Royal Pharmaceutical Society of Great Britain

Student Fitness to Practise

Report of the Academic Pharmacy Group Seminar held on 7 January 2005 at Aston University

Introduction

Dr Chris Rostron, Chair of the Academic Pharmacy Group opened the seminar by recognising that issues of fitness to practice and professionalism were increasing in significance for schools of pharmacy. While the recent Bristol and Shipman inquiries had concerned existing healthcare professionals, both reports raised key issues for those responsible for producing future healthcare professionals. The purpose of this seminar was to explore and discuss a number of key issues identified by pharmacy academics as relevant to fitness to practise. It is recognised that Schools of Pharmacy in educating and training students for potential future practice as a pharmacist have a role to play in fitness to practice issues.

Student selection

Dr Patricia Hughes of Council of Heads of Medical Schools said that while selection for admission to medical school was not an exact science, research was available which indicated predictors of future performance. At present the degree confers on graduates the right to join the GMC register and to practice, therefore medical schools have a responsibility to ensure that graduates are fit to practise. A number of factors are thought to contribute to being a good doctor including honesty, integrity, conscientiousness, helpfulness and empathy as well as good intellectual ability. At present intellectual ability in the form of A-level results are used in selection yet this does not necessarily predict good clinical ability. Clinical performance is predicted by structured interviews, previous study of English and humanities, learning style and empathy.

The Council of Heads of Medical Schools have agreed guiding principles for selection of students into medical schools which covers criminal behaviour and disability (the guiding principles are available on the Council's website www.chms.ac.uk).

Disability

Peter Burley, the Head of the Preregistration Division at RPSGB outlined work in progress at the Society and two projects which specifically deal with disability issues for pharmacists. He acknowledged that there were two areas that concerned the Society, entry to the profession and existing registrants who have become disabled since first registration but due to the audience he would be focusing on the first group. One of the

requirements for registration is the health declaration, which is a self-declaration countersigned by an appropriate registered medical practitioner stating that there is no medical reason why the applicant should not practise pharmacy.

The 1954 Pharmacy Act is due to be replaced with an Order under Section 60 of the Health Act 1999 in 2005. This is expected to allow the Society to set explicit standards for the health of applicants for registration and may allow those standards to be extended to applicants to Schools of Pharmacy. In parallel the Order will require the Society to set standards for practice which all members will need to meet. These powers should allow all the different considerations about disability to be joined up – but it was acknowledged that the legislation is currently not joined-up. The Society's Charter was renewed in 2004, and the third object "to promote and protect the health and well-being of the public through the regulation and professional leadership and development of the pharmacy profession and the regulation of other persons engaged in related activities" gives the Society a clear mandate to place the safety of patients above the aspirations of disabled applicants.

Two projects are exploring disability issues in relation to pharmacy the first project is commissioned by the Higher Education Funding Council for England and is about the student body and shows some interesting findings. The second project was commissioned by the Society and makes recommendations in relation to the new legal framework. What emerges is that both studies are more about disability than about pharmacy or about the Royal Pharmaceutical Society. Nonetheless they both reinforce the presumption of the balance of interests being in favour of the well-being of the public rather than of the aspirations of applicants to the profession. Within that presumption, however, both show that there is plenty of work the Society can do to create a transparent and coherent scheme properly to define this balance and then to confirm disabled applicants' rights under it.

Dishonesty

Ian Bates of the School of Pharmacy, University of London and Graham Davies of the University of Brighton, presented research exploring views and incidence of student dishonesty within universities. Twelve 'cheating' scenarios were developed through qualitative work and in separate studies academics at three institutions (72), students at 5 pharmacy schools (1037) and students from a range of courses at one institution (1165) were surveyed. Examples of cheating behaviour included concealing notes in exams, borrowing coursework without permission and cutting and pasting from internet sources. In the study comparing pharmacy with other courses (Biomedical Sciences, Business, Education, Humanities, Physiotherapy) pharmacy students had a higher 'dishonesty' score than the other students.

In the study comparing different schools of pharmacy the dishonesty score was variable indicating that dishonest behaviour is linked to institutional characteristics. The researchers have subsequently suggested that dishonesty may be related to other factors such as curriculum design and satisfaction with education.

Workshops

The afternoon session involved three workshops on the above issues.

- Student Selection facilitated by Jenny Scott (APG Committee Member)

Recruitment vs. Selection: Pharmacy schools 'recruit' from a small pool of students we do not 'select'. From the pool of students each year who apply for pharmacy, most are accepted somewhere into the system, due to varying geography and entry levels from different schools. 'Rejection' from Pharmacy overall is low and levels of rejection of students who make the grades from the different Universities are low. Overall rejection for any other reason than not making the academic grade (usually at A level) is very small.

This places pharmacy presently in a different context to medicine, where 'selection' is more applied due to the larger pool of applicants. Medical schools can afford financially to select.

The cost of a selection process as described by Dr Hughes would at present be unworkable within Pharmacy as it would require academic man hours that could not be diverted from teaching or research.

Role of the Pharmacy Schools: Teach pharmacy education rather than provide training. The preregistration year makes pharmacy schools under a different obligation to the medical schools as it acts as a 'buffer' to clinical practice and patient safety. Competence is judged as criteria for registration with RPSGB.

It was recognised that most students who enter pharmacy education want to be pharmacists – is it fair for them to fail at preregistration year if they never possessed the qualities necessary to become a pharmacist in the first place? Do we have a duty to the students (morally) rather than take their money to provide an education that they will not be able to use? However – most students come to us straight from school, they are still developing emotionally and personally therefore can we judge 'fitness to practice' in a 17 year old on entry? Is it fair to impose this at that stage? Perhaps there should be an ongoing assessment throughout the 4 year degree with a 'fitness to practice' certification by the School along with academic grades as part of the MPharm? The group was able to recognise students who initially had caused concerns but had matured into people who we felt were fit to practice. Others not fit could leave with a BSc Pharmaceutical Studies, for example. We all recognised some cases where this would be desirable for (including academically able) students with attitude problems that remain through to end of final year. This model however would not be acceptable to Higher Education Institutions unless driven across the UK from DH/HEFC/RPSGB.

Section 60 changes: It was recognised that Section 60 order will focus thinking on this matter. In order for change however to happen there are several factors the group considered important:

- It has to be driven centrally. RPSGB have to define competencies for students and they have to be measured by all SOPs (possibly even using the same system) –the lack of consistency in law and ethics and dispensing was cited as an example of current practice which is not consistent across all SOPs.

- It will cost money.
- It was recognised that the relationship between the MPharm degree and pre-reg will tighten up in future years, but this needs to be a consistent development otherwise each University will interpret things in its own way and apply its own models. Unfit students rejected entry from one SOP may then gain entry to another with a different set of 'fitness' criteria.

In summary, ongoing assessment was favoured across the 4 years rather than at entry, with a centrally dictated set of competencies against which all are measured, ideally using the same consistent system. In order for such a scheme to be developed significant finance will be needed to support it.

- Disability facilitated by Peter Seville (APG Committee Member)

This workshop built on the issues arising from Peter Burley's morning session. A number of issues were discussed, including:

What rights does someone with a notifiable communicable disease have with regard to access to HE?

> The group felt that we, as educators, have to legal right to bar entry to the course due to illness; indeed, this would be against the Disabilities Discrimination Act. Although a conflict between rights of an individual to study and public safety potentially exists, access to HE cannot be barred.

What liability is there, and where, if a student is enrolled on a course when the Admissions Tutor already knows they cannot complete it?
What position should an HEI take if a student's health changes while on a course in a way that will debar them from ever practising the regulated profession?

> The group felt that we should steer well clear of the issue of liability, and instead aim to support all students to achieve their potential. An interesting example was highlighted by representatives from Bradford, who described a student who had vastly exceeded academics' expectations, and was coping extremely well with the course. In addition, it was noted that HE institutions can only prevent access to a course on academic grounds, not disability. Indeed, the onus is on HE institutions to make "reasonable adjustments" to support disabled students. In addition, HE institutes do not have any control over whether a student goes on to practise, as this is the remit of the RPSGB. Funding arrangements would have to change (e.g. DOH funding instead of HEFCE) before HE institutes would be able to dictate that students must be fit to practise on completion of the degree.

Who pays for amanuenses?

> This topic was used as a general starting point for the issue of "reasonable provision". In the main, it was felt that home students are reasonably supported, and that grants are available to finance certain adjustments. However, a discrepancy was noted for overseas students, where there may not be such funding; this potentially leads to discrimination towards overseas disabled students.

The discussions raised probably more questions than were answered, although a few key points were made:

- Students should be supported to make an informed decision at the point of entry as to whether they will be fit to practise. To this end, the RPSGB needs to produce adequate guidance, rather than the usual comment that matters are considered on an individual basis, as this general guidance is unhelpful to both academics and students.

- HEIs cannot prevent entry to the undergraduate degree on disability grounds, and it would be illegal for them to do so. Entry can only be prevented on academic grounds.

- There may be a case for a registerable degree, although significant changes will have to be made to the current funding arrangements to enable this to occur.

- Dishonesty facilitated by Paul Gard (APG Committee Member)

The workshop considered the following:

1. An applicant who declares a previous (spent) conviction for shoplifting
2. An applicant who declares a previous (spent) conviction for a drug related offence
3. A student on the course guilty of cheating in coursework
4. A student on the course guilty of cheating in examination
5. A student on the course guilty of cheating in examination (clear evidence), but repeatedly denies it.
6. A student on the course guilty of road traffic offence
7. A student on the course guilty of a civil offence: theft
8. A student on the course guilty of a civil offence: recreational drug use
9. A student on the course guilty of a civil offence: supply of illicit drugs

Our suggested actions were:

1. Interview candidate, but ignore offence unless borderline decision concerning making an offer.
2. As above, but emphasise to student that there may be a problem with registration after graduation. Drug supply was seen as probably the only case where the student would not be considered for admission.
3. Adhere to University policy regarding Academic misconduct. Do not involve RPSGB.
4. As above.
5. Adhere to University policy regarding Academic misconduct. Report to RPSGB
6. This offence has no bearing on academic progression or award.
7. As above, but counsel regarding professionalism
8. As above
9. As above but inform RPSGB.

Conclusions:

The group saw a conflict between Academic decisions and decisions regarding professionalism. University Examination Boards make academic decisions. The group saw the need of an additional 'layer' e.g. a 'Fitness to Practise' committee, who could record, monitor, report to RPSGB and comment in all employment references on matters regarding professional conduct that fall outside Academic and normal University regulations. The nature of this committee was undecided: should it be one per SoP, one per University (to see equality between Pharmacists, Medics, Nurses etc), or one central RPSGB committee to see equality across all SoP?

Why is Professionalism Important?

Professor Sir Graeme Catto (President of the General Medical Council) recognised that medical schools have a slightly different role to schools of pharmacy in that medical graduates automatically join the GMC's register and so are explicitly involved in fitness to practise issues. The concept of professionalism has been criticised as being outdated, pompous and defensive yet what would the world look like without it.

"The alternative, namely external regulatory dependence, implacably leads… to a rising mass of codified petty regulation, swollen by the need for rules to enforce rules and to counter their avoidance…What is more, state regulation in such areas is apt to drive out self-policing and the force of individual conscience." (Andrew Phillips, Clinical Medicine, 2004, 4, 7-9).

The GMC was established for the protection, promotion and maintenance of the health and safety of the community by ensuring proper standards in the practice of medicine with the functions of education, registration, standards and fitness to practise. These purposes are carried forward through independent regulation rather than self-regulation as there is 40% lay input on the Council. Standards are set independently of sectional interests and of Government. It is essential that the standards are owned by the profession. GMC's proposals for revalidation were designed so that doctors could demonstrate their 'fitness to practice' on a continual basis. These proposals are currently under review by the Chief Medical Officer following the Shipman report.

The GMC's role with regard to education is that it is responsible for basic medical education and for co-ordinating medical education overall. There are ten curricular outcomes which graduates are expected to achieve/demonstrate including the principles of professional practice, good clinical care, relationships with patients and teaching and training. At present the medical schools are accredited by the GMC for meeting these outcomes but a national examination to ensure consistency has been mooted. A system of minimum standards may be more flexible and would encourage diversity.

Professor Sir Graeme Catto was asked what four things he wanted Medical Schools to do and he answered:

- Encourage a sense of professional responsibility from day one
- Ensure that both teacher's and student's professionalism is recognised at all times
- Encourage inter-professional learning
- Get students out of the university, laboratory, hospital and out into the community