why they would need to be changed.

The government states categorically that it will not be establishing any new statutory regulators (with the exception of the General Pharmaceutical Council which will take over the regulation of pharmacists from the RPSGB and possibly the PSNI). Rather than regulate new and extended roles that develop out of existing professions separately, the White Paper suggests that safety could be assured through post-registration training. The government also proposes that most new professions should be regulated by the HPC ‘which was designed for this purpose and has the most expertise in bringing new professions into statutory regulation and also in regulating a wide range of professions within a common system’ (Department of Health 2007b).

Strengths and weaknesses of the proposed reforms

The proposed changes aim to address a number of the government’s objectives for professional regulation. Regular revalidation of the competence of professionals and the recording of low-level complaints is expected to improve safety and quality assurance. Appointing professional council members rather than electing them by their colleagues and separating the adjudication of fitness-to-practise cases from the other work of the regulators is intended to enhance the confidence of the public and professionals in the fairness and impartiality of the system. Finally, requiring councils to report directly to parliament should improve their accountability.

The White Paper goes some way towards increasing the consistency of professional regulation across the different health professions: the councils are all encouraged to become smaller; none will have professional majorities; all will have an independent (and possibly common) adjudication panel; and the government has asked the CHRE to establish a common definition of ‘good character’ to be used by all councils when assessing suitability for registration.

The White Paper also recognises that the evidence base for reforms, such as the introduction of local fitness-to-practise procedures using GMC affiliates, is under-developed and that, as a result, implementation should proceed incrementally following discussions with stakeholders and evaluation of pilots.

The detail of the proposals focuses predominantly on medical NHS employees and a number of questions remain about how these proposals will improve the regulation of professionals who fall outside of this category.

Firstly, the White Paper does not set out developed proposals for non-medical professionals; instead the government focuses on the details for medical regulation and proposes further consultation with each regulator of non-medical professionals. There is no decision on whether or how the skills of non-medical professionals will be revalidated beyond a basic relicensing process. Nor is there any mention of the extent to which local fitness-to-practise procedures, including possible equivalents to GMC affiliates and recorded concerns, are to be introduced for non-medical professionals.

Secondly, although the proposals do refer to measures for employees of non-NHS organisations and the self-employed, the main reforms are constructed on the basis that professionals are NHS employees. For example, plans for relicensing are centred around the NHS appraisal system; and it is suggested that revalidation for non-NHS employees should be ‘supervised’ by commissioners or regulators, but no guidance is given on who will conduct the revalidation process itself or on what basis. Furthermore, the proposed resolution to the issue of English language tests for professionals from other EU countries is for regulators to work with NHS employers to develop arrangements for selective pre-employment tests.

This approach is problematic because it fails to recognize the existing and rapidly increasing diversity of employment settings in which health care professionals work. While there is no central, robust figure for the proportion of professionals regulated by the nine councils who work outside the NHS, the CHRE estimated in 2004 that it was over 50 per cent (Council for Healthcare Regulatory Excellence 2004). The government’s current enthusiasm for encouraging non-NHS providers to supply services to NHS patients suggests further that mechanisms for professional regulation that assume the professional is an NHS employee may prove inadequate.

Thirdly, more consideration needs to be given to the process by which new and extended roles might be regulated in the future. Adopting the existing approach of the HPC would mean a heavy reliance on new professional groups organising themselves in order to be eligible for regulation. Since individuals may, in the meantime, be already practising these new roles, this approach does not meet public interest requirements for safety. In addition, if extended roles are to be limited to existing professionals and not allowed to proliferate into new professional roles then educational and entry requirements must be clearly established.

Staff roles look set to continue evolving and becoming more flexible in response to changing health needs, developments in medical technology and information and communications technology, and changes in health policy objectives. In this environment, a system of professional regulation needs to be flexible and adaptable to include these professionals, particularly if their activities pose any risk to patients.

Finally, it is vital to ensure free movement of professionals within the United Kingdom and therefore that there remains a single UK-wide system of professional regulation. However, the proposals appear to have been drafted with the English NHS in mind; consideration of how they will translate in the devolved administrations has been left to the later stage of practical implementation. The proposals for licensing of professionals need to be ‘neutral’ to the organisation of the health system and provide assurance that all professionals treating patients are safe to do so.

Overall, the government’s proposed reforms should offer improved protection for patients by establishing a more pro-active approach to ensuring that health care professionals are competent to perform safely but it is important that the proposed reforms should result in these assurances being extended to those being treated in all parts of the United Kingdom and by health care professionals in non-medical, new and extended roles.

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