British Acupuncture Council

Response

to the

The Department of Health Consultation Document on the Regulation of Herbal Medicine and Acupuncture

June 2004

Introduction

The British Acupuncture Council (BAcC) was formed in 1995 by the unification of the five main associations representing traditional acupuncture in the UK. With over 2400 registered members it is now the largest of the voluntary self-regulating bodies for acupuncture. As well as providing professional indemnity insurance for all of its members it maintains Codes of Conduct and Safe Practice by which its members are governed. It has also gained a reputation for innovation and excellence, not least for its support of and partnership with the British Acupuncture Accreditation Board (BAAB) and more recently for launching a practitioner-centred Continuing Professional Development scheme well ahead of many of the equivalent comparable statutory bodies.

The BAcC undertook a detailed and lengthy consultation with its members in 2001 on the issue of statutory self-regulation (SSR). As well as publishing a detailed briefing paper on the central issues the Executive Committee conducted a large number of 'roadshows' to inform the membership at large and take soundings of their views. This culminated in a vote conducted for the BAcC by Electoral Reform Services in which 90% of those who voted gave the Executive Committee a mandate to 'pursue a suitable route to statutory self regulation'. As a consequence of this BAcC representatives were invited to join and contributed heavily to the work of the Acupuncture Regulatory Working Group (ARWG) on whose report some of the recommendations of the DoH Consultation Document are based.

The BAcC's Executive Committee (EC) has circulated the Department's Consultation Document to every member, as well as a detailed Briefing Paper from the EC outlining issues which the membership might need to consider in framing a formal response. In addition to this a dedicated members' forum was established on the BAcC website to enable members to share views and seek clarification from the Executive Committee. Several regional conferences and meetings have also been held to seek the membership's views. The final stage has been to conduct a second ballot of members on their support for this response.

The BAcC has undertaken a wide range of measures, therefore, to ensure that the comments that follow broadly reflect the majority view, but has re-emphasised to all members that they should respond individually, where appropriate, in order to ensure that any and all constructive suggestions find their way to the Department of Health for the next stage of the development of its plans.

The Questions

Q1: Do you agree that statutory regulation should apply to herbal medicine and acupuncture practitioners in all four UK countries – England, Scotland, Wales and Northern Ireland?

We agree with statutory regulation being applied equally across the whole of the UK.

Q2: Do you agree that a shared Complementary and Alternative Medicine Council (CAM Council) for herbal medicine and acupuncture is the model of statutory regulation which best meets the needs of patients, the public and practitioners?

We do **not** agree that a shared CAM Council is the best model of statutory regulation for acupuncture and herbal medicine.

We recognize the urgency stressed by House of Lords Select Committee Report for the statutory regulation of these two professions in the interests of patient safety, but also recognize that the safety issues are unique and specific to each of these professions. We do not believe that creating an overarching regulatory framework is consistent with addressing this need directly or that the risks posed by any other CAM bodies are likely to necessitate statutory protection alongside acupuncture and herbal medicine in the foreseeable future.

We have specific concerns about several statements in the document:

'A larger grouping of practitioners would have greater influence'
Any form of federal arrangement may offer a more effective voice for complementary medicine as a whole. We would point out, however, that the Council for Complementary and Alternative Medicine (CCAM) which we recently wound up had at its peak included osteopaths, chiropractors and homoeopaths alongside acupuncturists and western herbalists, and yet never achieved any significant influence.

'There would be advantages in interdisciplinary working'
The concept of interdisciplinary working usually relates to collaborative working between healthcare professionals in order to increase understanding of their different roles, to reduce the barriers between professions and to increase the effectiveness of patient care. There is little evidence that operating under a shared regulator has any effect on professional boundaries in this way. We have heard no compelling, or indeed any, arguments for this proposition, even from within orthodox healthcare settings.

'The costs would be lower through the sharing of overheads'
Sharing some of the overheads may reduce the unit cost of regulation. We believe, however, that the table of figures shown in the document as an

illustration of cost reduction with increasing size of organization are simplistic, and that complexity as much as size is an important determining factor in the cost of regulation. Our own research suggests that unit costs only begin to decrease significantly when the numbers of registrants reach the tens of thousands, and we are understandably concerned that if this is the case the first two professions would bear the brunt of the start-up costs for a larger organization than is necessary for their own immediate needs.

We also believe that the figure of £262 in the Consultation Document as the possible cost of registration is misleading. This figure is based on estimates for staffing and committee structures in the Herbal Medicine Regulatory Working Group's (HMRWG) Report which are at best optimistic and do not reflect the size and sophistication of the current structure being proposed. They also do not make allowance for the considerable cost of conduct proceedings and the costs of compliance with other legislation which SSR brings. We believe the true figure could be considerably higher, and our own calculations suggest that £400 may be a more realistic estimate.

Our underlying and deeper concern about cost is that should this be much higher than the figures presented in the Consultation Document there may be serious long-term consequences for the continued existence of the professional associations which we believe are essential partners in the delivery of effective statutory regulation.

We believe that only homeopathy amongst the other CAM disciplines shares the same overall structure of training and practice which placed it, along with osteopathy, chiropractic, acupuncture and herbal medicine, in the so-called 'Big Five', the 'discrete clinical disciplines' identified in the House of Lords Select Committee Report. Other CAM disciplines remain largely adjunctive to orthodox western medicine. Grouping together therapies with such broadly differing scopes and educational standards in a federal structure does not seem to us to be in anyone's best interests.

However, since there are no immediate plans to bring forward either homeopathy or any other complementary therapy to statutory regulation, for reasons of public safety or otherwise, we do not see that the creation of an open-ended regulatory structure is a pressing need. Equally, although the acupuncture and herbal medicine professions have clearly demonstrated in the past a commitment to incurring costs to improve and develop their professional standards (the acupuncture profession alone has invested more than £1 million in the British Acupuncture Accreditation Board), we do not feel that they should bear the cost of creating a structure beyond their own immediate needs.

Q3: If you do not support a CAM Council, what is your preferred model of statutory regulation? Do you favour the alternative model described in paragraph 28?

A General Acupuncture Council (GAcC) remains our preferred model and the one towards which we have been working for the past decade. The Acupuncture Regulatory Working Group (ARWG), after a year's extremely detailed work guided by representatives of both the Department of Health and the Foundation for Integrated Health as well as experienced lay members, also believed this to be both desirable and achievable. We believe that this would provide the best guarantee of the preservation and enhancement of the educational standards which have characterized the development of professional acupuncture in the UK and would, we believe, have greater direct influence and control over all users of acupuncture techniques, not just the acupuncturists on its register. A single Council, with a single register to which entry is determined by high educational standards, is also clearly what both the House of Lords Select Committee Report and the Kennedy Report favoured.

We are given to understand that current Government policy no longer seeks to regulate individual professions, and favours collaborative regulation. We would argue, however, that a General Acupuncture Council is itself a form of collaborative regulation. Most uni-professional statutory bodies have registered professionals with equivalent standards and duration of training. The acupuncture profession, however, has already shown a flexible and versatile approach to drawing all of the users of acupuncture from a variety of training backgrounds under the control of one regulatory framework, along with the aim of facilitating the integration of acupuncture into mainstream healthcare. We believe that the creation of a General Acupuncture Council is consistent with the policy of collaborative regulation and worthy of further consideration as one of the possible templates for innovation and development.

The Consultation Document does offer the option of two separate Councils with shared facilities and overheads as an alternative to a CAM Council. However, since the remainder of the Consultation Document is premised on the development of a CAM Council, and the financial and technical consequences of the alternative option are not explored further, we do not think that this is being offered as a serious alternative. Even were separate councils sharing overheads to be a real option, we believe that it is over-simplistic to argue that pooling central costs is cheaper. Sharing large items of capital expenditure such as computer systems and sharing premises may appear to produce savings at the outset, but our own experience suggests that costs rise with complexity, and that the merger of smaller organizations may actually increase costs, especially where a great deal of their infrastructure is profession-specific.

Another option for collaborative regulation, and one consistent with the mandate from the BAcC membership, would be the creation of a joint council for the acupuncture and herbal medicine professions, the Acupuncture and Herbal Medicine Council (AHMC), with a governing body whose membership is drawn

from both. Such a council could, for example, leave the educational requirements and functions within profession-specific, possibly statutory, committees but deal with the broader administrative and generic regulatory issues in joint committees. Such a committee structure would maintain the autonomy of the two professions and the diversity of individual traditions within each. It would also create fresh possibilities for the relationship between traditional acupuncture and western medical acupuncture, thereby addressing our concerns about nearly 5000 Western Medical (WM) professionals using acupuncture without direct reference to the regulatory body for acupuncture.

A further advantage of a joint council would also be that profession-specific costs could be charged to those whom they affect, and that acupuncturists would not be subsidizing any legal requirements arising from European law which will fall on herbal medicine, nor herbal medicine practitioners subsidizing those acupuncturists who use pre-prepared herbal formulae.

In conclusion, we would argue that creating either a General Acupuncture Council or an Acupuncture and Herbal Medicine Council would in both cases be consistent with exploring how collaborative regulation can be best effected and whether the principle or the format is capable of expansion or adoption by other professional groupings. These options would also build on the track record of the acupuncture profession for innovation and excellence, and could create fresh templates for federal arrangements in the developing field of integrated healthcare.

Q4: Is the name "CAM Council" a suitable name for a shared Council? If you do not agree, what alternative name would you suggest?

As we have already said, we disagree with the idea of a CAM Council.

Many feel that the 'Complementary and Alternative' designation is now becoming obsolete. There is a view that this is an unhelpful title in the broader climate of integrated healthcare, since it reinforces artificial divisions between styles and systems of treatment and creates barriers to effective collaboration.

We have already stated our preference for a General Acupuncture Council as our preferred option. Our preferred name for the form of shared council we support as an alternative is the 'Acupuncture and Herbal Medicine Council.'

Q5: Do you agree that a CAM Council should be capable of being extended to other unregulated CAM professions, where this is considered necessary in order to ensure patient and public protection?

In our answer to question 3, we have indicated that we disagree with the idea of a CAM Council. We are not aware of any other CAM therapies likely to have yet reached the stage where SSR is the next step forward, and among those most

likely to achieve sufficient professional unification none that present a significant risk to patients and public. We cannot, therefore, see the logic of creating an open-ended structure at this stage.

We do believe, however, that either a General Acupuncture Council or an Acupuncture and Herbal Medicine Council might provide important insights into and tests of the structures necessary to support collaborative regulation, and could envisage either being used as a template for other therapies sharing similar professional infrastructures and scope of practice.

Q6: Do you agree with the suggested titles listed in paragraph 31? If you do not agree, what alternative titles would you suggest?

We agree with the logic of creating a single simple title rather than a composite title with the word 'registered' which could leave the broader title of 'acupuncturist' free for general use. We also believe that many members of the public would not understand the difference and would regard the word 'acupuncturist' as the relevant and important element.

However, we have great difficulties with the use of the title 'Traditional Chinese Medicine practitioner' as a primary regulatory title. The titles 'acupuncturist' and 'herbal practitioner' describe general and clearly definable activities, whereas the title 'TCM practitioner' describes a specific modality for which there is no commonly agreed definition. We are concerned that such a title may not be able to be sufficiently well defined to be included within formal legislation and may not facilitate public understanding. We are aware, for example, that the term 'TCM' is used interchangeably to describe a specific style of practice developed in China in the 1950's, a specific combination of five disciplines (acupuncture, herbal medicine, dietetics, tui na and qi gong), and, as a broad descriptor, any system of medicine whose roots can be traced back to classical Chinese medical texts. We also have concerns that other traditions using both acupuncture and herbal medicine would have an equal claim for parity of separate legal title, and do not believe that the potential proliferation of primary titles would serve the public interest.

We believe that there should be two registers, one for acupuncture and one for herbal medicine, and one primary title to accompany each. We feel that there may be other ways by which the TCM, Ayurvedic, Tibetan or Japanese Medicine practitioners who use both herbs and acupuncture may be identified through the registers to allow people to make informed choices, and similar ways of reducing the costs of dual registration within a joint council. However, we also believe that a practitioner using both acupuncture and herbal medicine disciplines should achieve the same standards for each discipline as those using it as their sole modality.

Q7: Do you agree with the suggested subsidiary designations listed in paragraph 33? If you do not agree, what alternative subsidiary designations would you suggest?

We do not believe that creating a list such as this by statute is necessary. If anything, this directly contradicts the logic for using the title 'acupuncturist' rather than 'registered acupuncturist', namely that of not wanting to confuse the public. We believe that all acupuncturists and herbal practitioners should be capable of providing an equivalent level of practice whatever their style or training background, and that the public could not be made sufficiently aware of the differences to make sense of such a wide range of options.

We believe, however, that the registers should enable prospective patients to be able to identify particular training backgrounds and preferred styles of treatment, if they so choose. There should also be advice from the regulator about acceptable ways in which people can advertise what they do under the general heading of acupuncturist or herbal medicine practitioner.

Q8: Do you agree with the duties of the new Council set out in paragraphs 35 and 36?

We support the duties listed in paragraphs 35 and 36.

However paragraph 36 above is a cause for concern for us. The HMRWG Report also addressed in its terms of reference the overhauling of Section 12 of the Medicines Act 1968 and the impact of the EU Traditional Medicines Directive. As is quite clear from the parallel consultation by the Medicines and Healthcare products Regulatory Agency (MHRA), this may involve a long-term commitment to a system for keeping herbal medicine practitioners up to date with developments in the safety of herbal medicine and EC legislation.

Although we have been assured by the herbal medicine associations that a great deal of this expense will be incurred by other statutory agencies, we still have concerns that as acupuncturists we could be unfairly, in our view, sharing the costs of maintaining the safety of herbal medicine. As we have already noted, however, if the acupuncture and herbal professions were linked through a joint council with profession-specific elements, charges specific to either modality could be assigned appropriately.

Q9: Do you agree with the proposed composition of the CAM Council set out in paragraph 40? If you do not agree, please suggest an alternative.

We do not support the idea of a CAM Council and do not, therefore, agree with this proposed composition. Although we disagree with the overall structure being proposed, we do feel, however, that we should make our comments known about what we perceive to be weaknesses in the proposals.

As a general comment, we do not believe that the principle of ‘one person from every group on every committee’ is consistent with good governance. The presence of a representative of a group on a governing body is only one of many ways in which the views of constituent professions can be sought and heard. In our experience the primary role of governance for committee members over-rides partisan concerns, both in abstract principle and in reality. If seen as a safeguard, therefore, it is unlikely to be effective, and has the unwanted consequence of increasing the size of committees and their associated costs.

We have grave reservations about the disproportionate influence of small groups through the egalitarian way of assigning seats on the proposed Council. The smaller organizations, for example, have fewer than 100 members, and a representative from a much smaller group could wield a disproportionate amount of influence. A member from a smaller group might be more likely to act as a representative, thereby potentially undermining the primary role of governance by Council members, rather than sectional representation, to which most regulators adhere.

We also cannot support setting an upper limit on the number of practitioner members in the face of potentially unlimited expansion. This is not our preferred option for the regulation of the acupuncture profession, but even if it were we would be alarmed at the prospect that new member professions would gradually absorb all of the non-allocated places and leave each profession, irrespective of scope and structure, represented by a single person on a council of 26. We do not believe that could be properly described as the statutory regulation of the acupuncture profession.

In the existing proposals we do, however, support the fact that there should be a majority of practitioners over lay members on the Governing Council, the fact that the four UK countries are represented, and that there are two educationalists on the Council. We also feel that at least one member of the Council should have a background in public or financial administration.

One point of concern for us, however, is the statement about the lay members potentially being drawn from other health and social care professions. This creates the very real possibility that orthodox western medical professionals could in theory represent a block vote of almost half of the Council membership. We believe that lay representation is equally well served by people of broad ranging skills and backgrounds, and would prefer to see this made more explicit in the final proposals. We would especially favour a specific mention of representation for patient support groups and consumer groups.

Q10: Would it be possible for the herbal medicine traditions of Kampo and Tibetan herbal medicine to be individually represented on Council? Should any other herbal medicine or acupuncture traditions be individually represented on Council?

We do not believe that it is appropriate for all organizations which are sub-divisions of the registers to be individually represented. Individual traditions have for many years, for example, been successfully regulated and protected within the BAcC without the need for specific representation on committees. We believe that there may be more effective ways of ensuring that smaller groups can be protected and represented without the need to expand the committees in this way.

Q11: Do you agree with the term of office and method of appointment of Council members proposed in paragraph 42?

Although we disagree with the proposed CAM Council, we agree with the proposed appointment system in the initial stages of the Council with the proviso that there is adequate consultation with the profession(s) on the initial appointments. We also endorse the transition to direct elections by registrants after the first places on the Council become vacant.

Q12: Do you agree with Health Departments' proposals for collaborative regulation described in paragraphs 49 to 51?

We do not agree with the proposals for collaborative regulation in these paragraphs.

We have very great concerns over the divisions between practitioners of acupuncture that this will create. The House of Lords Select Committee Report recommended that there should be a single legal register and that the use of acupuncture by those already statutorily regulated should be to the same standards as those set by the regulatory body for primary registrants. These proposals undermine this conclusion on both counts, by separating practitioners into two groups, those using title and those using technique, and by equating the standards of those regulated already with the CPD scheme of the acupuncture regulator.

In our view the expressed fear about regulatory confusion is unfounded. Fitness to practise issues, while important, mainly concern generic areas of professional behaviour rather than technical issues about the modality, and are relatively infrequent. The need for trans-regulatory communication is likely to be relatively small, and the burden of explanation to members of the public equally light. In our experience the public are less concerned about who takes action than the fact that effective action is being taken.

By contrast, the effort involved in creating standards for trans-regulatory agreements on training and standards of competence is considerable, and we do not have great confidence that the current situation, where a registrant is usually required to take personal responsibility for ensuring that they are adequately

trained, will be much different. The probable perpetuation of this existing system would not, in our view, satisfy the requirements for meeting concerns about public safety, and we do not believe that the single line in the current proposals pointing to as yet unrealized systems is sufficient basis for sustaining the argument against dual registration.

We believe, therefore, that the lack of a single register will create confusion on a daily basis. In short, we believe that there are advantages to continuing to explore further the regulation of all acupuncturists under one Council or Committee as a means of maintaining overall standards, and do not support these proposals. We have also made the point earlier that we believe this strategy is itself an important and innovative example of collaborative regulation.

We note in passing that the concept of dual registration and regulation raises several issues about the potential hierarchy of regulators. There are many orthodox western health professionals who practise osteopathy, chiropractic, acupuncture and herbal medicine, and many in these groups who are currently dual registered. It is not clear to us whether registrants could themselves choose with which of the possible regulators they would register, or whether some regulators are 'more equal than others' and could require registration in order to practise the discipline. We do not believe the consequences of this policy have as yet been fully explored.

We also understand that discussions are taking place in anticipation of the publication of the Shipman Report about the creation of a common statutory conduct machinery for all statutorily regulated healthcare professionals. If this is the case it further undermines the argument about confusion cited in the Consultation Document. We believe, therefore, that this proposal needs to be reviewed and that the dual/multiple registration of practitioners be allowed in the interests of clarity and safety for patients.

Q13: Do you agree that the Council should be free to establish additional committees as it considers appropriate?

We agree that the Council should be free to create new committees as it sees fit.

We would particularly recommend the creation of a specific Safety Committee. Not only was safety a primary factor in the case for SSR for these two professions, but also standards of safe practice are being continually updated. We believe that a standing safety committee with appropriate expertise should be convened at least annually to review the standards in use.

Q14: What are your views on the composition of the Education and Training Committee? What numbers of lay and practitioner members are appropriate? Should the Chair be a lay Chair or a practitioner Chair?

We support the appointment of a lay Chair for this committee, and also support a majority of lay members and educationalists as an independent guarantee of standards. We apply the same caveat here as in our response to question 9 inasmuch as we have concerns about the possibility that the lay representation could consist solely of healthcare professionals from within the orthodox healthcare system. We believe that broader representation should be made explicit.

We are concerned about the breadth of the roles envisaged for this committee. From our own experience of providing accreditation, setting educational standards, registration, and a CPD programme, we do not think that it is possible to provide an equivalent level of service to that which we currently offer from the quoted registration fee of £262; either the service would have to diminish or the costs would rise. We believe that the Health Departments are equally committed to high standards, but need to be aware that excellence comes at a considerably greater cost than those mentioned in the Consultation Document.

The proposal also says ‘some or all’ of these functions might belong to this committee, with no indication, if the answer is ‘some’, where else this service might be provided. We suspect that this role would fall to the professional associations, and draw the Department’s attention to the crucial relationship between the cost of registration and the level of continuing support for the professional associations if these are intended to provide a necessary component of the educational and professional infrastructure.

We repeat our earlier comment that we do not believe the ‘one of every group on every committee’ is a good principle of governance. In the interests of cost-effective regulation and registration we would recommend that this committee is maintained at the minimum level of members consistent with effective governance in matters of education and training. We also believe that the new Council(s), whatever form it/they take, should find a positive and continuing role for existing education, training and accreditation arrangements.

Q15: Do you consider it appropriate for the CAM Council to establish a Registration Committee, or do you think that matters relating to registration should be addressed by the Education and Training Committee?

We believe, based on our own experience, that a Registration Committee will certainly be necessary for the first few years of the Register, however constituted, to deal with the likely range of ‘exceptions’ cases and establish the appropriate precedent rulings for future practice. There are also several matters relating to health and professional conduct which extend beyond the remit of the Education Committee alone.

Q16: Do you agree that the holding of an accredited qualification should enable herbal medicine and acupuncture practitioners to apply for automatic registration with the CAM Council?

We agree that a qualification from an accredited programme should be the primary factor in awarding automatic entry to the Register. However, we also believe that there are additional factors relating to health, safe practice and professional conduct which are not entirely within the province of the teaching institution awarding a qualification, and that some allowance needs to be made for this in the entry procedures.

Q17: Do you agree that practitioners who do not hold an accredited qualification should be individually assessed for entry on to the Register?

We agree that this should always be the case.

.Q18: Do you agree that a core curriculum, with elements that are specific to traditional acupuncture and Western medical acupuncture, should be developed for acupuncture, or should we move in the direction of National Occupational Standards?

We do not understand the rationale of this question. The two options mentioned, National Occupational Standards (NOS) and core curriculum, are not mutually exclusive.

National Professional Standards (our preferred title for NOS in line with the Herbal Medicine NPS) will define the outcome standards expected of an acupuncture practitioner capable of independent practice. The process of writing these will explore the possibility of extracting enough common elements from the western medical acupuncture (WMA) and traditional acupuncture professions to create a core curriculum.

Q19: Do you agree with the proposed arrangements for assessing overseas-qualified herbal medicine and acupuncture practitioners for entry on to the Register?

We support the proposed arrangements. It is vitally important in the definition of ‘capable of independent practice’ that someone is able to understand fully what is being said to them about medical conditions, especially in relation to medications, and is also able to keep up to date with professional requirements and maintain good communication with other health professionals.

Q20: Do you support the proposed groups of practitioners who would be eligible to join the Register through a grandparenting scheme?

We support the groups identified in the proposals but need to point out that there are people who will qualify in the year before the 'window' opens and who will not meet the 'three from five' test within the transitional phase. This will be of particular concern to students beginning their training in the next year or two. There will also be others who will graduate before the transitional window opens but will not meet the 'three years from five' criterion until the later stages of the 'window.'

We believe that there should be other criteria in place to provide limited exemption from this criterion for those who, had they graduated from the same institution a year later, would be automatic entrants to the register.

Q21: Do you agree with the proposed two-year transitional period for the registration of existing practitioners on to the new Register?

We support the idea of a two-year transitional 'window'; any less than this will not allow time to process all of the applications, and any more will create a climate of uncertainty as provisional registration carries on for years.

Disappointingly, however, there is no mention in this section of consultation on the methods of processing applications or description of the process and cost of identifying what counts as safe, legal and effective practice. The Consultation Document talks of comparable standards of training, but not how this would be assessed. The Consultation Document also talks of the time served criterion as 'three from the last five years or part time equivalent', a concept which we have struggled to understand.

Both Working Groups went into considerable detail on the issue of grandparenting arrangements, and both agreed that 'three years from five' would only be a part of the requirement and that there should be a 'hurdle' of some sorts to filter out those who do not meet the agreed standards. Given the focus on this aspect of the transitional arrangements in the opening of new registers in the last decade, the failure to consult on these issues seems to us an oversight that may need to be addressed urgently in the process of creating the new regulatory body.

Q22: Do you agree that the standards of proficiency maintained by the CAM Council should take account of the National Professional Standards for herbal medicine and any future National Occupational Standards for acupuncture?

We agree with this proposal whatever form the regulatory body may take, but feel that 'take account of' is not the same as 'directly informed by' and would wish to see a stronger statement of intent and linkage.

Q23: Do you agree that the CAM Council should develop and publish codes of conduct for herbal medicine and acupuncture practitioners?

We believe that the governing body of any regulator should develop its own Codes of Practice and Professional Conduct and would add that profession-specific Codes of Safe Practice would strike us as an absolute prerequisite for both professions.

Q24: Do you agree that the CAM Council should be responsible for determining CPD requirements for herbal medicine and acupuncture practitioners?

As with the previous question, we agree not only with the idea that any profession-specific Council should be responsible for determining the CPD requirements for its own registrants, but also believe that it should be responsible for setting the standards and **owning** the CPD process in its entirety through its educational infrastructure.

Q25: Do you support the fitness to practise schemes proposed by the working groups, or do you prefer the GMC's model?
Q26a: (If you prefer the fitness to practise model proposed by the working groups.) What are your views on the composition of the fitness to practise committees? What numbers of lay and practitioner members are appropriate? Should the Chair be a lay Chair or a practitioner Chair?
Q26b: (If you prefer the fitness to practise model consulted on by the GMC.) What are your views on the composition of the Investigating Committee and adjudication panel?

We are answering these three questions together.

The consultation process for the new GMC procedures only finished in October 2003, and we are not yet fully aware of their outcome. We are clearly, therefore, not in a position to be able to offer any definitive views on whether this should be preferred as an alternative to the proposals from both working groups. Were our answer to **Question 25** to be that the Working Group model is preferred, we would support a lay chair and equal numbers of practitioners and lay members.

We take the view that far from favouring practitioners, peer judgment is often harsh and reflects practitioners' concerns about professional colleagues letting the profession down. However, we also recognize that the majority of issues involving professional conduct are generic rather than profession-specific, and mainly deal with patient management and issues about professional boundaries. We are also aware that in other collaborative regulatory structures such as the Health Professions Council the generic conduct procedures have benefited greatly from cross-professional committees. We believe, therefore, that the equal balance of practitioner and lay members offers the best combination of skills to address the likely caseload.

We are aware that there is a developing policy in the sector towards establishing generic 'fitness to practise' committees covering all aspects of a practitioner's health and conduct. We have some concerns that this may lead to health

problems being seen as a disciplinary matter because they are dealt with by the same investigating machinery. We would recommend that any system for dealing with health issues should be applied sensitively and with a view to recovery and rehabilitation, with the possibility of disciplinary action only being raised where someone willfully ignores advice and puts themselves or their patients at risk.

Q27: Do you agree with the suggested sanctions for use in fitness to practise cases?

We agree with the sanctions as listed, but would add admonishments/cautions and fines. Not all breaches of conduct warrant conditions placed on registration. We would add fines because we believe that there may well be occasions where a fine would be entirely appropriate for someone making profits by behaving unethically in breach of the Codes. Refusal to pay, the usual difficulty mentioned, could lead to being struck off, and with a statutory register this may have sufficient force to ensure compliance.

Q28: Do you agree that an appeals tribunal should be constituted by the CAM Council to consider appeals relating to registration or renewal of registration?

We agree that the governing body of any regulator should convene appeals tribunals where these are necessary.

Q29: Do you agree with the creation of a formal working group to help prepare for the establishment of the first CAM Council?

We fully support this proposal, however the regulatory body is constituted, and we would like to see a strong and experienced chair, either with first hand knowledge of the pre-regulatory process or with a clear understanding of the profession(s) being regulated, and preferably both.

We believe that this is perhaps the most critical aspect of the proposals. We know even at this stage that the final shape of regulation will leave significant minorities discontented and frustrated, and the transitional period is likely to be turbulent. Unless this is handled well, the regulator may lose credibility before the register even opens.

Conclusion

We have considered carefully the proposals in the Department's Consultation Document, and do not support the proposal for a CAM Council. We do not believe that there is a pressing need to develop an open-ended regulatory structure for the acupuncture and herbal medicine professions. We also believe that the current proposals represent something of a hybrid form, neither lean enough to deal only with the key registration and generic regulatory structures, nor comprehensive enough to support fully the individual traditions being subsumed in the regulator under the banner of the two main professions.

We have counter-proposed two options. First is a General Acupuncture Council, based on the current majority view expressed in feedback from our members. This is accompanied by strongly held views about the need for high educational standards and the preservation of the work and professional standards which the BAcC has developed over the last decade. We believe that the manner in which this Council could create an effective regulator for all uses of acupuncture would itself be an innovative form of collaborative regulation and guarantee the public safety sought from statutory regulation.

Our alternative proposal is a joint Acupuncture and Herbal Medicine Council with a governing body drawn from both professions. We have also proposed that the council has two registers directly linked to two committees, possibly statutory, for acupuncture and herbal medicine. These committees, which will have an integral role in the setting of educational standards, will also act as a focus and forum for the development and maintenance of individual styles and traditions, and will be able to establish separate sub-committees for as many traditions as each chooses within their area of responsibility.

We are very concerned that the cost of regulation will undermine the professional associations which are vital to the success of the regulatory partnership as well as to the preservation of individual styles and traditions. We believe that the creation of representative committees is unnecessary, costly and potentially divisive. We also believe that acupuncture and herbal medicine are likely to be the only two CAM professions for which SSR is thought essential for at least another five years. With either of our two preferred options, if some of the key functions which the professional associations now undertake could be retained in the regulatory framework, we believe that the infrastructure necessary to deliver the core regulatory functions could be pared down without loss of effectiveness.

We do not believe that this is far from that which the Department is currently proposing. We believe that the key adjustments are the reduction in the size and complexity of the committee structures and the acknowledgement of the importance of the role of professional associations in delivering effective statutory regulation. We believe that this reflects the concepts underlying the creation of

the Health Professions Council, and as such could draw on the experience of this body's development in order to inform its work.

We commend these proposals to the Department and offer our continued support in reaching an effective solution to the statutory regulation of the acupuncture and herbal medicine professions.